THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Annual Report

2018 to 2019

Patterns in practice, key messages, and 2020 work programme

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1. Foreword

Since our first meeting in July 2018, we – the Child Safeguarding Practice Review Panel (the Panel) – has received rapid reviews relating to notifications for over 500 serious child safeguarding incidents.[1] This is a significant and troubling number of cases where children under 18 years have either died or been seriously harmed in the context of abuse and neglect.

We are in a privileged position to be able to look in detail at what happened to these children and work with local safeguarding partners[2] to extract the learning so that the system can improve its response to the needs of children and their families.

The statutory guidance is clear that safeguarding is everyone's business.[3] We take our responsibility to have oversight of the child safeguarding system seriously. We believe that this report gives a unique view of safeguarding practice in England formed by reading and evaluating 538 rapid reviews in our first 17 months of operation. Our analysis has enabled us to see patterns in practice which may have otherwise been overlooked and to draw together and share learning which can influence the work of safeguarding partners and practitioners locally and nationally. We hope the unique practice insights we have offered will support national and local efforts to improve practice.

We recognise that every day, multi-agency services and practitioners across England are successfully safeguarding children and promoting their welfare, by helping to support the complex social and health needs of a wide range of families. Schools, health services, local authorities, the police and probation services, as well as a myriad of other agencies, charities and community groups are all striving to achieve high standards of practice for children and families within limited resources.

When a child dies, or is seriously harmed, it is important to review the practice of all agencies involved with the child and family to reflect on what that practice tells us about the protection and support offered. Critically, through systematic review, we can build a picture of child protection practice more generally, highlighting repeat practice themes and focus on what needs to change.

Although this is our first annual report it covers 538 rapid reviews received

[1] See Working Together to safeguard children 2018, page 83.

[2] See Working Together to safeguard children 2018, page 72.

[3] Working Together to safeguard children 2018. https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

between July 2018 and the end of December 2019. Across the same time period, 126 serious case reviews have been completed and submitted to us. We have taken the learning and practice themes identified from all these reviews and triangulated them with the Triennial Reviews of Serious Cases from 2011-2014 and 2014-2017.

The messages from all these reviews are striking. They represent the lives of children who have been seriously harmed or have died – the overwhelming majority at the hands of their parents or other family members.

Of the 538 rapid reviews received we saw the highest numbers for youngest children with a further spike in the teenage years. On the latter we saw a significant number of serious child safeguarding cases which raised issues of complex and national importance in relation to adolescents at risk from criminal exploitation. We have made this the focus of our first review which we also publish today. '*It was hard to escape: Safeguarding children at risk from criminal exploitation'*.

The Panel has seen an unacceptably high level of deaths of babies from co-sleeping in families in the context of abuse and neglect - over 40 in 16 months. That is why our second review is looking at these cases.

27% (144) of the rapid reviews involved the death or serious harm of a child under 1 year old due to non-accidental injury. Perpetrators of such trauma on babies are overwhelmingly their parents or parental partners and we would welcome a dialogue with government about the actions they are taking to address the needs of our youngest children. Our response will be to make non accidental injuries in babies the focus of our next national thematic review.

We often pride ourselves that there are so few child deaths as a result of child abuse in England, compared to other countries. However, many more children, whilst they may not die, are seriously harmed.

Of the rapid reviews we received, 244 reported that children had died and 294 reported serious harm. Out of this latter group, 77 incidents were considered near misses i.e. the child could easily have died as a result of the serious incident.

Weak risk assessment and poor decision making were identified as a major practice theme within 41% (218) of all the rapid reviews we received. Poor information exchange at critical points between agencies was present in 40% (215) of all rapid reviews. These are not new issues but critical to address head on if we are to make progress in improving the response agencies make collectively to protect children. It is a very sobering experience indeed, to have learnt so much about the circumstances in which children have died or have been seriously harmed.

Every two weeks the Panel sees, across England, the circumstances in which things have gone tragically wrong for a child and their family.

It is our job to bring the practice learning quickly to the door of safeguarding partners, policy makers, and indeed the public, so that there can be collective action to do our very best to reduce the chances of such tragedies happening in the future. We know that government is considering a care review and we very much hope that this report will help steer the focus of that review.

This report also sets out in detail how we have worked together as a Panel and the focus of our priorities for 2020. For further information about the role and membership of the Panel see Annex 1.

If, after reading this annual report, you have views or thoughts about the overall content or about the work of the Panel, we encourage you to get in touch with us. We look forward to hearing from you and continuing to work with safeguarding partnerships. Thanks to all former Local Safeguarding Children Board Chairs, Safeguarding Partners and their teams for working with us so positively.

Child Safeguarding Practice Review Panel

2. Patterns in Practice

What we know about the children who have died or been seriously harmed

1. Whilst many children who die or are seriously harmed come from families not known to services other than universal provision, in 54% of the cases we have seen children's social care services were working with children and families at the time of the incident. In 13% of cases (70) children were on a child protection plan and in 15% of cases (80) children were looked after at the time of the incident. A brief summary of the common characteristics of the cases is recorded in the chart below.

2. The analysis suggests that the child protection system is usually successful in identifying the most vulnerable children. At least half of all children who died or were seriously harmed were already identified as vulnerable; but, despite that identification, the system was not able to prevent their death or serious harm.

3. To the lay person and even the experienced professional, it often seems incredible that we couldn't have done more to protect a child given the known risk factors. The problem is false positives: thousands of families in England have the same risk factors, but their children do not die, and they are not seriously harmed. The inherent tension in child protection practice is how best to identify those children most at risk without pulling into the child protection system thousands of families who would never seriously harm their children. We comment further on the quality of risk assessment and decision making later in the report.

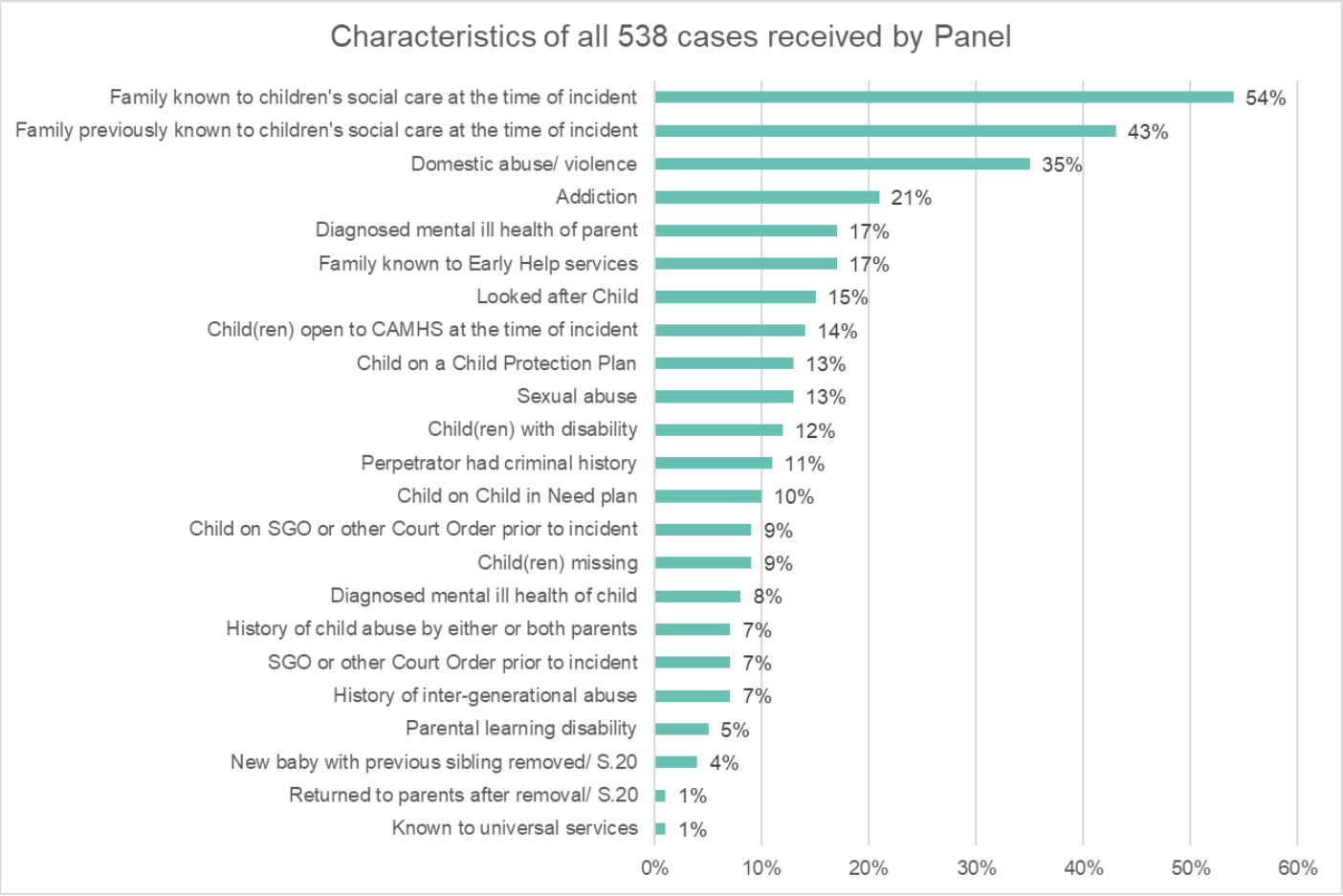
4. 46% of children who died or were seriously harmed were *not* known to children's social care. Should they have been? When a first child is born for example, little is known about the parents' capacity as caregivers. Some children are hidden from statutory services and sometimes, whilst families were using a range of public services, the abuse is hidden. Often the serious incident seemingly came from nowhere, with no specific risk factors and no family involvement with statutory agencies. This brings into sharp relief the unpredictability of many deaths or serious harm in the context of child abuse.

5. In most of the reviews, it was not possible to say that a child death or serious harm to a child could have been prevented. However, year after year similar practice learning is identified. The Panel is duty bound to highlight these repeat patterns.

6. Our collective responsibility, in partnership with the Government and safeguarding partners, is to design a

child protection system which is fair and balanced in relation to when it intervenes in private family life; a system that is fine tuned to recognise high risk with likely serious consequences; and a system that is highly ethical in its practice culture, and highly effective in its' interventions.

It is important to note the different timescales of the data we have used. The analysis of the patterns in practice (sections two and three) is over a 17-month period – from July 2018 to December 2019. In section four the timing and publication of notifications, rapid reviews and local child safeguarding practice reviews the data refers to our first year in operation – from July 2018 to June 2019.

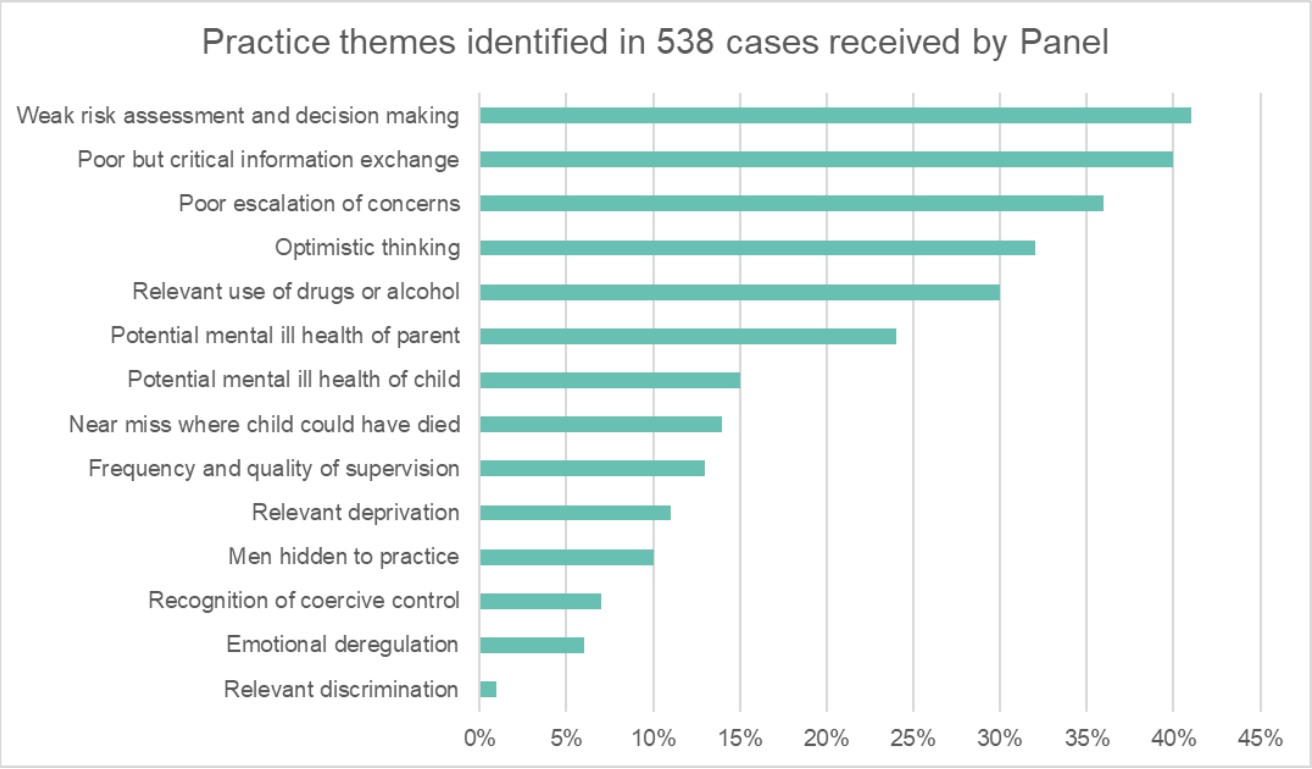


3. Key Practice Themes and Messages

7. Following a serious incident, safeguarding partners are required to submit a rapid review within 15 working days, setting out, in detail, the circumstances of the event. We want to set out the practice messages that we have taken from the rapid reviews which we think safeguarding partners and government departments should consider for further action. It is not possible to reflect in this report all the practice issues that have emerged, but we have collected information from each review and identified key themes.

8. We commissioned five members of our pool of national reviewers to undertake a learning exercise that looked at every rapid review from July 2018 to December 2019. As part of that exercise our reviewers recorded the key details of the incident including the facts, the learning already identified and a judgement on the practice themes the case raised.

9. The table below sets out the themes the reviewers identified.



10. We have decided in this report not to make recommendations but to set out the practice messages and urge safeguarding partners and relevant government departments to address the concerns in ways most productive to them through their responsibilities, existing programmes of work, and priorities for the future. Everyone involved in child protection policy and practice will recognise these messages and everyone has a responsibility to do something about them.

11. We do not have all the answers, but there is an opportunity, through the Government's upcoming review of the care system, to consider the central design principles of the child protection system in England and whether or not the arrangements we have in place are the best way to organise services.

12. The messages included here are the most relevant to share either because they are persistent problems in the system which need to be incorporated into the Government's care review or other policy developments, or because there is something relatively practical and straightforward that could be done by local safeguarding partners.

Optimistic Thinking – the Practice Context

13. We begin with optimism bias as this is such a long-standing concern which permeates every level of practice and organisation. 32% of rapid reviews were identified as appearing overly optimistic in the practice decisions. There are examples of this set out below. This is not easy to "fix", not least because it is inherently human to always look for the best possible outcome. Surely though, it is time to do something about it, and at the very least limit the worst outcomes.

14. Critically though, this is not just about individual practice judgements. The "rule of optimism" a concept developed by Dingwall[4], recognises that the child protection system itself is built through an optimistic lens. A system that often lacks clarity of purpose, with high workload and conditions of uncertainty, is destined to hope for the best. The Triennial Review 2014-2017 wrote *"the challenges facing practitioners are strongly evident particularly working within limited resources with high caseloads and high levels of staff turnover. Practitioners feeling overstretched and overwhelmed came through frequently in the reviews studied. Workload and budgetary pressures stand out as factors that threaten professional practice and through that imperil*

[4] Robert Dingwall et al "The Protection of Children: State Intervention & Family Life", 1995

children's safety and welfare". We did note, in the serious case reviews that we have read, an absence of analysis about how local and national system conditions consider human error.

15. Furthermore, it is not just what is going on inside the professional system but the wider social context within which families live. The Triennial Review 2014-2017 also found that "*practitioners can become desensitised to the impact of poverty and accept lower standards for children and families. Rectifying the physical manifestations of poverty and a chaotic lifestyle does not equate with children being safe. Practitioners should seek to understand how socio-economic issues can interact with other factors to influence parenting and outcomes for children. It is important not to ignore the impact of poverty nor to simply attribute the family's problems solely to economic hardship*".

Matthew, a six-month-old twin, was admitted to hospital with a fractured skull. The mother had six children and had been involved with social services since 1997. She had a serious on-going drug addiction resulting in the twins being placed on child protection plans at birth. Despite clear signs of increasing risk, notifications of several instances of neglect, and treatment for opiate addiction, the children remained in her care.

A mother was suspected of seriously injuring her first child in 2004. When her second child was born in 2015, two psychological assessments of the mother were undertaken as part of care proceedings: one negative and one positive; the more recent and more positive one was accepted and informed the decision to allow Baby Daisy to go home. A third child, Baby Rose, was born in 2017. Her mother killed her when she was only 8 months old. "Sufficient scrutiny and weight were not given to the original judgements relating to mother's ability to parent and the substantial adverse childhood experiences which mother herself had disclosed". The child's needs were overlooked despite all the information known about the mother and her history. An over optimistic wish to keep children with their parents can lead to dismissal of overwhelming evidence to indicate this is not in the child's best interests[...] it was clear that Rose's health needs included the necessity for intensive care and support[...] as a result of the premature birth[...] the assessment of mother's parenting capacity that she would respond well to such complex needs, whilst also providing sole care for Daisy as a toddler, was at best over optimistic, at worst, flawed.

Mother had engaged well with the initial early help assessment and appeared keen to engage with support around managing Billy's behaviour and her emotional health. However, mother started to disengage and did not participate in the support offered. She was more focused on Billy being the problem rather than wanting to consider her parenting. Professionals didn't challenge this.

Billy was six years old when admitted to hospital with serious injuries, having been involved in a road traffic collision. At the time of Billy's accident, he was subject to a child protection plan due to neglect. The issues included a lack of adequate care and supervision and the impact of mother's misuse of amphetamines).

Information sharing, risk assessment & decision making

16. Risk assessment and decision making is often found to be weak in many cases where a child has died or been seriously harmed. 41% of rapid reviews found that this was an area of concern. How best to ensure that the right information is shared and used at the right time between the right professionals has been a perennial challenge for the child protection system. A huge amount of work has been undertaken over the years to ensure that legislative frameworks, statutory guidance and other procedural and operational arrangements for information sharing are fit for purpose. Despite those efforts, time and again this is an area of practice highlighted as a learning point.

17. We want to emphasise that we understand it is extremely difficult to accurately predict what is going to happen to a child in any given set of circumstances, as there are so many variables that can quickly change the trajectory towards serious harm. We are also very mindful that it is not helpful to judge practice with the benefit of hindsight. However, in too many of the detailed explorations of practice we have seen, we are sure that different decisions could and should have been made. It is not comfortable to confront this fact, but it is our responsibility as the Panel to do so. This is not because we want to pinpoint responsibility onto individuals; far from it. We want to highlight the fact that there are systemic reasons why we see the same mistakes made repeatedly so that we can help build a case for change.

18. Information sharing is a means to an end. Information must be firstly identified as needed, then collected, recorded, shared, discussed and analysed. Decisions need to be made about what this information is telling us and what we should do about it. Without a fresh approach to responding to these critically important features of child protection practice – we believe we will see little significant

improvement. We need to move beyond the legislative and procedural, to the technological and the behavioural, and forensically explore how we can develop our multi-agency and multi-disciplinary practice in routine ways, and at critical points, which strengthens information sharing, risk-assessment and decision making.

19. Whilst technological solutions are a critical component, we also need to think in terms of human factors. Complexity of practice requires sophisticated conversation, hard wired into the DNA of our child protection practitioners. How do we help people talk to each other within a context of high-risk, high-volume and limited resource, often when practitioners are fearful of reprisals from families, employers and society at large?

A three-month old baby, subject to child protection planning alongside his three siblings, suffered serious head injuries. The review found that the risks to the children were not adequately assessed: “in particular the cumulative and compounding nature of multiple risks was not sufficiently recognised […] there is no information […] to suggest that any one agency or any multi-agency forum recognised the higher risk of coexisting domestic abuse, mental illness and substance misuse." This is in spite of five risk assessments having been undertaken by various agencies.

Madison was cruelly treated by her mother, stepfather and stepsiblings… she suffered emotional and physical abuse over several years. There were concerns that physical signs which could have been indicative of abuse were not recognised and that the evidence of emotional abuse and physical injuries had been insufficiently understood.

A serious case review of the intra-familial child sexual abuse of two young children, by the paternal uncle and paternal grandfather, found that the assessment of risk posed by the extended family wasn’t fully considered, nor was the social worker assigned to the case adequately supervised.

Daisy was three years old when she presented at hospital having ingested methadone. Her mother was on a treatment programme and was known to misuse heroine. Daisy had previously been on a child protection plan and was receiving a targeted health visiting service at the time of the incident. Mother has three older children who were removed from her care some years ago: the concerns then were about parental drug use and neglect. Prior to the hospital admission, appointments were being missed by the mother who was also seen "loitering for prostitution" on several occasions. Daisy was not being brought to appointments. She was regularly missing from nursery and had some speech and language delay. She struggled with concentration and routines in nursery and she regularly seemed hungry. On the previous occasion mother reported that Daisy had methadone on her hands and licked them. The parents were investigated by the police, but no further action was taken. A hair strand test taken from Daisy showed a low level of methadone over time. Her parents claimed this was environmental and deny giving her methadone. An expert consulted by the police would not rule out external factors such as touching the hair.

Children returned home post court proceedings

20. In 49 rapid reviews, children who died or were seriously harmed had previously been subject to public care proceedings because of concerns about significant harm. It is clear that, following the identification of serious known or suspected abuse at the hands of their parents, some children were then returned home, or to other carers, only to later experience serious harm or death. In 36 cases, children had been previously removed and permanently so, but their subsequent siblings, were not returned to court for protection as enough parental change was thought to have occurred. This has caused us great concern and is likely to be a theme for national review in the near future.

Adults with a history of offending

21. We were very troubled by the level of criminal activity of some parents and violence witnessed or experienced by children. We found that there were several examples where multi-agency public protection arrangements (MAPPA) had not worked well or that probation practice had fallen short. People with a history of child abuse, some of whom had been convicted, were not tracked sufficiently well, nor were new relationships explored properly, to establish whether they were in a relationship and/or living with children.

22. The Triennial Review 2014-17 offers the following commentary: "*a parental history of criminal activity including previous criminal convictions is a risk factor for both neglect and abuse. It is essential that in all cases of suspected maltreatment information is sought from the police about any records held. This extends to parents, carers and other family members or close contacts. It is particularly important for police to check information that may be held in relation to previous relationships or in other areas, including checking intelligence from other countries*".

A boy, aged six, died as a result of a physical assault by his mother's new partner, who had recently been released from prison and was known to pose a serious risk to adults and children. The National Probation Service was aware that he was in a relationship with a new partner and that she had a son, but no risk assessment was undertaken, nor was the case referred to MAPPA. The boy's mother had also visited this man in prison on four occasions before his release; he had 21 convictions for violence, including GBH on an ex-partner.

Domestic Abuse

23. Domestic abuse was a recognised feature of life for 35% of the children who were notified to us. We are concerned that child protection practice, when domestic abuse is the main issue, is at risk of becoming automated: where parents had attended particular domestic abuse programmes, attendance in itself was considered to be a protective factor, reducing the risks to children; where Domestic Abuse, Stalking and Harassment and Honour-based violence (DASH) scores had reduced and the family was part of the local Multi Agency Risk Assessment Conference (MARAC), this gave a sense of reassurance to practitioners which proved to be false.

24. We were concerned about the validity and the effectiveness of some of the responses to domestic abuse outlined above. Given widespread use, we think it only right that their evidence base is robust. A new programme of research should begin to ensure this is the case.

25. Advice to health professionals about the practice of routine enquiry should address how practitioners should manage situations where the partner is always present during antenatal care, GP, or health visitor appointments. Supportive partners may very well attend every appointment, and this is not something which should be discouraged. This does, therefore, raise questions about the effectiveness of this standardised procedure. We also wondered about the robustness of its evidence base.

26. The presence of coercive control within adult relationships in the

family was sometimes misunderstood or minimised. This is a relatively new area of practice which needs to be actively considered amongst practitioner groups in every local area. All practitioners need to be sufficiently sensitised to the power and fear that can arise from a coercive controlling relationship.

Adolescents: Autism, Mental Health & Suicide

27. We have received several rapid reviews involving extremely vulnerable young people with a history of self-harm, overdoses or other longstanding or historical mental ill health. Sometimes this was exacerbated by a history of abuse; other young people also had a diagnosis of autism. Many were in the care system at the time of the incident. Frequently we have heard about these young lives characterised by multiple placements during periods of being looked after, lives becoming increasingly chaotic, with frequent periods of going missing and mental health deterioration.

28. Professionals seemed on some occasions not to be able to hear what the young person was saying, even when it was quite specifically suicide ideation, in any practical or emotionally intuitive way. This was the situation for some young people who then went on to kill themselves. Where these high-level health and social care needs were in the context of a specific form of abuse, like child sexual exploitation, there was also some suggestion that the narrowness of focus led to the wider social needs being forgotten.

29. Many of the young people in the above category were looked after children. In 80 rapid reviews, children were looked after at the time of their death or at the point they were seriously harmed. We recognise that many of these children would have already been at serious risk of harm and it is this fact that resulted in them becoming looked after in the first place. However, the stark reality is that the system did not manage to protect them. This raises two critical questions. Firstly, is bringing children into the care system the right protective decision? It feels intuitively correct, but as the Panel's national review into criminal exploitation found, in some circumstances this can have unintended consequences. We saw examples of risk to the young person quickly escalating once in care. Secondly, if alternatives have been properly explored, did we do enough to support that child and their family once in care?

30. At the time of writing, we know that there is increasing concern from many quarters about the suitability of unregulated and unregistered care, the sufficiency of placements in general, for looked after children and specifically for Tier 4 mental health care. Our experience of the stories we have read validates the concerns being raised.

Including Men

31. The Triennial Review 2014-2017 found that there continues to be a "dearth of information" in practice, about men. The primary focus of health professionals and social workers continues to be on the needs, circumstances and perspectives of the mother. This is the case even in established relationships, when the mother's partner has a major role in looking after the children. Such a lack of professional curiosity in fathers and partners not only potentially leaves women and children vulnerable, it can also leave fathers feeling alienated and forgotten, and their role in bringing up the children dismissed. Services need to find ways to become more male friendly if they are to encourage the involvement of men in the lives of their children.

32. The role of men in the lives of children will be explored in the Panel's national review programme of work on non-accidental injury but safeguarding partners should review how this repeat theme is being addressed locally in all agency practice.

Health plans for children

33. Many reviews have raised concerns about the medical response to families not meeting requirements of health plans for children with life-threatening conditions. In some cases the capacity of parents or young people to meet those medical needs is limited. Questions were raised about the extent to which health professionals were able to access information about family history. Children repeatedly not brought to appointments, signs of disengagement and inconsistent responses to a child's health needs should be recognised early so that the potential risk can be assessed, particularly in vulnerable children.

34. The practice system within health services depends upon the patient being proactive in coming for appointments, reading letters and picking up telephone calls. Where families and young people need support to be proactive and consistent, it will be necessary to provide intensive support to make sure they get to the appointments that are so critical for their wellbeing. This should not be left to chance.

> Professionals including the dietitian, the speech and language therapist and continuing care nursing team, called the parents for routine updates and discussions; all but one of the calls went unanswered and were not returned. There was a long gap of five days between the initial request for antibiotics and the father attending for a prescription. The GP gave antibiotics but there was an over reliance on the parents to assess [the child's] health as there was no plan for a follow up and [the child] was not seen by the GP.

It is unreasonable and unrealistic to rely on parents' assessment of their child's health rather than conduct an examination, especially when the child has complex medical needs. It is not clear how the parents were supported to understand the child's needs re his chest health when managing the prophylactic antibiotics. There are parallel clinical processes which should have been in place to monitor his chest health in relation to his breathing and congestion which again would reduce the over reliance on parents to assess his health.

Children Educated at Home

35. There is a long-standing concern, particularly amongst child protection professionals and schools, about how to respond to situations where children who are home educated are suspected of being abused. Of the rapid reviews we received, a small number involved children who were educated at home. Four of those children died, and seven children suffered serious harm through neglect. Whilst this was a small group of children, it is an area of practice that we will want to review in the future. There is a consensus that attending school is a protective factor. School is a place where children are seen every day and by many different professionals and by peer groups and other families. It is a place where early indications of concern can build into decisive action because the concerns are in plain sight. When a child is educated at home, they become separated from the protective mechanisms which school provides. In these circumstances, it becomes even more critical that other indicators of concern from other agencies are properly connected.

36. We thought the recommendation from one serious case review, that online resources made available to electively home educated children should include a "help" button on the online learning provider landing/homepage, could be very effective. This would enable children to gain advice and or easily link to other online resources such as ChildLine, or advice on e-safety.

A 14-year-old contacted the NSPCC and disclosed that he nor his older sister had ever been to school nor received home schooling with the children largely confined to the house. The review found there were occasions when the opportunity to work together effectively to safeguard the family were missed. For example, each episode was seen in isolation, the voice of the child was not evident at some encounters, and there was a lack of follow up of actions or plans. The impact of this was that children were missing in the system.

Billy was found together with his siblings to be suffering from serious neglect and physical and emotional abuse. He had not been seen by any professionals since the age of 14 months, was not known to the local education authority and was not, and never had been, in receipt of education health or social care services to meet his additional needs and diagnosis of autism. Over time Billy's siblings had been variously removed from state and independent faith schools to be electively home educated. Billy and his siblings endured serious physical and emotional abuse and neglect at the hands of their parents over a period of many years.

Written agreements

37. There is widespread use of written agreements. For example, to prevent contact where there is a risk of sexual abuse, or more generally, to provide clarity about expectations between children's social care and the family. At best, written agreements had little or no protective effect, and at worst provided false reassurance that this would keep children safe.

38. In one case involving the systematic sexual abuse of three siblings by their father over a 15-year period, written agreements were used six times to prevent contact between the father and his children but each time these expectations were breached. Eventually because of the disclosures of the eldest child, once she had reached 18, the father was convicted and given a 21-year sentence. Safeguarding partnerships may wish to examine their use of written agreements and assure themselves that they function in the way in which they are intended. Ofsted's Annual Report published in January 2020 warns that too much responsibility is placed on mothers to manage the contact between abusers and their children. It criticises the use by some agencies of written agreements, drawn up on a voluntary basis, as a method of safeguarding children. The report warns that the use of such agreements place "unrealistic expectations" on the parent's ability to keep the child safe.

Resolving professional disputes

39. We have seen several examples where there was serious dispute amongst child protection professionals about what action to take when they had concerns about a child who later died or was seriously injured. Often it was unclear if and how practitioners could seek resolution, but safeguarding partners are expected to work together to resolve any disputes locally. Safeguarding partners need clarity about how differences of professional opinion about a child's safety should be resolved and most importantly, confidence in the effectiveness of those arrangements.

40. This report follows others that identify significant levels of historical dissonance and disagreement

between children's social care services and other practitioners from education and health that were not escalated through protocols designed to resolve differing thresholds of concerns about a child. The people who know the most about a child are often not those who have the statutory powers to investigate and assess. Although it is apparent that several professionals had misgivings about the slow pace of response at critical moments, none of them used the escalation procedure.

4. Timing and publication of notifications and reviews

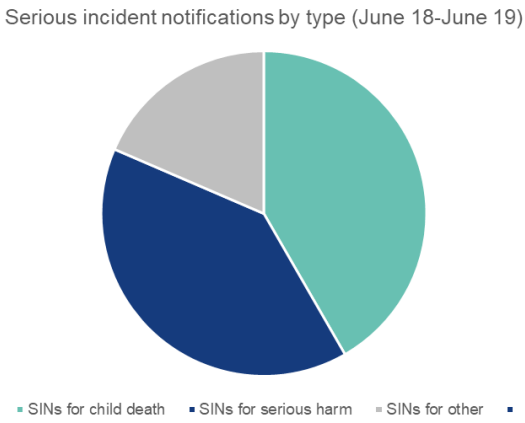
41. The Panel has collected a range of data that allows them to understand how the serious incident notification system is working. Whist it is too early to draw conclusions about the strength and timeliness of local decision making, the information below provides an overview and an opportunity to start to influence both the timeliness and quality of local decisions. It is important to note the different timescales in this annual report for the data we have used. The analysis of the patterns in practice (sections two and three) is over a 17-month period – from July 2018 to December 2019. The data in this section refers to our first year in operation – from July 2018 to June 2019.

Serious incident notifications

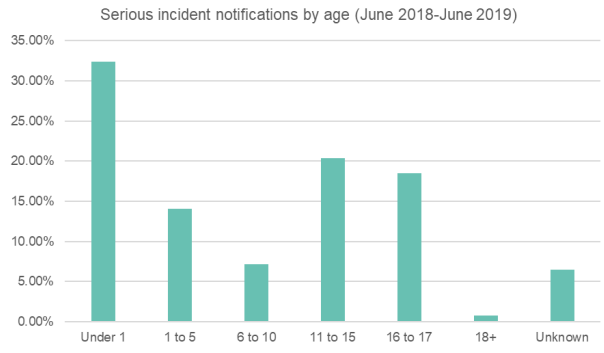
42. Local authorities are duty-bound to notify the Panel, and by extension the Department for Education and Ofsted, if it knows or suspects a child has been abused or neglected and that child dies or is seriously harmed in its area.

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

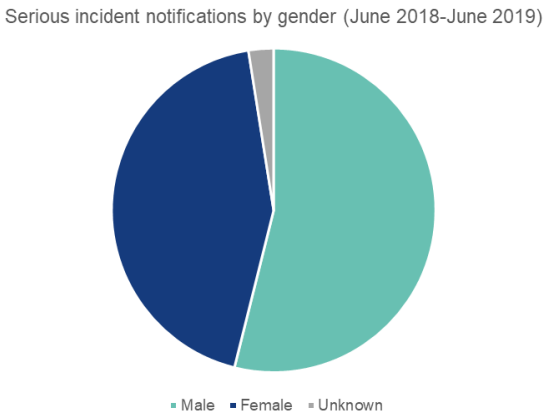
Of those 473 notifications, 198 were in relation to child deaths. 189 related to serious harm, and a further 86 notified us of other issues



Almost one-third of notifications were for children under the age of one. Over 20% of notifications related to 11 to 15 year olds, and over 18% for 16 to 17 year olds. Those aged six to 10 made up 7.2% of notifications.



53.9% of the notifications received related primarily to boys; 43.6% to girls; and 2.5% of notifications did not know the gender of the child at the point of notification.



44. Most local areas have notifying us of between three and six cases per year. There are three local areas that have notified us of a total of 33 cases and these are the outliers in a system that is operating within expected norms.

In 15 local areas no incidents were notified over the period.

Number of notifications	Number of local areas
0	15
1	32
2	26
3	29
4	10
5	15
6	7
7	7
8	7
9	1
10	1
11	1
12	1

45. In those 15 local areas there are over 30,000 Children in Need and over 5,000 Looked After Children. From this cohort it is unlikely that there were no incidents which would meet the criteria for notification. Safeguarding partners should regularly refresh their understanding of the criteria for notification and, whilst it is for them to determine whether a review is appropriate, it is important that all the learning is gained from each case even when they are similar. Our initial focus has been to assess whether or not we agree with LSCB / safeguarding partners' decisions on whether or not to carry out a serious case review / local child safeguarding practice review and whether the cases raise issues that are complex or of national importance such that a national review may be required. As safeguarding partners have come into operation, we and they have focussed more on the potential learning and improvements to practice, recognising their responsibility to determine whether a review is appropriate. Previously too many reviews of serious cases did not ask the right questions or establish why things had gone wrong. This meant genuine learning leading to improvements in practice was not taking place.

The Rapid Review requirements

46. Overall, safeguarding partners have adapted well to the new rapid review requirements and timescales. Many of the reviews describe the circumstances of the abuse or neglect, analyse the themes, identify

the learning, and set out clear ways forward. However, we have seen reviews that are lengthy, characterised by chronologies and too much detail, and that do not focus on the key questions that need to be asked. On occasions, boards and partnerships have seen links between cases and chosen to undertake a serious case review or local child safeguarding practice review that brings together the themes of the cases. While this is to be encouraged, as it can lead to better system learning, the individual features of a case should not be lost.

47. In the best rapid reviews, there has been thoroughness that has meant there has been no need for a further local safeguarding practice review and those areas have been able to move quickly to implement the learning across their system. These reviews feature: a concise statement of what has happened; the key questions which emerge from an appraisal of the case; a detailed and sufficient analysis which addresses those key lines of enquiry; and clearly related learning with actions to address any weaknesses.

48. The rapid review should always record which safeguarding partners were represented at the meeting and the proposed governance.

Publication

49. Some safeguarding partners recommend non-publication of a serious case review. Often the cases contain unnecessary personal and biographical details that could cause distress or harm to those involved. Safeguarding partners should consider carefully how to manage the impact of publication on children, family members and practitioners affected by the case. We urge safeguarding partners to ensure that reviews are commissioned and written in such a way that they can be published in full.

Timing and follow up

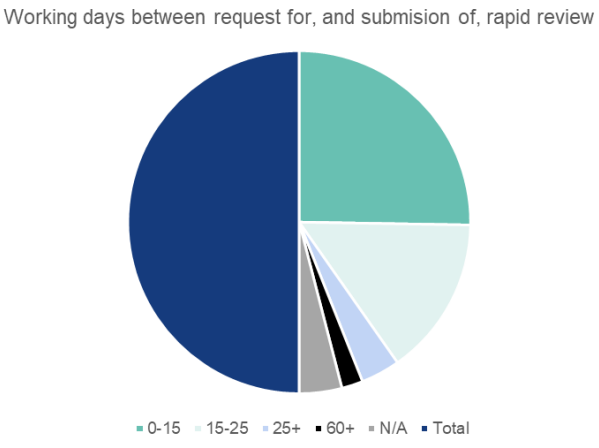
50. In too many instances, reviews are not rapid enough, subsequent serious case reviews / local child safeguarding practice reviews commissioning is too slow, and learning is not applied to practice quickly enough. We are concerned about the length of time it is taking for safeguarding partnerships to complete reviews because we want the learning from them to be relevant to current practice. We very much hope that all reviews will always be completed within the six months set out in statutory guidance, and in many instances, much quicker than that.

51. During our first 12 months, we issued 640 response letters to LSCB/ safeguarding partners. The table below shows the number of working days taken for the rapid review to be received once requested, the target is 15 days.

With only 51% of rapid reviews on time we want to work with safeguarding partners to ensure they are submitted in time. Those identified as 'N/A' are cases where no rapid review was requested at a local level.

Working days	Notifications
0-15	239
15-25	142
25+	35
60+	19
N/A	38
Total	473

The chart below highlights that almost half of rapid reviews take more than four times the expected time to be submitted.



The voice of practitioners, families, children

52. The rapid review process is designed to ensure that the system responds quickly to an incident of serious harm, to assess and review what has happened, and determine the key questions to be asked in any subsequent in-depth review. We encourage safeguarding partners to consider how the voice of the child and families can be incorporated into the learning arising from the rapid review process, recognising that the 'rapid' nature can make this difficult and that the families may feel unable to engage so soon after a serious incident has occurred. In one serious case review we saw the voice of the family helping to reach conclusions. The review recorded that:

MS repeatedly felt 'picked on' and thought that they (social workers) 'had it in' for her. She now admits she didn't always understand what was going on and found that difficult. If she saw some papers before meetings, she felt she couldn't change what it said once it was on paper and therefore couldn't add her side. She did not feel her children trusted social workers.

5. Identifying learning, priorities, and our 2020 work programme

53. Decisions about the Panel's work programme will be primarily driven by the annual analysis of serious case reviews (during the transition period), local child safeguarding practice reviews and rapid reviews.

54. The Department for Education will commission a final Triennial Serious Case Review report to cover the years 2017 to 2019. The Panel will then commission a first practice review alongside its next Annual Report. This will mean that the messages about practice and the practice system will be much more contemporary, whilst still retaining a very important, incremental and historical record of the health of the child protection system.

55. Alongside this, we will continue to systematically draw the initial learning from the rapid reviews received throughout the year. The data and the learning will underpin our annual work programme, as well as provide government, the sector and the public, with an ongoing opportunity to learn from practice.

Our Work Programme for 2020

56. Following our first full year in operation, 2019 has given us a solid platform from which we can confidently focus on priorities for the next year. We are very conscious that whatever we do, it should add value to what is already happening across the child protection sector, and that we must draw primarily from the serious case reviews, practice reviews and rapid reviews we receive.

57. In deciding what we should focus on in 2020, we have also considered the current national profile and related activity of other areas of practice, for example child sexual exploitation, domestic abuse and adolescent mental ill health. We think in 2020, we should concentrate on areas of practice which have just as much relevance to the protection of children, but currently not as much focus.

58. Some of those areas of practice need more in-depth review, to really get to the heart of what is happening in practice and why, to children and families, and what that can tell us about our national child protection system. These areas of practice will form a suite of national reviews in 2020 and beyond. Other quite specific areas are much more clear-cut, where we think there is ample evidence that action should be taken immediately, by government and by key agencies, to address these. There is a need, not for more review, but for more action to address system weaknesses.

59. Finally, we are also conscious that the nature of our statutory function means that we inevitably focus on the most serious incidents, and where the system may not have worked well. We also know there are many examples of excellent practice where families have been helped and children protected. A sole focus on the minority of cases where things go wrong can be counterproductive: it limits opportunities for best practice and shared learning; it can skew public perception of service failure and disproportionately undermines public confidence; it can adversely affect recruitment of professions aligned to child protection; and can exacerbate the reinforcement of a risk averse practice culture.

60. Furthermore, attempts in the review process to draw out pockets of good practice can often be lost amongst the horror and tragedy of serious harm. We are seeking to address this by commissioning a call for evidence of national examples of excellent child protection practice.

Priorities for 2020

61. Firstly, we want to ensure a better balance between the learning taken from incidents of serious harm, and the learning to be taken from highly effective child protection practice. Safeguarding partners will be invited to submit, with permission from families, examples which illustrate highly effective practice in complex child protection cases, and with demonstrable and sustainable improvements to child welfare. Evidence submitted will be reviewed by child protection experts independent to the safeguarding partners. We aim to publish this alongside our practice review and rapid review analysis in 2021.

62. As a statutory body we will be undertaking an annual stocktake of child protection practice and collective efforts to address the concerns we highlight. With this new and constant presence, we have high ambitions for helping to ensure our most vulnerable children get the protection they need. We will offer to lead a national conversation with statutory safeguarding partners about how best to address the matters we raise in this report.

63. Taking the learning from the last Triennial Review 2014 - 2017 and the practice messages from the rapid reviews that we have seen over the last 18 months, we are of the firm view that there are some big policy questions to consider:

- With the new statutory arrangements for safeguarding partners and with the local authority, police and health on an equal footing, is it now time to rethink how we are organised on the ground?

- How can we best strengthen information exchange, risk assessment and decision making?

- What is the multi-disciplinary knowledge and skill set needed to make good protective decisions about children? Is there an evidence base to help inform that?

- How is that knowledge and skill developed? By whom? And to what nationally consistent standards?

- Whilst we have national child protection procedures in the statutory guidance, Working Together, to what extent have we examined if they are the right procedures? Do we have effective checks and balances in the system?

- How can we use the best evidence to enhance our multi-agency working?

- What should be the focus for building new evidence to support practice?

64. These are big policy questions, and the extent to which they are addressed will be largely determined by national political appetite and local safeguarding priorities. We also know that the Government will be making decisions imminently about the focus for a care review. We think it imperative that the scope of the review is firmly focused, although not exclusively so, on the effectiveness of child protection practice and considers the questions we have set out. To our minds, there is no question that there is a need to address these systemic issues, such is the frequency with which we have seen the same practice concerns raised in the serious case reviews and rapid reviews submitted to us.

National Reviews 2020

65. The criteria and guidance when deciding whether it is appropriate to commission a national review of a case or cases is set out on Working Together 2018; criteria covers whether the case raises issues which are complex or of national importance. We have commissioned three national reviews.

A review of safeguarding children at risk from criminal exploitation

66. Our first national review, 'It was hard to escape: Safeguarding children at risk from criminal exploitation' identifies what might be done differently by practitioners to improve approaches to protecting children who find themselves threatened with violence and serious harm by criminal gangs. We hope the unique practice insights we have offered will be used well in the many national efforts taking place to reduce serious violence.

A review of Sudden Unexpected Death of Infants

67. In November 2019 we announced we would be undertaking a review into the sudden unexpected death of infants in the context of abuse and neglect. We have now completed fieldwork looking

in detail at 12 of the 40 cases where babies have died as a result of co-sleeping, and we expect to publish the report in the Spring.

A review of non-accidental injury to babies under one years old

68. We have been profoundly disturbed by the number of serious incidents involving the non-accidental injury of babies, often resulting in their death or life-long impairment. The level of violence involved, sometimes over a protracted period, is shocking. 27% of serious incidents notified and for which we have a rapid review, involved the non-accidental injury of a baby under 12 months old. Out of 144 rapid reviews 30 reported babies had died and 114 babies survived. However, it is often the case that those who survived did so not because the serious incident was necessarily less violent, but because of the sophistication and speed of medical intervention.

69. Most often the perpetrators were parents or their partners, other family members or carers. Whilst some families had no involvement with the police or children's social care, other families were well known. 16 rapid reviews reported babies who were subject to a child protection plan at the time they were seriously harmed or died. Perpetrators were often very young parents with minimal social support. Disturbingly, a small number of perpetrators had been previously convicted of serious violence or had their previous children removed because of physical abuse. For all these reasons, and because we think it will be a matter of public concern, we have decided to focus predominately on this as an area of practice for 2020. We are commissioning a literature review and reviewers to handle the fieldwork discussions with practitioners involved in the selected cases. The review will focus strongly on the motivation and behaviours of male perpetrators. We may decide to undertake further reviews in this area, either to look at related themes, or to undertake a forensic look at an incident.

Suicides; the secure estate, serious violence; and looked after children

70. We know there is considerable variation in how safeguarding partners interpret the statutory guidance about when to notify the Department for Education, Ofsted and the Panel about serious incidents. This is particularly pertinent for notifications regarding suicide, young people in custody, young people who are victims and perpetrators of extra familial serious violence, and when an incident involves a looked after child. We will undertake an analysis of all notifications that fall within these groups of children, to help facilitate a series of conversations with the sector and government. We hope this will result in greater clarity for safeguarding partners about their responsibilities to notify.

6. Child Safeguarding Practice Review Panel

How we have worked

71. We have included more detailed information about our role and membership in the Annex. The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with us and at a local level with the safeguarding partners. One of our responsibilities is to identify and oversee the review of serious child safeguarding cases which in our view raise issues that are complex or of national importance. We have the function to commission national reviews into such cases. We have met fortnightly since July 2018 to consider all cases that are notified to us where a child has died or is seriously harmed, and abuse or neglect is either known or suspected.

72. We have maintained an oversight of all rapid reviews, serious case reviews and local child safeguarding practice reviews. We want to use the learning from local and national child safeguarding practice reviews to bring about changes that will lead to an improved practice system for children and families and a reduction in child abuse and neglect.

Role of the Pool of Reviewers

73. A pool of reviewers assists us when we undertake national reviews. Reviewers are selected for individual reviews through open and fair competition. If there are no reviewers in the pool with suitable availability or experience to undertake a review, we may select a person from outside the pool.

74. We have recruited 11 reviewers to our national pool and their details are available here. They cover a broad range of experience across children's social care, health, police and legal professions. To enrich and expand the pool, we will continue to run recruitment rounds building on those already conducted. If you are interested in joining the pool, please let us know at: Mailbox.NationalReviewPanel@education.gov.uk.

Conclusion

75. The information and key practice messages from our analysis of the cases where children have died or been seriously harmed will be familiar to those immersed in child protection practice, particularly those who have been involved over many years. It is exactly because they are so well recognised that we strongly advise the Government to ensure that any review of children's social care extends to the practice issues identified here. At the very least the Government should assure itself that there is clarity of purpose and sufficient focus on child abuse amongst the broader set of safeguarding expectations; that the knowledge and skills of key child protection practitioners are sufficiently advanced to be effective in their function; and that the design and function of the child protection operating model is fit for the 21st Century and beyond.

7. Annex

About the Child Safeguarding Practice Review Panel

76. The Child Safeguarding Practice Review Panel is responsible at a national level for identifying and overseeing the review of serious child safeguarding cases which, in its view raise issues that are complex or of national importance. The Children and Social Work Act 2017 provides for the creation of a new Child Safeguarding Practice Review Panel. The Panel is appointed by the Secretary of State for Education but is independent of Government. The Panel became operational on 29 June 2018.

77. Our remit can be summarised as follows:

- We are responsible at a national level for identifying and overseeing the review of serious child safeguarding cases, which, in our view, raise issues that are complex, or of national importance.
    - 'Serious child safeguarding cases' are those in which:
        - abuse or neglect of a child is known or suspected; and,
        - the child has died or been seriously harmed.
    - 'Serious harm' includes serious and/or long-term impairment of children's mental health or intellectual, emotional, social or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain.
- We have a shared aim with safeguarding partners in identifying improvements to practice and protecting children from harm. For that reason, our partners, and we are expected to maintain an open dialogue. This will enable us to share concerns, highlight commonly recurring areas that may need further investigation (whether by local or national review or some other mechanism), and share learning, including from success, that could lead to improvements elsewhere
- We seek to establish consistency of practice and to that extent operate as a system adjudicator.
- We act as agents of change; our unique national perspective enables us to see patterns and note areas that require further investigation and consideration.
- We wish to influence and shape the work of safeguarding partners. We believe that the development of child safeguarding practice will be brought

about primarily through the work that everyone involved in the lives of children and young people does every day. In this respect we seek to bring about change to the way in which we work together to safeguard children, learning from events and how we have worked together. Following Sir Alan Wood's review and the changes detailed in the Children and Social Work Act 2017 and Working Together 2018, all Local Safeguarding Children's Boards made the transition to safeguarding partnerships by September 2019. During the transitional period whilst local areas were developing new safeguarding partnerships, we advised Local Safeguarding Children Boards about whether they should carry out a serious case review and, the proposed approach to publishing those reviews and their learning.

Appointments to the Panel

78. We were appointed following an open public recruitment. We are appointed as independent individuals, not representing any particular interest. The Chief Social Worker for Children and Families in England is a standing member of the Panel.

79. In line with the Nolan principles on public life, we have declared any aspects of our work that may be perceived to present a potential conflict of interest. As members, we also work in accordance with the Panel's Terms of Reference and Code of Practice. During our first year, individual panel members declared potential conflicts of interest in 21 cases that were considered by the Panel. In all such cases, the Panel members concerned were not provided with case papers and removed themselves from case discussions.

Who we are

Chair: Edward Timpson CBE (June 2018-June 2019)
Edward was appointed Chair of the Child Safeguarding Practice Review Panel in June 2018. Edward studied political sciences at Durham University and law conversion at the College of Law, London. He sat his bar exams at the Inns of Court School of Law. Edward was MP for Crewe and Nantwich from 2008 to 2017. During that period, he served as:

- Minister of State for Vulnerable Children and Families at the Department for Education (2016 to 2017)
- Minster of State for Children and Families (2015 to 2016)
- Parliamentary Under Secretary of State for Children and Families (2012 to 2015)
- Parliamentary Private Secretary to the Home Secretary (2010 to 2012)

He was also:

- A member of the Children, Schools and Families Select Committee
- A member of the Joint Committee on Human Rights
- Chairman of the All-Party Parliamentary Groups on Adoption

and Fostering, Looked-after Children and Care Leavers
- Vice Chairman for the Run-away and Missing Children Group

Panel Members (June 2018-June 2019)

Sarah Elliott
Sarah was appointed to the Child Safeguarding Practice Review Panel in June 2018. She has 38 years clinical and leadership experience in the NHS including Regional Chief Nurse for NHS England South. Sarah is also the Pan Island Chair of the Safeguarding Partnerships in the Channel Islands, an external assessor with the College of Policing and a special advisor with the CQC.

Mark Gurrey
Mark was appointed to the Child Safeguarding Practice Review Panel in June 2018. Mark is a qualified social worker and has practiced for 37 years. He has spent 20 years in senior management positions and the last 10 years working as a leader in several authorities in intervention. He is currently also Improvement Adviser and Chair of Sandwell Improvement Board.

Karen Manners QPM
Karen was appointed to the Child Safeguarding Practice Review Panel in June 2018. She was Deputy Chief Constable of Warwickshire Police, and has over 32 years of experience in policing, receiving a Queen's Police Medal (QPM) for services to policing in the fields of child neglect and vulnerability. Karen has experience in public protection work including child abuse investigations; she was also head of CID for Hampshire Police; national lead for child neglect and national lead on the vulnerability agenda leading to the first national vulnerability action plan for all 43 forces in England and Wales.

Peter Sidebotham
Peter is an Emeritus Professor of Child Health at Warwick Medical School. He has over 20 years' experience as a consultant paediatrician and academic specialising in child protection, including 15 years as a designated doctor for Safeguarding in Warwickshire prior to his retirement in October 2018.

Peter is co-editor of Child Abuse Review and trustee of the Association for Child Protection Professionals (formerly BASPCAN).

Dale Simon CBE
Dale was appointed to the Child Safeguarding Practice Review Panel in June 2018. She is a qualified barrister (currently non-practising) with over 20 years' experience of child abuse prosecutions and policy development.

She is currently a Non- Executive Director at the Parole Board and was previously the Director of Public Accountability and Inclusion at the Crown Prosecution Service.

Dr Susan Tranter
Susan was appointed to the Child Safeguarding Practice Review Panel in June 2018.

She is Executive Head Teacher of Edmonton County Schools and Chief Executive of Edmonton Academy Trust.

She is a member of the Audit and Risk Committee of the Office of the Children's Commissioner. She was a member of the Expert Panel of the Timpson Review of School Exclusion.

Isabelle Trowler
Isabelle took up her post as the Government's first Chief Social Worker for Children and Families (CSWCF) in September 2013 and sits on the Panel in her capacity as the CSWCF.

Since qualifying as a social worker in 1996 from the London School of Economics, Isabelle has held a variety of practice and senior leadership roles within the voluntary, statutory and private sectors, both in education and social care settings.

She is a founder member of the What Works Centre for Children's Social Care and is now a Trustee on its Board. She currently sits on the Home Office Domestic Homicide Panel and is on the Ministry of Justice Expert Panel reviewing domestic abuse cases in private proceedings. She is a member of the National Stability Forum and Family Justice Board.