The Child Safeguarding Practice Review Panel: Annual report 2018 to 2019

A summary of key messages from rapid reviews that were submitted by local safeguarding partnerships in England during 2018-2019.

March 2020

Background to the report

The Child Safeguarding Practice Review Panel was established under the Children and Social Work Act 2017 and became operational in June 2018. They are responsible for identifying and overseeing the review of serious child safeguarding cases that raise issues of complex or national importance in England.

Following a serious safeguarding incident, local safeguarding partners are required to submit a rapid review to the Panel within 15 working days. This should set out, in detail, the circumstances of the event.

› Find out more about the case review process in each UK nation at **nspcc.org.uk/casereviews**

This is the Panel's first annual report (Child Safeguarding Practice Review Panel, 2020a). It was published alongside:

- The Child Safeguarding Practice Review Panel's report on safeguarding children at risk from criminal exploitation (Child Safeguarding Practice Review Panel, 2020b).

- The Department for Education's triennial analysis of serious case reviews 2014-2017 (Department for Education (DfE), 2020).

Report findings

The annual report highlights the messages from 538 rapid reviews that were reviewed by the Child Safeguarding Practice Review Panel from July 2018 to December 2019. It shares key learning that safeguarding partners and government departments should consider for further action and sets out the Panel's priorities for 2020.

The children in these reviews

The report shares information about the children who died or were seriously harmed.

- 27% of the rapid reviews involved the death or serious harm of a child under 1-year-old due to non-accidental injury.
- In 54% of the cases children's social care services were working with children and families at the time of the incident.
- In 13% of cases children were on a child protection plan and in 15% of cases children were in care at the time of the incident.
- 46% of children who died or were seriously harmed were not known to children's social care.

Key practice themes and messages

The Panel highlighted the practice messages which they think safeguarding partners and government departments should consider for further action.

Optimistic thinking

Optimism bias is a long-standing concern that permeates every level of practice. In 32% of the rapid reviews, the Panel identified overly optimistic practice decisions.

Information sharing, risk assessment and decision making

Weak risk assessment and poor decision making were identified as an area of concern in 41% of the rapid reviews received. Poor information exchange at critical points between agencies was present in 40% of rapid reviews.

Children returned home post court proceedings

In 49 rapid reviews children had previously been subject to public care proceedings because of concerns about significant harm. In 36 cases, children had been permanently removed from their parents, but their subsequent siblings were not returned to court for protection because professionals thought parents had changed.

Adults with a history of offending

The Panel were troubled by some parents' levels of criminal activity and the violence witnessed or experienced by children.

People with a history of child abuse, including some who had been convicted, were not tracked sufficiently well. New relationships were not explored properly to establish whether someone with a history of child abuse was in a relationship and/or living with children.

Domestic abuse

Domestic abuse was a recognised feature of life for 35% of children notified to the Panel. In some cases, risks to children were assumed to reduce after parents attended a domestic abuse programme (attendance in itself was considered to be a protective factor). Professionals sometimes misunderstood or minimised the presence of coercive control within adult relationships in the family.

Adolescents: autism, mental health and suicide

The Panel received several rapid reviews involving extremely vulnerable young people with a history of self-harm, overdoses or other longstanding or historical mental ill health. For some young people this was exacerbated by a history of abuse; others also had a diagnosis of autism. Professionals seemed on some occasions not to be able to hear what the young person was saying.

In 80 rapid reviews, children were in care at the time of their death or at the point they were seriously harmed. The Panel saw examples of risk to the young person quickly escalating once in care.

Including men

The primary focus of health professionals and social workers continues to be on the needs, circumstances and perspectives of the mother. This is the case even in relationships where the mother's partner has a major role in looking after the children. A lack of professional curiosity about fathers and partners can leave women and children vulnerable. It can also leave fathers feeling alienated and forgotten, and dismisses their role in bringing up the children.

Health plans for children

Some of the reviews raised questions about the extent to which health professionals could access information about family history. If children are repeatedly not brought to appointments or parents disengage or respond inconsistently to a child's health needs, health professionals need to be able to recognise this as early as possible and assess potential risk. This is particularly the case with children who are already known to be vulnerable.

Children educated at home

A small number of the rapid reviews received by the panel involved children educated at home, of whom four died and seven suffered serious harm through neglect. Whilst this is a small group of children, it is an area of practice that the Panel will want to review in the future.

Written agreements

There was widespread use of written agreements, for example to prevent contact where there is a risk of sexual abuse or to clarify expectations between children's social care and a family. At best these had little or no protective effect, and at worst they created a false reassurance that they would keep children safe.

Resolving professional disputes

There were several examples of serious dispute amongst child protection professionals about what action should be taken. Safeguarding partners need clarity about how differences of professional opinion should be resolved and confidence in the effectiveness of these arrangements.

The people who know the most about a child are often not those who have the statutory powers to investigate and assess. Although several professionals in the rapid reviews had misgivings about the slow pace of response at critical moments, none of them used escalation procedures to raise their concerns.

Serious incident notifications

Local authorities have a duty to notify the Panel if they know or suspect a child in their area has been abused or neglected and the child dies or is seriously harmed.

The Panel collected data about serious incident notifications over a 12-month period to help them understand how the notification system is working. It is too early to draw conclusions but the report provides an overview of the data.

The Panel received 473 serious incident notifications between 29 June 2018 and 28 June 2019.

Age of the children

Almost a third of the serious incident notifications received were for children under the age of 1.

Over 20% of the notifications related to 11- to 15-year-olds.

Over 18% of the notifications were for 16- to 17-year-olds.

Children aged 6 to 10 made up 7% of the notifications.

Notifications by local areas

Most local areas have notified the Panel of between three and six cases per year, however there are three local areas that have notified a total of 33 cases.

In 15 local areas, no incidents were notified over the period. Given the number of looked after children and children in need in these areas, the Panel feels it is unlikely that there were no incidents that met the criteria for notification.

The Panel's work programme for 2020

Decisions about the Panel's work programme will be primarily driven by analysis of serious case reviews, local child safeguarding practice reviews and rapid reviews.

The Department for Education (DfE) will commission a final triennial review of serious case reviews to cover 2017 to 2019.

The Panel will commission a first practice review alongside the next annual report.

The Panel will be commissioning a call for evidence of national examples of excellent child protection practice with the aim of publishing this alongside the practice review and rapid review analysis in 2021.

National reviews for 2020

The review of safeguarding children at risk from criminal exploitation has been published (Child Safeguarding Practice Review Panel, 2020b).

Other reviews to be carried out in 2020 are:

- a review of sudden unexpected death of infants
- a review of non-accidental injury to babies under 1-year-old
- suicides, the secure estate, serious violence and looked after children.

References

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Department for Education (DfE) (2020) **Complexity and challenge: a triennial analysis of SCRs 2014-2017. Final report (PDF)**. London: Department for Education
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