THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Annual Report 2023 to 2024

Patterns in practice, key messages and 2024 to 2025 work programme

December 2024

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Evidence base

1. Primary sources

- **Serious Incident Notifications (SINs)** are made by local authorities to the Child Safeguarding Practice Review Panel, Department for Education and Ofsted when a child has died or is seriously harmed, and abuse or neglect is known or suspected. Local authorities are also required to submit a SIN where a child looked after has died, whether or not abuse or neglect is known or suspected. Only those SINs where abuse or neglect is known or suspected have been included in this report. Data for the SINs covers incidents that occurred during the 12-month period of April 2023 to March 2024.
- **Rapid reviews** are conducted for each notification. These reviews are undertaken by local safeguarding partners, with the written report to be submitted to the Child Safeguarding Practice Review Panel within 15 working days of the incident notification. The purpose of the rapid review is for partners to identify, collate and reflect on the facts of the case as quickly as possible to establish whether any immediate action is needed to ensure a child's safety and to identify potential practice learning. This includes deciding whether to undertake a Local Child Safeguarding Practice Review. Data for the rapid reviews presented in this report covers incidents that occurred during the 12-month period of April 2023 to March 2024
- **Local Child Safeguarding Practice Reviews** (LCSPRs) are undertaken to provide learning to improve safeguarding practice at both local and national levels and to prevent similar incidents from occurring in the future. When safeguarding partnerships decide to proceed with a local review, there is an expectation that these reviews are completed, submitted and published within six months of the rapid review. Data for the LCSPRs cover reports that had been considered by the Panel between April 2023 and March 2024 which had an incident date within the three previous years (i.e. from April 2021).

2. Thematic analyses published by the Child Safeguarding Practice Review Panel during 2023 to 2024

- Safeguarding children in elective home education was a briefing paper published by the Panel in May 2024.

Note: It is important to interpret the data presented in this report with care. We know there are inconsistencies in SIN submissions, where we believe there is likely to be under-reporting of serious incidents.

Foreword

The core of this report is the distressing and disturbing stories of many children who have been abused or neglected, inside and outside their families. We have a public responsibility to make sense of what happened to these children to consider how we might need to work differently to protect children's lives in the future.

Every day, thousands of professionals make exceedingly difficult decisions to help keep children safe. This report is about the intrinsically challenging work of finding out what is happening to children, of anticipating risks of harm and of knowing when decisive action is needed. This involves striking a fine balance between helping families and protecting children. In most instances, children receive the support, help and protection they need but sometimes children are seriously harmed, or worse, they die because of abuse or neglect.

The focus of this report is on serious incidents where children have died or suffered serious harm. It seeks to understand the patterns in practice that can be discerned through analysis of the 330 rapid reviews with incidents falling between April 2023 and March 2024, and 82 Local Child Safeguarding Practice Reviews considered by the Panel in this same period. Importantly, careful analysis of multi-agency practice when things have gone so catastrophically wrong in children's lives can shed light on the experiences of the broader group of children who need safeguarding.

The strains and stressors on children and families' lives have arguably increased rather diminished over the past decade. The long tail of the COVID-19 pandemic, increased rates of poverty and the diminished capacity of many services have affected the safety of many children, both inside and outside the home. The focus in this report on children with mental health needs, on pre-school children whose parents have significant mental health needs and on those who are at risk of harm outside their family helps illuminate the ability of agencies, working individually and together, to identify and respond to their safeguarding needs. This analysis evidences that very many practitioners bring enormous skill and imagination to safeguard children. It also demonstrates the myriad barriers and constraints that can impede our collective ability to protect children.

There are nonetheless grounds for a degree of optimism, notwithstanding the scale of need and engrained system challenges (for example, about timely information sharing). 10 pathfinder areas (over waves 1 and 2) are now piloting innovative approaches to helping families and protecting children. The new Children's Wellbeing Bill will usher in a swathe of reforms to mandate better and more integrated ways of working together, including through giving schools and other education settings a stronger voice in decision-making. The establishment of multi-agency child protection teams will provide an important lever for tackling some of the long-standing and deep-seated perennial problems in safeguarding children.

Revised 'Working Together' guidance (2023) has prompted fresh thinking about how safeguarding partners lead together across agency boundaries. The importance of leadership (nationally and locally) cannot be under-estimated. Leaders can and do lead by example, bringing courage, cultural humility and commitment to learning and improving practice. They are pivotal in creating the cultural fabric that helps practitioners work well together, for example through supporting constructive challenge, inquisitiveness and reflection about how biases and assumptions influence decisions about families.

Some of the data in this report warrants further consideration. In 2023 to 2024 there was an 18% reduction in the number of notifications, particularly those relating to serious harm. The drivers for this reduction need to be interrogated further, at both a national and a local level.

This is my last annual report as chair of the Panel as I will be stepping down next year. I believe that England now has a much more robust and maturing system for identifying and disseminating learning from serious incidents. Few other countries have such a well-developed approach. We can be less confident, however, about how well learning from these serious incidents engenders and sustains changes that make a difference to children and families. The Panel has commissioned work from Research in Practice, the Vulnerability Knowledge and Practice Programme, and the University of East Anglia to consider how learning might be enhanced. Related work to evaluate the Panel's impact should help us, over the next year, understand what needs to be done to yield the most benefit to children, families and practitioners.

There are many excellent initiatives taking place in and across the English safeguarding system. It is vital that these opportunities are used to quicken the pace of reform to support professionals to work effectively together, including in multi-agency teams. We will then have a better chance of tackling some deep-rooted challenges and for realising our ambitions to keep children safe.

Executive summary

The Child Safeguarding Practice Review Panel (the Panel)'s fifth annual report covers our work from 1 April 2023 to 31 March 2024. The report aims to share evidence and learning from our national oversight of rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs), as well as the Panel's reviews of national issues.

In addition to key data about the children and their families who are the focus of reviews, we spotlight three themes in this year's annual report:

1. Safeguarding children with mental health needs
2. Safeguarding pre-school children with parents with mental health needs
3. Extrafamilial harm

We have established learning that can inform the practice and policies of strategic leaders, managers and those working directly with children, young people and families. We have also considered the role of strategic leaders and the organisational conditions that will best enable and sustain the embedding of recommendations that will drive long-term change. We set out key findings here, although more detailed messages, learning points and reflective questions can be found in the report.

The evidence base

The findings presented in this report are based on:

- Serious Incident Notifications (SINs) for incidents that occurred during the 12-month period from April 2023 to March 2024
- rapid reviews for incidents that occurred during the 12-month period from April 2023 to March 2024
- a sample of LCSPRs presented to the Panel during the 12-month period from April 2023 to March 2024
- letters to safeguarding partnerships from the Panel covering incidents that occurred during the 12-month period from April 2023 to March 2024

We also draw on evidence from our published practice briefing, 'Safeguarding children in elective home education', published in May 2024. At the time of writing this report, we have two national reviews and two thematic projects in progress:

- a national review following the death of Baby Victoria
- a national review into child sexual abuse within the family environment
- a thematic analysis on neglect
- a thematic analysis on race, racism and racial bias in child protection and safeguarding

A window on the system

This year, there were 330 SINs and rapid reviews submitted for serious incidents occurring between April 2023 and March 2024 where abuse and/or neglect was known or suspected. This represents a decrease of 72 SINs from the previous year, primarily due to a reduction in serious harm incidents notified to the Panel. The average number of SINs per month decreased from 33.5 in 2022 to 2023 to 27.5 this year. Almost half of the incidents were due to the death of a child, and almost half were due to serious harm. Key findings are listed below.

- The age distribution of children was very similar to last year, with under 1s still experiencing the most harm, representing over a third of all incidents. However, this year, children aged 16 to 17 made up the second largest age group, overtaking the 11-to-15-year age group, which has been the second largest group for the last few years.
- There continues to be a fairly even split between boys (55%) and girls (45%), with observed variation when accounting for age.
- As identified last year, compared to the child population in England, children with a mixed/multiple ethnic background and Black/African/Caribbean/Black British children were over-represented in the reviews, while children from Asian/Asian British ethnicities or other ethnic groups were under-represented. We have observed variation when looking at ethnicity and age together.
- Unexplained Sudden Unexpected Death in Infancy or Childhood (SUDI/SUDC) was the most common likely cause of death (23%), followed by suicide (16%). Girls experienced higher rates of suicide than boys (21% versus 12%). Extrafamilial child homicide and extrafamilial fatal assaults were the most likely causes of deaths of boys (21%) compared to just one girl.

- Overall, the most common cause of serious harm was intrafamilial non-fatal assault with (30%), followed by non-fatal neglect (14%). Girls were more likely to suffer both intrafamilial and extrafamilial child sexual abuse combined than boys (32% versus 4%). However, boys experienced double the rate of both intrafamilial and extrafamilial non-fatal assaults compared to girls (54% versus 27%).
- In almost 9 out of 10 incidents, the family of the child in focus was known to children's social care (CSC), either as an open case or was previously known to CSC, similar to 2022 to 2023. Just over a quarter of children were either on, or had previously been on, a child protection plan. Around a sixth of children were classed as 'looked after' either at the time of the incident or previously, and 21% were subject to care orders or care proceedings.
- Over a fifth of children were recorded as having a mental health condition, either diagnosed or undiagnosed. In the 20 reviews where the diagnosed mental health condition was thought to be linked to the incident, 70% of children died, all of whom completed suicide.
- Notably, in a quarter of incidents, at least one parent or relevant adult was reported to have either a physical, mental health-related, learning or developmental disability, a substantial increase from the previous year. In just over half of the incidents, at least one parent was reported to have one or more mental health conditions, and in 43% of reviews, there was a parent with an addiction to or misuse of alcohol and/or substances.

Spotlight themes

Three spotlight themes were selected to provide a focus for this year's annual report: safeguarding children with mental health needs, safeguarding pre-school children with parents with mental health needs, and extrafamilial harm.

Safeguarding children with mental health needs: We found evidence of practitioners working tenaciously to engage and understand children's needs, which helped them be robust advocates in the context of care planning. The learning highlighted the need for awareness and assessment of demographic and situational characteristics that can impact a child's mental health and attendant risk. There were ongoing issues concerning suitable interventions, including confusion over the suitability of child and adolescent mental health services (CAMHS) involvement, long waiting times without support, and tensions involving thresholds for services. There is a critical absence of early intervention services for children with emerging emotional and mental health needs, and their families.

Safeguarding pre-school children with parents with mental health needs: Reviews highlighted that parental mental health was often overlooked as a potential risk factor when considering parents' capacity to care for their children. There tended to be an over-focus on visible contextual factors, such as home conditions, with less consideration of mental health, despite indicators of both historical and current deteriorating mental health. Findings also identified a lack of effective communication between and within statutory and non-statutory services, particularly adult services and child services. Reviews and literature identified a critical absence of support for parents with mental health needs or conditions who have children between the ages of 1 and 5, with research predominantly focusing on pre-natal and perinatal mental health.

Extrafamilial harm: Findings highlight both issues and opportunities for effective collaboration and information sharing. Learning has stressed the need for practitioners to identify and support additional needs of children that may put them at greater risk of extrafamilial harm, such as disabilities and neurodiversity, as well as the frequent crossover between harm occurring inside and outside the home. Education continues to play a pivotal role in protecting children, while online activity has become an increasingly important factor facilitating extrafamilial harm.

Panel at work and future priorities for the work programme

The Panel, as an independent body, is responsible for commissioning child safeguarding reviews as well as collating and disseminating the system learning from reviews at a national level. Through its work, the Panel continues to play a key role in child protection in England. This role is reflected by three factors.

1) System oversight: Maintaining oversight of the system of national and local reviews and how effectively it is operating.

   - Last year, we published the fourth annual report and entered into a collaboration with the Vulnerability Knowledge and Practice Programme to deliver a Data Insights Team, responsible for analysis of rapid reviews and LCSPRs.
   - This year and next, we continue this collaboration and will monitor trends arising from reviews, produce additional analytical products to inform our work, and disseminate the insights to safeguarding partners.

2) System learning: Identifying and overseeing the review of serious child safeguarding cases which, in the Panel's view, raise issues that are complex or of national importance.

- Last year we commissioned two national reviews: one regarding the death of Baby Victoria to be published in 2025 and the other regarding child sexual abuse in the family environment, which was published in 2024. We also commissioned two thematic analyses, one on neglect and the other on race, racism and racial bias. We also published a briefing in 2024 on elective home education.
- Next year, we will take evidence-based decisions on national and thematic reviews to commission. In addition to this, we will continue to monitor the progress of implementation from our previous national reviews, including our reports on safeguarding children with disabilities and complex health needs in residential settings.

3) System leadership: Identifying improvements to practice and protecting children from harm.

- Last year we increased and developed our engagement with safeguarding partners through a range of dissemination activities and events aligned to some of our national and thematic reviews. The Panel also responded to key national consultations on safeguarding issues.
- Next year, we will keep a focus on improvements to the quality of reviews through feedback and dialogue with safeguarding partners, our national support offer, and trialling a framework to improve consistency in learning from reviews. We will also continue to respond to important consultations and influence and advise on policy to make improvements to the system.

1. Introduction

1.1 This is the fifth annual report published by the Child Safeguarding Practice Review Panel (CSPRP) since its inception in 2018. The aim of the annual report is not just to serve as a reporting tool, but to capture and share evidence, good practice and learning with safeguarding partners, senior and middle managers, and practitioners working in child safeguarding and protection.

1.2 This report covers rapid reviews with incident dates falling between 1 April 2023 and 31 March 2024, aligning with the financial year to ensure consistency with reporting across the system. We have included LCSPRs submitted to the Panel between April 2023 and March 2024 with incident dates falling within the last three years (April 2021 to March 2024).

1.3 Our oversight of national and local reviews provides unique evidence and insights into patterns of practice in child safeguarding, enhanced by our national and thematic reviews. In the previous report, we examined the extent to which the six practice themes identified in 2022 remained significant in reducing serious harm and preventing child deaths caused by abuse or neglect. We found that these themes were still relevant, despite the identification of good practice.

1.4 For this year's report, we analysed reviews to gain insights and build an evidence base on patterns of practice in safeguarding, focusing on three key 'spotlight' themes. These themes were identified in the previous annual report and were selected to feature in this year's report to better understand the contexts of multi-agency working. This is relevant learning in the context of the Children's Wellbeing Bill which will seek to strengthen multi-agency child protection arrangements.

Spotlight themes

1. **Safeguarding children with mental health needs**
2. **Safeguarding pre-school children with parents with mental health needs**
3. **Extrafamilial harm**

1.5 Throughout the report, we have highlighted key messages, learning points and reflective questions to inform the practice of senior leaders, middle managers and those directly involved in practice. While we have included examples of good practice, the focus of these reviews on learning means that ‘good practice’ is not always featured or described in any depth.

Note on language

1.6 We recognise that the language used when referring to children, their families and communities can at times be contested and that preferred terms can develop and change quickly. A full glossary can be found in Appendix A.

1.7 We use ‘child in focus’ to describe the primary child involved in an incident, particularly when multiple children are affected. This term ensures the analysis of rapid reviews centres on the child who has experienced the most significant harm or is at the greatest risk. When unclear, we use criteria to determine the focus, prioritising the child who has suffered the most severe harm or, in cases of ongoing neglect and abuse, the eldest child. This approach ensures our efforts are directed towards the child most in need of immediate attention.

1.8 We use the term ‘children’ to refer to both children and young people throughout the report, reflecting the reality that those under 18 are legally recognised as children, which should always be kept in mind. We understand and acknowledge that some young people (aged 16 and 17) might prefer not to be referred to as ‘children’.

1.9 We use the term ‘serious harm’ when referring to incidents notified to the Panel and the subsequent rapid reviews and LCSPRs. This reflects the higher or more intense levels of harm experienced in these incidents. We use the term ‘significant harm’ when talking more generally about practice and legislation.

1.10 We use the term ‘Black and other minoritised communities’ when referring to communities affected by inequality. We use this term because it is important to recognise that experiences and challenges can vary for individuals with different ethnic or racial heritages. By using this inclusive language, the Panel aims to address the specific issues faced by various communities while emphasising the common goal of promoting equity and addressing disparities.

1.11 As far as possible we have tried to use person-first language. By that we mean language and phrases that place the person before any specific characteristic or feature as we think it is important to recognise the person first and foremost with any relevant descriptors after this – for example, referring to ‘children with disabilities’ rather than ‘disabled children’. We use person-first language because this promotes inclusivity and helps combat stigmas or stereotypes associated with certain conditions. Person-centred language is a step towards fostering understanding, dignity and recognition of the full range of an individual’s identity beyond their disability.

2. Context, conditions and safeguarding practice

2.1 Learning from serious incidents involves giving forensic attention to the minutiae of practice responses to risks of harm to children to make sense of how professionals worked to protect them. Practice will be shaped to varying extents by a range of contextual factors that influence both the daily lives of children and the conditions within which practitioners operate.

2.2 In our last annual report, we reflected on the suite of changes and reforms initiated by the previous government. This included publication of new 'Working Together' guidance and the launch of the national pathfinder programme to assess different ways of providing family help and child protection. While welcoming these important seeds of safeguarding reform, we also emphasised the imperative of ensuring strong momentum in delivering necessary changes. These changes are crucial not only for helping children and families, but also for supporting the complex and difficult work which many thousands of professionals undertake every day to protect children.

2.3 This annual report is being published at a critical juncture for all those working to safeguard children. The Children's Wellbeing Bill, to be introduced shortly, will set out some of the new government's aspirations for children's services. Among other things, it will seek to strengthen safeguarding practice, including through the establishment of multi-agency child protection teams, registers of children in elective home education, enhanced mental health support for children in schools, and a new unique child identifier initiative.

2.4 This chapter reflects on evidence about increased stress and vulnerabilities in some children's lives, about pressures in practice, and about opportunities resulting from emerging new national policy frameworks.

Strains and stressors in children's lives

2.5 Reviews repeatedly show how strains in many families' lives impact their ability to protect and keep children safe. These strains can stem from poverty, housing, and other social forms of deprivation and inequality, which too often corrode and compromise children's safety, wellbeing and ability to achieve their goals. The Centre for Young Lives report, 'An evidence-based approach to supporting children in the preschool years (2024a)', highlighted the disturbingly high number of children who are not ready for school and its relationship to deprivation, with 48% of children eligible for free school meals not being school ready.

2.6 It is estimated that around 30% of all children in the UK are living in poverty, based on the relative low-income measure, which refers to households with income below 60% of the median in a given year (Department for Work and Pensions, 2024). This represents an increase of around 100,000 more children from the previous year. The Department for Work and Pensions report highlights that children living in larger families are more likely to be living in poverty, with 40% of children in families with three or more children falling below the poverty line. Based on government data, children living in larger families are more likely to be living in poverty. Equally disturbing are the numbers of children living in insecure and inadequate housing. There were 109,00 homeless households in late 2024, which included 142,490 children. This was an increase of 12.8% from the previous year (Department for Levelling up, Housing and Communities, 2024).

2.7 Behind these statistics lies a picture of many children living in overcrowded, damp or otherwise unsuitable conditions. Such living environments can result in frequent school moves, disconnection from friends, family and familiar communities, and not knowing when and how to access support. The Panel's current thematic review on neglect is highlighting some of the practice challenges involved in differentiating between poverty and neglect. It is vital that children suffering neglect are effectively identified and that they receive the support and protection they need.

2.8 Far too many children are missing the benefits that education should bring to help them keep safe, thrive and enjoy their lives. A recent report from the Children's Commissioner indicates that, notwithstanding major data challenges related to definitions, around 117,100 children were missing education at any time (Children's Commissioner, 2024a). As the Commissioner comments, these children are ''some of the most vulnerable children, and they deserve our full attention and support". Reviews repeatedly show that not being in school creates and exacerbates risks for children, including those who are at risk of being harmed outside their families.

2.9 Additionally, we know that, for a range of reasons, the number of children being electively home educated has risen significantly in the past few years. The great majority of these children are safe and do well in home education. However, as our practice briefing highlighted, where children are at risk of abuse and neglect, being electively home educated means that they will not access the protective benefits and 'line of sight' on their lives that schools can provide (CSPRP, 2024b).

2.10 Growing up for some children can be exhausting, joyless and frightening. The Children's Society has indicated that, compared to their European peers, British 15-year-olds are reporting lower life satisfaction (the 'happiness index'), with girls and children from disadvantaged backgrounds particularly affected (The Children's Society, 2024). There is strong and powerful evidence showing that children and families from particular social communities, including disabled children and children from Black and other minoritised communities, experience disproportionate vulnerability. For example, a recent report from the Institute of Health Equity (2024) provides evidence about the unequal representation of ethnic minority groups identified with special educational needs (SEN). Black Caribbean children are twice as likely to be identified as having a social, emotional or mental health need as compared to their white British counterparts. The report suggests that "bias from teachers, racism and lack of understanding of cultural differences and ineffective classroom management" may all be contributing factors.

2.11 A decade and more of financial austerity has reduced the availability of preventative support and help, including youth provision and early help (Gomez-Quintero and others 2024). A recent Youth Endowment Foundation report showed that over the last decade, spending on services for young people has halved, down by more than half a billion pounds since 2012 to 2013, and the number of youth clubs operating in local authorities fell by 44% between 2011 to 2012 and 2018 to 2019 (Youth Endowment Fund, 2024).

2.12 There are also 'new,' or at least not well understood, risks for children arising from what might be regarded as the new existential threat of online harm to children (HM Inspectorate of Constabulary and Fire and Rescue Services, 2023). There is much to do to understand and respond to the online world of children and 'technology facilitated abuse'.

Pressures in practice

2.13 In our last two annual reports, we reflected on six key practice themes to make a difference to the system's ability to protect and help children at risk of significant harm. These themes were:

- effective leadership and culture supporting critical thinking and professional challenge
- considering racial, ethnic and cultural identity and impact on the lived experience of children and families
- the importance of the whole family approach to risk assessment and support
- recognising and responding to vulnerability of babies
- domestic abuse and harm to children – working across services
- keeping a focus on risks outside the family

2.14 These themes continue to have relevance to learning in rapid reviews, LCSPRs and national and thematic reviews undertaken by the Panel. This year's annual report focuses on three different themes (children's emotional and mental health, parental mental health and children aged 1 to 5, and extra familial harm). We chose these themes in part because of the regularity with which safeguarding partnerships have highlighted the importance of these issues in local reviews. These themes illustrate, in different ways, how at times professionals struggle to find the best and right resources and services which are needed to help keep children safe.

2.15 The Children's Commissioner report on children's mental health services (2024b) estimated that one in five children had a probable mental health condition and that this represented an increase from 2017 when the estimate was 1:8. Among the reasons for referral to CAMHS services in 2022 to 2023, and after discounting those recorded as 'unknowns', were anxiety (19%), in crisis (10.1%), neurodevelopmental conditions excluding autism (6.6%), depression (5.8%) and self-harm behaviours (4.8%). Later in this annual report, we present some of the evidence of the different ways that abuse and harm suffered by children have seriously impacted on their mental health and increased their vulnerability, often over many years.

2.16 The need for properly resourced mental health support for children is rightly now better recognised. However, the exponential rise in the use of deprivation of liberty orders (Care Quality Commission, 2024) highlights how we must respond more effectively and sensitively to the acute vulnerability of many children with complex mental health needs. Safeguarding partners repeatedly emphasise that the lack of appropriate tier four provision and residential care facilities for very distressed children constrains the ability of agencies to meet children's needs. This can create situations where children are at much higher risk of being harmed, harming themselves or others.

2.17 There has rightly been much policy and practice attention on safeguarding babies who are under 1 year old. This is the most vulnerable age group, as highlighted by data presented in the next chapter. The evidence also requires us to understand the vulnerability of the wider pre-school age group, with issues of neglect as well as physical abuse having a high profile, and parental mental health often being a key factor. 'Think family' approaches should encourage good, joined-up working between adult and children's services, however various barriers often impede this. Parents and carers may fear seeking help and support for mental health issues (including about substance misuse), and appropriate support, particularly for 'low' or 'medium' level mental health issues, may be lacking.

2.18 It is shocking and disturbing that in 2022 to 2023, there were 99 homicides of children aged 16 to 24, with Black children (predominantly boys) being six times more likely than their peers to die in these circumstances (Youth Endowment Fund, 2024). The challenges for practitioners of protecting children from serious and fatal harm, including exploitation outside their homes involving both sexual and physical violence, can sometimes feel overwhelming. The criminal exploitation of children rightly remains a high priority nationally and locally for communities, professionals, and government. It is important that, in various parts of the country, including London and Greater Manchester, safeguarding partnerships are working with other bodies to share intelligence and capacity, to deliver more cohesive and stronger multi-agency responses.

2.19 We know that Black children are more likely to go missing, with 16% of all missing children being Black compared to only 6% in the general population (ONS, 2021). A report from Missing People and Listen Up (2024) unpacks this disturbing data, highlighting how Black children are adultified and perceived to be 'more grown up'. This perception can lead to an under-identification of their emotional, mental health and neurodiversity-related needs (Davis and others, 2024). It is important that practitioners and leaders critically reflect on how assumptions, biases and the design of services contributes to Black children not getting the help they need.

2.20 A stable workforce with consistent organisational leadership is crucial to the delivery of sensitive and consistent services to children and families. Evidence indicates that, in some areas, high rates of staff turnover continues to be a major issue, particularly in terms of social workers and health visitors. There are also challenges in recruitment in some education settings and mental health services. The Panel sees in some reviews how frequent practitioner changes impact negatively on relationships with families, the quality of assessments, information sharing and decision-making.

2.21 The picture across the country is, however, not consistent and there are examples of local areas implementing workforce strategies with positive results. Important national initiatives are being progressed to tackle workforce supply problems. New statutory guidance for local authorities on the use of agency child and family social workers is designed to reduce over-reliance on and costs of recruiting in this way (Department for Education, 2024b).

2.22 The national reviews, 'Child Protection in England' and 'Safeguarding children with disabilities and complex health needs in residential settings' (CSPRP, 2022d; CSPRP, 2023a), highlighted the importance of staff retention and supporting the workforce through training and development and high-quality supervision. Our recently published national review about child sexual abuse within a family environment has similarly highlighted the vital need for good multi-agency training and professional development.

National government – new policy practice levers

2.23 The new government's policy framework for children's services is evolving. Its recently published policy statement 'Keeping Children Safe, Helping Families Thrive' sets out some important ambitions and reforms (Department for Education, 2024c). Attention will now be needed to translate these ambitions into tangible benefits for children and families.

2.24 As the Panel has argued (see, for example, 'Child Protection in England', CSPRP, 2022e), step changes are needed in the design and delivery of child protection roles and responsibilities to address some of the perennial practice changes which underpin so much analysis in national and local reviews. The proposal to establish multi-agency child protection teams has very significant potential for enhancing the effectiveness of decision-making when children are at risk of harm. Much innovative work is now being progressed and tested within pathfinder areas, the evaluation of which will inform and shape future policy and practice developments. While we have a good understanding of the nature of some of the barriers to high-quality practice, we need greater knowledge of how potential solutions might be best implemented.

2.25 The mission-led approach now being promoted across government is welcomed but it will be crucial that different ‘missions’ (for example, around ‘opportunity’ and ‘safer streets’) are carefully connected together. Safeguarding children involves many different government departments. Too often, competing departmental priorities and ways of doing things constrain and obscure what may be needed for children and families in practice. Working together is as important at a national level as it is when working at a local level.

2.26 The Panel is encouraged by the government’s commitment to address some of the long-standing problems within the safeguarding system. The proposed new children’s wellbeing legislation provides important enabling levers for improving the arrangements – strategically and operationally – for agencies working together. Successful implementation requires courage from practitioners and leaders to be open to different ways of working together, with good understanding about how to make proposals work in the best interests of children.

2.27 There is real potential too in other elements of the proposed legislation for improving children’s lives and experiences of safeguarding services. These include a much stronger mental health offer to children, breakfast clubs and registers of children in elective home education. The importance of the latter was highlighted by the Panel’s work on elective home education (CSPRP, 2024b).

2.28 The proposal for a unique child identifier is also important, but it will not, by itself, address the wider systemic and cultural challenges around multi-agency information sharing. Equally, if not more critical, is the importance of practitioners having sound professional relationships that enable good and challenging conversations about their work.

2.29 Reform is too often implemented in a piecemeal and sluggish way; children and families, however, cannot wait for change. The Panel was disappointed by the slow pace evidenced in government’s response to the recommendations we made in our national review about children with disabilities and complex health needs (CSPRP, 2023a). We welcome government’s recent acknowledgement of the need to be proactive and well-considered in finding solutions that best serve children and young people (Department for Education, 2024d).

2.30 Action is needed on a number of fronts, including to secure a skilled and well led workforce, through investment in new multi-agency approaches family help and child protection, and making better use of data and other forms of evidence to know what is happening in practice in work with children and families.

3. A window on the system

Key findings

- The number of SINs and rapid reviews submitted to the Panel has decreased by 18% this year. This reflects the national picture around SIN submissions and is related mainly to a decrease in submissions for serious harm. Overall, there were 330 rapid reviews: 49% related to deaths, 48% related to serious harm and 3% other.
- There continues to be a fairly even split between boys and girls who are the focus of the reviews, but the harm type differs between the sexes. For example, there were more incidents of extrafamilial harm for boys than girls, while there were more incidents of sexual abuse and/or exploitation for girls than boys.
- This year there has been a slight shift in age groups. Whilst under 1s remain the largest age group, 16-to-17-year-olds now make up the second largest age group rather than 11-to-15-year-olds as in previous years.
- There remains the over-representation of Black children and children with a mixed/multiple ethnic background within the reviews submitted and an under-representation of Asian children. We can also see distinct age variation within the ethnic groups.
- There continues to be a large number of reviews that do not report on the child's characteristics such as gender, sexuality and disability.
- SUDI and suicide remain the most common likely cause of deaths while non-fatal intrafamilial assaults remain the most common likely cause of harm.
- A high proportion of children who are the focus of these reviews have come into contact with, or their families are known to, CSC before the incident.
- A quarter of children of secondary school age either had an education, health and care plan (EHC plan) in place or were being assessed for one.
- A fifth of the children were reported as having one or more mental health conditions, affecting older children more.

- There were substantial needs of the parents with half reported to have mental health conditions, two in five reported to have an addiction to or misusing alcohol and/or substances, and a quarter reported to have a disability.
- Neglect continues to be a key factor in the child's life, as does domestic abuse and physical abuse. A fifth of children had previously experienced sexual abuse in their lives and a fifth had experienced emotional abuse.
- The most common learning and practice themes identified within the reviews were: lack of co-ordination or handover between services, lack of professional curiosity or failure to ask the second question, weak risk assessment and decision-making, issues about children's experiences and voices not being heard and understood, and poor escalation of concerns.

3.1 This chapter aims to provide insight into the incidents and challenges faced by safeguarding partners by sharing the unique information the Panel has access to through its oversight of serious safeguarding incidents and rapid reviews.

3.2 Under 16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017), a local authority in England must notify the Child Safeguarding Practice Review Panel if a child dies or is seriously harmed and it knows or suspects that a child has been abused and/or neglected. A notification can also be submitted if the child has perpetrated harm but there is evidence that they have experienced abuse and/or neglect. Local authorities must also submit a SIN where a child looked after has died, whether or not abuse or neglect is known or suspected. However, this analysis only includes those where abuse or neglect is known or suspected and is progressed to a rapid review.

3.3 This initial notification is known as a Serious Incident Notification (SIN). Following the SIN, and where abuse and/or neglect of the child is known or suspected, the safeguarding partnership for that area must carry out a rapid review to establish whether any immediate action is needed to ensure a child's safety and the potential for practice learning.

3.4 Only one SIN is submitted per incident and therefore may involve more than one child. Where this occurs, an 'index' child is often identified in the SIN and is the focus of the rapid review. In instances where this is unclear, we have followed a set criterion to identify the index child and subsequent order of input. Following these criteria, the index child would be identified as the child who has suffered the most obvious serious harm or death, or the eldest child involved in the incident as it could be assumed that they would have suffered the longest in cases of ongoing neglect and abuse. These children have then been identified as the 'child in focus' when discussing rapid reviews.

3.5 The first section of this chapter examines the data from SINs submitted by local authorities for incidents of death or serious harm where abuse and/or neglect is known or suspected, occurring between 1 April 2023 and 31 March 2024. Analysis conducted using child population figures have been calculated using the mid-year 2023 population estimates for 2023 to 2024 data and mid-year 2022 population estimates for 2022 to 2023 data (Office for National Statistics).

3.6 The following sections then present analysis based on information from rapid reviews undertaken for those incidents occurring over the 12-month period of April 2023 to March 2024. The analysis covers the characteristics of the child, the types of incidents reported, the service needs of the child and parent, and associated learning and practice themes where these are reported within the reviews.

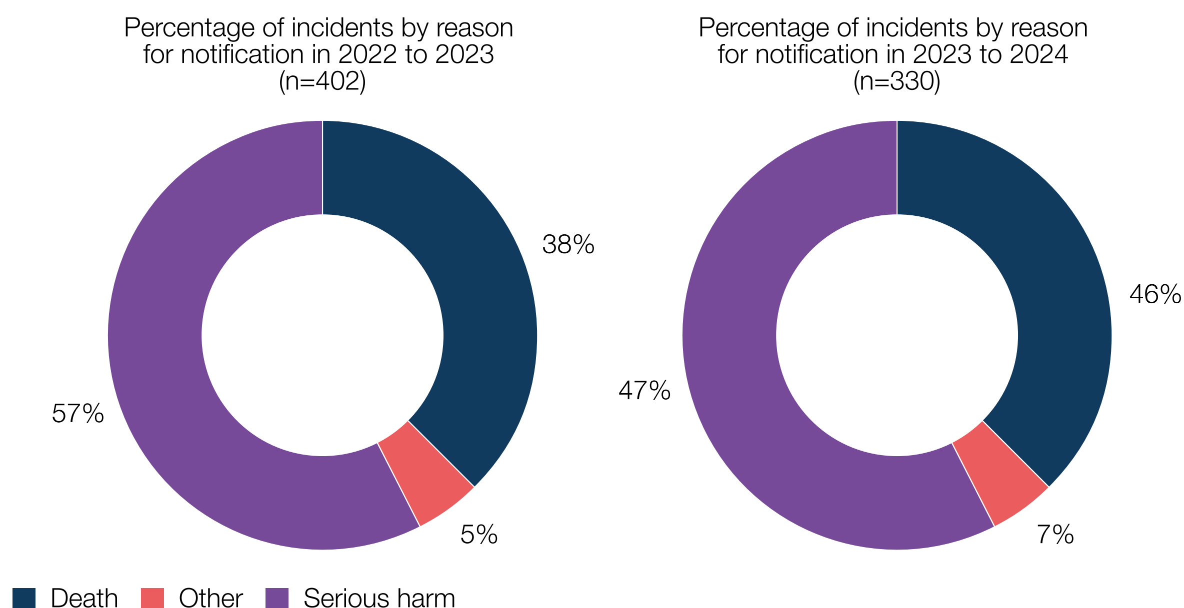
3.7 It should be noted that the numbers of incidents reported for this period may be liable to change in future reports due to the late identification or reporting of incidents.

3.8 There may be a small number of reviews where it is found that neither abuse or neglect was a cause of, or a contributory factor to, the death or serious harm of a child. The Panel recognises that sometimes this can only be established after conducting rapid reviews. The Panel would encourage local authorities to continue to submit these incidents, particularly where the family is known to CSC or there is concern about abuse or neglect.

Serious Incident Notifications

3.9 The Panel received notification of 330 serious incidents where abuse and/or neglect was known or suspected which occurred between April 2023 and March 2024 and progressed to a rapid review. Of those 330 notifications, 151 (46%) were in relation to child deaths and 155 (47%) related to serious harm. In addition, 24 (7%) notifications were classed as ‘other’ issues, for example where the child perpetrated a crime or a child had been exposed to a serious incident or trauma. In some incidents, ‘other’ has been recorded on the SIN where serious harm or death is yet to be established. Chart 1 shows the breakdown of reason for notification in comparison with the previous year.

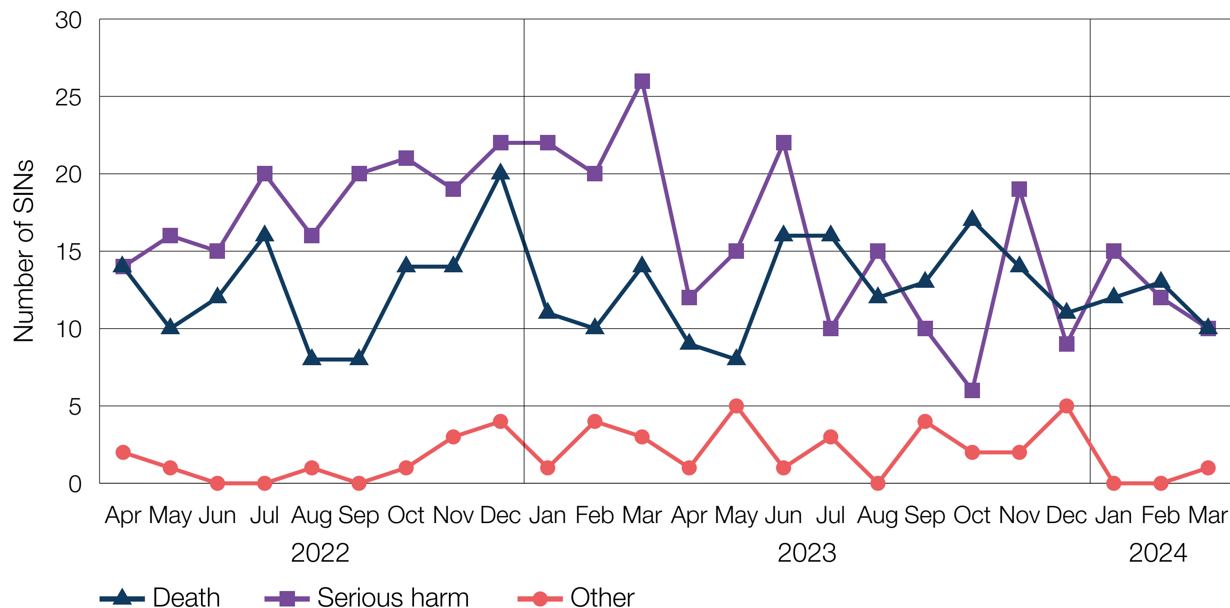
Chart 1: Proportion of incidents by reason for notification, 2022 to 2023 and 2023 to 2024



3.10 In comparison, there has been a decrease of 72 SINs (18%) on the previous year (2022 to 2023) when 402 SINs were received by the Panel and progressed to a rapid review, with the main difference being a reduction in the number of SINs for serious harm incidents being notified to the Panel.

The decrease in SINs received by the Panel is a reflection of the general decrease in the total number or SINs submitted over the year as reported by the Department for Education in their Serious Incident Notification statistical release. The Department for Education is aware that, in some instances, not all incidents that meet the definition for a serious incident are notified. It is not possible to ascertain whether the fall in 2023 to 2024 reflects a decrease in serious incidents or whether fewer notifications were reported compared with earlier years. Therefore, this needs to be considered when interpreting the fall. This reduction in SINs is being explored further by the Panel, working with Department for Education officials, to understand better what factors may lie behind the reduction.

Chart 2: Number of SINs by reason for notification and month of incident, April 2022 to March 2024

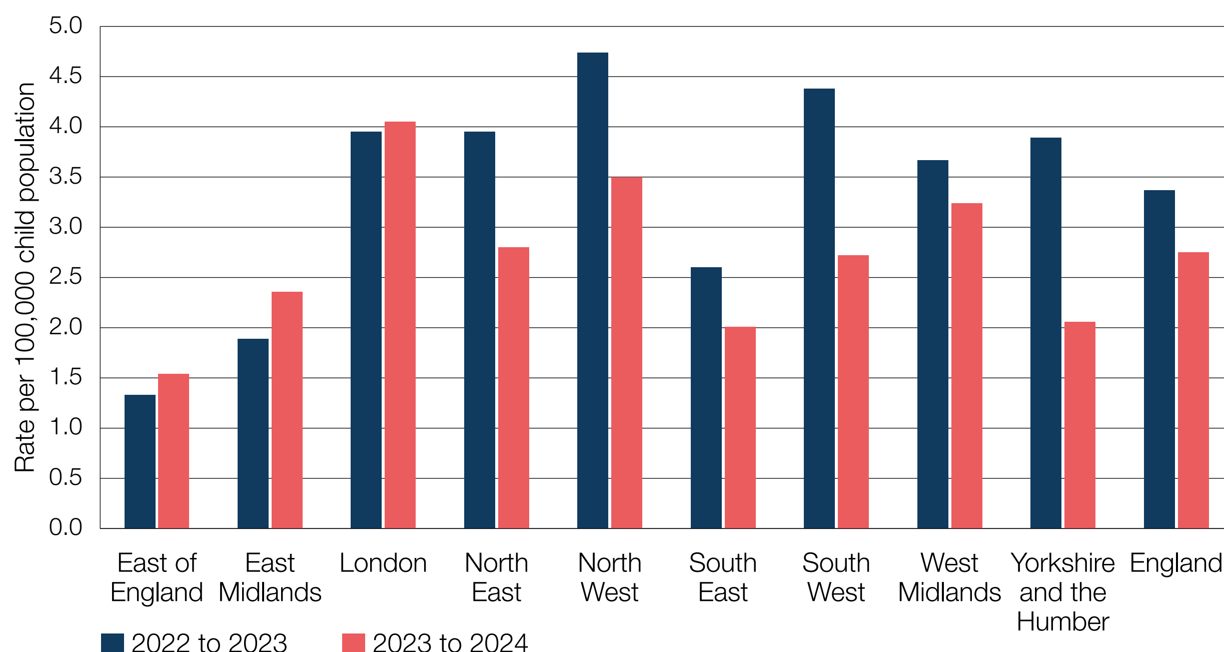


3.11 Chart 2 shows the number of SINs submitted by month of incident, broken down by reason for notification. This highlights that the number of incidents varied in 2023 to 2024 between a minimum of 21 in March 2024 to a maximum of 39 in June 2023. On average, 27.5 SINs were submitted per month in 2023 to 2024, compared to 33.5 in 2022 to 2023.

3.12 As mentioned previously, local authorities are asked to raise only one notification per incident, even if more than one child is affected. During 2023 to 2024, just over a fifth (22%) of the 330 reported incidents were reported to involve more than one child, which was similar to 2022 to 2023 (20%). Overall, 485 children were reported as likely having experienced harm. In 2022 to 2023 there were 538 children reported as being harmed in the 402 incidents reported.

3.13 In 62% of incidents where multiple children were reported within the SIN, the children had experienced serious harm incidents, including six incidents which reported five or more children as being involved. A quarter (25%) of incidents with multiple children involved related to fatal incidents and 13% related to 'other'.

Chart 3: Rate of SIN submissions per 100,000 child population by region, for 2022 to 2023 and 2023 to 2024



3.14 Across England there were 2.8 SINs submitted per 100,000 child population, as shown in Chart 3. This has decreased from the 2022 to 2023 rate of 3.4 per 100,000 child population, reflecting the overall decrease in the number of SINs submitted.

3.15 The regional rate of submission for 2023 to 2024 varied from 4.1 per 100,000 child population in London to 1.5 in the East of England. There are three regions that have seen an increase in submission from the previous year: East Midlands (1.9 to 2.4), East of England (1.3 to 1.5) and London (4.0 to 4.1). All other regions saw a decrease, with the greatest being in Yorkshire and the Humber from 3.9 to 2.1 SINs per 100,000 child population.

3.16 Further regional figures including the proportional split between submissions for deaths and serious harm can be found in Appendix B.

3.17 These numbers are not a comment on the practice of the regions, and it is important to note that differences in notification numbers across regions could be indicative of varying socio-economic contexts as well as child population sizes. An increase or reduction in the number of SINs submitted should not be interpreted as equalling greater or less harm, nor can a higher number of SINs in one region be seen as that area having higher rates of harm. However, we encourage safeguarding partners to investigate where submission rates have changed across the two years, particularly where large decreases have been seen.

Rapid reviews

3.18 The analysis in this section is based on information from the rapid reviews submitted to the Panel for incidents occurring between April 2023 and March 2024 and focuses on the child who was the subject of the review (the child in focus).

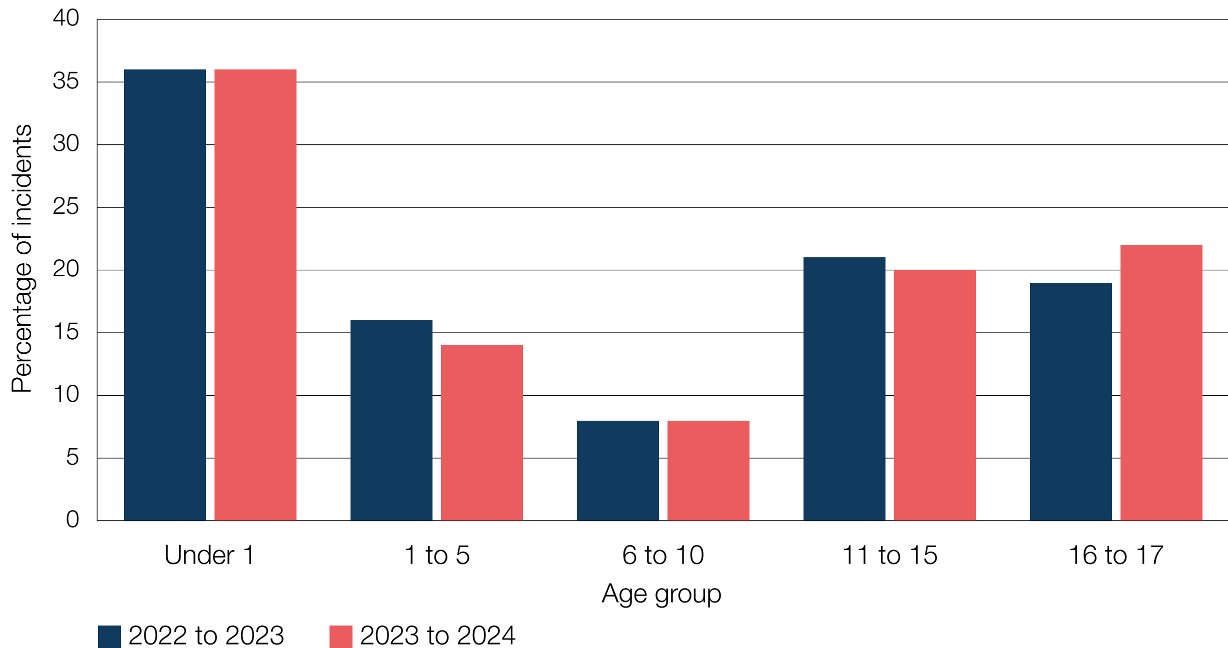
3.19 In some incidents, the type of harm/reason for notification changed between the SIN submission and the rapid review occurring, for example if the child died in the time between, or if the reason was no longer determined to be classed as 'other'. This means that among the 330 rapid reviews included in this analysis, there were 161 (49%) deaths, 160 (48%) serious harm incidents and 9 (3%) 'other' incidents.

Characteristics of the child

3.20 This section presents analysis on the characteristics of the child in focus with additional figures presented in Appendix D.

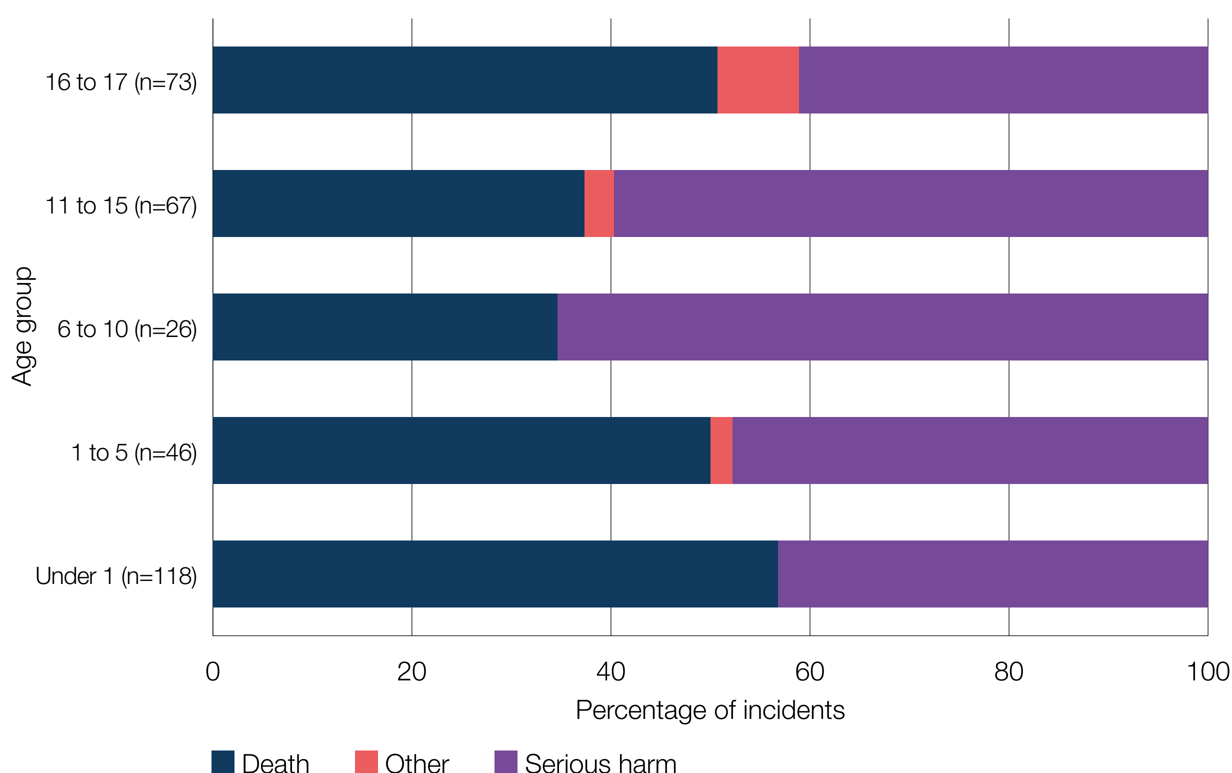
3.21 Out of the 330 reviews, 55% of the children in focus were recorded as boys and 45% were recorded as girls.

Chart 4: Proportion of incidents by age group for 2022 to 2023 and 2023 to 2024



3.22 Chart 4 shows the proportional breakdown of rapid reviews by age group and reporting year. In 2023 to 2024, under 1s remained the most represented group accounting for 36% of children, the same as the previous year. However, unlike last year, the next largest age group was 16- to 17-year-olds with 22%, which has increased from 19% in 2022 to 2023. There were slight decreases in the proportion of 11- to 15-year-olds and 1- to 5-year-olds while the proportion of 6- to 10-year-olds remained the same at 8%.

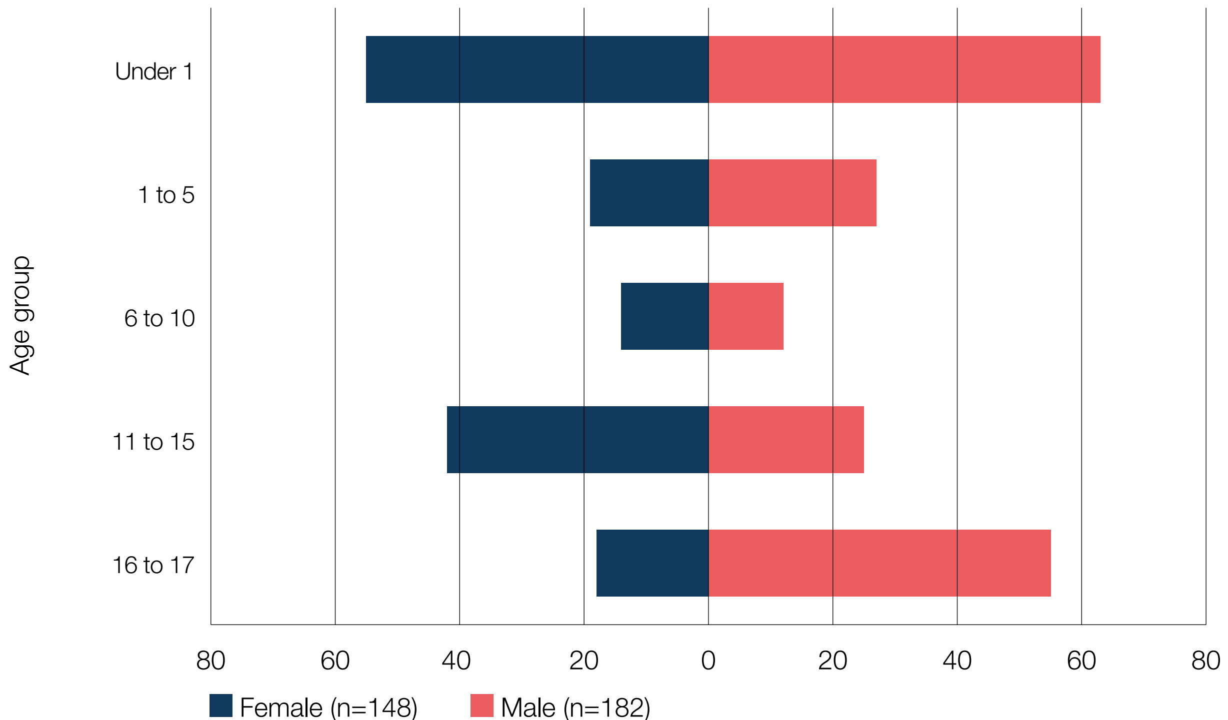
Chart 5: Proportion of incidents by age group and incident type, 2023 to 2024



3.23 Chart 5 shows the proportional split between the types of harm for each age group. The age group with the largest proportion of fatal incidents was children aged under 1 with 57% and the age group with the least was 6- to 10-year-olds with 35%. Additionally, 16- to 17-year-olds had the greatest proportion of other incidents (8%).

3.24 The ages of the children spanned the range of 0 to 17 years old. The average age of the child in focus was 7.3 years, although this was slightly lower for fatal incidents (6.7 years) than serious harm incidents (7.6 years). There was also a slight difference in mean age between the sexes, with the average age for girls in focus being 6.9 years compared to 7.7 years for boys.

Chart 6: Number of incidents by age group and sex, 2023 to 2024



3.25 Chart 6 shows the breakdown of incidents by age group and sex. As with the overall figure, under 1s was the largest group for both sexes, accounting for 37% of girls and 35% of boys. However, at the other end of the age spectrum there are bigger differences between the two sexes. There are more girls aged 11 to 15 years old than boys with 42 compared to 25. This age group accounts for 28% of girls compared to 14% of boys. Conversely, there are 55 boys aged 16 to 17 compared to 18 girls. This age group accounts for 30% of boys compared to 12% of girls.

3.26 In terms of the child's gender, nine children were reported to have a gender identity different from the sex registered at birth or to be non-binary. This is the same proportion as the previous year (3%). When looking at older children, for example those aged 10 and above, the proportion increases to 6% (n=9/144). Of these nine children, seven children were either 15 or 16 years old, one child was 14 years old, and one child was 11 years old and self-identified as non-binary. However, it should be noted that in most reviews where it may be age appropriate to do so, characteristics such as gender or sexual orientation were not recorded.

3.27 In addition, 11 (3%) children were recorded as being non-heterosexual, which is a slightly higher proportion than the previous year (2.5%). When looking at children aged 10 and above only, 8% were recorded as being LGBTQ+. Overall, there were seven children who were recorded as both identifying as LGBTQ+ and with a gender identity different to their sex at birth.

3.28 This year, the ethnicity of the child in focus was recorded in 98% of the 330 rapid reviews. This is an increase on the previous year where ethnicity was recorded in 95% of rapid reviews.

Table 1. Ethnicity breakdown of children in focus 2023 to 2024 (where ethnicity is known) compared to the 2021 Census figures for England

	2023/24		2021 Census[1]
	No.	%	%
White	**214**	**66.3%**	**72.5%**
1. White British	184	57.0%	66.9%
2. Irish	2	0.6%	0.3%
3. Gypsy or Irish Traveller	2	0.6%	0.2%
4. Any other white background	26	8.0%	5.1%
Mixed/multiple ethnic groups	**55**	**17.0%**	**6.8%**
5. White and Black Caribbean	21	6.5%	1.9%
6. White and Black African	9	2.8%	1.1%
7. White and Asian	5	1.5%	2.1%
8. Any other mixed/multiple ethnic background	20	6.2%	1.7%
Asian/Asian British	**16**	**5.0%**	**12.3%**
9. Indian	3	0.9%	3.5%
10. Pakistani	6	1.9%	4.5%
11. Bangladeshi	1	0.3%	1.8%
12. Chinese	3	0.9%	0.6%
13. Any other Asian background	3	0.9%	2.0%
Black/African/Caribbean/Black British	**32**	**9.9%**	**5.7%**
14. African	5	1.5%	3.7%
15. Caribbean	6	1.9%	0.8%
16. Any other Black/African/Caribbean background	21	6.5%	1.2%

	2023/24		2021 Census[1]
	No.	**%**	**%**
Other ethnic group	**6**	**1.9%**	**2.7%**
17. Arab	2	0.6%	0.9%
18. Any other ethnic group	4	1.2%	1.8%
Total known	**323**	**100%**	**100%**

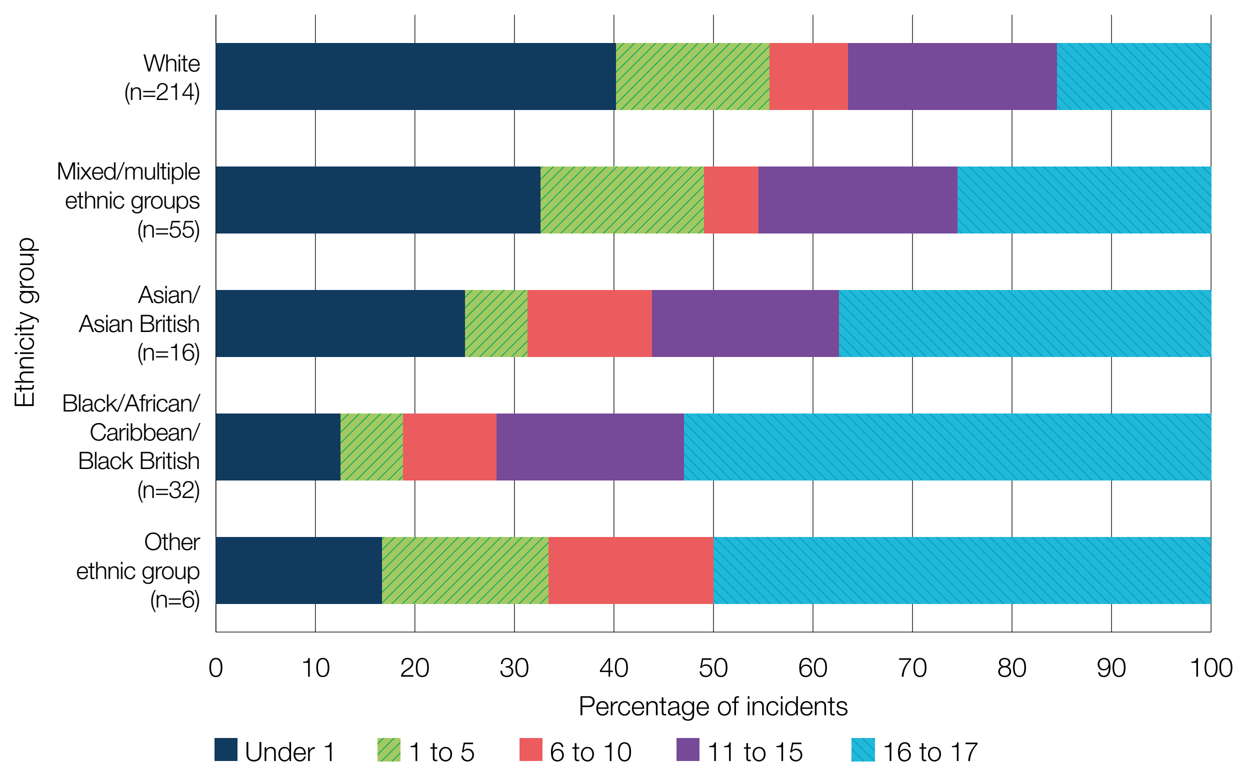
1. Source: Office for National Statistics, population of children aged 0 to 17 years old

3.29 Table 1 shows that two-thirds (66%) of children in focus where ethnicity was known were recorded as white, followed by mixed/multiple ethnic groups with 17%. The next largest ethnic group was Black/African/Caribbean/Black British with 10%, followed by Asian/Asian British with 5% and other accounting for 2%.

3.30 In comparison to the previous year, the proportion of children recorded with a mixed/multiple ethnic background has increased from 13% in 2022 to 2023 to 17% this year. Conversely, the proportion of children recorded as Asian/Asian British has decreased from 7% in 2022 to 2023 to 5% this year.

3.31 Table 1 also provides a comparison to the 2021 Census figures for children aged 0 to 17 years old. As identified in the 2022 to 2023 report, there is still an over-representation of Black/African/Caribbean/Black British children and those with mixed/multiple ethnicities within the reviews compared to the population aged 0 to 17 years old in England. Children with Black/African/Caribbean/Black British ethnicities were the focus of 10% of the reviews but make up 6% of the child population in England. Children with mixed/multiple ethnic backgrounds were the focus of 17% of the reviews but make up 7% of the English population. Conversely, there is under-representation of Asian/Asian British children within reviews, with 5% of incidents compared to 12% of the child population in England.

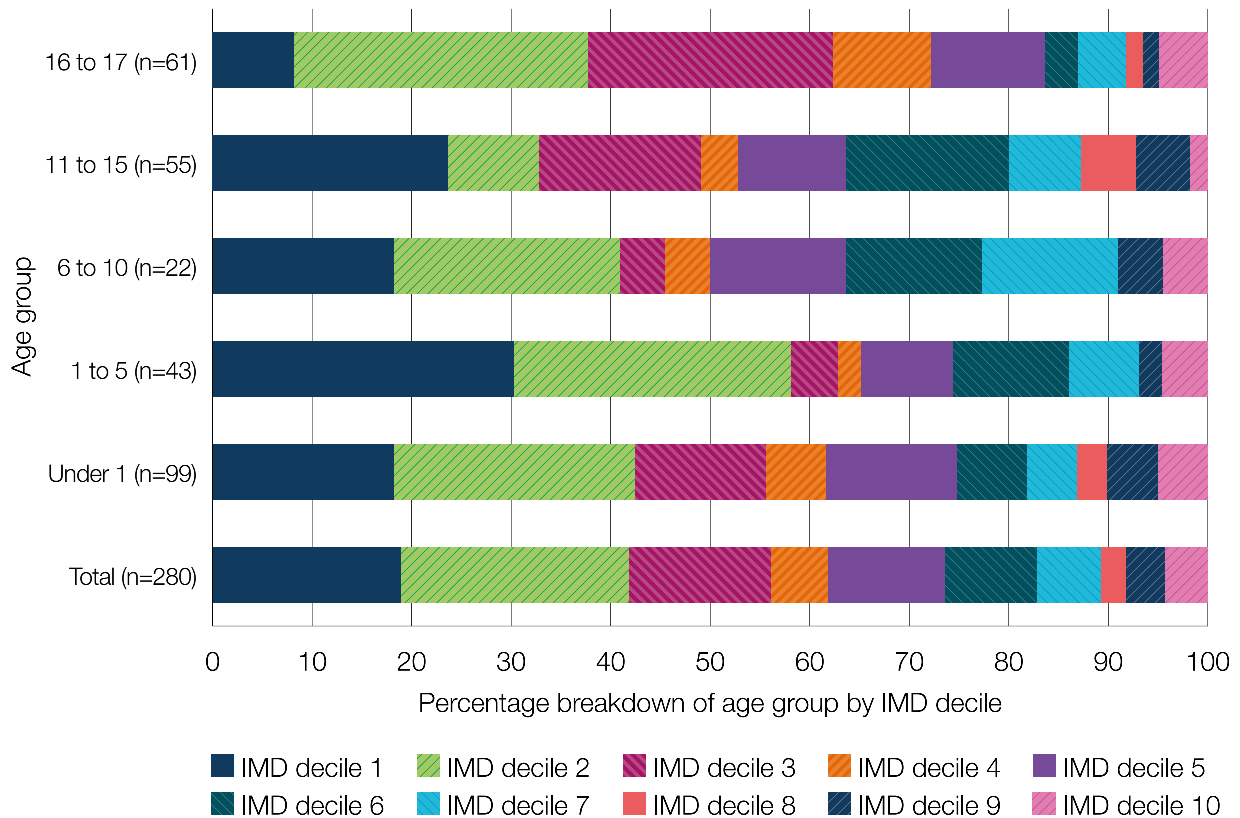
Chart 7: Breakdown of ethnic group by age group, 2023 to 2024



3.32 Chart 7 shows the proportional breakdown of ethnic group by age group, which is not consistent across the ethnicities. For example, 40% of white children were aged under 1, compared to 13% of Black/African/Caribbean/Black British children. Conversely, over half (53%) of Black/African/Caribbean/Black British children in focus were aged 16 to17 years old compared to 15% of white children. In fact, nearly a quarter (23%) of children aged 16 to 17 years old are Black/African/Caribbean/Black British even though this group only makes up 10% of the overall sample.

Intersectionality, or how a child's social identities such as race, sex, gender, sexual orientation and other characteristics interconnect, is important for safeguarding partners to consider in terms of how it may impact the daily life experiences of the child as well as influence the decision-making of practitioners. The Panel are currently exploring these issues further though our current thematic analysis about race, racism and racial bias.

Chart 8: Proportion of incidents by age group and index of multiple deprivation (IMD) decile (where known), 2023 to 2024



3.33 The index of multiple deprivation (IMD) decile was identified for 85% (n=280) of the incidents occurring in 2023 to 2024 based on the postcode of the placement recorded on the SIN. As shown in Chart 8, more than two-fifths (42%) of notified incidents with a known IMD decile occurred in the 20% most deprived areas of England. Overall, nearly three-quarters (74%) of serious incidents occurred in the 50% most deprived areas in England.

3.34 However, this does vary by age group. For example, 30% of serious incidents involving children aged 1 to 5 years old occurred in the 10% most deprived areas compared to just 8% for 16- to 17-year-olds. In addition, 84% of incidents involving 16- to 17-year-olds occurred in the 50% most deprived areas compared to 65% of 11- to 15-year-olds.

Child deaths

3.35 The likely cause of death reported within this section is based on the information presented in the rapid review and what was known at that time. In some circumstances cause of death may have been suspected but was still waiting to be confirmed and/or changed post-rapid review. Further definitions of the causes of death can be found in Appendix B.

3.36 Of the 161 fatal incidents which occurred in 2023 to 2024 ,59% were for boys and 41% were for girls, as shown in Table 2.

Table 2. Number and proportion of fatal incidents by likely cause of death and sex of the child, 2023 to 2024

	Female		Male		Total	
	N	%	N	%	N	%
Likely cause of death						
Unexplained SUDI/SUDC	16	24.2%	21	22.1%	37	23.0%
Suicide	14	21.2%	11	11.6%	25	15.5%
Child homicide – extrafamilial	1	1.5%	16	16.8%	17	10.6%
Medical	8	12.1%	9	9.5%	17	10.6%
Fatal assaults – intrafamilial	3	4.5%	13	13.7%	16	9.9%
Unclear	6	9.1%	6	6.3%	12	7.5%
Overt child homicide by primary caregiver	5	7.6%	4	4.2%	9	5.6%
Death from extreme neglect	5	7.6%	3	3.2%	8	5.0%
Accident/injury	2	3.0%	4	4.2%	6	3.7%
Covert child homicide by primary caregiver	5	7.6%	1	1.1%	6	3.7%
Fatal assaults – extrafamilial	0	0.0%	4	4.2%	4	2.5%
Risk taking behaviour	0	0.0%	3	3.2%	3	1.9%
Total	**66**	**100%**	**95**	**100%**	**161**	**100%**

3.37 Table 2 shows that nearly a quarter (23%) of rapid reviews relating to fatal incidents were for a SUDI or SUDC. The next largest category of death was suicide with 16%. However, suicides were more common in deaths of girls, accounting for just over a fifth (21%) compared to 12% of deaths of boys. Conversely, extrafamilial child homicide and extrafamilial fatal assaults (where the death followed a physical assault and there was no clear intent to kill the child) combined were the most likely causes of death in over a fifth (21%) of deaths of boys compared to just one (2%) death of a girl.

Serious harm incidents

3.38 As with fatal incidents, the likely cause of harm for serious harm incidents is based on the information reported in the rapid review and may have changed since the review took place. Further definitions of the causes of harm can be found in Appendix C.

3.39 Unlike fatal incidents, the spilt between male and female victims of serious harm was more equal between the sexes with 51% of the 160 incidents relating to girls and 49% relating to boys.

Table 3. Number and proportion of serious harm incidents by likely cause of harm and sex of the child, 2023 to 2024

	Female		Male		Total	
	N	%	N	%	N	%
Likely cause of harm						
Non-fatal assaults – intrafamilial	19	23.5%	29	36.7%	48	30.0%
Non-fatal neglect	8	9.9%	15	19.0%	23	14.4%
Non-fatal assaults – extrafamilial	3	3.7%	14	17.7%	17	10.6%
Child sexual abuse – intrafamilial	15	18.5%	2	2.5%	17	10.6%
Child sexual abuse – extrafamilial	11	13.6%	1	1.3%	12	7.5%
Other non-fatal incident	5	6.2%	7	8.9%	12	7.5%
Severe, persistent child cruelty	7	8.6%	4	5.1%	11	6.9%

	Female		Male		Total	
	N	%	N	%	N	%
Likely cause of harm						
Child sexual exploitation	4	4.9%	0	0.0%	4	2.5%
Attempted suicide	3	3.7%	0	0.0%	3	1.9%
Medical cause	2	2.5%	1	1.3%	3	1.9%
Unclear	2	2.5%	1	1.3%	3	1.9%
Risk taking behaviour	0	0.0%	2	2.5%	2	1.3%
Self-harm	1	1.2%	1	1.3%	2	1.3%
Accident/injury	0	0.0%	1	1.3%	1	0.6%
Child criminal exploitation	0	0.0%	1	1.3%	1	0.6%
Fabricated/induced illness	1	1.2%	0	0.0%	1	0.6%
Total	**81**	**100%**	**79**	**100%**	**160**	**100%**

3.40 The most common likely cause of harm, as shown in Table 3, was intrafamilial non-fatal assaults with 30% followed by non-fatal neglect (14%). Nearly two-thirds (65%) of the 23 non-fatal neglect incidents were against boys.

3.41 Serious harm incidents relating to child sexual abuse, both intrafamilial and extrafamilial, were more likely to relate to girls (32%) than boys (4%). Conversely, boys were more likely to be victims of non-fatal assaults, both intrafamilial and extrafamilial, as a cause of harm than girls. These accounted for over half (54%) of serious harm incidents for boys compared to 27% of incidents for girls.

Involvement with children's social care

3.42 In some incidents, the child in focus and/or their family are known to CSC before the incident occurring. This section looks at the capacity in which the child is known to CSC at the time of the incident, as set out in Table 4.

Table 4. Number and proportion of incidents by type of incident and contact with CSC, 2023 to 2024.

	Death/fatal incident		Serious harm		Total[1]	
	N	%	N	%	N	%
Family known to CSC						
Yes – current open case	80	49.7%	76	47.5%	161	48.8%
Yes – previous known	66	41.0%	58	36.3%	127	38.5%
Total known	146	90.1%	134	83.8%	288	87.3%
Child in need (CIN)						
Yes – at time of the incident	25	15.5%	22	13.8%	49	14.8%
Yes – previously	39	24.2%	41	25.6%	85	25.8%
Total CIN status	64	39.8%	63	39.4%	134	40.6%
Child protection plan (CPP)						
Yes – on CPP	15	9.3%	16	10.0%	32	9.7%
Yes – previously on CPP	29	18.0%	27	16.9%	57	17.3%
Total CPP status	44	27.3%	43	26.9%	89	27.0%
Child looked after						
Yes – child in foster care	9	5.6%	8	5.0%	17	5.2%
Yes – child in other residential setting	6	3.7%	7	4.4%	13	3.9%
Yes – child in residential home	8	5.0%	10	6.3%	18	5.5%
Previously looked after	3	1.9%	6	3.8%	9	2.7%
Total Looked After status	26	16.1%	31	19.4%	57	17.3%

	Death/fatal incident		Serious harm		Total[1]	
	N	%	N	%	N	%
Child subject to a care order						
Yes – currently subject to care proceedings	5	3.1%	1	0.6%	6	1.8%
Yes – emergency or interim protection order	8	5.0%	7	4.4%	15	4.5%
Yes – permanent care order	6	3.7%	12	7.5%	18	5.5%
Yes – other order	12	7.5%	11	6.9%	25	7.6%
Yes – previously subject to care order	3	1.9%	1	0.6%	4	1.2%
Total care order status	34	21.1%	32	20.0%	68	20.6%
Total incidents	**161**		**160**		**330**	

1. Total includes 9 cases with the incident type of other.

3.43 Families may be known to CSC for other reasons not related to the child in focus, for example in relation to a sibling or where a parent was known to CSC as a child themselves. Overall, 87% of families involved in the incidents were known to CSC either as a current open case (49%) or previously known (38%). This was slightly higher in incidents resulting in death, with 90% of families known to CSC, compared to 84% of families where a serious harm incident occurred.

3.44 Overall, 41% of children in focus were known as a child in need, either at the time of the incident (15%) or previously (26%). This is an increase on the previous year where 32% of children in focus were or had been classed as a child in need.

3.45 In addition, 10% of children were on a child protection plan (CPP) at the time of the incident and a further 17% had previously been on a CPP. This means that overall, over a quarter (27%) of the children harmed were, or had previously been, on a plan put in place to protect them.

3.46 15% of the children in focus were children who were looked after, which is the same as the previous year, with a further 3% who had previously been looked after. However, when looking at older children, a fifth (21%) of 11- to 15-year-olds and a quarter (26%) of 16- to 17-year-olds who experienced harm were children looked after.

3.47 Around one in five children (21%) were subject to, or previously subject to, a care order which is similar to the previous year (20%).

3.48 A greater proportion of boys either were or had previously been a child in need with 46% compared to 34% of girls. However, 28% of girls were on or had previously been on a CPP compared to 26% of boys, 17% of girls were children looked after compared to 13% of boys, and nearly a quarter (24%) were subject to a care order or care proceedings compared to 18% of boys.

3.49 Conversely, 147 children in focus (45% of all reviews) were not known to CSC at the time of the incident as a child in need, a child looked after, or a child on a CPP. However, a sizeable proportion of these children did have contexts such as physical abuse (50%) and neglect (39%) present in their lives prior to the incident. Additionally, 45% of these children were aged 1 and over.

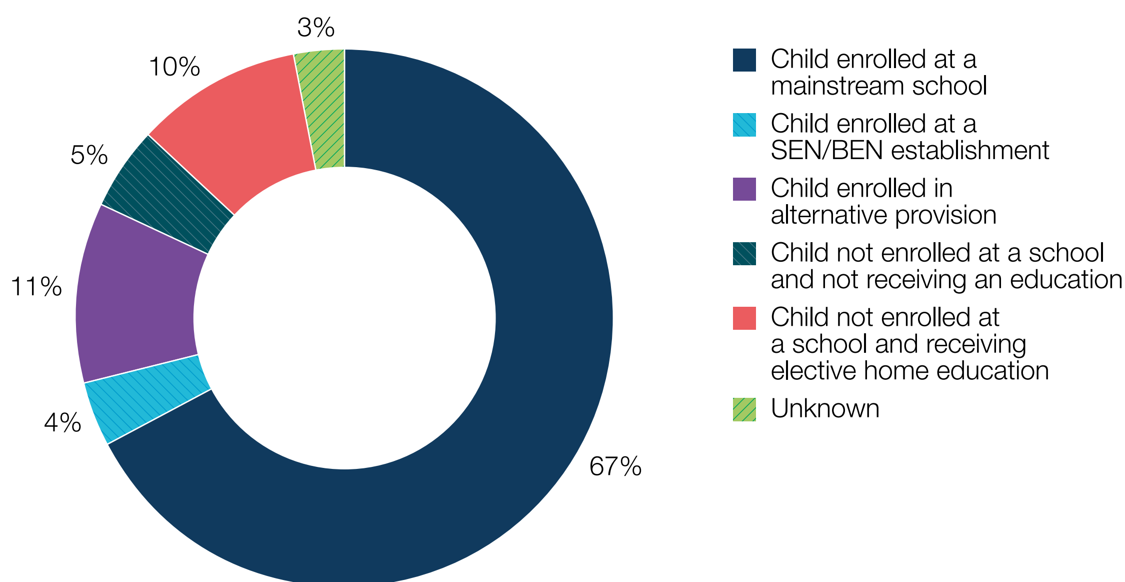
3.50 This year we have recorded whether the child in focus is also a carer, either as officially recognised by the local authority or as reported in the review as having undertaken caring responsibilities. In 12 (4%) incidents the child was thought to have caring responsibilities, with five of these children recognised by the local authority as a carer.

These findings align with broader trends noted in last year's report, which highlighted a steady increase in children in need and children in care since 2020, partly due to increased awareness and reporting of child welfare concerns. In 2023, there were 225,400 child protection Section 47 enquiries, the highest since 2013, with 28% resulting in a CPP, down from 30% the previous year. Further analysis of these broader trends is indicated and safeguarding partners will want to understand their local relevance and to ensure that the right children are receiving help and protection in a timely way.

Needs of the child

3.51 This section relates to the needs of the child in focus in relation to other service provision such as education, health and support services. Further data on this can be found in Appendix D.

Chart 9: Proportion breakdown of educational status of 4- to 15-year-olds at the time of the incident (n=101), 2023 to 2024



3.52 Chart 9 shows that of the 101 children of school age (aged between 4 and 15 years old) and the focus of a rapid review, two thirds (67%) were enrolled at a main-stream school at the time of the incident.[1] A further 15% were enrolled either at a special educational needs establishment or in alternative provision.

3.53 Overall, 15 children were not enrolled at school at the time of the incident with 10 of these reported to be receiving elective home education (EHE) and five thought not to be receiving an education. This is the same number of children as the previous year.

3.54 Three-quarters (75%) of girls were recorded as being in a mainstream school which is greater than for boys (57%). However, 21% of boys were recorded as being in a special educational needs establishment or alternative provision compared to 10% of girls. In addition, a greater proportion of boys were recorded as not enrolled in school with 19% compared to 12% of girls.

1 This excludes five children aged 4 years old where the review made it clear they were still attending nursery.

Elective home education was explored further in our 2024 briefing paper, 'Safeguarding children in elective home education', where we acknowledged that we are seeing evidence that children who are electively home educated were less visible to safeguarding agencies than those who attend school. While there can often be good reasons why parents decide to home educate their child, in some incidents a child's vulnerability can be increased through the loss of school as a protective factor. **The Panel welcome government's proposed introduction of registers for children who are being home educated in the Children's Wellbeing Bill.** The development of such a register needs to consider how best to ensure that children's views and voices are included in decision-making. Our briefing paper recommends that safeguarding partners assure themselves about the effectiveness of their local systems relating to safeguarding of children who are electively home educated.

3.55 Of the 68 children enrolled in a mainstream school at the time of the incident, 41% were reported as having regular absences or low attendance. Overall, across all school age children, 48% were recorded as missing from education, for example, through regular absences, exclusion or long-term health conditions.

3.56 Overall, there were 73 children in focus who were aged 16 and 17 years old. Of these, a third (33%) were recorded as not being in education, employment or training, which is similar to the previous year (31%). Of these 24, the majority (79%) were boys and 21% were girls. Extrafamilial harm was a key cause of harm for these children with seven suffering extrafamilial non-fatal assaults and four dying from extrafamilial homicide or fatal assaults. Extrafamilial harm is explored further in Chapter 6.

Children who are not in education, employment or training or frequently missing from school may be more vulnerable to extrafamilial harm and a higher risk of being targeted by individuals or groups seeking to exploit them. The structure and routine provided by regular school attendance can act as a buffer against these risks, offering a safe environment where children can develop resilience and receive support from trusted adults. As highlighted in our report, 'It was hard to escape', it is vital that there is good multi-agency collaboration to identify and support children at risk of not being in education, employment or training, or frequently missing from school, and to ensure that interventions are timely and effective.

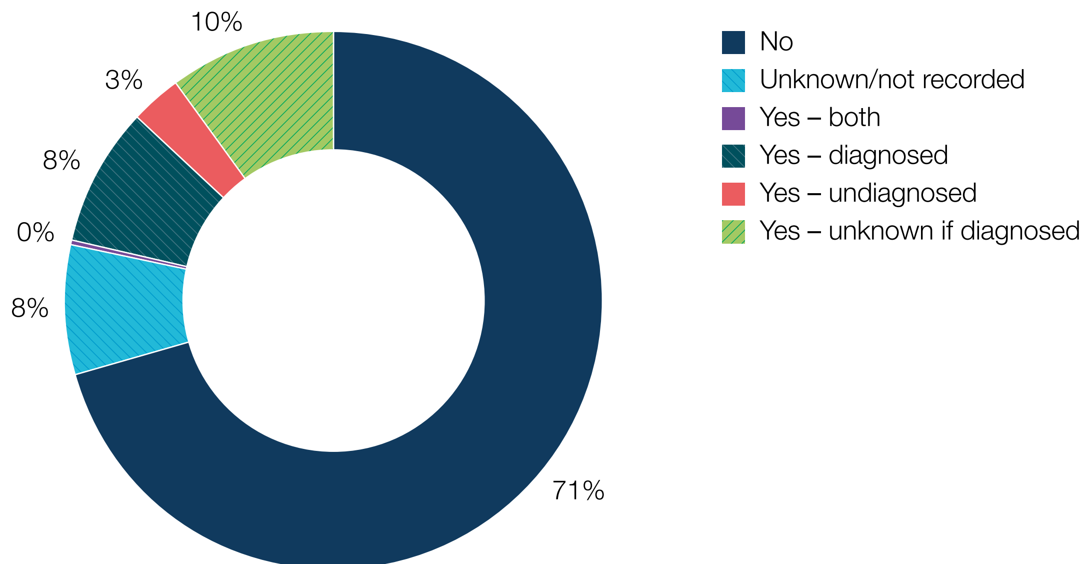
3.57 When looking at children across all ages (n=330), 9% were receiving special educational needs and disabilities (SEND) support. This was slightly higher among boys (10%) than girls (7%). The proportion of children receiving SEND support increased with age from 7% of 1- to 5-year-olds to nearly one in five (19%) 11- to 15-year-olds.

3.58 Children who need more support than is available through SEND services can be assessed for and receive an education, health and care plan (EHC plan) which sets out the child's needs. Overall, 11% of children were reported as having an EHC plan in place at the time of the incident with a further 2% being assessed for one and 1% having previously been on one. The proportion of boys on an EHC plan was greater than girls with 14% compared to 7%. A quarter (25%) of children aged 11 to 15 and 16 to 17 either had an EHC plan in place or were being assessed for an EHC plan.

3.59 Speech and language challenges were reported as affecting 12% of children. Of these 40 children, 38% were receiving support, 33% were not receiving support and in the remaining 30% it was unclear in the review if they were receiving support. The proportion of children affected by speech and language challenges was more apparent in the younger age groups with 42% of 6- to 10-year-olds and 28% of 1- to 5-year-olds affected compared to 7% of 11- to 15-year-olds and 14% of 16- to 17-year-olds.

This suggests that the children experiencing the harm leading to these reviews often require further support through SEND, an EHC plan or speech and language services, generally during their educational years. The SEND Code of Practice (2015) emphasises the importance of a co-ordinated approach involving educational, health and social care services. These children may benefit from mental health services, social work support, tailored educational interventions, occupational therapy, behavioural therapy and family counselling to address their unique needs. The recent report 'Support for children and young people with special educational needs' highlights that the current system is not delivering better outcomes for these children, despite increased funding and efforts to improve services. It also notes the need for routine reviews of individual EHC plans to assess their effectiveness, and benchmarks for local authorities to determine the cost of specialised provision.

Chart 10: Proportion of children recorded with one or more mental health conditions, n=330, 2023 to 2024



3.60 As shown in Chart 10, over a fifth (22%) of children in focus were reported to have one or more mental health conditions, either diagnosed or undiagnosed, which is similar to the previous year (21%). Mental health conditions reported include anxiety, depression and suicide ideation.

3.61 Within the reviews there was a greater proportion of girls (28%) reported as having one or more mental health conditions than boys (16%). The proportion of children with mental health conditions was also greater for older age groups with over half (52%) of 16- to 17-year and 45% of 11- to 15- years-olds reported as having one or more conditions.

3.62 A diagnosed mental health condition of the child in focus was reported in 28 reviews, with nearly half (46%, n=13) of these linking the condition to the incident. There were also an additional seven reviews where it was felt that the mental health condition was linked to the incident, but it was unclear if the condition had been diagnosed. Of the 20 incidents where the mental health condition was thought to be linked, 70% of children died, all of whom completed suicide. Mental health of children is discussed further in Chapter 4.

3.63 Overall, 14% of children were recorded as being neurodivergent. This is slightly lower than the previous year (16%). The proportion of children recorded with neurodiversity was greater among boys with 18% compared to 9% among girls. Interestingly, half (50%) of the children recorded as being neurodiverse were aged 16 to 17 years old.

3.64 Child and adolescent mental health services (CAMHS) support children experiencing mental health difficulties including those with neurodiversity. For the incidents occurring in 2023 to 2024, over a fifth (23%) of children were known to CAMHS which is similar to the previous year (22%). Of these 77 incidents, 40% were an open case, 39% had previously been supported by CAMHS and 21% were either on a waiting list or had a referral made.

3.65 In 12% (n=39) of incidents the child in focus was known to youth offending teams with two-thirds (67%) known at the time of the incident (66%) and a third (33%) known previously. This is the same proportion as the previous year. The majority (87%) of children who were known to youth offending teams were boys. In addition, the majority (77%) were aged 16 to 17 years old.

Needs of the parents or relevant adult

3.66 Of the 330 incidents reported to the Panel for incidents occurring in 2023 to 2024, 17% involved young parents aged under 25 years old, which is an increase on the previous year (13%). Of these incidents, 13% had one or more parents aged under 18, all of whom were known to CSC either as an open or previous case.

3.67 In addition, in 4% of incidents parents were recorded to be care leavers (under 26 years old and have previously been in the care system) although this was not always easy to identify from the reviews. This suggests that extra help from services may have been needed to support these groups of parents.

3.68 In a quarter (25%) of incidents at least one of the parents or relevant adults were reported to have a disability, whether it be physical, mental health-related, learning or developmental. This is an increase on the previous year (18%). The proportion of incidents where a parent was reported to have a disability was slightly greater for serious harm incidents (28%) than for child deaths (23%).

3.69 In addition, in over half (53%) of incidents, at least one of the parents or relevant adults were reported to have a mental health condition, although it was not always clear in the reviews as to whether these conditions were diagnosed or not. Again, this is a slight increase on the previous year (50%). The proportion of incidents where a parent was recorded with a mental health condition was slightly greater in incidents where the child had died (56%), compared to incidents of serious harm (51%).

3.70 In 43% of incidents at least one of the parents or relevant adults were recorded to have an addiction to or were misusing alcohol and/or substances (including prescribed substances), which is an increase on the previous year (39%). The proportion was similar in incidents where the child had died (44%) and where the child suffered serious harm (42%).

3.71 In the 141 incidents where parental alcohol and/or substance addiction or misuse had been recorded, over half (51%) were for substances alone, 29% were for both alcohol and substance misuse or addiction, and 20% were for alcohol.

3.72 In over half (57%) of incidents where a parent or relevant adult was recorded as having a mental health condition, a parent was also recorded as having alcohol or substance misuse or addiction. This proportion was lower in incidents where there was no parental mental health recorded (27%). In addition, 71% of those recorded with parental alcohol or substance misuse, also had a parent or relevant carer with a mental health condition.

3.73 As reported in our 2022 to 2023 annual report and outlined in 'Out of routine: A review of sudden unexpected death in infancy (SUDI)', a key risk factor of SUDI is parental use of alcohol and drugs during pregnancy and when co-sleeping. Of the 37 reported incidents of SUDI during 2023 to 2024, nearly two-thirds (65%) involved a parent who had alcohol and/or substance addiction or misuse recorded.

Risk factors

3.74 This section presents analysis on factors, which if present in a child's life, add to their vulnerability of harm. Additional figures are set out in Appendix D.

3.75 In our Annual Report 2022 to 2023 there was a focus on neglect, and we identified that it was a factor in over half of the notified incidents. This is at a similar level for 2023 to 2024 with 49% of children in focus having experienced neglect in their lives.

3.76 Of these 163 incidents where neglect was present, the families were known to CSC in all but 10 incidents. In most of these (62%) the families were an open case at the time of the incident with the remaining 38% having previously been known to CSC. In relation to the child in focus in almost half (47%) of these incidents where neglect was present, the child was (34%) or had previously been (66%) classified as a child in need. Additionally, in 42% (n=68) of incidents where neglect was present, the child was on a CPP either at the time of the incident (35%) or previously (65%). These figures underscore that the children and families that CSC are involved with often have complex, persistent and recurring child welfare issues.

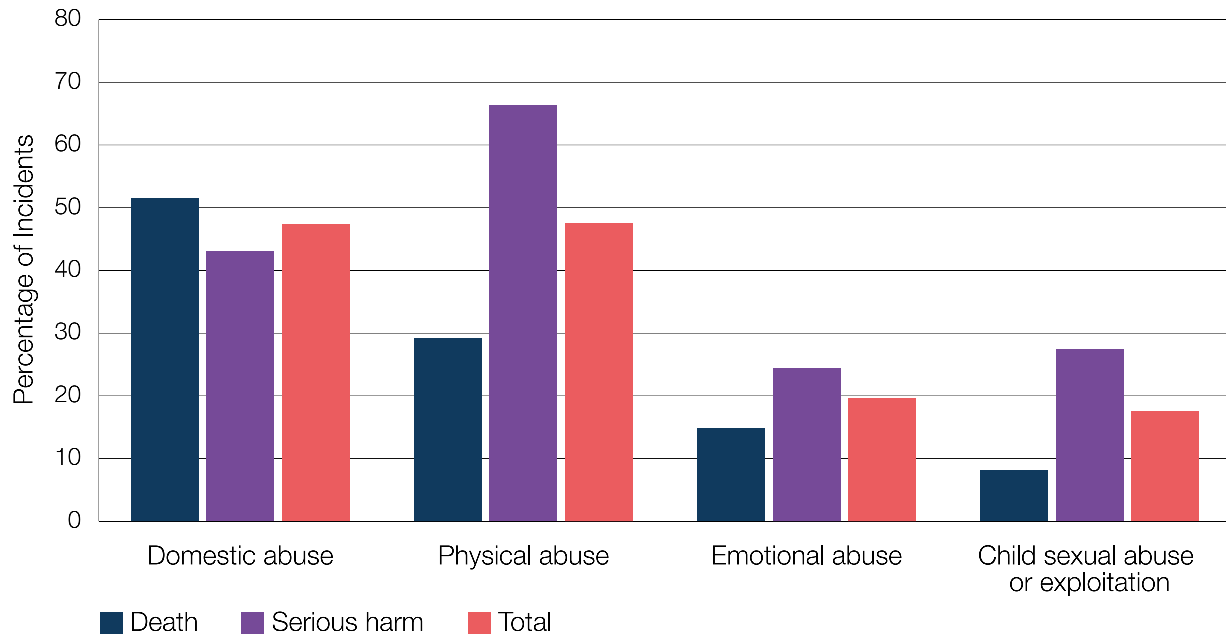
3.77 As identified in our Annual Report 2022 to 2023, poverty can often be a factor in neglect. In 17% of incidents the reviews suggested there was financial hardship within the family environment, although this was slightly greater among deaths (19%) than incidents of serious harm (14%). In 71% (n=39) of incidents where financial hardship was reported, neglect was also a factor. Housing issues, such as temporary accommodation, overcrowding and poor housing conditions, were also an issue in a third (33%) of incidents overall. Similarly to financial hardship, the majority (68%, n=73) of incidents with housing issues also included neglect as a factor. The Panel will be publishing a report on our thematic analysis focused on neglect in 2025. This will include discussion about some of the challenges in identifying and responding to children who are being neglected.

3.78 The presence of domestic abuse within the household was reported in nearly half (47%) of incidents occurring in 2023 to 2024 which is a slight decrease on the previous year (50%). The presence of domestic abuse was slightly higher in incidents where the child died (52%) compared to serious harm incidents (43%). These figures align with our 'Multi-agency safeguarding and domestic abuse' report (2022b), which highlights instances where the risk to children was underestimated, despite clear signs of domestic abuse, and critical information was not shared.

3.79 Overall, a history of inter-generational abuse was present in 14% of incidents, which is slightly higher than the previous year (10%). In over half (55%) of these incidents domestic abuse was also present.

3.80 In nearly a third (32%) of the 47 incidents where there is a history of inter-generational abuse, and in 28% of the 156 incidents where domestic abuse was present, the reviews also identified that men within the family were often 'invisible' to services. Since the Domestic Abuse Act 2021 came into effect, children are now recognised as victims if they witness, hear or experience the effects of domestic abuse.

Chart 11: Proportion of deaths and serious harm incidents by abuse type, 2023 to 2024



3.81 Often the children in focus have also experienced other forms of abuse prior to the incident that is reported. Chart 11 shows the proportion of deaths and serious harm incidents where these types of abuse had been present in the child's life. Out of the 330 incidents occurring in 2023 to 2024, the review identified that nearly half (48%) of the children in focus had experienced physical abuse, one in five (20%) had experienced emotional abuse and 18% had experienced sexual abuse or exploitation within their lives.

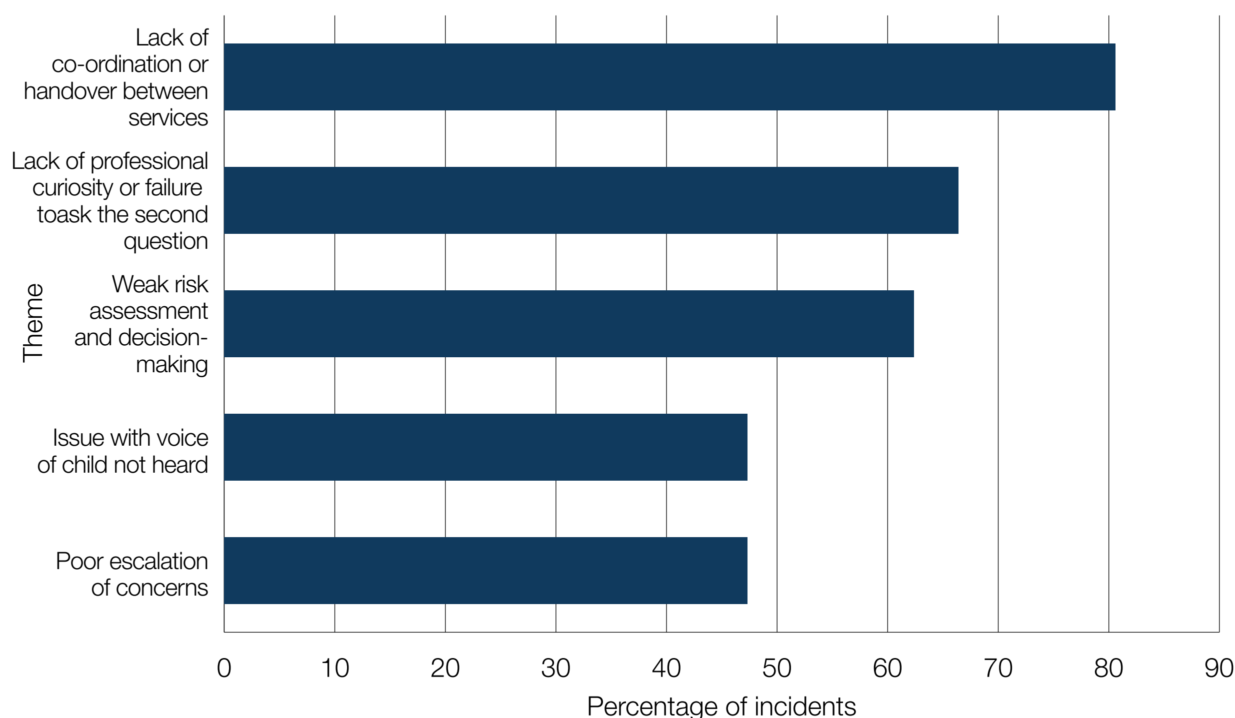
3.82 Child-on-child abuse (of any kind) was reported in 9% of incidents with most of these (73%) being extrafamilial in nature and 27% occurring within the family (intrafamilial). In half (50%) of these incidents the child in focus was aged 16 to 17 years old and in a further 37% the child in focus was aged 11 to 15 years old. Child on child abuse has also been identified as a growing issue within the Vulnerability Knowledge and Practice Programme's 'National analysis of police-recorded child sexual abuse and exploitation crimes' report.

3.83 Overall, 13% of incidents involved gang-related and/or youth violence and 13% involved child criminal exploitation (CCE) with 82% of these incidents involving both CCE and gang-related and/or youth violence. In 12% of reviews there was a victim/perpetrator overlap, where the child, as well as being the victim, had also previously committed crimes. Further analysis of incidents involving extrafamilial harm are presented in Chapter 6.

Learning and practice themes

3.84 In addition to identifying any immediate safeguarding actions, the purpose of rapid reviews is also to establish the potential for practice learning within the safeguarding system (CSPRP, 2022c). This section focuses on the most commonly identified learning and practice themes: lack of co-ordination or handover between services, lack of professional curiosity or failure to ask the second question, weak risk assessment and decision-making, understanding and listening to the voice and experiences of children, and poor escalation of concerns. These themes are not new and represent a continuation of themes identified in our previous annual reports. Chart 12 shows the proportion of incidents where these themes were featured.

Chart 12: Proportion of incidents by learning and practice theme, 2023 to 2024



3.85 Lack of co-ordination or handover between services featured in 81% of incidents. These often included failures in information sharing, inconsistent record keeping, role confusion, delayed responses and fragmented services. These issues can lead to critical information being missed and delays in addressing a child's needs. However, in 14% of incidents where this was an issue, good practice had also been identified in the form of effective information sharing and multi-agency communication.

3.86 Two-thirds (66%) of reviews noted a lack of professional curiosity or failure to ask the second question. This can lead to professionals missing signs of abuse or neglect, for example by accepting surface-level explanations, overlooking or failing to see when parents are seemingly co-operating but are not keeping to agreed plans, and not investigating inconsistent stories or red flags. This highlights the need for deeper questioning and thorough assessments. Where good practice had been identified, this was often when there had been effective communication about concerns or following up unattended appointments

3.87 Weak risk assessment and decision-making was evident in 62% of incidents. Weak risk assessment often involved overlooking critical aspects of the family context, such as the role of extended family members, other adults being present in the home, other children within the family, and failing to consider comprehensive information from all agencies. This can then lead to weak decision-making. Identified good practice included recognition of the impact and relevance of family history in assessments and proactive decision-making to identify risk of harm.

3.88 In nearly half (47%) of the incidents, not listening to and understanding children's voices and perspectives was identified as a key practice learning theme. The voice of the child, or consideration of the child's daily life experience, can be overlooked when professionals have infrequent direct contact, focus more on parents' needs, or misinterpret the child's communication. Ensuring the child's perspective is heard and prioritised is crucial for effective safeguarding, as this improves professionals' abilities to act in the child's best interest (National Society for the Prevention of Cruelty to Children, 2024b). Good practice identified within the reviews included strong consideration of the child's needs, using a trauma-informed approach and developing a positive relationship with the child.

3.89 Poor escalation of concerns also featured in nearly half (47%) of the reviews. Poor escalation of concerns can occur when risks in birth plans are unaddressed, disagreements on referral criteria are not resolved, conflicting assessments are ignored, and serious concerns are communicated too late. Good practice identified included professionals challenging decisions appropriately and escalating where needed.

Quality of reviews

3.90 This section focuses on data collected by the Panel to reflect on the effectiveness of the notification and review system, the timeliness of reporting of serious incidents, and the evaluation of the overall quality of submissions.

3.91 Working Together 2023 (HM Government, 2023) states that the local authority should submit a SIN within five working days of becoming aware of an incident where a child has died or been seriously harmed, and abuse or neglect is known or suspected. This year, just over half 51% of the 330 SINs met the five-day threshold, which is higher than the previous year (46%). There was an average of 12 days between the incident date and the notification date, which is less than the previous year's average of 19 days. Overall, 90% of notifications occurred within four weeks (28 working days) of the incident date. However, it should be noted that in some incidents SINs were submitted retrospectively, for example where there were delays in the identification of the incident or technical difficulties with the reporting system.

3.92 Rapid reviews are expected to be completed and submitted by safeguarding partners within 15 working days of the SIN. Over half (52%) were submitted within this timeframe, with the average time being 20 working days. The proportion of reviews submitted within 15 working days has fallen on last year where 78% of reviews met this requirement. However, part of the decrease this year may be due to a change in the data recording approach by the Data Insights Team to focus on the date of submission to the Panel rather than the date of the review meeting itself. In some incidents where there was a delay, extensions had been requested by the safeguarding partners. In other incidents, annual leave and holiday periods appeared to impact the delivery of the rapid review and for some reviews there was delay in getting the information due to the complexity of the case. It is important that partnerships meet the 15-day timeframe because this is a crucial period for identifying any urgent actions that may be needed and for responding to any immediate learning.

3.93 The Panel's guidance on rapid reviews states that they should provide a brief summary of facts, present any relevant information and conclude with a reflection on the case. The average length of rapid reviews for incidents occurring in 2023 to 2024 was 13 pages with the shortest being 3 pages and the longest being 33 pages.

3.94 Following consideration of the rapid review by the Panel, the safeguarding partners are sent a response letter confirming whether we agree with their decision to progress to a LCSPR. Of the 330 rapid reviews for 2023 to 2024, the Panel agreed with the majority (81%) of the safeguarding partners' decisions on whether an LCSPR was needed, which is an increase from 70% in 2022 to 2023.

3.95 For 10% of the reviews, we were unable to conclude on whether we agreed with the safeguarding partner's decision, and for 9% (n=30) we did not agree with the decision. In three-quarters (77%) of these, the safeguarding partners had decided an LCSPR was not needed but we felt there was still additional learning to be gained. In the reviews where safeguarding partners felt an LCSPR was needed but we disagreed, this was primarily due to questioning whether any additional learning would be identified through the process or whether proceeding with an action plan based on rapid review analysis might be more beneficial.

3.96 We also use the response letter as an opportunity to provide feedback on the quality of reviews. The majority of reviews submitted have been of good quality, demonstrating thorough and clearly articulated analysis that identifies relevant learning including about good practice. However, some reviews lacked necessary and thorough analysis, sometimes with incomplete information. Some reviews gave inadequate consideration about what life was or would have been like for a child. Analysis of the possible impact of race, ethnicity and culture on a child, their family and on practice responses was also absent in some reviews.

3.97 Our Annual Report 2022 to 2023 commented on the importance of including analysis about the impact of key characteristics of the child in reviews, including sex, gender, ethnicity and disability. This is important to better understand children's and families' lives and experiences, and practice decision-making. Although the proportion of recorded ethnicity has increased on last year, some reviews do not reference and consider the impact of characteristics such as gender, disability or sexual identity. It is difficult to establish whether this non-recording is due to the characteristic not being present or not being considered within a review. We would encourage safeguarding partners to record and consider these characteristics where appropriate.

Our current learning support project aims to test and co-develop ways to support safeguarding partners and other professionals to generate high-quality learning from LCSPRs. We expect to publish a report in early 2025. The Panel are also considering trialling a new framework for rapid reviews to support consistency and quality of information within these.

Summary

3.98 There were 330 SINs and rapid reviews submitted for incidents that occurred between April 2023 and March 2024. This is a decrease on the previous year, mainly due to a reduction of SINs submitted for serious harm incidents and reflects the national picture around SIN submissions. This warrants further scrutiny and analysis. The Panel is therefore undertaking work with the Department for Education to understand better some of the drivers and factors that may have shaped this decrease.

3.99 Overall, around half of rapid reviews were in relation to deaths, half in relation to serious incidents and a small proportion in relation to 'other' types of incidents, such as where the child is the perpetrator. This year we have seen an increase in the proportion of 16- and 17-year-olds as the child in focus although under 1s remain the largest age group, and SUDI remains the most common likely cause of death. As with the previous year, a high proportion of children or their families are known to CSC prior to the incident.

3.100 Neglect continues to be a key factor in the child's life, as do other types of abuse such as domestic abuse and physical abuse. Mental health is also a factor affecting both parent and child and is discussed further in the following chapters. The reviews also highlighted several key recurring learning and practice themes, including lack of co-ordination and handover between services, insufficient professional curiosity, weak risk assessment and decision-making, failure to hear the child's voice, and inadequate escalation of concerns. Safeguarding partners will want to consider whether and how they may need to address these issues to enable the very best child safeguarding practice.

4. Spotlight theme: Safeguarding children with mental health needs

4.1 The next three chapters spotlight three specific themes: safeguarding children with mental health needs, safeguarding pre-school children with parents with mental health needs, and extrafamilial harm. Last year's annual report, our national and thematic reviews, and our engagement with partnerships have all highlighted the importance of these themes to safeguarding practice. We conducted deeper analysis to provide an up-to-date picture of how these themes feature in reviews. Chapter 6 concludes with an overview of cross-cutting themes and areas of practice which were present across each of the spotlight themes.

4.2 The learning presented here is drawn from the quantitative analysis of 330 rapid reviews and the qualitative analysis of a sample of rapid reviews and LCSPRs. You can read about the methodology used in Appendix E. In these chapters, we have presented the relevant headline statistics. The detailed data tables can be found in Appendix F.

Children with mental health needs

4.3 Children with mental health needs consistently feature in reviews notified to the Panel. In our last annual report, we highlighted data on mental health in teenagers and described some of the emerging issues identified in reviews regarding children with complex mental health needs.

4.4 We wanted to explore these issues further and determine whether similar or additional issues featured in more recent reviews. It is recognised that service gaps about support for children's mental health are not easily resolved at a local level. Importantly, however, reviews continue to identify learning about how agencies work together in responding to children's mental health needs. Our analysis, therefore, sought to identify common learning and good practice focusing on multi-agency barriers and opportunities for practice.

Although there can be interchangeable use of terms to describe mental health services for children, more broadly known as Children and Young People's Mental Health Services (CYPMHS), throughout this report we generally refer to child and adolescent mental health services (CAMHS) when referring to NHS provision, as this is the terminology used most commonly in reviews.

Quantitative analysis of rapid reviews

4.5 To support the in-depth qualitative analysis of reviews, we conducted quantitative analysis on all rapid reviews with incidents that occurred between 1st April 2023 and 31 March 2024. Of the 330 incidents recorded during this period, in **just over a fifth of cases** (22%, n=71), the child in focus was recorded as having one or more mental health conditions. We record a 'mental health condition' where reviews report that the child has either a diagnosed or undiagnosed mental health condition, illness or need.

4.6 In 38% of these reviews the mental health condition was diagnosed, in 14% it was undiagnosed, and in one case (1%) it was both. However, in just under half (46%) of these cases it was unknown or unclear from the review if the condition(s) was diagnosed or not.

4.7 Most (96%) of the children recorded as having at least one mental health condition were aged 11 to 17 years old. This compares to 43% of children without a mental health condition(s) who were aged 11 to 17 years old. Mental health conditions in young children may be under-reported. The Royal College of Psychiatrists (2023) report that only a minority of under 5-year-olds with mental health conditions are being identified and receive treatment.

Making comparisons

Given that the vast majority (all but three) of children reported to have at least one mental health condition within our full dataset of 330 rapid reviews were aged 11 to 17, the data provided below compares **children aged 11 to 17 with a mental health condition** with **children aged 11 to 17 who did not have a reported mental health condition.** This provides a more accurate comparison across the two samples and reduces the possibility of any perceived differences between the two groups being overly influenced by age.

The two samples used for comparison were:

- 68 children who were aged 11 to 17 and had a mental health condition(s)
- 72 children who were aged 11 to 17 without a mental health condition(s)

Child characteristics

4.8 There was a higher proportion of girls and white children with a mental health condition(s) than in the comparison group (Table 4.1). Over half were aged 16 to 17 and just over a third were neurodivergent. Nine children were recorded as having a gender identity different to the sex they were assigned at birth and all but one of these children were recorded as having a mental health condition. Similarly, all but one of the 11 children identifying as LGBTQ+ had a mental health condition. We saw similar proportions for these characteristics in last year's analysis indicating some consistency in the rates of children with mental health conditions who have a different gender identity to those they were assigned at birth and those who identify as LGBTQ+.

Table 4.1: Socio-demographic characteristics for children with and without a mental health condition(s)

		Children with a mental health condition(s) N=68	Children without a mental health condition(s) N=72
		%	%
Age group	Aged 11 to 15	44%	51%
	Aged 16 to 17	56%	49%
Sex	Female	60%	26%
	Male	40%	74%
Gender	Gender identity different to sex registered at birth/non-binary/other	12%	1%
LGBTQ+	Identifies as LGBTQ+	15%	1%
Disability	Yes	32%	39%
Neurodivergent	Yes	34%	26%
Ethnicity	White	71%	42%
	Mixed/multiple ethnic groups	13%	22%
	Asian/Asian British	6%	7%
	Black/African/Caribbean/Black British	7%	25%
	Other ethnic group	1%	3%
	Unknown/not recorded	1%	1%

Death and serious harm

4.9 Just over half (53%) of the children with a mental health condition died. Suicide was the most common likely cause of death (64%) in these incidents. Most (92%) of the children who died by suicide within the whole dataset were recorded as having a mental health condition and the majority of children who died by suicide were girls (61%). Although small numbers, the boys with mental health conditions who died by suicide were slightly older than the girls (78% aged 16 and 17 years old compared to 36% for girls).

4.10 Among children with a mental health condition who experienced serious harm (46%), child sexual abuse or exploitation (CSA/E) was the most likely cause of harm in over half of these cases (52%). There were five cases where the child had caused serious harm to themselves, either through attempted suicide (n=3) or self-harm (n=2).

Child circumstances

4.11 Compared to children without such a condition, there were slightly higher proportions of children with a mental health condition who had an EHC plan in place (28%), were in a residential home at the time of the incident (19%) or were an open case to CSC (68%).

4.12 The five most common risk factors for children with a mental health condition were:

- physical abuse (56%)
- neglect (53%)
- CSA/E (51%)
- domestic abuse (50%)
- their addiction to or misuse of alcohol/substances (49%)

Neglect and CSA/E were notably higher among this group compared to the comparison group.

Qualitative analysis of reviews

4.13 In-depth qualitative analysis was undertaken on 20 reviews (15 rapid reviews and five LCSPRs) where the child in focus was recorded as having a mental health condition. Cases were selected to ensure a range of socio-demographic characteristics, as well as experience of different contextual factors, such as children missing education, experiencing online harm, bullying, domestic abuse, alcohol or substance use, or exploitation (Table 4.2).

Table 4.2: Socio-demographic characteristics of the qualitative sample of children with mental health needs

		N	%
Age group	11 to 15	10	50%
	16 to 17	10	50%
Sex	Female	11	55%
	Male	9	45%
Disability	Yes	7	35%
	No	13	65%
Ethnicity	White	13	65%
	Mixed/multiple ethnic groups	3	15%
	Asian/Asian British	2	10%
	Black/African/Caribbean/Black British	2	10%
	Other ethnic group	0	0%
Total		**20**	**100%**

4.14 Fifteen of the 20 children in the qualitative sample had received mental health diagnoses for a wide range of conditions, including: post-traumatic stress disorder, complex post-traumatic stress disorder, depression, attachment disorder, social phobia, obsessive-compulsive disorder, generalised anxiety disorder, panic disorder and childhood emotional disorder. Reviewers referred to experiences of trauma in four of the reviews.

4.15 Ten children had identified disabilities and additional needs, with three reported to have a developmental delay. Eleven children were considered to experience neurodivergence, however, there was frequent confusion between practitioners about whether the child had received a diagnosis.

Good practice

4.16 Reviews featured multiple examples of good joint working and inter-agency communication, in particular between CSC, CAMHS, education and health. Reviewers identified features of good multi-agency work when responding to mental health needs in children including regular, formal oversight of management and planning, the timely progression of assessments, and well-attended meetings. We saw some agencies actively challenging and questioning decisions made by other agencies they disagreed with.

4.17 Some reviews demonstrated particularly effective information sharing around children's needs and vulnerabilities. There were also examples of information being effectively shared when a child with mental health needs started a new care placement or when a placement was at risk of being disrupted. Some reviews reflected evidence of good information sharing within health, for example between different hospitals and between hospitals and community services. There were also examples of robust multi-agency communication with CAMHS which allowed schools to be aware of historical issues featuring in children's lives.

4.18 Effective and dynamic multi-agency planning was noted in work with children with mental health needs when circumstances changed or risk escalated. For example, legal orders, safety and care plans were reviewed and updated.

4.19 There were some good examples of the wider family network being included in assessments and planning, which meant that practitioners had a firm understanding of the family dynamics and methods to mediate between family members during times of crisis.

4.20 Good practice was often identified in responses by schools, highlighting their crucial role in building relationships with families and children. Poor mental health can impact a child's attendance at school and research has shown that parents can most often seek help and advice about children's mental health concerns from education services (Newlove-Delgado and others, 2023). Education and childcare settings have daily contact with most children and families, placing them in a unique position to identify concerns early on (HM Government, 2023). As such, schools provide opportunities for children to explore their experiences and access support. Good practice included planning to support children when they moved schools, as well as identifying and responding to their mental health needs.

4.21 There were some excellent examples of the child's voice and perspectives being central to care planning, with plans reflecting their wishes and feelings. The child's voice was strongly heard within these records enabling effective advocacy by practitioners. Professionals worked hard to accommodate a child's needs to increase their engagement with services. Examples included working flexibly to fit children's timetables, offering virtual appointments, and giving the child time and space to consider their decision to end service involvement. The effective use of legal orders and Deprivation of Liberty Safeguards (DoLS) to manage the risks to children was evident in several reviews.

Key findings

Assessing and responding to the mental health needs of children

4.22 Our analysis evidenced that the interrelationship between abuse and neglect and mental health is yet to be consistently recognised and explored by practitioners. The National Society for the Prevention of Cruelty to Children (NSPCC) have recently reflected that neglect is somehow seen as less harmful than other forms of maltreatment and that specialist expertise and response to neglect is lacking (NSPCC, 2024c). This may also impact the recognition of the interplay between neglect and mental health. In our analysis, children with mental health needs notably had additional challenges and experiences of abuse and neglect. Reviews demonstrated that recognising and responding to mental health needs was sometimes secondary to identification and response to abuse or neglect, or not recognised at all. While we saw single agencies responding to children's mental health needs as they emerged, robust multi-agency working was required to prevent emerging emotional issues becoming significant mental health needs.

4.23 Some reviews revealed an absence of effective holistic assessment of need. In some cases, there was a disconnect between the assessments conducted by single agencies, leading to confused or misaligned expectations and priorities. Although it is understandable that individual agency assessments might address differing needs, the importance of multi-agency engagement, information sharing and joined-up assessment of need is crucial when there is a significant risk of harm. As indicated earlier, the interconnected nature of children experiencing poor mental health and other contextual factors needs to be comprehensively understood.

4.24 Assessments and interventions did not always consider the child's needs in the round and the risks of harm they might be facing, with focus often being primarily about the presenting issue. Practitioners in statutory services sometimes made assumptions about children's mental health and neurodevelopmental conditions which were then wrongly documented in agency records, potentially impacting responses. There is a clear need for diagnoses to be clarified with health or specialist professionals, recorded accurately, and appropriately understood in terms of how they might manifest in a child's behaviour or the most appropriate way of responding to their needs and behaviour. Managing the behaviours of children with complex needs could sometimes become the focus of practitioner attention, rather than exploring underlying causes. Presenting behaviour was often attributed to the known or assumed diagnosis, rather than any harm the child may have experienced. Practitioners need to consider behaviour as a form of communication, being curious about the child's experiences and how better engagement with them might provide opportunities to disclose harm. Training in trauma-informed care and understanding neurodivergent behaviours can further support this approach.

Case study: Considering diagnoses appropriately and identifying risk

A 17-year-old Black Caribbean boy was seriously injured in a stabbing incident. The child had childhood diagnoses of obsessive-compulsive disorder and post-traumatic stress disorder after the murder of his friend. He wore a stab vest to help himself feel safe, which was recognised by some agencies owing to awareness of his diagnoses through his EHC plan. However, the police were not made aware of his EHC plan and identified the behaviour as a risk indicator for gang involvement. The review highlighted how the wearing of a stab vest indicated that the child was at risk and likely to suffer significant harm, but child protection strategy discussions did not occur, despite Section 47 criteria being met. There were also assumptions that the child was autistic, which became incorrectly documented in some agency records and yet his actual diagnoses were not factored into practitioner considerations.

4.25 There were missed opportunities for agencies to recognise a deterioration in the child's mental health or an escalation of risk in their behaviour. Mental health risks can escalate quickly, requiring close communication between parents or residential care settings and mental health services. Risk assessments need to be dynamic, and any changes quickly communicated. Agencies reported difficulty in identifying risks to mental health in adolescence, where emotional fluctuation becomes more heightened. Reviews identified learning around improved understanding of risk indicators concerning mental health, as well as practitioners having access to resources to help with this.

4.26 Sometimes plans focused solely on the present and although they did not usually include escalation and de-escalation strategies, where they did these were in line with what the child was currently experiencing, rather than considering how this might change in future and what contingencies might be required. Children were subject to repeat plans with important triggers missing or with previous failed interventions simply included again. There were missed opportunities at the point of case closure to have understood some of the remaining issues in the child's life and their progress, and to robustly assess continuing risks. Some cases were being closed even when actions were still outstanding, leaving the child's needs unmet or risks unmanaged.

4.27 Several reviews described weaknesses in record-keeping which made it difficult to track and address the needs of children effectively. Lost assessments or reports needed to be redone, resulting in delay and further impact on the child.

Think Family

4.28 Part of the comprehensive holistic assessment of risk and need requires careful consideration of the child's family and living circumstances, taking a whole family or 'Think Family' approach. Reviews identified that when providing support for children with mental health needs, this needs to include parents who may not live with them. A 'Think Family' approach, when used, facilitated families' involvement in decision-making and care planning. Some reviews highlighted the absence of fathers and other male carers from engagement, with their role in the child's life left unexplored. Understanding and working with family networks is essential for safety planning, especially when there are concerns around parental capacity to keep the child safe. Reviews showed that practitioners overestimated how well parents and carers understood their child's needs, and the capacity of parents to look after a child with mental health needs.

4.29 In families where more than one member received support or supervision from different agencies, many different professionals could be involved, with service involvement for each being dealt with separately, inhibiting a whole family approach. Reviews also pointed to the importance of mapping children's significant relationships as a method for practitioners to understand family dynamics and their impact, including identifying the names of adults accompanying children to appointments, and their specific relationship to the child. We discuss the interface between adult and child services further below.

Race, ethnicity and culture

4.30 Children's ethnicity and culture were seldom addressed or explored in review reports concerning children's mental health. Only one review highlighted the lack of exploration into a family's ethnicity and culture by practitioners. Another review noted that a Black Caribbean child felt racially discriminated against by the police, being viewed primarily as a perpetrator rather than a victim. Some reviews also observed that children from minoritised ethnic backgrounds experienced adultification bias, both from practitioners and within their home environments. Cultural barriers, including stigma and mistrust, often hinder the admission or referral of children for mental health or neurodiversity assessments. One review emphasised the need for further investigation into how CAMHS and specialist mental health services engage with Black children and their families to improve culturally appropriate service provision.

Legislative frameworks and interventions

4.31 There was good practice in some reviews of legal orders being used effectively to safeguard children. However, some reviews identified missed opportunities to have done so. There were also differences, as well as confusion, in professionals' understanding and application of legislative frameworks concerning mental capacity, especially in making assessments about the child's capacity to be able to make specific decisions at specific times. Reviews identified a need for practitioners to think more reflectively when assessing capacity, consent for intervention and the corporate responsibility of the local authority when giving consent for children who are looked after.

4.32 The need for training and better local expertise around the application of the Mental Capacity Act 2005 and DoLS when working with children was also referenced. In one review, although DoLS were used effectively within a hospital setting, issues arose when the child then transferred to a residential unit. The ability to implement safety strategies and measures differed between the two settings but the DoLS was not updated to reflect these differences, meaning that the child was able to run away, which is when the serious incident occurred. A recent report by the Care Quality Commission also highlighted a limited understanding of when and how to apply DoLS (2024).

4.33 At times greater understanding of gaps between a child's actual age and their level of functioning was required for more effective communication and support for them. Other literature has highlighted that the chronological age of the child can be the focus as opposed to the child's level of emotional or psychological development (NSPCC, 2023a). Children aged 16 to 17 were treated as adults in terms of consent, however in some cases there was scope to better explore their capacity to understand the impact and consequences of their decision-making. In one case, practitioners did not consider whether Gillick competence (see the glossary in Appendix A for an explanation) could be established for younger children in a family where their parents had declined treatment for them. Had this been done, the children may have been able to consent in relation to specific decisions affecting them.

Engaging with children and their families

4.34 Reviews often detailed ongoing problems with services being able to effectively engage children and families. Learning pointed to the need for practitioners to more thoroughly question and explore why a child may not be brought to appointments, or families might appear to be reluctant for the child to engage with services, or why a child wishes to cease engagement or parents decline consent.

4.35 The Panel's evidence, along with that of many other bodies, has previously highlighted the critical role of practitioner relationships with children and families in fostering the engagement necessary to address needs. Unfortunately, reviews and other research continue to reveal that workforce-related issues too often undermine the ability for professionals to develop effective and good relationships with children. Frequent staff changes, reliance on agency staff and the involvement of multiple practitioners can be very detrimental to the quality of practice. The effects can be overwhelming and significantly impact children and their families (NSPCC, 2021b). For example, when practitioners leave an organisation without having a proper handover, gaps in knowledge about a child's needs can become overlooked. Reviews also indicate that turnover within CSC can result in inconsistent quality in the monitoring and delivery of safety plans for children.

4.36 Schools and education providers can effectively support engagement with children and families, especially when other services struggle to do so. However, a significant number of children with mental health needs are either not in education or unable to attend consistently. A recent report highlighted that children with a probable mental health condition were seven times more likely than children unlikely to have a mental health condition to have missed more than 15 days of school (11.2% compared with 1.5%) (Newlove-Delgado and others, 2023). This lack of direct contact further limits the opportunity to identify their needs or any risks they may face. In our qualitative sample, two children were not in any educational provision, six had a history of exclusions, and another six had had school attendance issues identified. Seven children required or had EHC plans or special educational needs provision. While EHC plans were sometimes used effectively to secure alternative educational placements, some reviews found that the plans were either not fit for purpose or only provided when children were under the supervision of youth offending teams.

Referrals

4.37 Reviews indicated that referrals to appropriate mental health or emotional wellbeing services were not always made promptly, even when parents reported emerging problems at home or concerns for children in care. Often, necessary follow-up on referrals was not conducted, leaving children without identified support or leading agencies to believe that specific actions had been taken when they had not. Reviews described how some referrals were not properly triaged, causing further delays, and how some did not accurately reflect the full range of concerns regarding the child, resulting in rejected referrals. This issue is particularly problematic given the often very long waiting lists for access to CAMHS.

4.38 Referrals to specialist and general CAMHS mental health services were frequently rejected as they were judged to fall below the level of risk or organisational threshold for assessments and interventions to be put in place. This is an issue that has previously been identified in our other reports and in other research (CSPRP, 2024a; CSPRP 2021a; NSPCC, 2023a; NSPCC 2015b). There was significant confusion among practitioners working outside health about what CAMHS offers, especially about emotional wellbeing or behavioural issues. When investigating the suitability of referrals, at times practitioners made assumptions about what support the child was already receiving, or about other agency thresholds. This highlighted learning around the need for fact checking what intervention services had actually been offered. New referrals were often assessed in isolation, rather than considering any relevant context of historical referrals, and their outcome, for the child.

4.39 The inclusion of specialist services in multi-agency meetings and processes was identified as important when supporting children with mental health needs. However, while other practitioners were reassured by the involvement of mental health specialists, this did at times lead to assumptions that the child had adequate support via those specialist services and practitioners did not fully understand what specific help was being provided and what gaps remained.

Adult-child services interface

4.40 Some reviews identified the critical need for stronger and closer working relationships between adult and children's services, with significant gaps in information sharing, shared decision-making and effective risk assessment for children approaching adulthood. Similar issues have been identified in studies exploring cases where children have experienced neglect (NSPCC, 2022b). Considerations about how a child might need to transition to adult services did not always capture all areas of a child's life, and discussions about eligibility for particular services often occurred too late to be effective. Improvements in provisions for 16- to 17-year-olds were evidently required, as agencies frequently stepped down support without contingency plans. There is a need for a shift in thinking about the nature of provision for 16- to 17-year-olds, with a call from some for commissioning local placements that are dual registered (Ofsted and the Care Quality Commission) to support children's transitions into adulthood.

4.41 A transitional safeguarding approach (Department of Health and Social Care, 2021; Holmes and Smith, 2022) can help support young people as they move into adulthood. There is also a need to recognise the significant change in service thresholds when a child turns 18. Some of the issues which are prioritised within a child safeguarding context may become de-prioritised at the point of transition to adult services. It is important that any ongoing support or safeguarding needs are jointly considered and planned for by children's and adult services. For example, one review highlighted the need for joint supervision to ensure the focus remained on the young person, their childhood trauma and how they could be best supported as they move into adulthood. Transitional multi-agency plans were identified as particularly important for children with complex needs, including mental health needs, special educational needs and those known to youth justice services to ensure their support into adulthood.

Case study: Challenges supporting children approaching adulthood

A 17-year-old white British boy had a history of disordered eating and there were concerns about neglect. His GP faced challenges referring him for support relating to both his weight and to the safeguarding concerns. On one occasion when the child was taken to a GP appointment with low weight, he disclosed suicidal ideation and no thoughts for the future. Mental health services, the school nurse and a social worker all became involved. However, the GP did not refer to him to dieticians because he was not under the care of paediatricians (making it difficult for dieticians to see him) and he would not have been accepted to adult services due to being under 18. The GP contacted the multi-agency safeguarding hub who confirmed that they could not make an adult safeguarding referral due to his age and advised him to speak to early help. On contacting early help, the GP was informed that the case had been closed but they were unable to provide further information over the phone and a request needed to be made in writing. The GP followed up this request via email and spoke with the local authorities' named nurse for safeguarding who was not aware that the case had been closed to CSC. The uncertainty about which services could support the child due to his age, and poor communication regarding case closure meant that his needs, including mental health, were not being effectively addressed and there was a lack of comprehensive understanding among agencies about what was happening.

System issues

4.42 The insufficiency of suitable placements and service provision for children with complex needs, including mental health, is well known and featured again in the reviews analysed here (CSPRP, 2024a; NSPCC, 2024a; NSPCC 2024d). Reviews noted challenges with identifying appropriate local care and health placements as well as a lack of specialist provision, which is a national issue. Consequently, there was evidence of poor risk management, with risk and behaviour plans not being regularly reviewed or updated while children awaited placements or were moved around short-term or interim placements. There was also an absence of crisis management and de-escalation strategies, especially for children known to experience dysregulation. One review commented that responsibility for risk management tends to be placed on either social care or placement staff but actually requires multi-agency planning and accountability. Issues were also noted with foster care placements for children with specialist needs. Matching children to suitable placements could be challenging, especially where practitioners needed to work closely with foster carers to help them understand and meet the child's needs. Reviews also discussed the needs of foster carers, including access to overnight and therapeutic support when a child has significant needs, and offers of learning and developmental opportunities.

4.43 There was also an identified need for safeguarding partners and local agencies to understand the nature and extent of children's mental health risk and forward plan to anticipate future demand for placements for children at risk of becoming more distressed and dysregulated because of past trauma as they enter adolescence. Two reviews suggested the use of national research as well as local learning around complex development trajectories where childhood trauma, neurodiversity and learning disabilities are known. There were also gaps identified in the provision of early intervention or emerging emotional wellbeing support for children not eligible for specialist mental health support. Some reviews identified that practitioners did not understand the pathways for support and missed opportunities to refer children early enough.

4.44 Waiting lists continued to be a significant area of concern and were frequently mentioned in reviews, an issue which we have previously highlighted (CSPRP, 2024a) and which has been recently raised again in a Care Quality Commission report (Care Quality Commission, 2024). The impact of waiting for appropriate services requires greater recognition and response by agencies to support children and their families effectively during these often very lengthy periods. While individual agencies can implement action to support, there need to be local mechanisms to support multi-agency discussion and response.

Key learning points

Learning for direct practice

- Although children may primarily come to the attention of agencies to be safeguarded from abuse and neglect, it is critical to consider the interrelationship between neglect, abuse and mental health.
- Working closely with multi-agency colleagues, including those with specialist mental health knowledge, and adopting a Think Family approach can assist in the assessment of risk and need, helping to identify where family members are able to help protect the child and identify when their mental health may be deteriorating.
- Keeping the voice of the child central in plans and interventions to support their mental health is crucial for fostering their engagement. Given that many children with identified mental health needs are adolescents, they should be fully involved in the care planning process. It is also crucial that a child's capacity to fully understand and consent to interventions, whether health-related or not, is understood.
- Assumptions about diagnoses (whether related to mental health, neurodiversity, learning needs or disabilities) need to be avoided and there needs to be recognition that they might not be the sole cause of presenting behaviour. This can support a better understanding of how best to respond to the child. Seeking advice and support from specialists can help in formulating the appropriate response.

- Following up on referrals made for mental health assessments or support services is crucial to ensure outcomes are known and integrated into plans.
- Good working relationships between general health and mental health practitioners and others are particularly critical when safeguarding children with mental health needs. Practitioners need to understand relevant information sharing processes in their area, including those relating to communication about missed appointments, children not being brought to appointments, hospital admissions or discharges, changes in professionals working with the child, or changes in medication.

Learning for strategic leaders and senior and middle managers

- Effective and consistent relationships between practitioners and children experiencing mental health difficulties are critical to support engagement and continuity of care. Appointing a lead practitioner or key worker can help improve continuity of care, monitor the quality and effectiveness of plans, and address any delays or lack of timely responses to actions.
- The transition of young people from child to adult services when they have identified mental health needs requires very careful planning and preparation.
- It is important to be clear about acceptance criteria before making any referrals. Referrals need to be of the highest quality and comprehensively completed. This will help them to be dealt with by the most appropriate services and prevent unnecessary delays.
- Reviews identified gaps in early intervention and emotional wellbeing support. When such gaps exist at the local level, it is important to consider alternative sources of support and ensure that practitioners, parents and children are aware of these options.

4.45 This analysis has revealed much good practice by multi-agency partners in responding to children with mental health needs, often under very difficult circumstances. It builds on some of the learning identified in last year's annual report and highlights again some of the enduring multi-agency barriers to providing the best help and protection to this group of children. The following reflective questions will benefit practitioners, managers and leaders as they consider arrangements in their safeguarding partnership areas, building on their local learning and the learning identified here.

Reflective questions

For practitioners

- When working with a child with mental health needs, do you ensure you check and accurately record if they have a formal diagnosis? Do you feel confident raising questions about the diagnosis if it is unclear or if the child's presentation and behaviour appear inconsistent with the diagnosis?
- How confident are you in exploring and understanding the voice and experiences of children with mental health conditions? How well do you engage with specialist providers to support you, and are you clear about what to do with any information you receive from the child (such as escalating safeguarding concerns or instigating multi-agency processes)?
- Are you confident in your understanding of the legislative frameworks concerning mental capacity in children and young people and how this might apply to children with mental health conditions? Do you know when and what children and young people can consent to?
- What interim support (local, regional or national) is available to children with mental health needs and their families while they are awaiting assessment or to access services? Do you understand what early support and early help services exist in your area? Do you know how to refer to them?

For strategic leaders and senior and middle managers

- How well do you understand the specific mental health needs (and diagnoses where available) of children in your areas, both those receiving support or services and those awaiting assessment or placement? What do you know about the specific needs of and service responses to children from different groups, including Black and minoritised communities, children with disabilities and children who are neurodiverse? How well aligned is current service provision to those identified needs?
- What do you understand about the rates of and reasons for unsuccessful referrals to CAMHS or other mental health and emotional wellbeing support services in your partnership area? Do you have processes in place to ensure referrals are high quality, containing the necessary information for appropriate assessment?
- How effective are your current arrangements in supporting children with identified mental health needs as they transition to adult services? Are there appropriate alternative mental health support services for those who will not transition to adult services?

5. Spotlight theme: Safeguarding pre-school children with parents with mental health needs

5.1 One of the emerging themes identified in our last annual report was how mental health needs can impact the capacity of parents to care for their children safely. This issue was also discussed in relation to one of the six previous practice themes: recognising and responding to the vulnerability of babies. Learning had highlighted that parental mental health is often overlooked as a potential risk factor. It is an important contextual factor when considering parents' ability to care for their children and adhere to any necessary arrangements and plans put in place by agencies. Another evident issue related to parental mental health was the lack of effective communication pathways between services for adults and services for children.

Although we use the terms 'parents with mental health needs' and 'parental mental health' here by way of shorthand, in our analysis we include the mental health of other significant adult carers for example, grandparents, stepparents or partners of the child's parent.

5.2 A review of the existing literature reveals a gap in the specific consideration of parents with mental health needs who have pre-school children. There also appears to be limited literature on learning for multi-agency practice related to this theme. Consequently, this was an issue the Panel wished to examine further. Knowledge about pre-school children can be somewhat limited between the post-natal period of more intense health visiting and monitoring and the time they start school. Some children will be attending different types of early years provision, including nurseries and child minders. Early years providers therefore play an important role in helping protect children in this period of children's lives. There will tend nonetheless to be fewer opportunities for agencies to identify patterns of concern or safeguarding issues at a relatively early stage. It is very important that early years settings have appropriate safeguarding and child protection procedures in place and that practitioners in those settings have the necessary knowledge and training to identify and respond to any concerns about children (NSPCC, 2021).

5.3 We were interested in what reviews could tell us about multi-agency co-operation in incidents of serious harm or death of pre-school children where parental mental health needs are identified, including examples of good practice. In addition to exploring multi-agency working, we wanted to understand what other common contextual factors featured in the lives of these children and their parents or carers, which might impact mental health needs.

5.4 In this chapter, we present the findings from our quantitative analysis of 27 rapid reviews involving pre-school children where parental mental health was a factor. We then present learning identified from our in-depth qualitative analysis of 17 reviews (13 rapid reviews and 4 LCSPRs).

Quantitative analysis of rapid reviews

5.5 Within the 330 rapid reviews analysed for this report, 27 (8%) involved pre-school children aged 1 to 5 years old with a parent or relevant adult recorded as having either a diagnosed or undiagnosed mental health condition. This accounts for over half (57%) of all children in that age group.

Making comparisons

Given that the focus of our analysis here is pre-school children, all data considered below compare pre-school children aged 1 to 5 years with a parent with a mental health condition to pre-school children aged 1 to 5 years who did not have a parent with a reported mental health condition. This provides a more accurate comparison across the two samples.

The two samples used for comparison were:

- the 27 children who were aged 1 to 5 years with a parent with a mental health condition(s)
- the 19 children who were aged 1 to 5 years with no parent with a mental health condition(s)

Child characteristics

5.6 Table 5.1 shows socio-demographic characteristics for children aged 1 to 5 with a parent with a mental health condition(s) compared to children of the same age without a parent with a mental health condition(s). The proportions of boys and girls and children with disabilities and neurodiversity in this sample were similar to those in the comparison group. However, white children appear to be over-represented in the sample of children aged 1 to 5 with a parent with a mental health condition.

5.7 The proportion of children with speech and language challenges was higher in the sample of children aged 1 to 5 with a parent with a mental health condition than in the comparison sample. Although the proportion of children with disabilities was similar across both samples, our in-depth qualitative analysis revealed how the challenges of caring for a child with complex needs could impact the mental health of parents. Five of these reviews involved parents with mental health needs caring for a child with complex needs or disabilities. This is discussed further below.

Table 5.1: Socio-demographic characteristics for children with and without a parent(s) with a mental health condition(s)

		Children with a parent(s) with a mental health condition(s) N=27	Children without a parent(s) with a mental health condition(s) N=19
		%	%
Sex	Female	41%	42%
	Male	59%	58%
Disability	Yes	44%	42%
Neurodivergent	Yes	7%	5%
Ethnicity	White	81%	58%
	Mixed/multiple ethnic groups	19%	21%
	Asian/Asian British	0%	5%
	Black/African/Caribbean/Black British	0%	11%
	Other ethnic group	0%	5%
Speech and language challenges	Yes	33%	21%

Death and serious harm

5.8 Fifteen of the children in this sample died and 12 experienced serious harm, most of which were reportedly due to the actions of the parent or relevant adult, usually involving assault or homicide. Extreme neglect was the reported cause of death or serious harm in six reviews.

Parental or relevant adult characteristics

> Due to the way our data is currently recorded, the information provided here does not indicate which specific parent or relevant adult the characteristics or contextual factors relate to. Therefore, the findings detailed in this section of the chapter do not imply these characteristics specifically relate to the parent or relevant adult who had the mental health condition. Instead, these characteristics existed for one or more of the parents or relevant adults in the families included in this sample. We have included this information as it provides helpful broader context about the family and the circumstances the child was living in at the time of the serious incident resulting in the review.

5.9 In a third of the reviews featuring a child aged 1 to 5 with a parent with a mental health condition (33%), a parent or relevant carer was reported to have a disability. A quarter of these (26%) involved families with young parents (those under 25 years old), and in four reviews, the parent was recorded as a solo parent (all were mothers).

5.10 Reviews did not always specify whether the parent's mental health condition was diagnosed or not. However, out of the 27 cases, the majority (59%) reported diagnosed conditions.

Child circumstances

5.11 In all but one of the 27 rapid review incidents, the families were known to CSC. Nearly half (48%) were an open case at the point of the serious incident leading to the review, and nearly half (48%) had previously been known to those services. Additionally, 44% were known to early help services. Nearly half of the children (48%) were considered a child in need, and over a quarter (26%) were subject to a CPP (either before or at the time of the incident). A fifth (22%) of the children were subject to a care order, and 7% were subject to care proceedings at the time of the serious incident.

5.12 In addition to having a parent or carer with mental health needs, several additional risk factors were common within the family context and circumstances the young child was living in at the time of the incident. The most common risk factors were:

- neglect (67%)
- having a parent or relevant adult with addiction to or misuse of alcohol or substances (including prescribed) (56%)
- domestic abuse (52%)
- physical abuse (48%)
- housing issues (44%)

Qualitative analysis findings

5.13 The findings below result from the in-depth qualitative analysis of all 17 reviews (13 rapid reviews and four LCSPRs) that met the criteria for selection (see Appendix E). Table 5.3 shows the characteristics of the children in those reviews.[2]

Table 5.3: Socio-demographic characteristics of children aged 1 to 5 in the qualitative sample of parents with mental health needs

		N	%
Sex	Female	10	59%
	Male	7	41%
Disability	Yes	8	47%
	No	9	53%
Ethnicity	White	10	59%
	Mixed/multiple ethnic groups	5	29%
	Asian/Asian British	0	0%
	Black/African/Caribbean/Black British	1	6%
	Other ethnic group	0	0%
	Unknown/not recorded	1	6%
Total		**17**	**100%**

2 One LCSPR was included which was published in 2020, sitting just outside our inclusion timeline, however the review includes relevant learning for our analysis and did not alter it in any way.

5.14 Although reviews do not routinely refer to the ethnicity or heritage of parents or carers, this information was described for seven parents or carers in this sample. Six were reported as Black (five Black African and one Black Caribbean) and one as white British. Two reviews referred to the religion of the parents/carers (one Mormon, one Buddhist).

Known previous history of parental mental health needs

5.15 All but one of the reviews in our qualitative sample involved incidents where agencies were aware of previous mental health history of the parent or parents. Sometimes this awareness was long-standing and involved some service engagement, including three incidents where the parent's needs had been identified in their own childhood.

5.16 The most frequently experienced mental health conditions referred to in the reviews in our qualitative sample are presented in Table 5.2 below. The table also details the rates of parents or carers with other previous specific indicators of mental health need.

Table 5.2: Mental health conditions and experiences of parents or carers with pre-school children and detailed in qualitatively analysed review reports

Mental health conditions	Number
Anxiety and depression	9
Bipolar affective disorder	3
Post-traumatic stress disorder	2
Personality disorder	1
Postpartum psychosis	1
Experiences of parents or carers with mental health conditions	**Number**
Attempted suicide	4
Self-harm	4
Sectioned under Mental Health Act	4
Suicidal ideation	3
Residential mental health unit	1

5.17 This indicates that almost all of these incidents involved a parent or parents with mental health needs which were already known to agencies, and that the extent and nature of those needs were quite significant.

Other contextual factors

5.18 Just as wider contextual factors including mental health, substance misuse, domestic abuse and deprivation have been linked to non-accidental injury in infants (CSPRP, 2021b), they remain relevant when considering risk to pre-school and older children. In the 17 reviews included in the in-depth qualitative analysis, several common contextual factors featured alongside parental mental health needs. In particular, domestic abuse was a dominant and concerning feature in almost three-quarters of these reviews (71%). Other contextual factors were alcohol misuse (41%), substance misuse (41%), poverty (35%) and neglect (29%).

5.19 Over a third of reviews in the qualitative sample included families known to be experiencing poverty, deprivation or financial difficulties. Reviews reflected families' reliance on foodbanks, difficulties meeting living and housing costs, threats of or actual homelessness, or living in temporary housing. All incidents involving families experiencing poverty also featured neglect. Academic research shows how poverty can impact parenting capacity in material ways and in psychological ways, impacting parental stress and mental ill health (NSPCC, 2024c).

5.20 Although the prevalence of these factors differs between the qualitative sample and the quantitative rapid review sample (as shown in the Appendix F), both data sets reflect the extensive presence of numerous other issues co-existing alongside parental mental health in these families with pre-school children.

Good practice

5.21 Some reviews commented on good practice by practitioners, particularly GPs and health visitors, in identifying and managing risk related to the mental health of parents. This included examples of persistently following up on unattended appointments, conducting the child's development review at the family home rather than expecting the mother to bring the child to clinic, and making an urgent referral to, and having a case management discussion with, the perinatal mental health team. There were also situations where medical professionals pursued and challenged other services to ensure appropriate action was being taken where they had identified concerns.

5.22 Good practice was also described in the use of pre-birth assessments and perinatal mental health screening to address parental vulnerabilities, including mental health, and in the support provided by perinatal mental health and health visiting teams.

5.23 Some reviews commented on the examples of good information sharing and action planning by multi-agency partners, some going back over a period of years of involvement with families.

Key findings

Identifying, assessing and responding to the mental health needs of parents and risk to children

5.24 The reviews reflected learning around agencies effectively identifying and responding to parental mental health needs and any associated risk of harm that there may be for children. A key theme noted in this analysis, which has also been identified in our previous reports and other analysis (NSPCC, 2022b), relates to assessments and interventions undertaken with families where the focus is too often only on the issues that prompted the initial engagement with agencies. This results in insufficient consideration of parents' mental health needs. It can also mean there is little exploration of how other issues might impact on the parent's mental health, wellbeing and capacity to safely care for the child. Additionally, there was sometimes a lack of consideration about how potential mental health needs might result in some of the behaviours central to the focus of concern, such as neglect or drug or alcohol misuse or conversely how these can exacerbate mental health needs. Often the main focus of agencies was on neglect, including responding to poor home conditions, meeting the child's complex health needs or addressing the risks associated with domestic abuse. Other areas of focus for services were protection from sexual harm, physical harm and dealing with unstable housing.

5.25 This highlights the importance of taking a holistic approach to understanding the wider family circumstances and considering the interconnected nature of issues parents face including their mental health needs. It also reflects the need to consider what life is like for very young children in those circumstances. Reviews reflected examples where practitioners did not appear to fully consider the impact on the daily life of the pre-school child living with, or being cared for, by a parent experiencing mental health difficulties. Consequently, such considerations did not inform risk assessment or safety planning. This is an important area of learning, given the importance of stability, nurturing and safe relationships for children at this critical stage in their development.

5.26 The absence of a comprehensive familial history, including current and historical detail about the mental health of parents, was identified as a significant gap in the assessment process in some reviews. This gap in information often led to incomplete or inaccurate assessments of the family and potential risk to the children. Some reviews described how although appropriate mental health assessments or risk assessments had been undertaken and action identified, appropriate follow-up action was lacking or not timely enough. There were also occasions where unannounced visits or other checks on children's welfare could have been employed earlier.

5.27 There were occasions where a parent's mental health had previously been identified in relation to their care of older siblings, but these issues were not taken into account when the later child was born and in their early years. This meant that risk assessments were either not undertaken or did not consider previously known mental health concerns.

5.28 In some cases, although agencies had successfully identified a parent's mental health needs, these were not then fully explored or assessed to determine potential risk to their pre-school child. There were instances where notifications to other agencies were not made, further assessments were not undertaken, or safety plans to account for mental health deterioration were absent. Opportunities were also sometimes missed to refer families for early intervention or to specialist help pathways. Child in need, child protection or other plans were not always being actively reviewed and revised when concerns about parental mental health were escalating.

5.29 Reviews also commented on practitioners demonstrating a lack of professional curiosity, over-optimism about a parent's ability to cope or care safely for the child, or over-reliance on the parent's self-reporting about their mental health and wellbeing. These issues have been repeatedly raised in the previous triennial analyses of serious case reviews (Dickens and others, 2022a; Dickens and others, 2022b). In our analysis there were examples of professionals not probing further when parents with known needs reported that they were effectively managing their mental health, even when there were indications that might not be the case or when a parent said they had stopped taking or had reduced their medication.

Engaging with parents and carers

5.30 Most of the incidents analysed reflected the challenges in services effectively engaging parents with support for their mental health needs. This included difficulties in securing consent for mental health assessments and successfully engaging parents in perinatal or antenatal care, adult social care mental health services, or other support services (such as wellbeing services or early help support). Often the perceived lack of engagement by parents resulted in referrals being discontinued and cases being closed or discharged, even where the potential concerns around the parent's mental health needs appeared to be quite significant.

5.31 Linked to this, some reviews identified children not being brought to their health appointments which might in turn have been associated with the parent's mental health and other challenges they were facing at that time. Critically and sensitively exploring the reasons for non-attendance might have assisted in better engagement by understanding and unblocking any manageable barriers for parents. Work undertaken by the Children's Hospital Alliance (2023) reflects some recent initiatives to improve the way that practical support is given to help children get to hospital appointments.

5.32 These issues highlight the challenges for practitioners and agencies when trying to successfully engage parents in discussing the impact of these issues. Mental health needs can fluctuate between periods of stability and instability, improvement and deterioration. This, along with the presence of other stressors or vulnerabilities, means practitioners and services may need to be as flexible and accommodating as possible when working with parents in these circumstances. Safeguarding partnerships will want to identify and share examples of good local practice and consider whether local procedures and guidance support engagement with families in these circumstances.

5.33 Six reviews indicated issues with agencies not knowing about the men (including biological fathers) involved in the child's life and the identification of any mental health needs they might have been experiencing. In three of these incidents, these men were implicated in the death or serious harm to the child. Five reviews highlighted that GPs and medical services did not know about the connection between the adult male and the child (even where they were the child's biological father) and consequently did not share any concerning information about their mental health needs or conditions with other agencies. Some reviews revealed issues with other services, most commonly health visiting and maternity services, knowing about the presence of these men in the lives of the children in some way, but then not fully exploring who they were, what was known about them and whether they might present any risk to the child.

5.34 Our national review, 'The myth of invisible men' (CSPRP, 2021b), highlighted how therapeutic and other forms of mental health support were rarely offered to, or accepted by, fathers. This applied for all age services, either when they were young through CAMHS or during adulthood via adult mental health services. The focus for intervention is not usually on their role as parents. While that national review focused on harm to children under 1, the same or similar risks of harm can also apply to older children if the underlying issues, including mental health, are not recognised and addressed.

Information sharing

5.35 One of the most common issues about information sharing reported in reviews related to how information is shared both within different health services and between health services and other agencies. This affected the ability of services to assess any possible risk of harm associated with parental mental health and to provide timely support.

5.36 Within health services there were examples of GPs not sharing information about a parent's poor mental health with maternity, health visitor or paediatric services. This could mean that families were not placed on appropriate service pathways. Reviews also revealed some issues with information about parental mental health needs, recorded in GP and medical records, not being shared between practices where each parent or carer had a different GP. There were also occasions when information was not shared between acute physical health hospitals and community mental health services when mental health needs were present. Some reviews referred to instances where medical practitioners had not shared information with other statutory partners, for example leaving CSC unaware of a pattern of missed GP appointments. Conversely, there were also times when other agencies had not shared information about safeguarding concerns with health partners when they should have.

5.37 These information sharing issues, both within health and between health and other services, are not new and have been identified in previous Panel reports and those produced by the NSPCC (CSPRP, 2022a; CSPRP, 2021a; NSPCC, 2015b). Some of these refer to issues with IT systems and differing paper system issues leading to a lack of accurate cross-service patient information exchange in relation to records held by GPs, health visitors, maternity services, paediatricians, CAMHS and adult mental health services. Differing interpretations of policy, procedures and protocol around information can also have an impact.

5.38 Of particular relevance to safeguarding pre-school children are issues highlighted in two reviews about missed opportunities for relevant information relating to parental mental health being shared with children's nurseries. Other learning from case reviews relating to the early years sector (NSPCC, 2021a) also identifies the same issue with information exchange between early years settings and other agencies working with pre-school children. This could lead to pre-school practitioners being unaware of previous parental mental health concerns or vulnerabilities and less able to recognise continuing patterns of behaviour or signs that a child or parent needed extra support.

Adult and child service interface

5.39 Most of the issues identified with communication between adult and children's services related to health services and have been already discussed. Other issues concerned the effectiveness of co-ordination between adult social and mental health services and nurseries, substance misuse teams and children's services.

Case study: Adult-child services engagement

A 2-year-old Black British girl was found alone after her mother died in the family home. She had been on and off child in need plans and CPPs since birth as her mother had been known to a range of agencies for many years as a result of alcohol misuse, domestic abuse and her mental health needs. There had been difficulties with services being able to engage the mother consistently, which affected the provision of support. The review found that service involvement was often focused on responding to presenting needs at the time of specific incidents as opposed to considering the wider, cumulative needs. This meant that risk of harm appeared to have been minimised. There was evidence of good multi-agency engagement with high levels of information sharing during child in need, CPP and Common Assessment Framework meetings but poor communication between adult and children's services.

5.40 Concerns about parents' ability to care for their children, particularly in the context of mental health needs or conditions, were not always escalated within agencies, with staffing issues being cited as a reason within several reviews. Also, when staff members were on leave or off duty, cases often went unassigned or were inadequately managed. A lack of reflective supervision was also reported in some reviews as affecting the ability of staff to manage these often-complex cases effectively. Reflective supervision for practitioners in early years settings, who are key partners in pre-school safeguarding, has also been found to be lacking (NSPCC, 2021a). Reviews indicated that there was sometimes a lack of follow-up on whether assessments or escalations had been completed, often linked to agencies being unclear about their roles and responsibilities. Government has introduced a new Mental Health Bill to provide better support to people affected by mental health issues, including through the greater involvement of families and carers (Department of Health and Social Care, 2024). It is vital that this includes supporting effective partnership working between children and adult mental health services.

Engagement between statutory and non-statutory partners

5.41 Some reviews identified the need for better links between adult mental health practitioners and specialist or disability services practitioners to design a plan that supports both parents with mental health concerns and children who have additional needs. A need for better interaction between specialist teams was commonly mentioned in reviews. One review suggested that this is because of the problematic assumption that if specialist mental health services are involved with a family, they are managing and supporting the family's needs adequately. This can lead other agencies to step back, believing that the specialists have all the necessary knowledge needed and are providing necessary support. This in turn can result in other services not challenging decisions or offering additional insights that could benefit the family, under the belief that the specialist services are best equipped to determine action.

5.42 The psychologist's report (Godsi, 2021) undertaken as part of our national review of non-accidental injury in under 1s (CSPRP, 2021b) also raised the issue that 'referral doesn't equal treatment'. It highlighted the risks of practitioners assuming that just because a parent is referred to mental health services, any intervention takes place and that risks are being reduced. The need for follow-up is important, as is ensuring that information about lack of attendance or engagement is passed on to GPs and other agencies working with the family.

Race, ethnicity and culture

5.43 With the exception of two reviews, none reported on any considerations relating to race, ethnicity and culture for families with pre-school children and parents with mental health needs. One of the reviews that did raise the question of whether the mother or her family may have perceived a cultural stigma relating to mental health. At the same time, the review reported that the mother's parents had raised their concerns about a potential deterioration in her mental health, suggesting that there was not necessarily any culturally related stigma associated with mental illness.

One review explicitly stated that "culture and diversity were not an issue identified within the LCSPR", but then went on to describe potential concerns around the mother's immigration status and a referral made to a Black, Asian and minority ethnic support service for her. The heritage of the children who were the focus of the review and the impact of the race, ethnicity and culture of their mother and her partner were not described in the review report. Two reviews referred to issues with agencies' understanding of the child or parent's race, ethnicity or culture. One noted that the child's ethnicity was never ascertained by services and had been incorrectly recorded on various systems as white British (as no services had explored who her father was). Another noted that health records reflected an absence in seeking to explore and understand this family's culture or identity.

Racial disparities have been evidenced within adult mental health services, with Black and minority ethnic groups more likely to report poor experiences and to be reluctant to talk about their mental health and engage with mental health services (Bignall and others, 2019; Public Health England, 2021). Not being taken seriously, fear of harm and negative previous experiences, such as racist care and medical neglect, were cited as a key barrier to seeking out mental health support (Bansal and others, 2022). The design of mental health services and their bias could also negatively impact parents' willingness to seek help (Bansal and others, 2022).

Key learning points

Learning for direct practice

- When there is information about a new pregnancy, and a parent has previously known mental health needs, there should be thorough assessment of current and future needs to inform any plans required to support the parents and new baby.
- Knowledge about fathers, or other adult partners (regardless of sex or gender), is important in understanding any risk of harm or protection they may provide. Understanding whether they experience or have experienced mental health difficulties is also important.
- The impact on the pre-school child of living with, or being cared for, by a parent experiencing mental health difficulties needs to be understood to support assessment of their needs and of any risks that there may be.
- The mental health of some adults can deteriorate quite rapidly. Contingency planning may be necessary so that appropriate and timely support can be provided when necessary.
- The focus of work with families may be on one or two presenting issues that prompted the initial engagement with agencies. It is important to consider how different issues may interact with each other.
- Before closing down referrals or contact with a family, when agencies have not been able to engage successfully with parents, it is important to explore why this has been the case and whether different approaches would assist.
- Effective and timely information sharing between health and other agencies is imperative and requires close co-operation between adult and child services. An integrated and comprehensive family history, including about current and historical parental mental health, will support practitioners from different services to work together, and respond to any early indicators of concern or changes in the mental health of parents.

- Good communication pathways with nurseries or other pre-school providers are important in helping identify and manage emerging risk given their likely regular contact with families.

Learning for strategic leaders and senior and middle managers

- Maintaining effective links and communication between statutory and non-statutory services can provide an important safeguard when working with parents with mental health needs caring for pre-school children. Voluntary sector organisations provide much of the regular support to families and parents may feel more comfortable engaging with such services. Voluntary organisations therefore need to be included, as necessary, in multi-agency decision-making systems.
- It is important that local information systems and processes support different health services, including GPs, to know about, and share when necessary, relevant information about mental health issues of parents, including non-resident parents.
- Difficulties in services being able to effectively engage parents can result in supportive referrals being discontinued, cases being closed or discharged. Having an understanding about the scale and nature of this in your safeguarding partnership might help identify specific actions that could be taken to help, supporting prevention efforts.
- Enabling opportunities for effective reflective supervision is important in supporting practitioners to consider issues such as engaging with families where there are complex or sensitive needs, including mental health.

This latest analysis of relevant reviews highlighted some of the practice issues which can inhibit effective responses to children where parents have significant mental health needs which may undermine their ability to care for their children safely. The following reflective questions seek to assist practitioners, managers and leaders in considering practice in their area.

Reflective questions

For practitioners

- How do you make sure that you understand what life is like for this group of young children?
- How might a Think Family approach support you to have a rounded and accurate view of a child and family's needs? Is this based on a good understanding of family history, and knowledge about the support and strength of family networks? Is there shared consideration of the impact of parent's mental health needs on the development, wellbeing and safety of the child?
- What opportunities are there for improving working with other services, including across adult and children's services?

For strategic leaders and senior and middle managers

- Is there good understanding and evidence about how well children with parents with mental health needs are supported and protected in your area? What do you know about the specific needs of, and service responses to, children from different groups, including children from Black and minoritised communities, disabled children and young carers?
- Do you need a system of periodic review of families where they have been closed to services and agencies have not been able to engage with parents/carers?
- What systems are in place in your area for the sharing of information between GPs and other health services (especially health visiting, maternity and mental health) where family members are registered with different GPs? Are there barriers that can be overcome? If IT systems are a problem that cannot be easily or quickly addressed, are there effective alternative processes that are used consistently?
- How effective is collaborative working and information sharing between statutory and non-statutory children's and adult services in your area, including in relation to adult mental health, alcohol and substance abuse, and domestic abuse? Do non-statutory services understand when and who to contact when they need to raise potential safeguarding issues?
- How effectively does your safeguarding partnership work with education and childcare providers working with pre-school children in your area (including childminders)?

6. Spotlight theme: Extrafamilial harm

6.1 Keeping a focus on children who experience risks outside the family home was one of six practice themes that we explored in last year's annual report (CSPRP, 2024a) and was also the focus of our national review report 'It was hard to escape: safeguarding children at risk from criminal exploitation' (CSPRP, 2020a). Reviews have featured both good practice and missed opportunities in this area, particularly in identifying crucial transition points for young people within education and in moving from child to adult services. In considering issues related to extrafamilial harm, it is important to remember that the term covers a range of different forms of abuse and neglect, including sexual exploitation of children, criminal exploitation, institutional based abuse and online harm.

6.2 Last year's annual report highlighted the impact of exclusion from school upon behaviour (CSPRP, 2024a). Recent research has emphasised the need for a national exploitation strategy, and has highlighted how existing legislation, policy and criminal processes are not fit for purpose (Action for Children, 2024). Studies have also been conducted to evaluate approaches to tackling youth violence and to inform local and national responses to child exploitation and extra-familial harm (Baidawi and others, 2023; The Tackling Child Exploitation Support Programme, 2023).

6.3 This year's report considers further some of the barriers and characteristics of good multi-agency practice. The analysis explored incidents where children's education had been seriously disrupted and considered what agencies were doing to mitigate the impact of extrafamilial harm on children's education. We also considered the role that online activity can play in extrafamilial harm and how practitioners work with children who have underlying support needs such as neurodiversity.

6.4 Our analysis focuses on extrafamilial harm to children that occurred primarily in the environment outside the home and was perpetrated by adults and peers who were not members of the child's own family. It does not include harm that occurred within a care or residential setting. However, we recognise that there is often a crossover between abuse that happens within and outside of the home and family, and that children can experience abuse and exploitation in both contexts. Our analysis also focuses on incidents where the child experienced any of the following:

- youth or gang-related violence
- child criminal exploitation (CCE)
- child sexual abuse or exploitation (CSA/E) where this was perpetrated by a person(s) outside the family
- a combination of these types of harm

Please see Appendix A for a definition of these types of harm.

6.5 We recognise that there are also other forms of extrafamilial harm experienced by children, such as modern trafficking and slavery, and we are looking at developing our data collection tools going forward to help improve understanding of other forms of extrafamilial risk and harm.

Quantitative analysis of rapid reviews

6.6 To support the analysis of reviews featuring extrafamilial harm, we have undertaken quantitative analysis on all rapid reviews with incidents that occurred between 1 April 2023 and 31 March 2024 (330 incidents). Of the 78 incidents featuring extrafamilial harm, 56% of children had experienced youth or gang-related violence, 55% had experienced CCE, and 40% had experienced CSA/E. Nearly half of children (49%) had experienced more than one type of extrafamilial harm.

6.7 Children who had experienced extrafamilial harm tended to be older than children who had not. The average age was 15 years old, and the majority were aged 11 to 17 (97%). This compares to an average age of 11 years old for children who had not experienced extrafamilial harm, with only 25% being aged 11 to 17 years old.

Making comparisons

As most children who experienced extrafamilial harm were aged 11 to 17 years old (only two were under 11 years old), we have compared children in this age bracket who experienced extrafamilial harm with children of the same age who did not. This provides a more accurate comparison across the two samples and reduces the possibility of any perceived differences between the two groups being overly influenced by age. The two samples used for comparison were:

- 76 children who were aged 11 to 17 and experienced extrafamilial harm
- 44 children who were aged 11 to 17 who had not experienced extrafamilial harm

Child characteristics

6.8 Table 6.1 shows the socio-demographic characteristics for children aged 11 to 17 who experienced extrafamilial harm compared to children of the same age who were not known to have experienced extrafamilial harm.

6.9 The proportion of male children (the child's sex as registered at birth) in the extrafamilial harm sample was higher than in the comparison sample. However, and as might be expected, this varied according to the type of extrafamilial harm. The majority of children who had experienced youth or gang related violence or CCE were male (95% and 98% respectively), whereas nearly four in five children who had experienced CSA/E were female (79%).

6.10 There were four incidents in the extrafamilial harm sample where children identified with a gender different to their sex as registered at birth. All incidents featured CSA/E, with none featuring youth or gang-related violence or CCE.

6.11 The proportion of Black children was three times higher in the extrafamilial harm sample than in the comparison sample and the proportion of white children was notably lower. This varied by type of extrafamilial harm. Black children formed the largest ethnic group for children who had experienced youth or gang-related violence, or CCE (30% and 39% respectively). Other research has also evidenced that Black children are disproportionately likely to be victims of homicide and are over-represented at all levels of the criminal justice system (Youth Endowment Fund, 2024). For children who had experienced CSA/E, white children formed the largest ethnic group at 83%.

Table 6.1: Socio-demographic characteristics for children who have experienced extrafamilial harm and those who have not

		Children who experienced extrafamilial harm N=76	Children who did not experience extrafamilial harm N=44
		%	%
Age group	Aged 11 to 15	36%	63%
	Aged 16 to 17	64%	38%
Sex	Female	33%	55%
	Male	67%	45%
Gender	Gender identity different to sex registered at birth/non-binary/other	5%	8%
LGBTQ+	Identifies as LGBTQ+	8%	8%
Disability	Yes	24%	34%
Neurodivergent	Yes	32%	28%
Ethnicity	White	47%	66%
	Mixed/multiple ethnic groups	20%	16%
	Asian/Asian British	7%	6%
	Black/African/Caribbean/Black British	24%	8%
	Other ethnic group	3%	2%
	Unknown/not recorded	0%	3%
Speech and language challenges	Yes	12%	9%

Death and serious harm

6.12 Of the extrafamilial harm incidents, 50% related to serious harm and 41% were due to a fatal incident. Seven incidents (9%) were categorised as ‘other’, whereby the child in focus was recorded as the perpetrator of the extrafamilial harm incident. Three quarters (74%) involved extrafamilial harm as the main likely cause of the incident that triggered the review.

Child circumstances

6.13 Among those children who had experienced extrafamilial harm, 26% were not enrolled at school or receiving an education, 59% had poor school attendance, 67% had been or were currently a child in need, 38% had been or were currently on a CPP and 49% were known to a youth offending team. These proportions were all higher than for children who had not experienced extrafamilial harm (see Table C in Appendix F).

6.14 The five most common risk factors recorded in rapid reviews for children experiencing extrafamilial harm were:

- being repeatedly missing (57%)
- physical abuse (55%)
- overlap between being a victim and a perpetrator (47%)
- domestic abuse (45%)
- CSA/E (41%)

Qualitative analysis of rapid reviews and LCSPRs

6.15 In-depth qualitative analysis was undertaken on 20 reviews (14 rapid reviews and 6 LCSPRs) where the child who was the focus of the review had experienced extrafamilial harm. Reviews were selected where the child had experienced youth or gang-related violence (12), CCE (14), extrafamilial CSA/E (6), or a combination of these types of harm. All 12 reviews involving youth or gang-related violence featured CCE.

6.16 Reviews were selected to ensure the inclusion of a range of socio-demographic characteristics (see Table 6.2). Within this sample, children who had experienced youth or gang-related violence or CCE were male, and most children who had experienced CSA/E were female, with one child identifying as a transgender male. Reviews were also purposively selected if children had missed education (9) or if the incident involved online harm (4). Although there were only four reviews where the incident leading to the review had an online aspect involved, 10 in this sample featured some form of online harm for the child.

Table 6.2: Socio-demographic characteristics of the qualitative extrafamilial harm sample

		N	%
Age group	11 to 15	6	30%
	16 to 17	14	70%
Sex	Female	6	30%
	Male	14	70%
Gender	Female	5	25%
	Male	14	70%
	Transgender	1	5%
Disability	Yes	7	35%
	No	13	65%
Ethnicity	White	12	60%
	Mixed/multiple ethnic groups	3	15%
	Asian/Asian British	1	5%
	Black/African/Caribbean/Black British	4	20%
Total		**20**	**100%**

Summary of the extrafamilial harms that children were experiencing

6.17 Of those who had experienced youth or gang-related violence, many had been stabbed and one child had been shot. Some children carried knives for protection, sometimes from as young as 9 years old. Many of these children had been both harmed by violence and perpetrated acts of violence.

6.18 Less information was available about children who had experienced exploitation. Reviews often discussed concerns relating to CCE, or described children as being at risk, but there were few situations where practitioners had detailed knowledge about the child's actual experiences. This is likely to reflect the challenges involved in gaining information and intelligence around exploitation, which is discussed in more detail below. Similarly, children were sometimes thought to be being sexually exploited but this had not been conclusively evidenced, despite frequent missing episodes and other indicators, such as online messages, which suggested the strong possibility that a child might be being exploited or was vulnerable to exploitation.

6.19 Online harm was a feature in several reviews. Many of the CSA/E incidents involved online activity and included strangers interacting with children and the sharing of explicit images, which were being shared by others without consent. Some children affected by gang activity or youth violence had also posted videos of themselves with weapons on social media that were aimed at frightening rivals or demonstrating 'toughness'. One child died at a party that had been organised online.

Good practice

6.20 Many of the reviews highlighted good practice from practitioners working to safeguard children who experience extrafamilial harm. There were some positive examples of practitioners being consistent and persistent in their attempts to engage with children and families. This included demonstrating flexibility and adapting to meet children's needs, particularly if initial approaches were not successful. Continuity of workers, regular contact, good communication, being proactive rather than reactive and taking an 'outside the box' approach to engagement were all highlighted as positive practice. Linking in with agencies that had a good working knowledge of the family, including those in the voluntary sector, was also deemed to be valuable. Some practitioners utilised trusted relationships that children had with other services as a means for understanding better what was happening to children and their perspectives.

6.21 Strengths-based approaches used by practitioners and services were highlighted as good practice. This included identifying opportunities and reachable moments to explore what motivates the child, and which could be used as a 'hook' for engagement. However, these opportunities often tended to be identified in hindsight. Given the adverse experiences that children had experienced, a trauma-informed approach was used by some practitioners to build relationships, which facilitated trust and centred children's wellbeing. There were also a few examples of practitioners recognising and responding to children's vulnerabilities and needs at an early stage.

6.22 Experiencing extrafamilial harm can have a serious impact on children's education (CSPRP, 2020a; CSPRP, 2021a; CSPRP, 2022a; CSPRP, 2024a). Within reviews there were many positive examples of schools working to try and ensure children continued to receive an education. Good communication between schools and support from inclusion teams helped improve what can be a difficult transition from primary to secondary school. There were also examples of schools being flexible to help with low attendance and to enable children to sit exams. Schools sometimes adopted strengths-based approaches, focusing on children's interests and abilities to help maintain their interest in learning.

Case study: Supporting children experiencing extrafamilial harm to stay in education

A 15-year-old white British boy was a potential victim of exploitation and had been involved in criminal acts and rivalries with other gangs. He was also neurodiverse but had struggled to receive support as he did not have a diagnosable mental health problem. As a consequence, he had experienced significant disruption to his education, including periods of suspension and permanent exclusion, and had a history of being missing. He had spent time in alternative provision and had also been subject to several managed moves between schools. Despite these challenges, the child was well supported by his current school. Following a number of suspensions and incidences of aggression, the school put in place a tailored programme of support to maintain his education. The school was consistent in their approach and showed commitment to meeting the child's educational needs. The school also had significant knowledge of the local community and peer relationships. The local authority education service in this area noted that there were a number of children in the locality who were not in education and there was not capacity to offer interventions to so many children. The Inclusion Service was therefore putting in place a new attendance support team to support schools to reduce absence by tracking children who were persistently absent.

6.23 Several reviews highlighted good practice in multi-agency working. This included good attendance at meetings by relevant partners, good communication and effective joint working. Good practice was noted around schools liaising regularly with other professionals and attending meetings for child protection and multi-agency child exploitation. Effective cross-boundary working was also observed for children who were looked after and placed in a different area. This involved a strong relationship between CSC in the child's home authority and the new placement, having a multi-agency plan that was regularly updated, regular meetings to evaluate current risks of harms, and appropriate actions being taken every time that a child went missing.

6.24 There were some good examples of direct interventions undertaken with children and families, including activities such as discussions and workshops to improve children's knowledge and understanding of exploitation, grooming, drugs misuse and knife awareness. Work was also being undertaken with parents around how to help keep children safe.

Key findings

Practitioner expertise in extrafamilial harm and contextual safeguarding

Identifying and recognising extrafamilial harm

6.25 Similar to our previous work in this area, this analysis continued to indicate that practitioners struggle to identify extrafamilial harm and do not draw on a contextual safeguarding approach when needed. Contextual safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families (please see Appendix A for a full definition). Sometimes there was a lack of understanding around what constitutes CCE, and one review discussed how police found involvement in gangs difficult to identify as they were a 'relatively new concept' in the local area. Practitioners could also struggle to recognise and understand the manifestation and effects of coercion and other dynamics of abuse involved in extrafamilial harm.

6.26 Commonly, we saw that early indicators of extrafamilial harm were not being recognised by practitioners, as has been highlighted in previous research (Ball, 2023; NSPCC, 2023b; NSPCC 2021b; Mason-Jones and Loggie, 2020). This could stem from a lack of curiosity around contextual risks or around children's backgrounds. A tendency to focus on more serious indicators of concern could also mean that other forms of extrafamilial harm, such as bullying by peers, was overlooked. In the rapid reviews, repeatedly going missing was a common risk factor for children experiencing extrafamilial harm, yet several reviews pointed to missing episodes not being escalated, not being considered within the context of exploitation, not being responded to with robust multi-agency plans, and not being assessed as high risk. Reviews also highlighted how practitioners often had little or no information regarding where children were going when they were missing or what was happening to them.

6.27 Reviews highlighted the importance of proactive work to respond to early indicators of extrafamilial harm and exploitation but the early help which could have been beneficial to children had not been successfully provided, sometimes because of a lack of meaningful engagement or necessary services not being available.

Child first approaches

6.28 We saw evidence of inconsistent adoption of a 'child first' approach for children experiencing extrafamilial harm, which could also lead to labelling and adultification bias (see Appendix A for definitions). Studies have evidenced how Black children are more likely to experience adultification and how this increases the risk of their safeguarding needs not being met (Davis, 2022). Within the reviews, adultification was apparent where practitioners were working with children who were both vulnerable to risk and posed a risk to others, which was common in incidents involving youth violence, gangs and CCE. Working Together (2023) emphasises how all children, including those who may be causing harm to others, must receive a safeguarding response first. Reviews evidenced that too often service responses focused on offending behaviour and could be seen to be punitive in nature. For example, children as young as 12 were being treated predominantly as offenders, so indicators of exploitation were not recognised or acted on as their involvement in criminal activity was seen as a 'choice'. Recent research with Black children who have gone missing also highlights how they can be stereotyped, adultified and criminalised by services, leading to a misperception that they are not vulnerable (Davis and others, 2024).

Understanding children's lived experiences

6.29 Children who had experienced extrafamilial harm had often experienced trauma and adversity, but practitioners sometimes did not recognise how this may affect their behaviour and their willingness to engage with services. For example, when children are seen as 'aggressive', their vulnerabilities and underlying needs may not be properly recognised. There were also challenges around exploring the interaction between risks inside and outside the home. Our analysis also explored practitioners' understanding of children's learning and developmental needs, neurodiverse conditions, mental health, and ethnicity and identity, and how these impacted on their responses to children experiencing extrafamilial harm. These findings are discussed below.

Education, learning and developmental needs

6.30 Some of the children in the sample had learning or developmental needs and a number had EHC plans or were receiving another form of educational support. These needs were sometimes not adequately considered or assessed. In some reviews, children had learning needs that were diagnosed late in their education and the outcomes of these assessments were not always shared with other agencies.

6.31 We saw from the quantitative analysis of rapid reviews how a higher proportion of children who experienced extrafamilial harm had disrupted education. A recent report by the Centre for Young Lives (2024b) highlights how missing education can signal serious safeguarding issues, including criminal exploitation. All the children in the qualitative sample had also had their education disrupted in one form or another. Children were often missing or absent from school and multiple suspensions and exclusions contributed to low attendance rates, with two children in the sample permanently excluded from the age of 12. Schools did not always consider the impact of exclusion on the child. Education could also be disrupted by frequent school moves and the transition from primary to secondary school was sometimes highlighted as a difficult period for children, with attendance or educational performance subsequently declining.

Neurodiversity

6.32 Reviews highlighted some challenges for practitioners when working with children who were neurodivergent and experiencing extrafamilial harm. There was sometimes uncertainty around correct diagnoses, and in some cases, diagnoses had not been confirmed or were reported by a parent rather than a medical professional. There could be confusion over whether symptoms indicated attention deficit hyperactivity disorder (ADHD) or were a response to trauma. In two cases the diagnosis had been withdrawn or reconsidered, with professionals unable to reach agreement. There were also issues with managing the symptoms arising from neurodiverse conditions, such as accessing medication or taking medication as directed. Confusion around diagnoses and issues relating to understanding neurodiversity was also evident in our analysis on children with mental health conditions.

6.33 Some practitioners lacked understanding of how diagnoses relating to neurodiversity can impact on a child’s lived experience and on professional decision-making. One review discussed an absence of police training on communicating with young people who are neurodivergent and are involved in crime. Another highlighted the importance of health professionals attending strategy meetings to provide their perspective and knowledge on how neurodiversity can affect children’s behaviour and decision-making.

Mental health

6.34 We saw examples of children at risk of, or experiencing, extrafamilial harm struggling to receive support for mental health needs due to thresholds for CAMHS. Reviews discussed how children could not access support without an identified mental health need, including support for neurodiversity. This may be a particular issue for children experiencing extrafamilial CSA/E, as quantitative analysis showed a higher proportion of those children had mental health conditions and more reviews raised issues about the service response to the child's undiagnosed mental health condition (see Table C in Appendix F).

6.35 One review highlighted how CAMHS would not work with children with mental health needs if there were associated risks with gangs and CCE, leaving vulnerable children without support. Another emphasised the heightened challenges addressing contextual risks for children who had significant mental health needs. Even where referrals were made there could also be delays in treatment given current resourcing challenges for those services.

Race, ethnicity and culture

6.36 Ethnicity and cultural identity were other key aspects of children and family's lived experiences that were sometimes not explored by practitioners. This was also reflected in the review reports themselves, where discussions of race, ethnicity and culture and service responses to children's ethnicity were limited.

6.37 A number of the reviews did not mention the child's ethnicity at all. Other reviews described the child's ethnic group but did not discuss the significance of this within the review. How children's ethnic and cultural identities were understood by practitioners and potentially influenced service responses to extrafamilial harm was therefore largely invisible. This is both concerning given the over-representation of children from Black and minoritised communities who experience youth or gang-related violence or CCE. Several reviews discussed how practitioners missed opportunities for engaging with children through gaining better knowledge about the child and their family, including considering the child and family's experiences of racism and discrimination. Our thematic analysis on race, racism and racial bias is exploring some of these issues in further detail.

Gender identity and sexual orientation

6.38 There was also evidence of the need to consider better the relevance of gender identity or sexual orientation, particularly for children who had experienced CSA/E. These issues were sometimes not explored by practitioners as they were responding reactively to crises rather than having the collective expertise and resources to help children explore their identities. Consequently, little was known about children's gender and sexual identities and whether this lack of exploration and support may have affected their vulnerability to harm from CSA/E.

Working with children and families experiencing extrafamilial harm

6.39 Some reviews highlighted how practitioners were not doing enough to learn more about the risks children were facing, including exploitation, but also other indicators such as drug use and knife crime. Where there were positive relationships between practitioners and children, reviews highlighted the need to use these to explore risks. However, practitioners sometimes struggled to develop these relationships. In other cases, despite a range of positive approaches being adopted, they were met with little success. Practitioners were therefore often not able to gather relevant intelligence from children and families alone, and innovative approaches to identifying and understanding risk were not often evident. In one review, there was a resource for interpreting drill music, which can reveal information about gang alliances and intelligence that might help ascertain risk, but the service was being decommissioned. Practitioners with limited knowledge of children's lived experiences sometimes made assumptions, such as a child carrying knives with intent to harm rather than for protection.

Case study: risks of CCE being overlooked due to lack of agency contact

A 16-year-old white British boy had a history of being missing and repeat indicators of CCE. He was on a full care order and was being managed by multi-agency child exploitation processes (arrangements for responding to children at risk of exploitation, please see Appendix A for definition). There was a six-month period described as a 'period of perceived calm', where there were no reports of criminal activity or police intelligence. He was no longer seen as exploited and due to a reduction in concerns, agencies ended their involvement with him. He was removed from the multi-agency child exploitation process and the care order was revoked. However, the review revealed how during this time the child was actually being given greater responsibility by the gang exploiting him, being expected to complete more serious criminal activities and ensuring other members were following orders, which reduced his visibility to services. The child said this was a period "when things got really bad". Yet as agencies were not seeing him or engaging with him, they were unaware of these developments and assumptions were made about the risks he was facing. Described as "hidden in plain sight", shortly after he was missing for a considerable amount of time and was linked to involvement in significant criminal activities. At the age of 17 he was seriously assaulted and sustained life-changing injuries. Throughout this period his voice and perspectives were missing from the way that practitioners assessed and responded to his needs and the significant risks he faced.

6.40 Practitioners talked about the challenges of working with the complexity of situations where children were being harmed outside their homes. There was sometimes a lack of support and supervision for staff carrying out work in this area, particularly for those who were inexperienced. Consequently, staff could feel anxious and 'stuck' about how to respond. Responding to extrafamilial harm can be stressful and fast-paced, leading to reactive rather than proactive approaches. While many reviews cited a range of activities and interventions that were being undertaken with children, there was sometimes a lack of reflection and evaluation as to their effectiveness in improving the lives of children. Some reviews highlighted how practitioners did not adopt different approaches or try new methods despite evidence that approaches were not working.

6.41 One review helpfully highlighted how this work requires a specific suite of supervision, skills and tools, such as de-briefing processes for staff and joint supervision alongside other multi-agency colleagues. Some reviews highlighted possibilities for cross-team support, such as contextual safeguarding teams or forensic CAMHS supporting children open to other teams. These opportunities were not always utilised however, and a lack of expertise and support impacted the effectiveness of work undertaken to keep children safe from extrafamilial harm.

Access to services and support

6.42 There were sometimes missed opportunities to refer children to support services for ADHD, mental health concerns, education and substance misuse. Referrals for extrafamilial harm were also sometimes delayed or not taken forward, leaving children vulnerable while they waited for a service response. This included referrals to Youth Offending Service, National Referral Mechanism and Violence Reduction Units.

6.43 Service thresholds could provide a barrier to support, particularly for early intervention, when children did not meet the criteria and alternative support was not available. At other times, there was a lack of clarity regarding whether service thresholds had been met. Where there was not sufficient evidence of exploitation, teams with expertise in contextual safeguarding were unable to work with children, leaving practitioners uncertain how best to support them. In a couple of cases, DoLS had been considered but had not been used because the child's needs and circumstances were not seen to meet the relevant threshold.

Assessments and interventions

6.44 Delays in assessments for extrafamilial harm could leave children vulnerable to risks. In some cases, there were missed opportunities to use screening tools or they were not used consistently. There could also be a lack of understanding around the purpose of screening tools, which were sometimes regarded as mechanisms for referring or for sharing information and updating colleagues, rather than as frameworks for understanding risk, with defined actions and outcomes. Assessments were also sometimes described as weak, with a lack of analysis and a failure to identify extrafamilial harm or consider cumulative harm, which could lead to the level of risk being underestimated.

6.45 Many of the interventions described in reviews tended to involve direct work with children aimed at changing their behaviours. Although some of this work was described as good practice (see page 79), in many of the reviews there was unfortunately little evidence that interventions intended to keep children safe from harm were working. Other interventions tried to create distance between the child and the source of harm, sometimes by moving children looked after to a residential placement and which was often in a different area.

6.46 Moving children from one area to another had mixed results. For children experiencing CCE this was sometimes deemed to be beneficial – reviews noted an immediate reduction in risk, with one citing improvements for the child in education, training and attitude. Other reviews reflected that such movements could be disruptive, causing instability and negatively impacting education. Children would often abscond and were at increased risk during these periods. We highlighted in a previous annual report how moving children away from a local area may not be a long-term solution to protect them from criminal gangs (CSPRP, 2021a).

6.47 Some reviews questioned the value of placements away from home for children experiencing CSA/E. Children can feel isolated and lose contact with important relationships. Their support needs can be high, and we know that there is a national shortage of good quality placements for children with complex needs. In some cases, the placements themselves were not safe, proving poor risk assessments and an inability to meet children's needs. Yet analysis highlighted that residential homes or placements were more often used for children experiencing CSA/E compared to other groups (see Table C in Appendix F). This is likely to be, in part, a reflection of their age. One review suggested that despite secure placements often being the default agency response to children who are looked after and at risk of CSE, there is little evidence that such placements effectively reduce the child's exposure to it.

6.48 Moving children out of area also sometimes meant that they lost access to important forms of service support. There could be a lack of co-ordination, meaning that relevant agencies were not made aware that the child had moved area, or they did not receive relevant or up-to-date information. Cross-boundary working could also be a challenge due to different practice in different areas. Reviews evidenced that this was a more common issue for children experiencing CSA/E compared to other groups (see Table C in Appendix F). Reviews highlighted how children who are at risk of harm outside their families require the very best multi-agency co-ordination and planning, particularly when they move from one area to another as risks may sometimes increase rather than diminish.

6.49 Reviews highlighted how the system needs to work better to help practitioners understand the 'bigger picture', including the child's full circumstances and with whom they associate. A few reviews referenced the value of mapping the child's peer group to try and understand the links between the child and their peers and identify if others were at risk. However, several reviews highlighted the challenges with this, as children and families were often reluctant to share information with agencies. Some reviews discussed how improvements need to be made to systems and processes with real time information sharing, mapping and analysis for children who are being exploited. This is vital in making sure that multi-agency responses are robust, timely and tailored to the child's needs.

6.50 Opportunities to gather evidence and disrupt extrafamilial harm were sometimes missed by agencies, particularly police. In one case involving an investigation into online CSE, no evidence was secured from the child's laptop or mobile, and police reportedly did not speak to the child or mother. In another review police failed to take into account the age and history of a 12-year-old child who was experiencing exploitation and consequently missed multiple opportunities to disrupt his involvement in criminal behaviour by talking to or engaging with him.

6.51 We previously highlighted the benefits of employing a contextual safeguarding approach when working with children at risk of extrafamilial harm (CSPRP, 2022a). Reviews considered for this report evidenced again the importance of making contextual spaces safer, including the way that children are safeguarded in schools and education settings. One review noted how difficult it can be to assess and respond to harms arising online. The picture can change very rapidly and work across area boundaries may be needed, rendering it especially challenging for practitioners to maintain an up-to-date and detailed understanding of the risks.

Key learning points

Learning for direct practice

- Identifying early indicators of risk of extrafamilial harm, particularly missing episodes, is essential for preventing harms escalating into exploitation or entrenched gang involvement. Missing episodes should be carefully analysed to understand patterns and inform risk management and potential disruption work.
- As far as possible, children experiencing extrafamilial harm should have contact with a single lead practitioner who has oversight of their lived experience and support needs. This person can act as an advocate for the voice of the child.

- Significant ‘reachable’ moments in children’s lives can provide opportunities for improving engagement. These moments may be positive or negative in impact but can be a means of establishing a ‘hook’ for engagement where children may be more receptive to change. These can include transitions and incidents that increase contact with services, such as escalations and referrals, arrests and hospital admissions.
- Exploring innovative approaches to engaging children experiencing extrafamilial harm might help improve service engagement and understanding around children’s lived experiences and the risks they are facing.
- Maximising all potential support for children to continue in education when they are facing risks outside the home is critical in helping prevent further exposure to extrafamilial harm.
- Practitioners need to be able to work well with families, and especially parents and carers, to improve outcomes for children experiencing extrafamilial harm. This includes developing positive relationships, understanding and responding to any risk of harm factors associated with the home environment, and assessing the ability of parents or carers to help keep children safe.

Learning for strategic leaders and senior and middle managers

- Working with children who experience or are at risk of extrafamilial harm can be particularly challenging for practitioners. Robust support, supervision and training – including multi-agency group supervision and training – is required to support staff working in this area to ensure the best outcomes for children and manage practitioner wellbeing.
- There is a need for practitioners working within safeguarding to have a better and collective understanding of contextual safeguarding approaches for children who experience extrafamilial harm. This can be addressed through training and through working closely with teams with expertise in this area.
- Thresholds for services need to be clear so that practitioners know when and which services they can refer children to. There should also be processes and pathways for working with children who do not meet the criteria for specialist contextual safeguarding teams or panels.
- It is important for practitioners to understand the significance of neurodiversity on children’s behaviours and on their engagement with services. Health practitioners can help provide this insight in multi-agency meetings and training, including for police officers. This can help with engaging with children at times of crisis or increased risk of extrafamilial harm.
- Interventions to reduce the risk of extrafamilial harm should be evaluated so that practice is based on evidence of what works. Where interventions do not lead to improved outcomes, different approaches should be tried.

6.52 Analysis of reviews where children have experienced serious harm or death due to risks that they encountered outside the family continue to highlight the challenges practitioners are facing in this developing area of practice. There is evidence of emerging multi-agency good practice that can be built on and developed. The following reflective questions will assist practitioners, managers and leaders to consider arrangements in their areas to develop their practice responses to children who are at risk of being harmed outside their homes and families.

Reflective questions

For practitioners

- Are you confident that you can recognise the early indicators of extrafamilial harm? What resources do you have access to, to prevent risks from escalating?
- How can you work with your professional networks to enable meaningful engagement with children experiencing extrafamilial harm? How do you discuss and explore challenges in this area of practice with your peers or managers?
- Do you know your local services that can support children experiencing, or at risk of, extrafamilial harm? Is there any specific support for families including siblings?
- If working with a child whose vulnerability is increased by other support needs such as neurodiversity, what training and specialist health or social care support is available to you to further your understanding of the child's communication and ability to engage?

For strategic leaders and senior and middle managers

- How might the analysis presented in this report influence your local children safeguarding partnership strategy and approach to working with children who are at risk of extra familial harm?
- What do you know about the experiences of different groups of children, including Black children, girls and children who are neurodiverse or have disabilities?
- Do you need to review and clarify your local partnership arrangements for responding to extrafamilial harm? Is there good understanding and use of these arrangements? Does this include the community and voluntary sector?
- Are you confident as a partnership that practitioners are effectively using screening and assessment frameworks for extrafamilial harm and developing appropriate action plans and interventions in response? How do you review the impact of local practice to know what is working well and where improvements need to be made?
- What formal and informal support is available to all staff who work with children experiencing, or at risk of, extrafamilial harm?
- Are local strategies in place to make the local environment safer for children and to work effectively with them?

7. Cross-cutting findings from spotlight analysis

Cross-cutting findings

7.1 While the previous three chapters have identified some distinct learning for strategy and practice in relation to each of the three themes described, our analysis has also demonstrated some common multi-agency practice themes. Table 7.1 details common multi-agency practice themes and Table 7.2 highlights some broader themes that were apparent in reviews relating to the three areas of focus.

Table 7.1: Cross-cutting practice themes for multi-agency working

Multi-agency working
Reviews across all three themes frequently described a lack of a co-ordinated, multi-agency approach when working with children and families, further highlighting the need for more robust collaboration and communication between services. The evident complexity of some children's and families' needs means that the most effective responses do not always fit neatly into existing service design or legislative frameworks. They require close collaboration and flexibility across agencies. Different panels and statutory meetings may be focusing on specific areas of need but these are not always joined up, creating gaps in knowledge about what is happening to children and families or duplicating effort. An absence of effective comprehensive assessment of need was evident across many reviews where a range of agencies, both statutory and non-statutory, were involved. Incomplete identification and assessment of need also led to ineffective plans and actions. Actions were not always being followed up or plans updated when circumstances changed. Some reviews highlighted a lack of collaboration or necessary challenge between agencies. In some cases, support for children was sometimes being stepped down or ending, without it being apparent why and not being challenged.

There was a lack of clarity and consensus among agencies about what were the right services and interventions for children and families. Effective multi-agency responses require that all partners have a clear understanding from the outset of their own roles and responsibilities and those of others they are working with. Reviews across the themes identified how confusion about referral criteria, threshold for services and specific support that could be offered could lead to inappropriate referrals, lack of follow-up, delays in accessing services or opportunities for early intervention being missed. Many reviews also identified how the absence of key agencies from multi-agency meetings impacted on information sharing, joint planning and decision-making in the best interests of the child.

Information sharing and triangulation of information

Information sharing and triangulation of information across agencies is central to effective multi-agency engagement. Many reviews reflected how missed opportunities for effective information sharing impacted on having a clear and rounded understanding about the child, family and their needs. The importance of information sharing within and between health and other agencies was particularly evident in cases involving both child and parent mental health. Opportunities for better information sharing with education were identified across all three themes. Schools and nurseries did not always receive safeguarding information or information from assessments, hindering them from being able to support the child, including making sense of the emotions or behaviours of a child.

There were examples of agencies not being updated when a child's circumstances changed, new information emerged, or assessments had been completed. Reviews across the three practice areas reflected examples of required information either not being shared proactively or in a timely way. Some reviews identified how concerns about the mental health of a child or parent were not always escalated and shared with professionals across the multi-agency network. This included information about missing appointments, and changes in medication and key professionals and when someone had been admitted to hospital.

Voice and perspectives of the child and their lived experience

Good practice requires the voice and experiences of the child to be central in identifying and responding to their needs (NSPCC, 2023a; Vulnerability Knowledge and Practice Programme, 2023b). Yet this was frequently identified as missing in reviews for children with mental health conditions or those who were being harmed outside their homes, despite these children often being adolescents. Reviews highlighted the need for information to be sought and recorded about children's experiences, views and wishes so they could be shared and considered across agencies. Keeping the child's voice and perspectives at the centre of plans and responses and comparing and contrasting information provided by parents, children and across agencies would have provided a more robust understanding of circumstances children and families faced. For children with mental health needs, it was not always appreciated that children's perspectives, feelings and mental health can fluctuate, requiring regular communication with them and plans to be reviewed and revised accordingly.

Where the voice and perspective of the child was missing, there was sometimes a reliance on information from parents or carers. Where children had mental health concerns, this was noted to be a consequence of practitioners not always speaking to the child alone. This was particularly important for them in terms of sensitive information being shared about their mental health, physical health and disabilities. Where children were at risk of extrafamilial harm, reviews reported that sometimes parents or carers would limit the child's access to and communication with practitioners or they could be reluctant to share information with practitioners about what was happening. This could result from a fear of responses to or a lack of confidence in practitioners being able to keep them safe.

Adult-child service interface

We have commented in our previous reports (CSPRP, 2021a; CSPRP, 2024a) about how insufficient links between adult and children's services can contribute to risks not being identified, underlining the importance of taking an 'end-to-end' multi-agency approach to the design of services to enhance communication and joint working. This is very crucial when parents have issues relating to mental health, substance misuse and domestic abuse.

Reviews analysed this year also highlighted that multi-agency responses to child and parental mental health could have been strengthened with better information sharing, co-operation and planning between services for children and services for adults working with members of the same family. The importance of making these connections was also highlighted in terms of older children with mental health issues making the transition to adult services.

Reviews highlighted too that when there were multiple incidents or concerns, sometimes these were not effectively communicated or shared across different adult and children's services. Instead issues tended to be viewed in isolation rather than as part of a larger, more comprehensive picture about what was happening in a family. This lack of co-ordination then made it harder to recognise and respond to escalating risks.

Engaging children and families

Good and consistent practitioner-child relationships are central to effective engagement with children and families. Reviews featuring child mental health and extrafamilial harm highlighted how many children did not have a single trusted relationship with a practitioner and how this impacted on the ability of services to engage effectively with them and offer necessary support. This could mean that there was no practitioner with an overview of the child's circumstances and the challenges they were facing.

Reviews for children who had experienced extrafamilial harm noted how high staff turnover in some services, particularly social workers, could mean that the process of building a relationship with the child would frequently have to start again. This undermined the ability of practitioners to communicate and work effectively with families. Practitioners also did not always involve families in decisions that affected the child, including discussing the interventions that were being used, for example, to address concerns about exploitation. This is an issue that has also been identified elsewhere (Department for Education, 2023; Ball, 2023; Mason-Jones and Loggie, 2020).

In some reviews, practitioners described the challenges of being able to effectively and consistently engage children and their families which resulted in services and offers of support not being implemented. Perceptions of a 'lack of engagement' could lead to referrals being discontinued or cases closed, or information or referrals not being followed up. It is very important that practitioners and their managers carefully explore the many reasons why children and families might find it difficult to engage with agencies, considering how practice approaches might need to be adapted and be more flexible to a child and family's needs.

7.2 Table 7.2 details some of the main additional themes that were apparent in reviews across the three areas of spotlight focus, highlighting other areas for partnerships to consider in developing multi-agency responses.

Table 7.2: Other cross-cutting themes

A focus elsewhere	Across the reviews analysed it was clear that mental health needs and extrafamilial harm were not sufficiently in focus when identifying and managing risk. The focus was often firmly centred on one or two other presenting issues, meaning agencies missed opportunities to respond early to emerging risks and provide support.
Thresholds	Thresholds for access to assessment and support for CAMHS, adult mental health services and contextual safeguarding teams were an evident barrier to providing support. Insufficient understanding or assumptions about thresholds or access criteria meant inappropriate or poor-quality referrals were being made which could lead to rejection or significant delay.
Early help and interim support	Reviews across the three themes consistently identified missed opportunities for early help and support to be provided to children and families. Some children faced lengthy waiting times for mental health or extrafamilial harm assessment and support, and during those periods the risks for them increased. This highlights the critical need for the provision of interim support and monitoring.
Race, ethnicity and culture	The Panel has previously commented on the limited consideration of children's race, ethnicity and culture within review reports. This analysis continues to reflect the same issue. Reviews that did reflect some relevant considerations often lacked substantive analysis or were sometimes contradictory. Our forthcoming thematic report on race, racism and racial bias will further spotlight these issues within reviews. It is imperative that agencies and partnerships better understand how race, ethnicity and culture are considered in service provision and use this understanding to inform the structure and design of services to meet the needs of children and families in their areas.

The importance of education	The importance of education in the lives of children and as a safeguard when risks were identified came across strongly in this analysis. This is particularly important in terms of the role that schools and pre-school settings play in supporting children with their mental health needs. They can also help identify concerns at an early stage and know when the support of other agencies is needed.
Hidden men	We continue to see evidence of fathers, male partners or other male carers not being identified or considered by agencies when assessing potential risk or protective factors in children's lives. Although we refer to 'hidden men', and it was primarily males in these reviews, it is important for agencies to consider any adult partners or significant adults in the child's life regardless of sex or gender.

7.3 We invite safeguarding partnerships to consider the relevance of these cross-cutting issues to identify both areas of local strength and where and how local practice needs to develop and improve.

8. The Panel at work and forthcoming priorities

The Panel at work

8.1 The Child Safeguarding Practice Review Panel (the Panel), as an independent body, is responsible for commissioning child safeguarding reviews as well as collating and disseminating the system learning from these reviews at a national level. This chapter provides an overview of the Panel's priorities aligned to statutory obligations, including commentary on the progress of last year's commitments and priorities for the forthcoming year.

System oversight: Maintaining oversight of the system of national and local reviews and how effectively it is operating

8.2 The Panel receives and considers all rapid reviews produced by safeguarding partners and provides feedback on the decision of whether to conduct an LCSPR. This process helps promote consistency across the system. Occasionally, we may disagree with a partnership's decision or find insufficient evidence in the rapid review to support their conclusion. In such cases, we engage with local safeguarding partners to understand and support their decision-making processes. Ultimately, the decision to conduct an LCSPR rests with the safeguarding partnership. According to Panel guidance for safeguarding partners, LCSPRs should be submitted to the Panel at least seven days before the publication date to allow time for discussion of the learning and recommendations. We encourage early discussion if an LCSPR is likely to attract public or media attention or contains national recommendations.

Progress on last year's priorities and commitments

8.3 We have continued to review every serious incident of harm, abuse, and/or neglect notified to us by safeguarding partners. We published our fourth annual report in January 2024, supported by the Data Insights Team's analysis of rapid reviews and LCSPRs. The current report disseminates intelligence about the multi-agency safeguarding system, including practice themes and the quality of reviews.

Priorities for the coming year

8.4 We will continue to work with the Data Insights Team to monitor trends from reviews. This collaboration will also support the production of additional analytical products in the coming year, such as the annual report, national and thematic reviews, and briefings. The Data Insights Team will also begin to provide capacity to draw out and disseminate learning for the system.

8.5 We will also deliver a project to evaluation the Panel's impact. This project aims to understand how stakeholders use our publications, webinars, regional roundtables and other events and how these activities and products influence child safeguarding practice. It will also help us understand our levers for change, stakeholders' perceptions and expectations of the Panel, and provide an evidence base to support future development and workplans.

System learning: Identifying and overseeing the review of serious child safeguarding cases which, in the Panel's view, raise issues that are complex or of national importance

8.6 The Panel does this by commissioning national reviews and thematic analyses in part based on trends from rapid reviews to tackle perennial and complex barriers to practice.

Progress on last year's priorities and commitments

8.7 In November 2023, we announced a national review following the death of Baby Victoria. The review is examining the learning around practices of working with people who conceal pregnancies, working with parents and carers who evade or do not engage with agencies, systemic lessons around working together across different areas and jurisdictions, management of serious offenders, and responsibilities of private health providers and safeguarding agencies to protect children where healthcare is provided outside the NHS.

8.8 In December 2023, we also announced a national review into child sexual abuse within the family environment. This review explores the specific challenges in identifying, assessing and responding to child sexual abuse within the family environment. It aims to understand how multi-agency local and national safeguarding practice can change to better protect children from intrafamilial child sexual abuse. We published our report, '"I wanted them all to notice", in November 2024 (CSPRP, 2024c).

8.9 We also initiated two thematic analyses last year. The first, a thematic analysis of neglect, is considering the extent and nature of serious incidents notified to the Panel where neglect is the primary cause of death or serious harm, or where it is a contributory factor to death or serious harm. It also explores key issues around inter-agency working that have been identified as contributing to the death or serious harm.

8.10 The second thematic analysis, commissioned alongside the production of this annual report and being undertaken by the Data Insights Team in collaboration with a Panel sub-group, is exploring the learning from reviews regarding practices related to race, racism and racial bias. This work aims to understand how these factors influence child protection practice and decision-making.

8.11 In May 2024, we also published a new briefing on safeguarding children in elective home education, considering evidence gathered from relevant serious incidents where children who have been electively home educated have suffered serious harm or died because of abuse and/or neglect.

Priorities for the coming year

8.12 The Panel will make evidence-based decisions about other national and thematic reviews to be undertaken in 2024 to 2025.

System leadership: Identifying improvements to practice and protecting children from harm

8.13 The Panel disseminates evidence, insights and learning from local and national reviews through an extensive communication and stakeholder engagement programme. This ensures we maximise the impact of learning from safeguarding reviews, enabling robust and co-ordinated leadership nationally and locally. This element of our work includes offering challenges to contemporary practice and policy where evidence indicates that this is inhibiting effective access to help and protection for different groups of children.

8.14 We work with stakeholders to identify areas of synergy and influence. Nationally, we work in a cross-governmental context with officials and ministers from various government departments. We also engage routinely with a range of other national stakeholders, including Children and Family Court Advisory and Support Service (Cafcass), Office for Standards in Education, Children's Services and Skills (Ofsted), Association of Directors of Children's Services (ADCS), National Police Chiefs' Council (NPCC), the College of Policing, the Independent Office for Police Conduct (IOPC), Children's Commissioner, Royal College of Paediatrics and Child Health (RCPCH), and the National Network of Designated Healthcare Professionals (NNDHP). We also engage with various national voluntary sector organisations including the NSPCC to contribute to and influence the development of research and policy on child safeguarding practice.

Progress on last year's priorities and commitments

8.15 In the last year, we have increased and developed engagement with safeguarding partners in a range of different ways, including:

- disseminating our activities through regular newsletters
- hosting two webinars in April 2023 to share key messages and recommendations with safeguarding partners following the publication of phase 2 of the national review into safeguarding children with disabilities and complex health needs
- hosting two webinars for safeguarding partners and frontline practitioners on elective home education
- hosting two policy workshops aligned with our two national reviews on child sexual abuse in the family environment and Baby Victoria
- hosting 11 virtual roundtables with safeguarding partners from each region of England, which fostered open conversations about key issues and trends in child protection practice and the safeguarding system – themes included neglect, the impact of professional bias on decision-making, and the effects of the cost of living and poverty on families
- hosting two roundtables with safeguarding partnerships to support the development of the reflective questions contained in this annual report, one of which centred on child and parent mental health, and the other on extra-familial harms – we shared the emerging findings with attendees and created space for dialogue to ensure the reflective questions were relevant to practice and leadership

8.16 We have responded to several important national consultations, including:

- **Stable Homes, Built on Love** – we shared our view that this provides a good starting point for securing several necessary changes, but also expressed our belief that the strategy should go further and faster
- **the Department for Education's Information Sharing Consultation** – we suggested the inclusion of additional guidance, specific examples, and/or a question and answer section
- **the Home Office's Consultation on Mandatory Reporting of Child Sexual Abuse** – we shared our view that mandatory reporting is unlikely to make a substantial difference to the effectiveness of children's safeguarding in statutory agencies where there is already a professional duty to report – but we also noted that some aspects of safeguarding practice could be improved through a mandatory reporting system, such as by increasing information sharing
- **the Education Select Committee Inquiry on Children's Social Care in January 2024** – we welcomed the initiation of the pathfinder programme but also highlighted the system's pressures and challenges on practice with children and families

8.17 We continue to provide advice and challenge to the Department for Education policy teams on the pathfinder programme by visiting pathfinder areas to understand its progress and future areas for development.

Priorities for the coming year

8.18 We will develop a series of practice briefings from data, scoping projects and the existing evidence base.

8.19 We will focus on improving the quality of reviews and maximising local and national learning and impact from serious incidents in the following ways:

- delivering high-quality, clear and valuable feedback to safeguarding partners about rapid reviews and LCSPRs
- refreshing the guidance on rapid reviews to support work of safeguarding partnerships and to build the evidence base for future Working Together updates
- considering trialling a framework for safeguarding partnerships to use in producing rapid reviews to understand how this might support and enhance the quality of learning we are seeing

8.20 We will also work to support safeguarding partnerships in practice improvement through:

- quarterly meetings with safeguarding partnerships by a regional representative from the Panel to discuss reviews and the learning emerging from them
- a learning support project, delivered by Research in Practice with the University of East Anglia and the Vulnerability Knowledge and Practice Programme to better understand how safeguarding partners deliver LCSPRs
- a national offer of bespoke support for safeguarding partners, which will be available to improve quality, consistency and impact of local practice reviews

8.21 Finally, we will continue to respond to important consultations, influence and advise on policy, and deliver events aligned to our national and thematic reviews. These efforts aim to engage partnerships in dialogue around practice and leadership improvements.

9. Conclusion

9.1 Safeguarding children and young people involves continuous reflection and analysis of some of the factors that influence professional decision-making and delivery of services to children and their families. This report provides detailed analysis of data and qualitative information provided in rapid reviews and child safeguarding practice reviews undertaken by local safeguarding partnerships across England.

9.2 Analysis of the three spotlight themes considered in this report highlights some important themes in multi-agency practice. They point in particular to the continuing need for strong co-ordination in the work of all agencies and professionals, including in seeking and sharing information about what is happening in children and families' lives. The importance of strong and effective links between children's and adult services has also been clearly evidenced.

9.3 The analysis has underlined once more the imperative of bringing skill and imagination to finding out and considering what life is like for children, knowing what they are thinking and feeling, and not making assumptions about their lived experience. In too many reviews, there was limited reflection and consideration of the impact of children's race and ethnicity, including of any professional bias in the way that children's needs for protection were identified and addressed.

9.4 The importance of education settings, including pre-school provision, has been highlighted as a key feature in how effectively children are safeguarded. While not a formal statutory partner, these settings can have 'real time' knowledge about what is happening to children and families. The government's recently published policy statement 'Keeping Children Safe, Helping Families Thrive' sets out important measures to strengthen the role of education within multi-agency safeguarding arrangements (Department for Education, 2024c). Implementing these measures in a consistent and effective way will be crucial.

9.5 We invite safeguarding partnerships to use the data and analysis in this report to help reflect on and benchmark their local context and practice. In this way the report can help strengthen strategic and direct practice, building on what is working well while continuing to improve how agencies work together to safeguard children.

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Appendix A – Acronyms and glossary

Term	Acronym	Definition
Absolute low income	-	An individual is in absolute low income if their household income is below 60% of the median in a base year, adjusted for inflation, usually 2010 to 2011 (Francis-Devine, 2023).
Adultification	-	The practice of authority figures being less protective of and more punitive towards children of racial minorities.
Black magic	-	A branch of magic which is believed to involve death, destruction, manipulation, and spells. A belief that magic is used for evil purposes by invoking the power of an evil spirit or devil (Slough Safeguarding Partnership, 2023).
Care leaver	-	A care leaver is a person who has been in local authority care (such as residential or foster care) for a period of at least 13 weeks or more, or periods amounting in total to 13 weeks or more, since they were age 14 and ending after age 16.
Child criminal exploitation	CCE	Where an individual or group takes advantage of a power imbalance to coerce, control, manipulate or deceive someone under 18 into any criminal activity in exchange for something the victim needs or wants, and/or for financial gain or other advantage of the perpetrator and/or through violence or the threat of violence.
Child and adolescent mental health services	CAMHS	Specialised health services that assess and treat young people with emotional, behavioural or mental health difficulties.

Term	Acronym	Definition
Child first		Child First practice places children at the heart of practice: recognising their developmental difference from adults, promoting their individual strengths and capacities, collaborating with them, and diverting them from the criminal justice system and criminalisation.
Child in focus		This identifies the primary child involved in an incident, especially when multiple children are affected. This term ensures the rapid review centres on the child who has experienced the most significant harm or is at the greatest risk. When unclear, we use criteria to determine the focus, prioritising the child who has suffered the most severe harm or, in cases of ongoing neglect and abuse, the eldest child.
Child looked after	CLA	A child who is looked after by the local authority.
Child in need	CIN	Section 17 of the Children's Act 1989 defines a child in need as: "he/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority; his/her health or development is likely to be significantly impaired, or further impaired without the provision for him/her of such services; he/she is disabled."
Child Protection Conference	-	A multi-agency meeting between a child's parents/carers, the child (if appropriate) and practitioners involved in the child's care, organised by the local authority. The aim of the conference is to look at all the relevant information and decide what steps need to be taken to ensure the safety and welfare of the child.

Term	Acronym	Definition
Child protection plan	CPP	A child protection plan is a written record detailing the actions and responsibilities of services and parents to protect those children identified to have been seriously harmed or to be at risk of significant harm.
Care Quality Commission	CQC	An independent body that monitors, inspects and rates health and social care services in England.
Child Safeguarding Practice Review Panel (the Panel)	CSPRP	An independent panel set up under the Children and Social Work Act 2017, working with the Department for Education. The Panel commissions reviews of serious child safeguarding cases with a focus on improving learning, professional practice and outcomes for children.
Child sexual abuse	CSA	Child sexual abuse is all forms of sexual abuse against someone under the age of 18.
Child sexual exploitation	CSE	A form of child sexual abuse where an individual or group takes advantage of a power imbalance to coerce, manipulate or deceive someone under the age of 18 into sexual activity in exchange for something the victim needs or wants, and/or for financial advantage or increased status of the perpetrator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact – it can also occur using technology.
Children's social care	CSC	Departments within local authorities who are concerned with all forms of personal care and other practical assistance for children and young people who need extra support

Term	Acronym	Definition
Contextual safeguarding	-	Contextual safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse.
Deprivation of Liberty Order	DoL	Lawful order for a child to be deprived of their liberty who cannot consent to their care and treatment in order to keep them safe from harm (Social Care Institute for Excellence, 2022).
Domestic Abuse, Stalking, Harassment and Honour-Based Violence Assessment Tool	DASH	A multi-agency risk assessment tool used by practitioners to identify risks following domestic abuse, particularly to identify those victims who are at high risk of harm.
Department for Education	DfE	A ministerial department responsible for children's services and education including early years, schools, higher and further education policy, apprenticeships and wider skills in England.
Early help	EH	Provides early support and intervention to families to improve outcomes for children or to prevent escalating need or risk.
Education, health and care plan	EHC plan	A plan that outlines a child's special educational, health and social care needs.
Elective home education	EHE	Where parents have decided to educate their children at home or in some other way instead of them attending school full-time.

Term	Acronym	Definition
Extrafamilial harm	-	Risks to the welfare of children that arise within the community or peer group, including sexual and criminal exploitation. A key element of extrafamilial harm is that in general, harm does not arise from the home environment; parents may not be aware that their child is at risk or may be struggling to protect their child and the family from harm against exploiters.
General practitioner	GP	A doctor working within primary care.
Gillick competence		Where children under the age of 16 can consent to their own treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment (NHS, 2024a). Gillick competency applies mainly to medical advice but it is also used by practitioners in other settings (NSPCC, 2022a).
Hate crime	-	Any criminal offence which is perceived by the victim or any other person, to be motivated by hostility or prejudice based on a person's race or perceived race, religion or perceived religion, sexual orientation or perceived sexual orientation, disability or perceived disability, and any crime motivated by hostility or prejudice against a person who is transgender or perceived to be transgender.
Information technology	IT	Electronic systems and infrastructure used for storing, retrieving and sending information.
Index child	-	The child who is the focus of a rapid review and/or LCSPR because of a serious incident.

Term	Acronym	Definition
Intrafamilial harm	-	Harm that occurs within a family environment. Perpetrators may or may not be related to the child and a key consideration is whether the abuser is seen as a family member or carer from the child's point of view.
Intersectionality	-	The concept of intersectionality describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination 'intersect' to create unique dynamics and effects.
Joint Targeted Area Inspection	JTAI	A joint multi-agency inspection conducted by Ofsted, the Care Quality Commission and HM Inspectorate of Constabulary and Fire and Rescue Services into themed areas of child protection and safeguarding.
Lesbian, gay, bisexual, transgender and queer (or questioning)	LGBTQ+	Used to represent non-heterosexual identities and orientations.
Local Child Safeguarding Practice Review	LCSPR	An in-depth multi-agency review in response to a serious child safeguarding incident to identify system learning and practice changes to improve the safeguarding of children and young people.
Looked after children (this may also be referred to as child looked after)	LAC	A child who has been in the care of their local authority for more than 24 hours.
Multi-agency child exploitation	MACE	Relates to activity to identify, assess and manage the sexual and/or criminal exploitation of children, including 'County Lines' and missing children.

Term	Acronym	Definition
Multi-Agency Risk Assessment Conference	MARAC	A meeting involving statutory safeguarding partnerships and other services to share information and discuss those at the highest risk of domestic abuse to create a coordinated action plan.
Minoritise	-	To make (a person or group) subordinate in status to a more dominant group, its members or another person.
National Referral Mechanism	NRM	The National Referral Mechanism allows safeguarding statutory partners to refer individuals who they believe are at risk of criminal exploitation, modern day slavery and trafficking, creating a framework for identifying victims and providing them with appropriate support.
National Society for the Prevention of Cruelty to Children	NSPCC	A UK child protection charity.
Not in education, employment or training	NEET	A young person who is no longer in the education system and who is not working or being trained for work.
Place-based approaches		A collaborative, long-term approach to build thriving communities delivered in a defined geographic location by identifying and responding to local needs and improving social, economic and physical wellbeing in a particular location.
Rapid review	RR	A multi-agency review of a serious incident where a child has died or been seriously harmed and where abuse and/or neglect is suspected to identify, collate and reflect on the facts of the case with the aim of establishing if any immediate safeguarding action is needed and identifying the potential for practice learning.

Term	Acronym	Definition
Return Home Interviews	-	A Return Home Interview is an in-depth conversation with a child who has gone missing from home and has been reported to the police. It is an opportunity to learn about the child's life, including any intrafamilial or extrafamilial risk to harm.
Safeguarding partners	-	Local safeguarding arrangements are led by three statutory safeguarding partners: the local authority, the police and the integrated care board.
Serious Incident Notification	SIN	Local authorities have a duty to notify the Child Safeguarding Practice Review Panel (the Panel) and by extension the Department for Education and Ofsted, if a child has died or been seriously harmed and abuse or neglect is known or suspected. They must also notify the Secretary of State and Ofsted where a child looked after has died, whether or not abuse or neglect is known or suspected. This is done by submitting a Serious Incident Notification.
Strengths-based approach	-	A holistic and co-productive approach which focuses on an individual's strengths and abilities (personal, social and community networks) keeping them at the centre of all decisions. It focuses on their individual abilities and circumstances rather than making the deficit the focus of intervention (Department of Health and Social Care, 2019)
Structural racism	-	Systematic discrimination and disadvantages faced by racial and ethnic minority groups as a product of a system in which policies, practices, cultural representations, and other norms perpetuate racial inequity by reinforcing a cycle of discrimination and exclusion (European Network Against Racism, 2023).

Term	Acronym	Definition
Sudden and Unexpected Death in Infancy/Childhood	SUDI/C	When an infant or a child dies unexpectedly and there is no obvious cause.
Transitional safeguarding		Recognition that the needs of young people do not change or stop when they reach 18. It is an approach to safeguarding that moves through developmental stages, rather than just focusing on chronological age.
Trauma-informed approach		An approach grounded in understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development. The approach aims to reduce the negative impact of trauma experiences and avoid re-traumatisation (Derbyshire Safeguarding Adults Board, no date).
Triangulation of information		Triangulation of information involves analysing and combining multiple data sources to understand the situation thoroughly. For example, comparing and contrasting information from different agencies with how a child is behaving or how their parents are reacting, to try and determine a comprehensive view about what is happening.
Vulnerable, exploited, missing, trafficked	VEMT	Children who are considered vulnerable, at risk of or being exploited, missing, or at risk of or being trafficked.
Working Together	WT	Statutory guidance on inter-agency working to safeguard and promote the welfare of children. The latest version was published in 2023.
Youth offending team	YOT	A multi-agency team that supports and diverts children from the criminal justice system.
Youth violence		Violence either against or committed by a child or adolescent, which can impact on individuals, families, communities and society.

Appendix B – Cause of death

Category of death	Definition
Accident/injury	Where a death has occurred from an accident or accidental injury.
Child homicide – intrafamilial	Deaths where a child is killed by someone within the family, other than a parent or primary caregiver. This would include homicide perpetrated by siblings, grandparents, aunts, uncles, cousins etc.
Child homicide – extrafamilial	Deaths where a child is killed by someone other than a family member, primary caregiver or other adult with caring responsibilities.
Overt child homicide by primary caregiver	Deaths where a child is killed by a parent or primary caregiver using overtly violent means, or with no attempt to conceal the homicide, and where there appears to have been some intent to kill the child.
Covert child homicide by primary caregiver	Deaths where a child is killed by a parent or primary caregiver using less overtly violent means, and with some apparent attempt to conceal the fact of homicide with some apparent intent to kill the child.
Death following self-harm	Deaths where the child has deliberately harmed themselves but there is no indication that they intended to complete suicide.
Death from extreme neglect	Deaths where the child dies directly as a result of severe neglect/deprivation of their needs with evidence that this has been deliberate, persistent, or extreme.
Fabricated/induced illness	Deaths where a parent or caregiver has exaggerated or deliberately caused symptoms of illness resulting in the child's death. This includes a parent or caregiver inducing illness which led to the death, or a where a child dies from medical intervention in response to a fabrication or induction of illness and there is evidence of behaviours carried out to convince professionals of an illness where there is no objective evidence of a medical condition.

Category of death	Definition
Fatal assault – intrafamilial	Deaths following physical assaults (non-accidental injuries) where the suspected perpetrator is a primary caregiver or adult with caring responsibilities and there was no clear intent to kill the child.
Fatal assault – extrafamilial	Deaths following physical assaults (non-accidental injuries) where the suspected perpetrator is someone other than a family member, primary caregiver or adult with caring responsibilities and there was no clear intent to kill the child.
Medical cause	Deaths resulting from medical causes.
Risk taking behaviour	Deaths resulting from the child engaging in dangerous activities including drug related deaths, or accidents from risk-taking behaviour where there is no evidence that the child intended to complete suicide.
Severe, persistent child cruelty	Deaths where a child dies directly as a result of a physical assault or neglect and there is evidence of previous severe and persistent child cruelty. This includes deaths where a post-mortem examination reveals previous inflicted injuries or long-standing neglect.
Suicide	Deaths where there is evidence that the child has completed suicide including cases still under investigation, but circumstances suggest suicide.
Unclear	Deaths where the cause remains completely unclear and with no obvious pointers to any of the other categories.
Unexplained SUDI/SUDC	Deaths viewed as Sudden Unexpected Death in Infancy (SUDI) or Childhood (SUDC) which were not anticipated as a significant possibility 24 hours before the death, or there was a similarly unexpected collapse leading to or triggering the events with no specific cause of death found (whether natural or external).

Appendix C – Cause of serious harm

Category of serious harm	Definition
Accident/injury	Serious harm arising from accidents or injuries.
Attempted suicide	Cases of injury or serious harm resulting only from the child's attempt to complete suicide.
Child criminal exploitation	Where an individual or group takes advantage of a power imbalance to coerce, control, manipulate or deceive someone under 18 into any criminal activity in exchange for something the victim needs or wants, and/or for financial gain or other advantage of the perpetrator and/or through violence or the threat of violence.
Child sexual abuse – intrafamilial	All forms of sexual abuse where this was the predominant form of maltreatment or the incident which led to notification and where the suspected perpetrator is an immediate or wider family member, primary caregiver or adult with caring responsibilities for the child in the home.
Child sexual abuse – extrafamilial	All forms of sexual abuse where this was the predominant form of maltreatment or the incident which led to the notification and where the suspected perpetrator is a person other than a family member, primary caregiver or other adult with caring responsibilities for the child.
Child sexual exploitation	A form of child sexual abuse where an individual or group takes advantage of a power imbalance to coerce, manipulate or deceive someone under the age of 18 into sexual activity in exchange for something the victim needs or wants, and/or for financial advantage or increased status of the perpetrator. This can involve violence or the threat of violence.

Category of serious harm	Definition
Emotional abuse	All forms of emotional abuse where this has been the predominant form of abuse, or the incident which led to recognition or notification of harm.
Fabricated/induced illness	Serious harm caused when parent or caregiver has exaggerated or deliberately caused symptoms of illness in the child resulting in serious harm. This includes a parent or caregiver inducing illness which led to serious harm, or a child is seriously harmed from medical intervention in response to a fabrication or induction of illness and there is evidence of behaviours carried out to convince professionals of an illness where there's no objective evidence of a medical condition.
Medical cause	Serious harm arising from medical causes.
Non-fatal assaults – intrafamilial	Serious harm from severe physical assaults (non-accidental injuries) where the suspected perpetrator is a primary caregiver, an adult with caring responsibilities for the child at the time of harm or another child within the family (e.g. sibling, cousin).
Non-fatal assaults – extrafamilial	Serious harm from severe physical assaults (non-accidental injuries) which has been caused by someone other than a family member, primary caregiver or other adult with caring responsibilities for the child within the home. Encompasses child-on-child violence by children external to the family.
Non-fatal neglect	Serious harm as a result of severe or chronic deprivation of the child's needs with evidence that this has been deliberate, persistent or extreme.
Other non-fatal incident	Any other non-fatal serious incident which does not clearly fit one of the other categories.
Risk taking behaviour	Serious harm due to the child engaging in dangerous activities including serious harm following drug related incidents, or accidents from risk-taking behaviour where there is no evidence that the child intended to harm themselves.

Category of serious harm	Definition
Self-harm	Where the child deliberately harmed themselves but there is no indication they intended to complete suicide.
Severe, persistent child cruelty	Serious harm as a result of a physical assault, emotional abuse or neglect, and there is evidence of previous severe and persistent child cruelty. Encompasses serious harm where medical examination reveals evidence of previous inflicted injuries (e.g. healing fractures) or long-standing neglect in addition to the primary cause of serious harm.
Unclear	Other non-fatal serious harm where the nature of maltreatment is not clear.

Appendix D – Rapid review figures

Table A: Regional figures

	2022/23					2023/24
Region	Child population estimates mid-2023	Rate per 100,000 pop.[1]	Rate per 100,000 pop.[2]	% of region's SINs for deaths	% of region's SINs for serious harm	% of SINs for incidents occurring in region's 20% most deprived areas
East of England	1,367,078	1.33	1.54	57.1%	33.3%	25.0%
East Midlands	1,016,250	1.89	2.36	45.8%	54.2%	39.1%
London	1,899,880	3.95	4.05	40.3%	48.1%	28.6%
North East	535,227	3.95	2.80	73.3%	26.7%	40.0%
North West	1,599,260	4.74	3.50	35.7%	58.9%	62.8%
South East	1,988,962	2.60	2.01	45.0%	42.5%	27.3%
South West	1,101,876	4.38	2.72	46.7%	50.0%	33.3%
West Midlands	1,325,199	3.67	3.24	51.2%	41.9%	54.8%
Yorkshire and the Humber	1,164,914	3.89	2.06	50.0%	45.8%	60.9%
England	**11,998,646**	**3.37**	**2.75**	**45.8%**	**47.0%**	**41.8%**

1. Calculated using mid-year 2022 population estimates
2. Calculated using mid-year 2023 population estimates

Table B: Characteristics of the child

	Death		Serious harm		Total[1]	
	N.	%	N.	%	N.	%
Total	**161**	**48.8%**	**160**	**48.5%**	**330**	**100%**
Sex						
Male	95	52.2%	79	43.4%	182	100%
Female	66	44.6%	81	54.7%	148	100%
Age group						
Under 1	67	56.8%	51	43.2%	118	100%
1-5	23	50.0%	22	47.8%	46	100%
6-10	9	34.6%	17	65.4%	26	100%
11-15	25	37.3%	40	59.7%	67	100%
16 and 17	37	50.7%	30	41.1%	73	100%
Ethnic group						
White	102	47.7%	109	50.9%	214	100%
Mixed/multiple ethnic groups	29	52.7%	25	45.5%	55	100%
Asian/Asian British	9	56.3%	5	31.3%	16	100%
Black/African/Caribbean/ Black British	13	40.6%	16	50.0%	32	100%
Other ethnic group	3	50.0%	3	50.0%	6	100%
Unknown	5	71.4%	2	28.6%	7	100%
Gender						
Different to sex	6	66.7%	3	33.3%	9	100%
LGBTQ+						
Yes	7	63.6%	4	36.4%	11	100%
Mental health conditions						
Yes – diagnosed/ undiagnosed	37	52.1%	33	46.5%	71	100%

	Death		Serious harm		Total[1]	
	N.	%	N.	%	N.	%
Neurodiverse						
Yes	21	45.7%	24	52.2%	46	100%
Disability						
Yes	34	45.3%	35	46.7%	75	100%

1. Total includes 9 incidents that were recorded as 'other'

Table C: Needs of the child

	Death		Serious harm		Total[1]	
	N	%	N	%	N	%
Total 4- to 15-year-olds	**38**	**37.6%**	**61**	**60.4%**	**101**	**100%**
Education status						
Child enrolled at a mainstream school	25	36.8%	43	63.2%	68	100%
Child enrolled at a SEN/ BEN establishment[3]	3	75.0%	1	25.0%	4	100%
Child enrolled in alternative provision	4	36.4%	6	54.5%	11	100%
Not enrolled at a school and not receiving an education	1	20.0%	3	60.0%	5	100%
Not enrolled at a school and receiving elective home education	4	40.0%	6	60.0%	10	100%
Unknown	1	33.3%	2	66.7%	3	100%

3 BEN: behavioural and emotional needs.

	Death		Serious harm		Total[1]	
	N	%	N	%	N	%
Child missing school						
Yes – regular absences/ poor attendance	14	37.8%	23	62.2%	37	100%
Yes – other	2	18.2%	8	72.7%	11	100%
Total 16- to 17-year-olds	**37**	**50.7%**	**30**	**41.1%**	**73**	
Not in education, employment or training						
Yes	10	41.7%	12	50.0%	24	100%
All children	**161**		**160**		**330**	
SEND support						
Yes	13	44.8%	13	44.8%	29	100%
EHC plan						
Yes – EHC plan in place	17	45.9%	13	35.1%	37	100%
Child previously on EHC plan	3	100%	0	0.0%	3	100%
Child being assessed for EHC plan	2	40.0%	3	60.0%	5	100%
Speech and language support						
Yes – receiving support	10	66.7%	4	26.7%	15	100%
Yes – not receiving support	3	23.1%	9	69.2%	13	100%
Yes – unknown if support being provided	4	33.3%	8	66.7%	12	100%
CAMHS						
Yes – on a waiting list	0	0.0%	1	100%	1	100%
Yes – open case	16	51.6%	15	48.4%	31	100%
Yes – previously	13	43.3%	16	53.3%	30	100%
Yes – referral made	9	60.0%	5	33.3%	15	100%

1. Total includes 9 incidents that were recorded as ‘other’

Table D: Risk factors

	Death		Serious harm		Total[1]	
	N	%	N	%	N	%
Total	**161**	**48.8%**	**160**	**48.5%**	**330**	**100%**
Environment						
Neglect	82	50.3%	78	47.9%	163	100%
Housing issues	59	54.6%	47	43.5%	108	100%
Financial hardship	31	56.4%	22	40.0%	55	100%
Domestic abuse	83	53.2%	69	44.2%	156	100%
History of intergenerational abuse	22	46.8%	24	51.1%	47	100%
Physical abuse						
Yes – extrafamilial	12	44.4%	14	51.9%	27	100%
Yes – intrafamilial	31	25.8%	87	72.5%	120	100%
Yes – both	4	57.1%	2	28.6%	7	100%
Yes – unknown	0	0.0%	3	100%	3	100%
Emotional abuse						
Yes – extrafamilial	0	0.0%	4	100%	4	100%
Yes – intrafamilial	23	39.0%	34	57.6%	59	100%
Yes – both	1	50.0%	1	50.0%	2	100%
Sexual abuse/exploitation						
Yes – extrafamilial	4	19.0%	16	76.2%	21	100%
Yes – intrafamilial	6	23.1%	20	76.9%	26	100%
Yes – both	3	30.0%	7	70.0%	10	100%
Yes – unknown	0	0.0%	1	100%	1	100%

	Death		Serious harm		Total[1]	
	N	%	N	%	N	%
Child on child abuse						
Yes – extrafamilial	15	53.6%	8	28.6%	28	100%
Yes – intrafamilial	1	12.5%	7	87.5%	8	100%
Victim/offender overlap						
Yes	21	51.2%	15	36.6%	41	100%

1. Total includes 9 incidents that were recorded as 'other'

Appendix E – Qualitative analysis methodology

Dates used for sample selection

The samples for qualitative analysis were drawn from 330 rapid reviews with an incident date between April 2023 and March 2024 and 82 LCSPRs that had been considered by the Panel between April 2023 and March 2024 which had an incident date within the three previous years (between April 2021 and March 2024). Due to the time required to undertake LCSPRs and the time lag between the incident date and the submission of the report to the Panel, we needed to include a longer time period of incident dates for the LCSPRs to have a suitably large sample to select from. We also considered that limiting the date of the incident to those falling within the three preceding years of submission to the Panel would help ensure that the learning remained relatively recent and more applicable to current practice. Depending on the theme additional selection criteria were used.

Qualitative analysis sampling

To help us select the sample for in-depth analysis, we used data from rapid reviews to identify cases that would help us to explore the three themes of interest: child mental health, parental mental health and pre-school children, and extrafamilial harm.

- For child mental health we identified cases where children had a mental health condition(s) and had experienced a range of contextual issues such as missing education, bullying, online harms, alcohol or substance abuse, exploitation/abuse and domestic abuse.
- For parental mental health and pre-school children we identified cases where the child was aged 1 to 5, had not started school and had a parent(s) with a mental health condition, and where there were other contextual factors of interest such as neglect and parental drug and alcohol misuse or dependency.
- For extrafamilial harm, we identified cases where the child had experienced youth or gang related violence, CCE and/or CSA/E and had experienced contextual issues such as missing education and online harms.

We then selected cases that met our criteria and included a range of socio-demographic characteristics, including age group, sex, disability, ethnicity and neurodiversity. These cases were sifted and scanned to ensure that there was sufficient information and learning within the review for in-depth analysis.

We selected a total of 57 cases: 20 cases featuring issues relating to child mental health, 17 cases that involved parental mental health and pre-school children (children aged 1 to 5 who had not started school) and 20 cases that involved extrafamilial harm. The breakdown of rapid reviews and LCSPRs is detailed in Table E1 below.

Table E1: Number of reviews selected for qualitative analysis, by theme

Theme	Rapid reviews	LCSPRs	Total
Child mental health	15	5	20
Parental mental health and pre-school children	13	4	17
Extrafamilial harm	14	6	20
Total	**42**	**15**	**57**

Table E2 provides detail on how the socio-demographic characteristics featured in each of the theme samples.

Table E2: Characteristics of the qualitative sample

	Child mental health		Parental mental health		Extrafamilial harm	
	N	%	N	%	N	%
Age group						
1 to 5	0	0%	17	100%	0	100%
11 to 15	10	50%	0	0%	6	30%
16 to 17	10	50%	0	0%	14	70%
Total	**20**	**100%**	**17**	**100%**	**20**	**100%**
Sex						
Female	11	55%	10	59%	6	30%
Male	9	45%	7	41%	14	70%
Total	**20**	**100%**	**17**	**100%**	**20**	**100%**
Disability						
Yes	7	35%	8	47%	7	35%
No	13	65%	9	53%	13	65%
Total	**20**	**100%**	**17**	**100%**	**20**	**100%**
Ethnicity						
White	13	65%	10	59%	12	60%
Mixed/multiple ethnic groups	3	15%	5	29%	3	15%
Asian/Asian British	2	10%	0	0%	1	5%
Black/African/Caribbean/ Black British	2	10%	1	6%	4	20%
Other ethnic group	0	0%	0	0%	0	0%
Unknown/not recorded	0	0%	1	6%	0	0%
Total	**20**	**100%**	**17**	**100%**	**20**	**100%**

Analysis

Content analysis was used to code the rapid reviews and LCSPRs. Content analysis is a way of interpreting text through the systematic classification process of coding and identifying themes or patterns (Hsieh and Shannon, 2005). We used a 'directed approach' to content analysis, drawing on themes and sub-themes identified in our previous reports, to help deepen our understanding and capture recent learning, while also identifying codes particularly relevant to the three themes under analysis. Data was analysed in Excel by members of the analysis team and quality assured by managers.

An iterative and constant process of discussion and reflection between all those conducting the analysis was used to ensure consistency of understanding and 'sense check' emerging findings. Regular discussions with Panel members throughout the analysis supported this sense-checking and meaning-making process.

In addition to the qualitative analysis of the rapid review and LCSPR sample, we also identified rapid reviews from the full dataset where the specific characteristics related to the three themes featured, and where practice issues were identified. Free text responses for these reviews were also analysed and compared with the findings from the in-depth rapid review and LCSPR analysis to check consistency of findings across the datasets. Content analysis was used to code the rapid reviews and LCSPRs against the three themes.

In addition, members of the Panel's Data Insights Team held two workshops with representatives from safeguarding partnerships when the key findings were identified. This helped further sense check the findings and assist in the translation of learning from the findings into reflective questions for strategy and practice.

Quantitative analysis

To support the qualitative analysis, we also undertook quantitative analysis on the 330 rapid reviews to compare children who met the criteria for each theme with children who did not meet the criteria for each theme.

For all three themes, children who met the criteria for the theme fell predominantly within a particular age bracket. The vast majority of children with reported mental health conditions and those who had experienced extrafamilial harm were aged 11 years old or older. The theme for parental health chose to focus on pre-school children aged 1 to 5 years old. Consequently, for each theme, we compared children who met the criteria for the theme with those within the same age bracket who did not meet the criteria. This reduced the possibility of any perceived differences between the two groups being overly influenced by age. This resulted in the following samples.

Table E3: Samples for qualitative analysis

Theme	Yes	No
Children with a mental health condition(s) aged 11 to 17 years old	68	72
Pre-school children aged 1 to 5 years old with a parent(s) with a mental health condition(s)	27	19
Children who had experienced extrafamilial harm aged 11 to 17 years old	76	44

To compare the two groups for each theme we produced frequencies and percentages for variables of interest. The figures from this analysis can be found in Appendix F.

Limitations

While rapid reviews and LCSPR reports provide a source of rich data on multi-agency practice in child safeguarding, there are some limitations that must be acknowledged. First, these reviews represent serious cases of death and harm that are identified as such and accepted by safeguarding partnerships. Therefore, they do not represent all cases of death and harm of children, nor do they represent the full picture of multi-agency response to safeguarding needs.

Second, our analysis was necessarily dictated by the types of cases chosen by safeguarding partners for review. The balance of these reviews tends towards intrafamilial cases, although we have purposefully explored extrafamilial cases as one of the three themes of focus. They also tend towards cases where there is scope for new learning to emerge and therefore do not represent the whole system.

Third, the time it takes between commencing an LCSPR and publication can be lengthy, by which time practice may have moved on or been addressed through new guidance or training. It is worth noting that as many of the incidents within the LCSPRs date from April 2021, they took place before the learning from more recent reports was published and so reviews may not necessarily always reflect current practice. However, we also know that new directions in, or guidance on, practice may not be absorbed equally across partnerships. We believe, therefore, that much of the learning we are seeing continues to be relevant – even if some areas have successfully addressed some of the issues. In recognition of the 'learning lag', we work closely with stakeholders to ensure the messaging and learning points within our reports remain current. Additionally, by limiting the date of the incident to those falling within the three preceding years of submission to the Panel, we hoped to help ensure that the learning contained within those remained relatively recent and more applicable to current practice.

Fourth, the quality and quantity of information about the role of agencies in these cases is variable within reviews. Sometimes reviewers primarily describe agency responses, with little analysis or reporting of the reasons why the practice occurred. In part, we know that reviewers may themselves be limited by the quantity and quality of information they are able to access when conducting reviews. Without good detail about the explanations for errors or missed opportunities, we are less able to target messages for practice at the 'right level'.

Fifth, relevant characteristics of cases, like ethnicity and gender, are often missing from reviews which limits our ability to examine the lived experiences of children (see Chapter 3 for a discussion on the quality of reviews).

Sixth, and finally, reviews take a 'deficit' model approach which means they seek out what went wrong, rather than what went right. Reviewers do praise practitioners for good practice on occasion, but specific detail about the features of good practice is often weakly described, limiting our ability to articulate what 'good' looks like.

Appendix F – Spotlight themes rapid review figures

Table A: Child mental health

Children with a mental health condition(s) (all ages)		
	N	%
Mental health condition(s)		
Yes – diagnosed	27	38%
Yes – undiagnosed	10	14%
Yes – both	1	1%
Yes – unknown if diagnosed	33	46%
Total	**71**	**100%**
Age group		
c. 6 to 10	3	4%
d. 11 to 15	30	42%
e. 16 to 17	38	54%
Total	**71**	**100%**

Children aged 11 to 17 years old with a mental health condition(s) compared with children of the same age without a mental health condition(s)				
	Children with a mental health condition(s)		Children without a mental health condition(s)	
	N	%	N	%
Death and serious harm				
Death and serious harm				
Death	36	53%	26	36%
Serious harm	31	46%	39	54%
Other	1	1%	7	10%
Total	**68**	**100%**	**72**	**100%**
Likely cause of death				
Medical	1	3%	3	12%
Accident/injury	1	3%	2	8%
Fatal assaults – extrafamilial	2	6%	2	8%
Risk-taking behaviour	2	6%	1	4%
Child homicide – extrafamilial	7	19%	10	38%
Suicide	23	64%	2	8%
Child homicide – intrafamilial	0	0%	1	4%
Overt child homicide by primary caregiver	0	0%	2	8%
Death from extreme neglect	0	0%	2	8%
Unclear	0	0%	1	4%
Total	**36**	**100%**	**26**	**100%**

Children aged 11 to 17 years old with a mental health condition(s) compared with children of the same age without a mental health condition(s)				
	Children with a mental health condition(s)		Children without a mental health condition(s)	
	N	%	N	%
Likely cause of serious harm				
Attempted suicide	3	10%	0	0%
Child sexual abuse – extrafamilial	9	29%	1	3%
Child sexual abuse – intrafamilial	5	16%	6	15%
Child sexual exploitation	2	6%	1	3%
Medical cause	1	3%	2	5%
Non-fatal assaults – extrafamilial	2	6%	1	3%
Non-fatal assaults-intrafamilial	1	3%	15	38%
Non-fatal neglect	4	13%	1	3%
Other non-fatal incident	2	6%	4	10%
Self-harm	2	6%	4	10%
Risk-taking behaviour	0	0%	2	5%
Severe, persistent child cruelty	0	0%	2	5%
Total	**31**	**100%**	**39**	**100%**
Child and family characteristics				
EHC plan				
Yes – EHC plan in place	19	28%	13	18%
Child being assessed for EHC plan	1	1%	2	3%
Child previously on EHC plan	2	3%	1	1%
No	46	68%	56	78%
Total	**68**	**100%**	**72**	**100%**

Children aged 11 to 17 years old with a mental health condition(s) compared with children of the same age without a mental health condition(s)				
	Children with a mental health condition(s)		Children without a mental health condition(s)	
	N	%	N	%
Child looked after				
Yes – child in foster care	2	3%	4	6%
Yes – child in other residential setting	6	9%	4	6%
Yes – child in residential home	13	19%	4	6%
No – Previously looked after	2	3%	4	6%
No	45	66%	56	74%
Total	**68**	**100%**	**72**	**100%**
Family known to children's social care				
Yes – current open case	46	68%	42	58%
Yes – previous known	20	29%	25	35%
No	2	3%	5	7%
Total	**68**	**100%**	**72**	**100%**
Risk factors				
Physical abuse	38	56%	34	47%
Neglect	36	53%	24	33%
CSA/E	35	51%	14	19%
Domestic abuse	34	50%	37	51%
Addiction to or misusing alcohol/ substances	33	49%	25	35%
Emotional abuse	28	41%	15	21%
Bullying	10	15%	4	6%
Total incidents	**68**		**72**	

Table B: Parental mental health of pre-school children

	Pre-school children with a parent with a mental health condition(s)		Pre-school children without a parent with a mental health condition(s)	
	N	%	N	%
Death and serious harm				
Death and serious harm				
Death	15	56%	8	42%
Serious harm	12	44%	11	58%
Total	**27**	**100%**	**19**	**100%**
Likely cause of death				
Accident/injury	1	7%	0	0%
Covert child homicide by primary caregiver	3	20%	0	0%
Death from extreme neglect	2	13%	2	25%
Fatal assaults – intrafamilial	4	27%	2	25%
Medical	2	13%	2	25%
Overt child homicide by primary caregiver	3	20%	0	0%
Unclear	0	0%	2	25%
Total	**15**	**100%**	**8**	**100%**

	Pre-school children with a parent with a mental health condition(s)		Pre-school children without a parent with a mental health condition(s)	
	N	**%**	**N**	**%**
Likely cause of serious harm				
Fabricated/induced illness	1	9%	0	0%
Non-fatal assaults –intrafamilial	5	45%	2	18%
Non-fatal neglect	4	36%	3	27%
Other non-fatal incident	1	9%	1	9%
Accident/injury	0	0%	1	9%
Child sexual abuse – extrafamilial	0	0%	2	18%
Severe, persistent child cruelty	0	0%	1	9%
Unclear	0	0%	1	9%
Total	**11**	**100%**	**11**	**100%**
Child and family characteristics				
Child in need				
Yes – at time of the incident	4	15%	5	26%
Yes – previously	9	33%	3	16%
No	14	52%	11	58%
Unknown	0	0%		0%
Total	**27**	**100%**	**19**	**100%**
On child protection plan				
Yes – on CPP	3	11%	1	5%
Yes – previously on CPP	4	15%	3	16%
No	20	74%	15	79%
Total	**27**	**100%**	**19**	**100%**

	Pre-school children with a parent with a mental health condition(s)		Pre-school children without a parent with a mental health condition(s)	
	N	**%**	**N**	**%**
Care order				
Yes – currently subject to care proceedings	2	7%	0	0%
Yes – interim care order	1	4%	0	0%
Yes – other order	3	11%	2	11%
Yes – permanent care order	0	0%	1	5%
Yes – previously subject to care order	1	4%	1	5%
Yes – special guardianship order	1	4%	0	0%
No	19	70%	15	79%
Total	**27**	**100%**	**19**	**100%**
Family known to children's social care				
Yes – current open case	13	48%	9	47%
Yes – previous known	13	48%	7	37%
No	1	4%	3	16%
Total	27	100%	19	100%
Family known to early help/ intervention				
Yes	12	44%	5	26%
No – early help refused by family	0	0%	3	16%
No	15	56%	11	58%
Total	**27**	**100%**	**19**	**100%**

	Pre-school children with a parent with a mental health condition(s)		Pre-school children without a parent with a mental health condition(s)	
	N	**%**	**N**	**%**
Parent characteristics				
Young parents (under 25 years)				
Yes – under 18	2	7%	1	5%
Yes – 18 to 24	5	19%	0	0%
No	16	59%	16	84%
Unknown	4	15%	2	11%
Total	**27**	**100%**	**19**	**100%**
Parent/relevant adult with addiction to or misusing alcohol/ substances (including prescribed)				
Yes – alcohol	3	11%		0%
Yes – substances	7	26%	6	32%
Yes – both	5	19%	1	5%
No	9	33%	6	32%
Unknown	3	11%	6	32%
Total	**27**	**100%**	**19**	**100%**
Parent/relevant adult with disability				
Yes	9	33%	5	26%
No	16	59%	9	47%
Unknown/not recorded	2	7%	5	26%
Total	**27**	**100%**	**19**	**100%**

	Pre-school children with a parent with a mental health condition(s)		Pre-school children without a parent with a mental health condition(s)	
	N	%	N	%
Single parent/ ‘invisible’ (absent) parent				
Yes – single mother/absent parent	4	15%	1	5%
Yes – single father/absent parent	0	0%	1	5%
No	23	85%	15	79%
Unknown/not recorded	0	0%	2	11%
Total	**27**	**100%**	**19**	**100%**
Risk factors				
Neglect	18	67%	12	63%
Parent/relevant adult with addiction to or misusing alcohol/substances (including prescribed)	15	56%	7	37%
Domestic abuse	14	52%	7	37%
Physical abuse	13	48%	9	47%
Housing issues	12	44%	8	42%
Financial hardship	7	26%	4	21%
Emotional abuse	6	22%	3	16%
CSA/E	1	4%	2	11%
Total	**27**		**19**	

Table C – Extrafamilial harm

Children who have experienced extrafamilial harm (all ages)		
	N	%
Extrafamilial harm		
Gang related/youth violence	44	56%
Child criminal exploitation/county lines	43	55%
Extrafamilial CSA/E	31	40%
Total	**78**	**100%**
Age group		
b. 1 to 5	2	3%
d. 11 to 15	27	35%
e. 16 to 17	49	63%
Total	**78**	**100%**

Children aged 11 to 17 who have experienced extrafamilial harm compared with children of the same age who have not							
	Children who have experienced extrafamilial harm					Children who have not experienced extrafamilial harm	
	All		Gangs	CCE	CSA/E		
	N	%	%	%	%	N	%
Has mental health condition(s)	36	47%	23%	26%	83%	32	50%
Total	**76**	**100%**				**64**	**100%**

	Children who have experienced extrafamilial harm		Children who have not experienced extrafamilial harm	
	N	**%**	**N**	**%**
Death and serious harm				
Death or serious harm				
Death	31	41%	31	48%
Serious harm	38	50%	32	50%
Other	7	9%	1	2%
Total	76	100%	64	100%
Child and family characteristics				
Child's education status				
Child enrolled at a mainstream school	21	28%	31	48%
Child enrolled at a SEN/ BEN establishment	0	0%	4	6%
Child enrolled in alternative provision	15	20%	3	5%
Child in 6th form, college or other EET (16- to 17-year-olds)	15	20%	10	16%
Child not enrolled at a school and not receiving an education	20	26%	7	11%
Child not enrolled at a school and receiving elective home education	0	0%	5	8%
Unknown	5	7%	4	6%
Total	**76**	**100%**	**64**	**100%**

	Children who have experienced extrafamilial harm		Children who have not experienced extrafamilial harm	
	N	%	N	%
Child missing education (under 16 years old)				
No	11	28%	23	49%
Unknown	5	13%	6	13%
Yes – other	4	10%	2	4%
Yes – permanently excluded	2	5%	15	32%
Yes – regular absences/ poor attendance	17	44%	1	2%
Total (under 16s)	**39**	**100%**	**47**	**100%**
Child in need				
Yes – at time of the incident	19	25%	6	9%
Yes – previously	32	42%	23	36%
No	22	29%	31	48%
Unknown	3	4%	4	6%
Total	**76**	**100%**	**64**	**100%**
On child protection plan				
Yes – on CPP	7	9%	6	9%
Yes – previously on CPP	22	29%	11	17%
No	44	58%	45	70%
Unknown	3	4%	2	3%
Total	**76**	**100%**	**64**	**100%**

	Children who have experienced extrafamilial harm		Children who have not experienced extrafamilial harm	
	N	%	N	%
Child known to youth offending teams				
Yes – at time of the incident	25	33%	1	2%
Yes – previously	12	16%	1	2%
No	38	50%	60	94%
Unknown	1	1%	2	3%
Total	**76**	**100%**	**64**	**100%**

Child looked after

	Children who have experienced extrafamilial harm					Children who have not experienced extrafamilial harm	
	All		Gangs	CCE	CSA/E		
	N	%	%	%	%	N	%
No	50	66%	77%	74%	48%	51	80%
No – previously looked after	3	4%	7%	7%	0%	3	5%
Yes – child in foster care	3	4%	5%	2%	3%	3	5%
Yes – child in other residential setting	7	9%	5%	5%	14%	3	5%
Yes – child in residen-tial home	13	17%	7%	12%	34%	4	6%
Total	**76**	**100%**				**64**	**100%**

Risk factors				
	Children who have experi-enced extrafamilial harm		Children who have not ex-perienced extrafamilial harm	
	N	%	N	%
Repeat missing child	43	57%	6	9%
Physical abuse	42	55%	25	39%
Victim/perpetrator overlap	36	47%	5	8%
Domestic abuse	34	45%	37	58%
CSA/E	31	41%	18	28%
Total	**76**		**64**	

Learning and practice themes raised within the review							
	Children who have experienced extrafamilial harm					Children who have not experienced extrafamilial harm	
	All		Gangs	CCE	CSA/E		
	N	%	%	%	%	N	%
Cross boundary is-sues	27	36%	30%	28%	48%	9	14%
Service response to undiagnosed mental health of the child	12	16%	7%	12%	28%	9	14%
Total	**76**	**100%**				**64**	**100%**