Summary: The Child Safeguarding Practice Review Panel

Annual Report 2022/23 - Patterns in practice, key messages and 2023/24 work programme

The Child Safeguarding Practice Review Panel (the Panel) is responsible for commissioning and overseeing national and local reviews of serious child safeguarding cases to improve learning, professional practice and outcomes for children in England.

This is the fourth annual report from the independent Child Safeguarding Practice Review Panel. It captures evidence and learning from: **Serious incident notifications (SINs)** that progressed to a rapid review; data from **rapid reviews**; data from **local child safeguarding practice reviews (LCSPRs)**; **thematic reports** and letters from the Panel to safeguarding partnerships, used to assess the quality of rapid reviews.

Context, change and challenges

The Panel identified four current 'critical issues' which can impact the safeguarding and child protection system's ability to help and protect children:

- Services' capacity to assess, help and protect the increased numbers of children suffering mental and emotional health challenges, particularly since the COVID19 pandemic.
- The suitability and sufficiency of placements and quality of care provided for children looked after by local authorities.
- Challenges in workforce recruitment and retention, particularly in children's social care and health visiting.
- Significant pressure on preventative and early help support services due to resources being reduced over several years.

The Panel also found that safeguarding partners and the government need to make sure that the impact of different policy changes is clear in day-to-day practice. Practitioners need the time and training to integrate changes into practice.

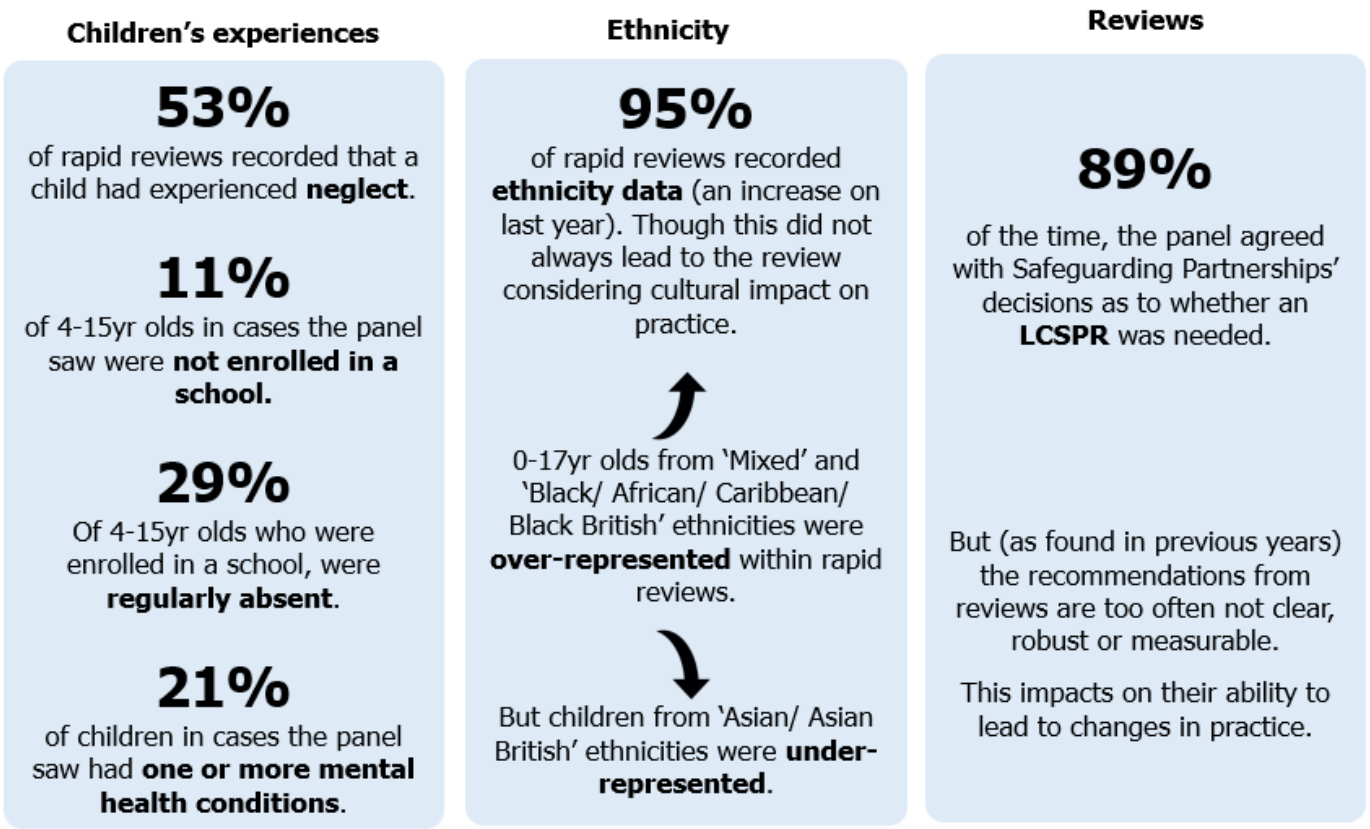
Some ongoing challenges within safeguarding practice are hard to solve through policy and procedural changes. The Panel saw increasing evidence of learning reviews looking at why certain practice issues keep resurfacing, but more work is needed.

A window on the system:

The annual report considers data over a 15-month period – from January 2022 to March 2023 (the revised period of analysis is to inform reporting aligned to the financial year). More specifically, it focusses on the period between April 2022 and March 2023, and observes that the Panel received **393** serious incident notifications, of which 146 (37%) related to child deaths and 227 (58%) concerned incidents where children had suffered serious harm.

Analysis shows that in over three-quarters of cases reviewed, the family of the child was known to children's social care, and a third of children were either on, or had previously been on, a child

protection plan. In addition, nearly a fifth of children were being 'looked after' by the local authority, either at the time of the incident or prior to it. 21% of children were reported to have a mental health condition.



The report also considers the impact of contextual factors affecting the lives of children and Safeguarding practice. It looks at the quality of reporting and reviews and highlights how the quality of reviews continues to improve, though they need greater focus on 'why' particular practice problems occurred.

Practice themes to make a difference:

The Panel's 2021 annual report highlighted 6 *practice themes to make a difference* in reducing serious harm and preventing child deaths caused by abuse and neglect. These themes continue to be seen in rapid reviews and LCSCRs and remain relevant, despite some good practice being identified.

The report reflects in some depth on those six key themes (summary below):

Effective leadership and culture supporting critical thinking and professional challenge.

- ❑ Limited commentary and assessment about leadership and culture. Some cases where practitioners would have benefited from more time, resources, and training to gain knowledge, skill, or confidence in relation to different aspects of child protection work, and in working in a multi-agency context.
- ❑ Earlier intervention by senior or middle managers in complex or long-standing cases might have resolved blockages and facilitated necessary action sooner for children and families.
- ❑ A weak translation of learning into practice, with previously identified learning not always leading to significant changes in practice and approach.
- ❑ Continued lack of professional challenge between colleagues and between agencies as well as concerns not always being escalated where there was disagreement between agencies.

- ❑ This lack of professional challenge between colleagues and agencies reflects the need for senior leaders to help foster an environment for safe professional challenge within multi-agency child protection work.

Giving central consideration to racial, ethnic, and cultural identity and the impact on the lived experiences of children and families

- ❑ Race, ethnicity and culture and their importance for understanding the lived experience of children are not always being explored within reviews
- ❑ some examples of good practice that demonstrate how some practitioners are making these issues much more central to their work.
- ❑ Important that the Panel, safeguarding partners and other stakeholders continue to develop and enhance our understanding about the impact of race, racism, ethnicity and culture on both the lives of children and families and how agencies, individually and together, design and deliver services to help and protect children.

The importance of a whole family approach to risk assessment and support

- ❑ Absence of a whole family approach was evident with services often focused on one specific family member, most often the mother or the child who was the focus of the review.
- ❑ The vulnerabilities of other family members were not routinely recognised or included in assessments, nor was the impact of these vulnerabilities within the household always considered.
- ❑ 'Silo' working in individual agencies at times led to missed opportunities for partnership relationship building and more effective co-ordinated multi-agency responses.
- ❑ Importantly, while the child should be the focus of child protection activity some reviews continued to show that the voices of children themselves were absent from service records.

Recognising and responding to the vulnerability of babies

- ❑ Most prominent issues that emerged centred on the challenges practitioners face when exploring the vulnerability of babies with parents and wider family, and whether and how they recognise contextual factors, such as parental mental health and trauma, when assessing risk to babies.
- ❑ Challenges in information gathering and sharing was also prevalent, relating to information both within and between agencies.
- ❑ Continues to be a real need for practitioners to fully consider any potential risk to children from fathers, any new partners of parents, or other adults with close and regular contact with the family, regardless of sex, gender, or sexuality.

Domestic abuse and harm to children

- ❑ Limited understanding of domestic abuse among practitioners, which is affecting their ability to respond in a timely and appropriate way.
- ❑ In cases where parents have co-parenting responsibilities, there tended to be a focus on removing the perpetrator without considering whether this may in some regard be harmful for the children, particularly if the perpetrator may also have a protective role in their care.
- ❑ Opportunities to identify and respond to domestic abuse were sometimes being missed.
- ❑ Limitations in information sharing meant that key agencies were not always aware of domestic abuse within families where they may have had important information to share or a role to play.

Keeping a focus on risks outside the family

- ❑ Practitioners focusing on a child's behaviour which challenges rather than seeing this as a potential sign of child exploitation.

- ❑ Focusing on behaviour links closely to previously identified issues around a lack of professional curiosity where services have undertaken assessments with a narrow focus.
- ❑ Complexity of the transition or crossover between 'exploited-exploiter' and the overlap between victim and perpetrator was not fully recognised, understood or explored by professionals.
- ❑ Practitioners and systems often overlooked the intersectionality of different vulnerabilities experienced by children that increased their potential for exploitation and risk outside the family.
- ❑ Missed opportunities to address known risks outside the family on a multi-agency basis, impacting the potential for a more comprehensive response.

Six emerging themes are also introduced. These relate primarily to specific groups of children and families:

Parenting capacity and children with disabilities and health needs.

- ❑ Themes relating to parenting capacity of children with these types of needs, and how these can be compromised by ecological factors.
- ❑ Where practitioners' primary focus is on the child's health condition or needs, there is a risk that abuse and neglect go unnoticed.

Children with complex mental health needs.

- ❑ High prevalence of mental health conditions for teenagers identifying as being LGBTQ+ and those recorded as having a gender identity different to the sex registered at birth or being non-binary.
- ❑ Significant proportion of teenagers with reported mental health conditions were also recorded as experiencing alcohol and/or substance misuse.
- ❑ Suicide a cause of death for nearly half of those teenagers with mental health conditions who had died, and all of whom were known at the time or previously to Child and Adolescent Mental Health Services.

Parental mental health and parenting capacity.

- ❑ Could be overlooked, highlighting a need for practitioners to assess parents' awareness of their child's needs.
- ❑ When parental mental health is not fully considered services can also overlook the viability and practicality of parenting arrangements and safety plans.
- ❑ Parents struggling to meet the expectations within plans can then be framed as neglectful rather than as evidence of parents feeling that the demands of them from some agencies are overwhelming.

Children not in school.

- ❑ Difficulties with a lack of suitable placements and support for children with complex needs and stretched resources within special educational needs services.
- ❑ Too many children spend long periods of time outside of formal education as a result. It is during these periods that some children have died or experience serious harm.

Young carers.

- ❑ Agencies are not always recognising this role for children and the impact this has upon them.
- ❑ Children can be providing crucial support for their parents or other adults, sometimes where they have substance misuse problems, mental health needs or where domestic abuse is present, all which impact on their own capacity to support their children.

Working with Gypsy, Roma and Traveller communities.

- ❑ The importance of exploring the impact of cultural identity and community factors on individual children and families.
- ❑ Cultural barriers could mean that traditions and parenting approaches of Gypsies, Roma and Travellers, as well as those of other ethnic and cultural groups, were not always understood by services and their impact rarely assessed or analysed.

National reviews and thematic analysis

The Panel considered three important cross-cutting themes that have surfaced from our own national and thematic reviews undertaken in 2022 and continue to be observed in rapid review and LCSPR data presented in this annual report.

These themes are:

Knowing what life is like for children..

1. highlighting the centrality of children's voices and experience, and those of their parents, carers, and wider family members,
2. but also the knowledge, skill and confidence required to build a full picture of children's lives to enable the best safeguarding, support and protection.

Information sharing and seeking..

1. which is a perennial issue in child protection and safeguarding work.
2. Issues in this area undermine the ability of practitioners and agencies to have a full and accurate understanding of what is happening in children and families' lives, including any risks of harm.

Working across agency boundaries..

1. on which information sharing is reliant and which is essential for building holistic pictures of children's lives.

The Panel at work and future priorities for the work programme

The Panel plays a key role in the child protection and safeguarding system through:

- its role in **system oversight** of national and local reviews and how effectively it is operating;
- in **system learning**, by identifying and overseeing the review of serious child safeguarding cases which raise issues that are complex or of national importance;
- in '**ystem leadership** through identifying improvements to practice and protecting children from harm.

The Panel will continue to deliver its core work in oversight of the system and continue to build on

engagement with safeguarding partners to share practice and disseminate learning and will also be commissioning work to evaluate its impact.

Additionally, the Panel:

- ❑ have commissioned ***2 new national reviews*** in 2023, one on child sexual abuse in the family environment and one following the death of Baby M
- ❑ are undertaking ***2 thematic analyses*** in 2024, one on neglect and the other on race, culture, and racism, to support the tackling of perennial issues
- ❑ will ***strengthen relationships with safeguarding partners*** to maximise the impact of learning from safeguarding reviews, supported by delivery of a new learning support project
- ❑ will continue to use its unique position to ***influence important stakeholders*** to secure improvements in the multi-agency child protection system including through its contribution to the design and delivery of the Families First for Children pathfinder pilot project

Conclusion

The report concludes with a series of reflective questions for safeguarding leaders to support their work in enabling high standards of safeguarding practice and making sure that learning reviews drive longer term change to help and protect children. **These questions are organised around 6 key strategic themes:**

Culture:	❑creating an inclusive culture where professional challenge is promoted.
Clear partnership intent:	❑ensuring clear and balanced partnership working.
Strategy to delivery:	❑ensuring strategy is carried through to frontline practice.
Assessing effectiveness:	❑evaluating impact of the safeguarding system.
Getting upstream:	❑ensuring learning feeds into prevention, early intervention and the commissioning of services.
Workforce:	❑working together effectively across agencies and promoting development.

The reflective questions are included at appendix 1

Things to consider:

1. The themes highlighted are similar to those we are seeing in our practice reviews - *Any new learning for us? How can we share the learning across the partnership workforce? Briefings? Training/workshops? Link with Practice Learning Group*.
2. Reflective questions have been formulated to help safeguarding partnerships consider how best to embed learning, and to sustain changes and improvements in their local safeguarding system – *Do we want to use these to seek assurance? if so, what would be the best way to do this?*
3. *Anything else?*

Appendix 1: Reflective questions for safeguarding leaders

The following questions have been formulated to help safeguarding partnerships consider how best to embed learning, and to sustain changes and improvements in their local safeguarding system.

1. Culture	Assurance / response	Any actions?
a) Is there an understanding across multi agency leadership of the different contexts, responsibilities, and operating challenges across partners?	❑	❑
b) How do you role model behaviours that create an inclusive culture where diversity is understood, and multi-agency and multi-disciplinary working is celebrated?	❑	❑
c) How do you role model a culture of professional challenge, including questioning one another's assumptions, and be seen to resolve difference of opinion in a restorative and respectful way?	❑	❑

2. Clear partnership intent	Assurance / response	Any actions?
a) Has a clear and balanced partnership intent developed from assessment of local need and threat, in addition to shared understanding of each other's contexts, responsibilities and challenges?	❑	❑
b) Is there clear evidence that responsibilities are shared and equal?	❑	❑
c) Is there the right support, challenge, and accountability across agencies so that everyone can be more ambitious in achieving the goal of seeing families thrive, and understand the impact of their services?	❑	❑

3. Strategy to delivery	Assurance / response	Any actions?
a) Does the strategy get informed by and contribute to front line practice?	❑	❑
b) Is there evidence of a data strategy and investment in joint analysis and audit, which supports delivery of the strategy to be effectively reviewed, issues and good practice to be escalated and monitoring for new threats?	❑	❑

4. Assessing effectiveness	Assurance / response	Any actions?
a) How do you know what you are doing is effective?	❑	❑

b) How are independent scrutiny, audit, local and national practice reviews, and inspections being used to assess impact of the arrangements to the benefit of children and families, as well as the strength of local leadership?	❑	❑
c) How is the voice of children and families experiencing the multi-agency systems utilised in the design and delivery of local arrangements? This should include information sharing and decision making, organising referral pathways, delivering services and support.	❑	❑

5. Getting upstream	Assurance / response	Any actions?
a) How do you use learning to focus efforts on prevention and early intervention, providing help and support to meet the needs of children as soon as problems emerge?	❑	❑
b) How does this feed into wider analytical assessments to inform service commissioning?	❑	❑
c) How do you use horizon scanning as a partnership and respond based on this? This can include consideration of thresholds documents, design of referral pathways and services.	❑	❑

6. Workforce	Assurance / response	Any actions?
a) How do you work together across agency on shared issues related to the workforce?	❑	❑
b) How is multi-agency training commissioned, delivered and monitored for impact? How does learning from reviews/audits/inspections feed into training priorities? How do you undertake any multi-agency and interagency audits?	❑	❑
c) Do you have a recruitment and retention strategy? How do you develop strategic leads and ensure leadership maturity? How do you support recruitment using safe working practices?	❑	❑
d) How do you ensure capacity for workforce to engage in peer-learning and knowledge-exchange, peer-audit, group/individual supervision, and observation and promote staff welfare?	❑	❑