THE CHILD
**SAFEGUARDING**
PRACTICE REVIEW PANEL

# Annual Report 2021

## Patterns in practice, key messages and 2022 work programme

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# Evidence base

All data is for the period 1st January 2021 to 31st December 2021.

1. Primary Sources

- **Serious incident notifications** are made by local authorities to the Child Safeguarding Practice Review Panel and Department for Education when a child has died or is seriously harmed, and abuse or neglect is known or suspected.

- **Rapid reviews for each notification**. A rapid review report created by local safeguarding partners must be submitted to the Child Safeguarding Practice Review Panel within 15 days of notifying the incident. The purpose of the rapid review is to gather the facts of what happened, to consider the potential for learning and decide whether or not to undertake a Local Child Safeguarding Practice Review.

- **Local Child Safeguarding Practice Reviews** (LCSPRs) are undertaken to provide learning to improve safeguarding practice at a local and national level and to avoid similar incidents occurring in the future. There is an expectation that these reviews are completed, submitted and published within six months of the rapid review.

2. National reviews and thematic analysis commissioned by the Child Safeguarding Practice Review Panel

3. Commissioned reports:

- Quantitative analysis of serious incident notification data and rapid reviews received during 2021, undertaken by Alma Economics for the development of this report.

- Qualitative analysis of the 84 LCSPRs received during 2021. A detailed analysis report by the University of East Anglia (UEA) and the University of Birmingham (UoB) has been published alongside this annual report.

- Analysis of safeguarding partners' yearly reports received by the Panel for the period 2021 undertaken by What Works for Children's Social Care (WW CSC).

- A report undertaken by YouGov during 2021 that tested the knowledge, understanding and communications of the Panel with safeguarding partners and frontline practitioners via focus groups, surveys and interviews.

# 1. Foreword

This annual report from the Child Safeguarding Practice Review Panel (the Panel) offers insights and reflections on how the English safeguarding system is working. It provides an overview of learning from serious incidents where children have suffered serious harm or death because of abuse and neglect. The circumstances of the children at the heart of this report are, without exception, disturbing and distressing. Each child's story is unique, reminding us again how important it is for safeguarding practice to be sensitively attuned to what is happening to an individual child and family at a particular time and in a specific place.

This report presents our collective understanding of how best we can help keep children safe through effective practice. The Panel acts as a 'weathervane' on the health of the safeguarding system, signalling evidence and learning from reviews and, equally importantly, suggesting ways in which practice should change and improve. Within this we are mindful of how our biases and assumptions shape our decision making.

Learning from serious incidents is inherently challenging; it requires a will and an ability to stand back and make sense of what has happened to a child, without hindsight bias. It involves robust evaluation of practice and being open and transparent about what might have been done differently.

This report highlights the pivotal role of senior safeguarding leaders in creating the conditions that enable practitioners to undertake the most complex and complicated of public service roles. Safeguarding leaders must not only have their fingers on the pulse of practice, but they must also go out of their way to lead collaboratively and with compassion across agency and professional boundaries. They promote constructive challenge and create a culture of learning and continuous improvement. Without effective multi agency leadership, some children will continue to be let down by fragmented and siloed responses to their needs.

A second critical message of this report is that there is much more to do to develop practice frameworks that take account of intersectional thinking to explore how ethnicity, age, gender, sexuality and other social factors including age, sexuality poverty shape the identities and experiences of children and families. Evidence about the impact of bias and prejudice has perhaps been most articulated in terms of disproportionality of Black boys among children who are criminally exploited. We need to be more inquiring about how cultural assumptions and biases shape how we 'see' and safeguard different groups of children. Too often attention is scant and somewhat superficial.

We saw many high-quality reviews in 2021 that conveyed a real and compassionate sense of children's experiences, were honest about what should have been different, and clear about the changes needed to protect children better. The importance of critical thinking and professional challenge was a key theme of very many reviews. Crucial decisions in

children's lives are sometimes made reactively, without considered multi agency analysis of what is known and understood. We need decision making environments that will best help practitioners and managers make what are always finely balanced but life altering decisions about children.

Finally, I want to thank the many people and organisations who contributed to the work of the Panel during 2021, both directly, or indirectly through the rich dialogue and conversations we have with our diverse partners and stakeholders. Very importantly, I would like to acknowledge the very thoughtful and active engagement of safeguarding partners across the country in debates and discussions about how together we can keep children safe.

**Annie Hudson**

Chair of the Child Safeguarding Practice Review Panel

# 2. Introduction

2.1 This is the third annual report published by the Panel since its inception in 2018. We recognise that producing an annual report is more than a reporting tool; it is one of the most important mechanisms for the Panel to capture and disseminate our evidence and learning to those working in the child safeguarding and protection system. We hope this document provides rich and valuable insight for safeguarding partners to draw from and use in local areas.

2.2 It was the Panel's intention to publish our annual report during the summer of 2022. However, work on the report was delayed by our undertaking of two major national reviews which necessarily diverted the Panel's resources for much of this year. In addition to this, from next year we will align our annual reports with the financial, rather than calendar, year to ensure consistency of reporting across the system.

2.3 The Panel's oversight of national and local reviews provides a unique evidence base and insight into patterns of practice in child safeguarding, illuminated by the Panel's national reviews and wider analysis of local reviews. We have used this to highlight six practice themes which we believe can make a difference to reducing serious harm and preventing child deaths caused by abuse or neglect.

2.4 Some continue from those practice themes set out in the 2020 annual report, such as recognising the importance and impact of organisational leadership and culture on good outcomes. Others have evolved as we have learned more about the effectiveness of the system. For example, broadly speaking we are seeing much greater demonstration of the understanding of what a child's daily life is like in reviews. However, during 2021 the Panel has identified the need to give greater and more specific consideration in practice and in learning to the impact of racial, ethnic and cultural identities on both children's and families lives and on how professionals have responded to their needs.

**Six key practice themes to make a difference (2021):**

1. Supporting critical thinking and professional challenge through effective leadership and culture
2. The importance of a whole family approach to risk assessment and support
3. Giving central consideration to racial, ethnic and cultural identity and impact on the lived experience of children and families
4. Recognising and responding to the vulnerability of babies
5. Domestic abuse and harm to children – working across services
6. Keeping a focus on risks outside the family

# 3. A window on the system

3.1 The Panel is an independent body that was set up to identify, commission and oversee reviews about children who have suffered serious harm or died as a result of abuse or neglect. It brings together experts from social care, policing, health, education and the third sector to provide a multi-agency and multi-disciplinary perspective on child safeguarding practice. In particular, the Panel seeks to identify incidents which raise issues that are complex, or of national importance in order to draw out learning to improve the safeguarding system.

3.2 The Panel maintains end-to-end oversight of the child safeguarding practice review process from notification of serious incident to publication of local child safeguarding practice review, where appropriate. This provides a unique 'window' through which the Panel can look to understand how the child safeguarding system is operating, including the effectiveness of practice and challenges faced by safeguarding partners.

3.3 The first section of this chapter examines the data from serious incident notifications received by the Panel between 1st January 2021 and 31st December 2021. We have focused our attention on highlighting important themes relating to the demographics of the children involved and their involvement with a range of different services to children and families. A detailed breakdown of the serious incident notification data can be found at Annex A.

3.4 The second section summarises analysis of all rapid reviews undertaken by safeguarding partnerships and submitted to Panel in 2021.

3.5 The third section considers the learning from a review of LCSPRs published in 2021, commissioned by the Panel and undertaken by the UEA and UoB. The full report has been published simultaneously; however, the key messages from the review have been extracted for use in this annual report to support safeguarding partners.

## Serious incident notification data highlights:

- Between 1st January 2021 and 31st December 2021, there were **379 serious incidents notified to the Panel, relating to 398 children**. Of those children notified in 2021, 156 (39.2%) died and 242 (60.8%) suffered serious harm.
- There were also 325 children affected indirectly by the serious incident, therefore, the number of children affected in total by a serious incident in the year 2021, is greater at 723.
- The gender of 397 out of 398 children was known, with 252 (63%) specified as male and 145 (36%) as female.
- Ethnicity was known for 354 of the 398 children, while for the remaining 44 it was either marked as 'Unknown'/'Information Not Yet Obtained' or was entirely missing. The majority of children were White British (61%) with Mixed and Black ethnicities at 11% each.
- The age distribution of these children showed a typical bi-modal pattern with a predominance of infants under the age of 1 (32%) and a second peak in the age group 11-15 (26%).

**Child protection plans (CPP)**

- Of the 398 children directly involved in a serious incident, 44 (11.1%) were on a Child Protection Plan (CPP) at the time. Twenty-five of this group of children (56.8%) had been on a CPP at least once before.
- The number of children who had been on a CPP at some point prior to the incident was higher at 105 children (26.4%).
- Of the children who were on a CPP at the time of the incident, most were under the age of 1 (around one-third of children currently on a CPP) or at least 11 years old (nearly half of all children currently on a CPP).

**Children's social care (CSC)**

- There were 132 families of children recorded as open to CSC at the time of the serious incident (33.2%) and 266 families which were previously known to CSC (66.8%).
- The majority of children (around 60%) whose families were open to CSC at the time of incident were 11 or older, and a further 20% of children were younger than 1 year old.
- Of the 132 families open to CSC at the time of the incident 126 had had some involvement with the service at least once before (95.5%) although involvement may have been an assessment rather than being provided with other services.
- 140 children had families were previously known to CSC but were not open at the time of the incident (35.2%).

**Chart 1: Number of fatal incidents by specified gender of the child**

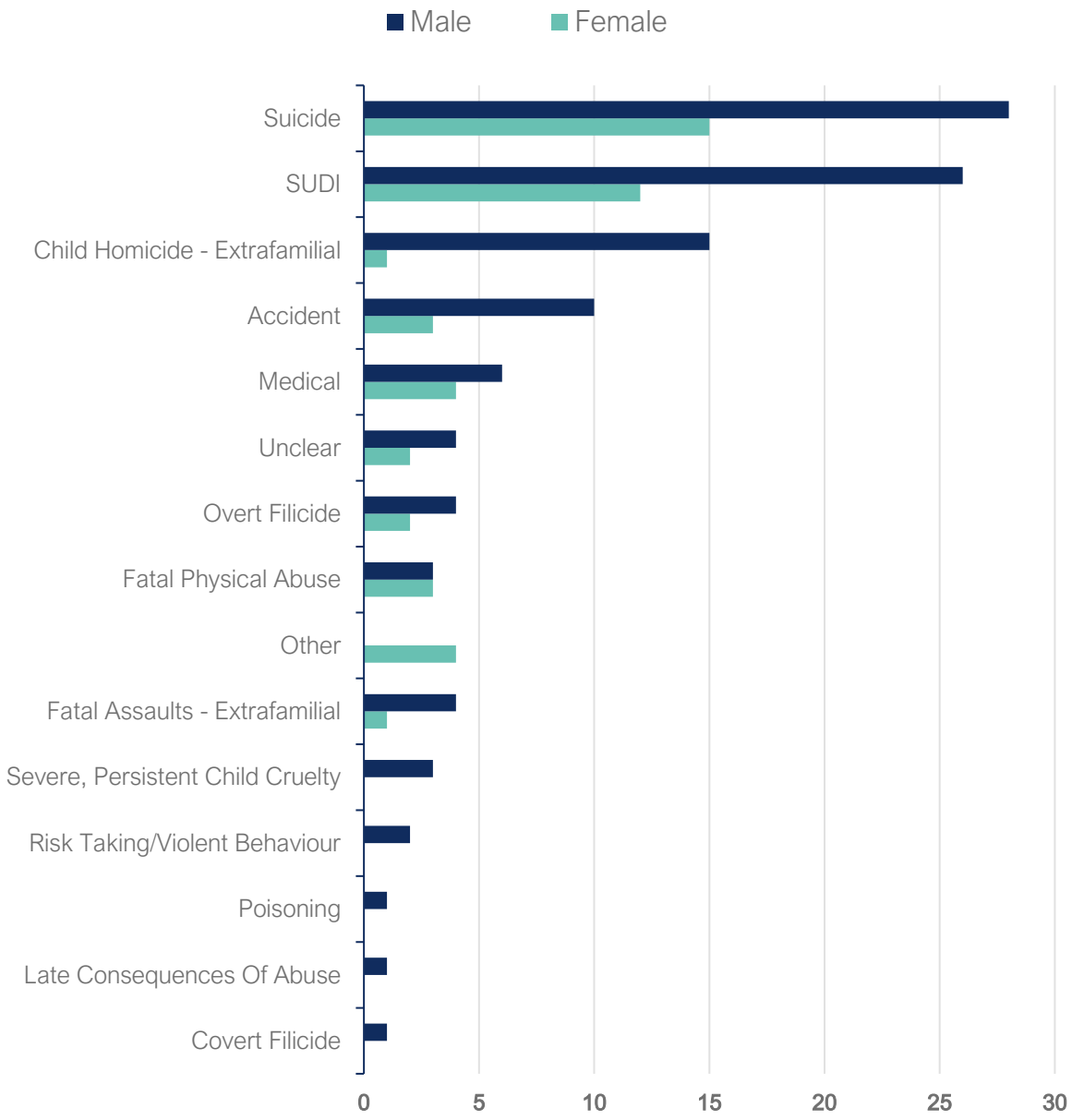
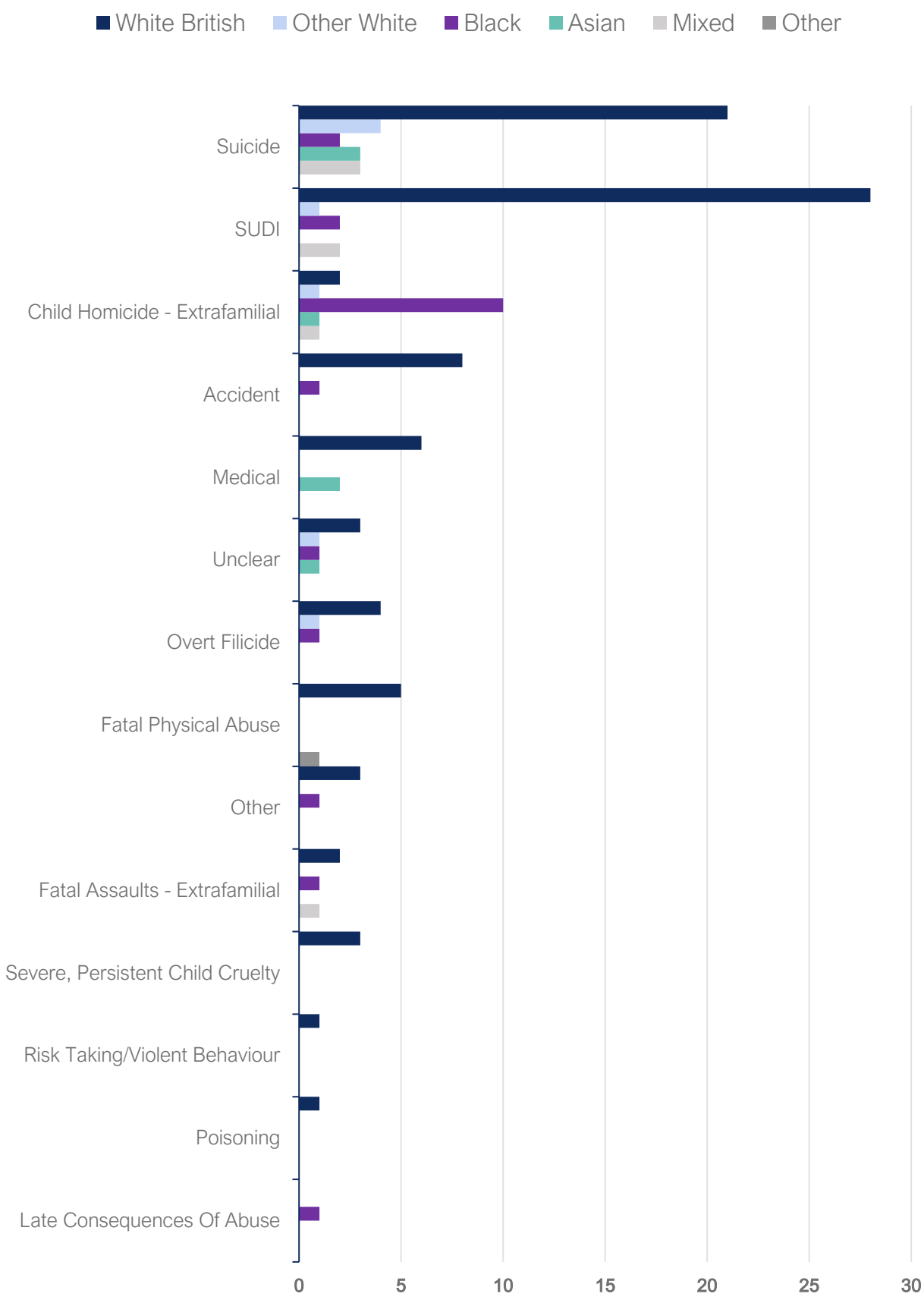


**Chart 2: Number of fatal incidents by ethnicity of the child**



# 4. Serious incident notifications

4.1 Overall, the number of serious incident notifications (379) represents a 21% reduction in notifications compared to 2020 (when the Panel received 482 notifications of safeguarding incidents). Although the overall numbers are lower than those recorded in 2020, this is in keeping with the general pattern of year-on-year fluctuations, and with a general increasing trend in the number of notifications from 2015 onwards.

4.2 The distribution of incidents is similar to the previous year and marks a difference from previous years when the incidents of death outnumbered those of serious harm.

4.3 It is important to note the finding that there were an additional 325 children indirectly affected by the serious incident. These children were either recorded as witnesses of serious incidents without however having been the focus of a rapid review, or protection plans had been considered or initiated for them following a serious incident in their family or household that did not involve them directly.

4.4 The number of children therefore affected in total by a serious incident in the year 2021, is greater and totalled 723**.**

**To put this into perspective, for every child directly affected by a serious incident in 2021, there was almost always another child affected indirectly, indicating the wider impact of a safeguarding serious incident on the lives of children, their families, and others in their immediate environment.**

## Demographics of serious incident notifications

### Age and gender

4.5 The age and gender of the children involved in the serious incidents in 2021 was very similar to previous years and showed a typical bi-modal pattern with a predominance of infants under the age of 1 (32%) and a second peak in the age group 11-15 (26%).

4.6 In general, male children were more likely than female children to be involved in a serious incident and were over-represented compared to the general population (Figure 1). The gender of 397 out of 398 children was known, 252 (63%) being male and 145 (36%) female.

**Chart 3: Number of incidents of serious harm by age**

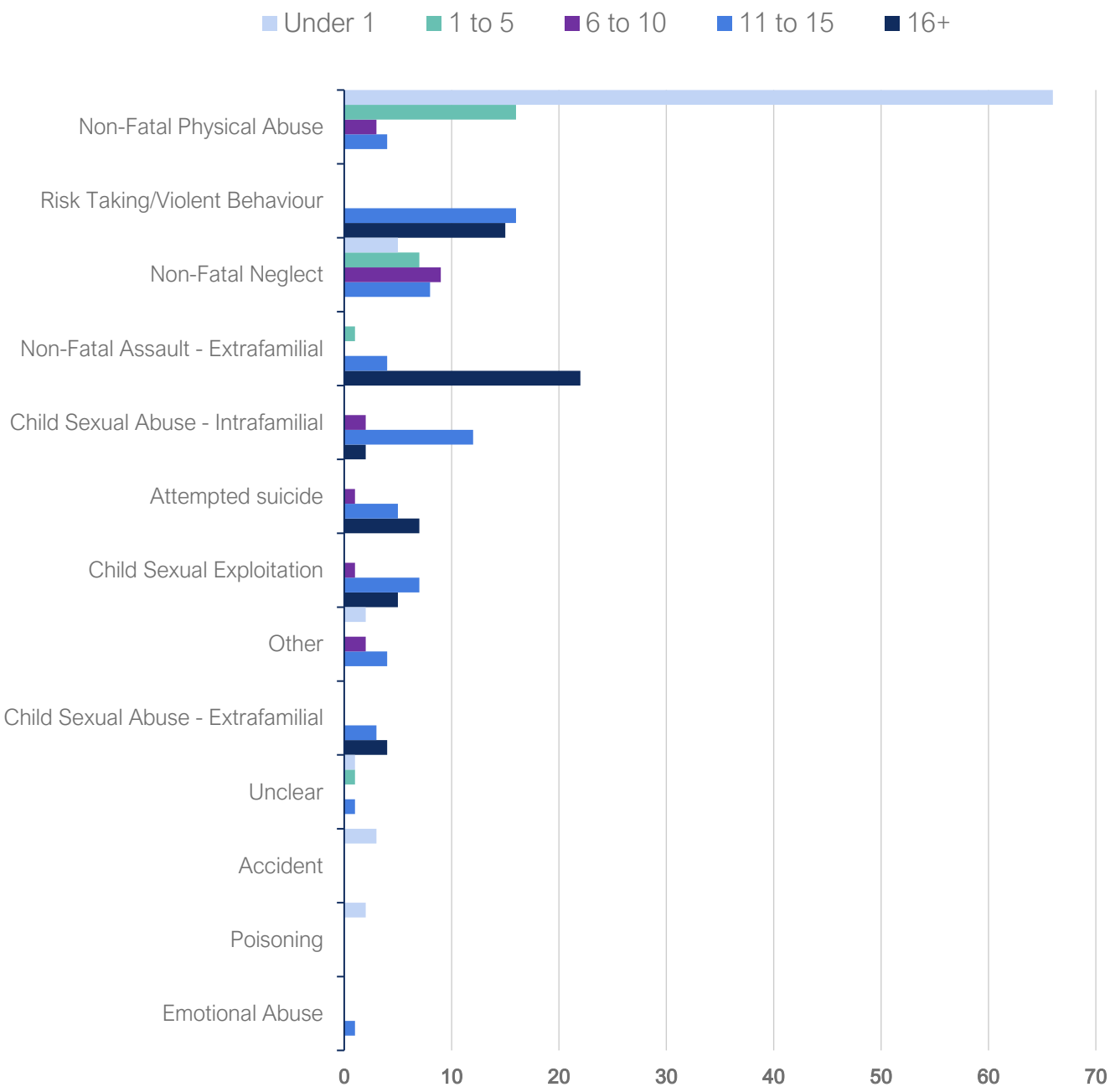
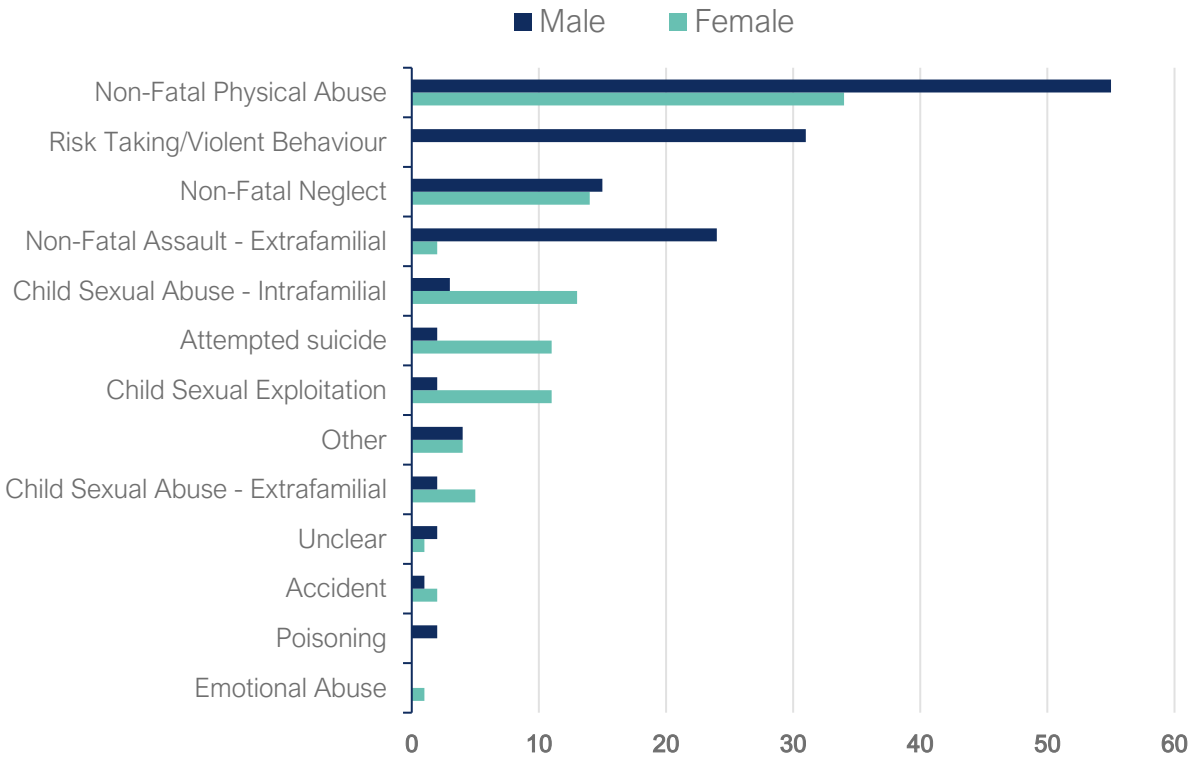


**Chart 4: Number of incidents of serious harm by gender**




## Ethnicity

4.7 Ethnicity was known for 354 of the 398 children, while for the remaining 44 it was either marked as 'Unknown' or as 'Information Not Yet Obtained' or the relevant entry was entirely missing.

4.8 The majority of children involved in serious incidents were White British-61%. However, children of Mixed (11%) or Black (11%) ethnicities were overrepresented compared to the ethnic breakdown of the 0-17 population in the 2011 census.

4.9 Those from Asian (8.5%) ethnic groups were slightly underrepresented in all age groups compared to the general population.[1]

[1] ONS categorisations of ethnicity, according to which:
- White British consists of White: English / Welsh /Scottish / Northern Irish / British.
- All Other White consists of White: Irish / Gypsy or Traveller / Other White.
- Mixed / Multiple ethnic groups consist of: White and Black Caribbean / White and Black African / White and Asian / Other Mixed.
- Asian /Asian British consists of: Asian British / Indian / Pakistani / Bangladeshi / Chinese / Other Asian;
- Black / African / Caribbean / Black British consists of: Black British / Black African / Black Caribbean / Other Black; and
- Other ethnic groups encompass Arab / Any other ethnic group.

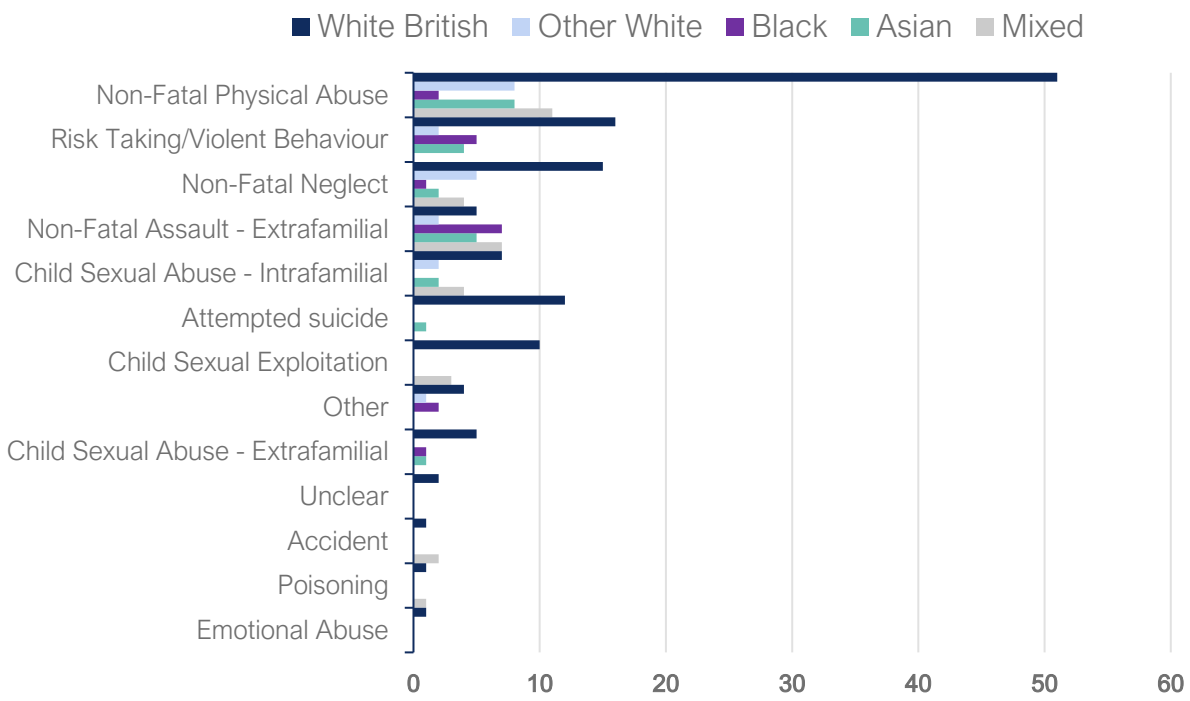



**Chart 5: Number of incidents of serious harm by ethnicity**

## Involvement of families with children's social care

4.10. The reasons families could be open to CSC either at the time of the incident or before did not always directly involve the index child. Looking in greater detail at the circumstances of the families that were open to CSC at the time of the incident and where the index child was not on a CPP at the time, some of those issues included:

- Involvement of other children of the family (siblings or half-siblings living in the same household) in other serious incidents
- Long-lasting neglect of children in the family, several times as a result of parents being overwhelmed by their own personal challenges (such as physical and mental health, addictions and abusive relationships)
- Series of incidents of violence (encompassing physical and sexual) in the family
- Tensions in the household, such as siblings not getting along with each other, or not getting along with one or both parents
- Financial issues impacting the family's stability and quality of housing, sometimes resulting in shorter- or longer-term homelessness[2]
- Unlawful behaviour or criminal involvement of parents, (usually) older siblings or other close relatives having access to the household.

[2] Homelessness as a term including but not being limited to:
- rooflessness (without a shelter of any kind, sleeping rough)
- houselessness (with a place to sleep but temporary, in institutions or a shelter)
- living in insecure housing (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence, or staying with family and friends known as 'sofa surfing')
- living in inadequate housing (in caravans on illegal campsites, in unfit housing, in extreme overcrowding).

(Definition adapted from Public Health England, 2019, Guidance – Homelessness: applying All Our Health)

# 5. Quality of reporting and rapid reviews

**5.1** This section considers some of the learning and key practice themes highlighted by analysis of all rapid reviews completed by safeguarding partners and received by the Panel in 2021. It is based on quantitative and qualitative analyses of 379 rapid reviews relating to 398 children. The findings and key learning are summarised below.

Key learning from rapid reviews

- It is important to undertake 'whole family' assessments, that involves all family members and/or carers, and that considers the impact of vulnerabilities on the dynamics within the household.
- Effective risk assessment and decision-making moves beyond parental self-report, asks "the second question" and always understands the child's perspective.
- Practitioners need to be supported to develop skills in using their professional authority to challenge families and other practitioners, as necessary, and well supported by regular quality supervision.
- Rapid reviews will be most effective where a culture of learning is promoted by senior leaders across the partnership.
- A review should be based on full and accurate information about family and child characteristics (especially race, ethnicity, gender, disability).
- It is good practice to identify immediate learning, how and when this will be or has been disseminated. There needs to be a clear rationale for the decision about whether an LCSPR will be initiated.

Throughout the engagement of services with children and their families prior to the serious incident, the following issues were identified by safeguarding partners in rapid reviews**:**

- Weak risk assessment and decision making for 279 cases (70.1%)
- Lack of frequency and quality of supervision by services for 268 cases (67.3%)
- Poor escalation of concerns for 253 cases (63.6%)
- Lack of professional curiosity or failure to ask 'the second question' for 290 of the total 379 cases (72.9%)
- Lack of coordination or handover between services for 225 cases (56.5%).

The following section explores three overarching themes arising from the analysis of rapid reviews which the Panel believes raises important learning for the safeguarding system.

**Theme 1:** Rapid reviews identified a 'whole family' approach as one of the crucial aspects of risk assessment - that is conducting assessments involving all family members and carers and exploring how recorded vulnerabilities affect the dynamics in the household.

5.2 Out of the 279 cases characterised by **weak risk assessment and decision making**, 150 were also known to feature **major risk factors in the family** or the child's immediate environment (there were in total 210 of the 379 cases with major risk factors, which includes 52.8% of all index children).

5.3 Overreliance on the ability of parents to play a decisive role in keeping their children safe from harm was the main issue found to affect services' weak risk assessment. This has been noted as particularly problematic where parents were known to be facing challenges of their own (such as physical and mental health problems, addiction to substances, financial issues, etc.).

5.4 Out of the 253 cases characterised by **poor escalation of concerns,** 148 also featured **lack of frequency and quality of supervision.**

5.5 There was a frequently observed overreliance on the parents' interpretation and reporting of a situation, without enough probing from professionals to gain a better understanding of what was happening. Additionally, sometimes there were inadequate efforts to build relationships with children, to engage directly with them and to have a sense of their views about their lives. Where home visits are conducted, professionals should see children on their own, taking care to triangulate parental or carer accounts of incidents with what they have observed and with information from other professionals. Equally important is that practitioners have access to high quality supervision, offering support and challenge to their work and that, where necessary, professionals are able to escalate concerns to more senior managers.

**Theme 2:** It was stressed in rapid reviews that professionals need to be supported to further develop their skills if they are to question a parent's version of events or a decision they have made in a productive way that does not cease their cooperation.

5.6 Sometimes frequency and quality of supervision could not be distinguished in rapid reviews. This might be due to professional practice, organisational culture, or because poor record keeping meant the information, such as notes and reports written by practitioners following home visits or their contact with children, was not available.

5.7 Out of the 290 cases characterised by lack of professional curiosity/critical challenge or professionals' failure to ask 'the second question', for 200 of them there was also recorded lack of coordination or handover between services.

5.8 Providing professionals with the appropriate training enhances the skill needed to provide critical challenge and the right working environment to enable professionals to be skilled and comfortable to further probe parents or question their narratives when the answers they get are not satisfactory or include discrepancies.

5.9 It was identified many times that staff (either frontline practitioners or managers) were not challenging the decisions of their colleagues even when their professional judgement led them to think that those decisions were inappropriate. For example, hierarchical design of service delivery teams created barriers and a culture that prevented staff feeling able to question more senior colleagues. In addition, a culture of not challenging or disagreeing with the approach taken by a different service was also identified. Disagreement tended not to be progressed to ensure the collaboration of services would not be halted by misunderstandings.

**Theme 3:** Rapid reviews repeatedly identified the need for practitioners to be skilled and have necessary confidence to use their professional authority to challenge the decisions and perspectives of other colleagues, be they from the same or another service if this is suspected to negatively impact the circumstances of a child or their wider family.

5.10. Out of the total 225 cases from the sample characterised by lack of coordination or handover between services, for 80 of them it was recorded that this was either due to or further sharpened by cross-borough communication and information sharing issues.

5.11. This reinforces the importance of clarifying communication channels (such as shared software options) within as well as between services so there is shared knowledge and understanding.

5.12. This can prove particularly challenging when families move from one council area to another and across the country and the data from cases showed that GPs were recorded as the primary point of contact for frequently moving families. Therefore, clarifying communication channels is also important for GPs to be able to share necessary information in a timely way with other relevant services, or to stay informed about a family's circumstances so that they can pay appropriate attention.

**Conclusion and next steps**

5.13. Our analysis of the most effective rapid reviews suggests that they benefit from the influence of a culture which recognises and privileges the importance of constructive challenge to drive good decision making and continuous practice improvement. Senior leaders across all agencies have a responsibility to provide clear strategic direction about how services will develop and change in response to learning from reviews. Reflective analysis balances out what went well, factors outside the control of the agencies involved and sets out important lessons to shape future work. They identify immediate learning, how and when that learning can be disseminated across the partners. There is a clear rationale for the decision about whether to initiate an LCSPR, and there is good analysis that help identify areas for further improvement and exploration. As a result, the partners will be in a strong position to bring about change and improvement.

5.14. Within some of the rapid reviews that the Panel sees, there continues to be too much detailed chronology (often structured around each agency's contacts rather than as a more coherent overarching picture) and insufficient analysis of what happened and why to inform either immediate learning or aspects for review through an LCSPR. Often, there is crucial detail missing about the lives of children and families, with the consideration about the characteristics of who they are (especially race, ethnicity, gender, disability) often absent.

5.15. Learning from the rapid reviews considered by the Panel in 2021 has been used to inform the recent revisions to the Panel's non-statutory guidance. The rapid reviews received by the Panel continue to help us identify trends and themes in safeguarding challenges faced across the country. Using this evidence and intelligence, the Panel commissions specific pieces of work to further understand and address perennial problems. This included work on non-accidental injury of under 1s and domestic abuse and which are explored further in this annual report.

# 6. Learning from LCSPRs published in 2021

6.1 This chapter summarises the learning from LCSPRs undertaken by safeguarding partners in 2021. It draws on the findings of a review commissioned by the Panel, undertaken by the University of East Anglia (UEA) and University of Birmingham (UoB), which analysed the 84 LCSPRs completed and submitted to the Panel in the calendar year 2021 and engagement with safeguarding partners and practitioners. The review analysed the learning from LCSPRs including learning for the national system, the processes used in LCSPRs, the implementation of recommendations and the impact of LCSPRs. The full analysis report will be published separately alongside this annual report.

6.2 The 84 LCSPRS published in 2021 related to 33 deaths (39%) and 51 cases of serious harm (61%). The two largest age groups are infants aged under 1, making up 30% of the cases, and 16–17-year-olds, who make up 28%. The median length of time to complete an LCSPR after the rapid review was 58 weeks, compared to the statutory requirement of 26 weeks. The longest review took over two and a half years.

**Key learning: for practitioners**

These echo messages from the analysis of rapid reviews, specifically the confidence to ask questions and the skills needed in giving and receiving professional challenge. There is further exploration of the importance of:

- access to specialist support and services for children and their families.
- exploring and giving weight to racial, ethnic and cultural identities as well as to cumulative social hazards which may be harmful to children.
- skills in working with parents from minoritised communities, recognising and allaying their fears about professional involvement.

**Key learning: for the role of the Panel**

- Moving from a perceived “top down” approach to dialogue and engagement with the sector is an important area for development.
- Where LCSPRs are identifying serious resource shortages the panel has a unique role and opportunity to influence national policy.
- Understanding the LCSPR system would benefit from further in-depth study of the process.

**Key learning: for the review process**

- There should be clear rationale as to why an LCSPR is required. The process should be a clear 'step higher' than a rapid review and the lessons more distinctive.
- Contributions of family and children should be visible and analysed in a high quality LCSPR.
- The quality of the LCSPR correlates with the potential for impact. There needs to be a set of focused recommendations that can be converted into SMART action plans. These action plans should then be published.

# Findings of the LCSPR review

## Practice

6.3 As with the analysis of rapid reviews, the UEA and UoB analysis identified the need for safeguarding partners to establish cultures within organisations that promote professional curiosity and give staff the confidence to ask questions. Practitioners need to be able to give and receive challenge while working together to resolve professional differences need. At the same time, they require proper support from senior leaders and sufficient resources for their work – especially given the demanding nature of safeguarding practice.

6.4 The analysis of LCSPRs identified that the realities of day-to-day frontline practice are not always visible in reports. Without returning to long chronologies, it is important to understand the strengths and shortcomings of practice, and what additional support practitioners may need.

## Race, ethnicity, and culture in LCSPRs

6.5 Racial, ethnic, and cultural identities are often central factors in the daily lives of children and families from minoritised communities and should be given proper weight when exploring the lives of children and families in practice and in reviews. Some LCSPRs highlighted some of the implications for practice, for example how some children became marginalised and made responsible (at least in part) for their situation, with their childhood vulnerability and innocence being diminished. While these are important issues for all children, they can have greater resonance and impact with children from minoritised communities.

6.6 Furthermore, for some children the impact of racism is magnified by cumulative adversities including poverty, intra-familial difficulties, learning needs and negative peer relationships. Practitioners need to be aware of the intersectional nature of social hazards and to consider how these may impact on practice. For example, poor parental engagement by minoritised parents has been linked with fear, including fear of perceived power practitioners hold. Professionals need to recognise, explore and seek to address these fears in their work with parents and carers.

6.7 In reports, it is important for reviewers to specify the racial, ethnic and cultural background of the children and their families, and explore other characteristics such as age, gender, disability and sexuality. Reviewers should discuss explicitly how these characteristics shaped families' and children's lives, experiences, and views, and how practitioners and services responded to them.

## Quality and methodology of LCSPRs

6.8 Safeguarding partners should make sure there is a clear rationale for completing an LCSPR and it is important that safeguarding partners ensure that the process for undertaking LCSPRs is a clear 'step higher' than a rapid review, building on a rapid review, and that the learning for practice is more distinctive.

6.9 The UEA and UoB analysis suggests that a systems approach should be used, however, application of this was not always clear in reports analysed for the review. A range of methodologies were cited in reports, but in practice most used similar methods to undertake the review. Reviewers should be looking to understand the dynamic between individual actions and decisions, and the social, organisational and professional systems within which the individual operates.

6.10 In terms of content, there is wide variation in style of writing, length of reports, grounding in evidence, analytic detail and clarity of learning. The UEA and UoB analysis suggests that the key determining factor of review quality is the skills and approach of the individual author. In high quality reviews, the contributions of the family and young person, and of practitioners, are clearly visible and analysed, not just taken at face value.

6.11 Partnerships could establish their own internal pool, providing appropriate training and mentoring opportunities and other resources as well as taking steps to build a wide range of contacts with skilled independent reviewers. Or as is done in some areas already, it may be helpful to develop reciprocal relationships with other partnerships to exchange resource.

## The impact of LCSPRs on practice

6.12 Safeguarding partners identified a direct link between the quality of the LCSPR and the potential for impact. Recommendations which focused too heavily on 'macro level' issues beyond the control of the partnership were less likely to lead to impact.

6.13 LCSPRs need to contain recommendations easily converted by the partnership into SMART action plans. These should be published alongside the LCSPR for accountability and as a sign of the partnership's commitment to learning and improvement.

6.14 'Bite-sized' approaches to dissemination of learning from LCSPRs are favoured by many safeguarding partners such as 'seven-minute briefings', 'lessons learned' briefings and short YouTube videos. Partnerships favoured the use of multi-agency and themed audits to measure practice change. However, they identified difficulties evidencing impact in relation to long-term cultural change and changes to face-to-face practice with families.

## Learning for the Panel

6.15 The review undertaken by UEA and UoB identified three recommendations for the Panel to consider. Below is a summary of the recommendations and the Panel's response.

**Recommendation one:** the Panel should continue to build on its engagement with safeguarding partners to address underlying concerns – such as safeguarding partners producing timely, quality reviews - however it also suggested that some safeguarding partnerships experience what they described as 'top down' mentality from the Panel.

6.16 **Panel response:** The Panel has significantly increased its engagement with safeguarding partners and will continue to build on this in the coming year. Dialogue with the system provides the Panel with insight on practice, including some of the challenges faced by safeguarding partners but it is also crucial in our dissemination of Panel learning.

**Recommendation two:** analysis also highlighted the need for the Panel to use its unique role and position to influence national policy as well as practice at a local level. For example, LCSPRs indicate that many of the issues that undermine the effectiveness of safeguarding practice are to do with serious resource shortages.

6.17 **Panel response:** The Panel plays a unique role in the child safeguarding system, being a conduit between local safeguarding partnerships and national government. As set out above, the Panel works closely with safeguarding partners, but it also has a very clear role in advising, and providing intelligence to, central government on child safeguarding issues that are of national importance. This includes engagement with

government as it develops its response to the findings of three national children's social care reviews; including the Panel's own review "Child Protection in England".

**Recommendation three:** the review also found that the Panel's understanding of the LCSPR system would benefit from an in-depth study of the process, not only the outputs. This should include the ways that 'methodologies' and 'methods' are understood and used, the roles of the reviewers, and how day-to-day practice is addressed.

6.18 **Panel response:** The Panel will consider this as an opportunity for further work through the business planning process.

## Conclusions and next steps

6.19 The Panel has already taken a number of steps to implement the learning from the analysis of the LCSPRs in 2021. Learning from LCSPRs has been used to update the Panel's non-statutory guidance and the learning and recommendations from the review have informed our programme of work for 2022/3 and revisions to the Panel's non-statutory guidance.

# 7. Practice themes to make a difference

7.1 The previous section of this report sets out the learning from serious incident notifications as well as learning identified by safeguarding partners in rapid reviews and LCSPRs. This work alongside the Panel's thematic analysis (summarised in the following section) has helped the Panel to identify six key practice themes for improving the safeguarding system. These build on those set out in our 2020 annual report which provided a framework for the Panel's work during 2021.

## Supporting critical thinking and professional challenge through effective leadership and culture

7.2 Organisational culture and leadership that supports critical thinking and professional challenge is critical to securing good outcomes for children. This was a key message in the 2020 annual report and our work during 2021 confirmed the importance of effective leadership in safeguarding practice, particularly in supporting sound risk assessment and decision making.

7.3 Supervision as a crucial component of this culture is a theme that emerges through very many of the reviews considered by the Panel. Supervision will play a central role in challenging attitudes and assumptions and keeping a focus on the lived experience of the child. This was noted by the analysis of rapid reviews which concluded that practitioners need to be supported to further develop their skills in providing good and sensitive challenge to families and other professionals through regular quality supervision. This will enable a move from a reliance on self-reported information when assessing risk and to look below the surface and ask the "second question".

7.4 The UEA and UoB analysis also commented that the most effective LCSPRs benefit from the influence of senior leaders in promoting a culture that welcomes professional challenge and recognises the importance of challenge to drive improvement.

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

7.5 Abuse of a child does not exist in isolation. Our data show that in 2021 there were 325 children *indirectly* affected by the 379 serious incidents notified to the Panel – perhaps siblings or close relatives of those children involved.

7.6 Data analysis of serious incident notifications and the analysis of rapid reviews also picked up on this theme. The latter analysis noted the importance of integrated assessment which involves all members of the family and takes account of dynamics within the household.

7.7 Our thematic review of safeguarding children under 1 from non-accidental injury ("The Myth of Invisible Men") specifically focused on men within a child's household and found evidence that agencies need to be more proactive in involving men in work with universal through to specialist services. The review made several recommendations aimed at improving the involvement of men at all stages of our work including recognising the importance of effective work with perpetrators.

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

7.8 The need for a whole family approach should be taken hand in hand with the need to recognise the unique characteristics of each family and understand their histories, racial, ethnic, and cultural context. One of the key messages for practice from the UEA analysis of LCSPRs is the need to explore and give weight to racial, ethnic and cultural identities as well as other social factors such as poverty which may be harmful to children.

7.9 While it is important to understand what the life of any child is like, this has added resonance when working with children from minoritised communities because serious incident notification data shows that black or mixed ethnicity children are more highly represented compared to census data.

7.10 In terms of Panel learning, serious incident notifications and reviews do not consistently identify the child's ethnicity suggesting that in too many reviews there is scant and inadequate consideration of the impact of race and ethnicity. Of the 379 serious incidents in 2021, 44 contained no information on the child's ethnicity at all.

7.11 Even where reviews do identify race and/or ethnicity of children, often (with the exception of some reviews, particularly those with themes surrounding criminal exploitation) consideration of race, culture and ethnicity are presented in a very superficial way. Few reviews demonstrate in depth reflection about the influences of race, culture and ethnicity on children's lives and on service design, and how access to support may have shaped a family's actions and response. Furthermore, some reviews have indicated that practice biases and cultural assumptions, for example, about ways of parenting, may have shaped decision making but unfortunately these are not always highlighted as areas for learning. It is important that practitioners ask questions sensitively and demonstrate curiosity as to how this might influence and impact on parental response.

## Recognising and responding to the vulnerability of babies

7.12 Babies under the age of one have consistently been the largest category of serious incidents notified to the Panel. In 2021, 32% of incidents of non-fatal physical abuse involved children younger than a year old.

7.13 As previously stated, The Myth of Invisible Men review focused on the role of male carers and identified a number of challenges for safeguarding partners. This included the need to explore the vulnerability of babies under one, in depth, with both parents (regardless of whether they live together or are in a relationship with each other) as well as with other new partners. The review also identified the familiar difficulties with information sharing, both within different sections of the health service and across the wider safeguarding system.

7.14 In response to the information sharing issues highlighted in the review, the government is taking steps to improve data capture and sharing to help join up agencies who work with vulnerable families. Government has also indicated that the timeliness and usefulness of data on serious incidents will be enhanced, and data matched with the National Child Mortality Database as identified in the review recommendations. (The Panel is actively contributing to cross-government work in this area following the publication of the national review into the tragic deaths of Arthur Labinjo-Hughes and Star Hobson.)

## Domestic abuse and harm to children – working across services

7.15 Domestic abuse featured in over 40% of cases notified to the Panel in 2020. However, our analysis of partnership annual reports for 2021 found that domestic abuse was not one of the most common priorities identified by partnerships although it was identified as a common theme in 9/18 annual reports.

7.16 Analysis for The Myth of Invisible Men also identified a theme of domestic abuse in the lives of the children. Four of the men we interviewed admitted to being perpetrators of domestic abuse, another man was both a perpetrator and a victim and another had been a victim of such abuse. Although there is a need for more research into links between domestic abuse and harm to children it was clear that there is a need for strong multi agency approaches that bring together systems aimed at working with children (child protection), adult victims (MARAC) and perpetrators (prisons, probation and therapeutic programmes) are important aspects of practice. This is particularly important in the light of the Domestic Abuse Act 2021 which identifies children as the victims of domestic abuse that is perpetrated against their parent or carer.

7.17 In 2022, the Panel published a briefing paper setting out key findings from thematic analysis of rapid reviews and LCSPRs where domestic abuse featured. This briefing paper includes examples of practice and recommendations for safeguarding partners.

## Keeping a focus on risks outside the family

7.18 In 2021, themes relating to extra-familial harm continued to feature in the serious incidents notified to the Panel. Of those children notified to the panel, 20 (5%) were victims of extra-familial child sexual abuse or child sexual exploitation; 21 (5%) died following extra-familial assaults or homicide and a further 27 (7%) were victims of non-fatal extra-familial assaults. Furthermore, our 2021 thematic analysis confirmed that there are continuing challenges in protecting children outside their family, including the overlaps between intra-familial harm and extra-familial vulnerability, the role of safeguarding services alongside wider community services in addressing extra-familial harm, and the balance between protective measures for individual children and disruptive measures aimed at perpetrators.

7.19 A follow up study to the Panel's national review, *It was hard to escape,* suggested that the findings and conclusions of the initial review are still very relevant today. The challenges and barriers identified are still present and are impacting on the safeguarding workforce's ability to effectively protect children and young people from criminal exploitation. In particular, this study found that the point of exclusion from education is continuing to play a part in the escalation of vulnerability among young people who become victims of exploitation and the role of education is key in ensuring a more holistic and earlier intervention.

7.20 We identified a need for more proactive disruption activity and a more considered contextual safeguarding approach. We also identified areas for further development, including collaboration between the criminal justice and child protection frameworks, the role of mental health, trauma and childhood adversity and missed opportunities at critical points of transition. Issues around housing were identified as an important concern and good liaison with housing departments was seen to be a crucial part of a child safeguarding.

7.21 Practitioners working with children at risk of harm outside the home need to have access to high quality supervision and support to help them see beyond children and young people's presenting behaviours so that they focus on their underlying needs, considering intersectional factors that may be contributing to vulnerability. The role of mental health, trauma, and childhood adversity in our understanding of, and response to, criminal exploitation is an area for practice development, as are the challenges of intersectionality, discrimination, and adultification of young people. These are issues which the Panel will continue to explore in our work.

7.22 As a Panel we are very aware of the challenges faced by safeguarding partners in reviewing cases of extra-familial harm. While the circumstances of each case vary, we

have included some prompts in our updated panel guidance to help local areas in their decision making around such cases. We are keen to hear of any examples of good practice where local services have been able to coordinate work between agencies in both disruption and prevention and in appropriate reviewing of cases of extra-familial harm.

# 8. National reviews and thematic analyses

8.1 This chapter brings together the findings from the national review and a range of thematic analyses completed by the Panel in 2021. These findings have informed the overall practice themes and key messages set out in the preceding chapter of this report.

8.2 The thematic work considered some of the most significant safeguarding challenges and used the rich source of information contained within rapid reviews and LCSPRs as well as other evidence gained from engagement with different safeguarding stakeholders.

## The Myth of Invisible Men: safeguarding children under one from non-accidental injury caused by male carers

### Why did the Panel choose this national review topic?

8.3 The Panel was concerned that 37% of serious incident notifications involved babies under the age of one, with a substantial proportion involving serious injury or death. The Panel were also aware from rapid reviews that many of the perpetrators of the abuse were men, yet males were often described as invisible to agencies involved with the family. Therefore, in September 2021 the Panel published its third national review into safeguarding children under 1 year old from non-accidental injury caused by male carers.

### The focus of the national review

8.4 The review focused on how the safeguarding system can be more effective at engaging, assessing, and planning for and with men in the protection of children (or those for whom they have a parenting responsibility) and included case analysis, discussions with partnerships, and a literature review.

### What did we do?

8.5 We explored a sample of 23 cases that had been notified to us. We primarily did this though discussions with 322 leaders, managers and practitioners in the relevant partnership. We also interviewed 8 male perpetrators, commissioned a literature review and held a roundtable discussion with key stakeholders.

### What did we find / next steps

8.6 The review highlighted an urgent need to improve how the system sees, responds to and intervenes with men who may represent a risk to the babies they are caring for. It also identified the importance of the role of midwives and health visitors in identifying

fathers/male carers and the role of contextual factors such as domestic abuse, substance misuse and mental ill health when assessing risk. It set out some key questions for consideration by safeguarding partners and outlined a four-tier model to help leaders and practitioners develop a full understanding of the history and personal circumstances of fathers and to develop more detailed and balanced assessments and engagements thereafter.

8.7 The report makes recommendations to Government in five areas in order to bring about a significant change in the understanding of the factors associated with non-accidental injury in under 1s and the ability of services to work with children and families to prevent incidents occurring:

- research to understand the psychology and behaviours of men who have physically harmed or killed babies;

- support to develop models of good practice for children's social care in working with fathers. One route could be through strengthening the family safeguarding model developed in Hertfordshire;

- investment in "end to end service redesign pilots" – multi agency, integrated pilots that will address the wide range of issues in both universal and specialist service identified in our review;

- making sure that some of the very positive work underway across a number of areas (work stemming from the Leadsom Review, Family Hubs, Domestic Abuse Act, Better Births, Supporting Families 2021/22 and beyond) have an explicit focus on engaging fathers and evaluate the impact; and

- that the inspectorates take account of this review and its findings.

8.8 The cross-government response to this national review has been positive. Some of the work moving forward focuses on:

- Government funding to Hertfordshire Local Authority to scope adaptions to their multi-disciplinary Family Safeguarding model so that it addresses the needs of under 1s and focuses on male carers.

- Government funding to 13 local authorities across five regions to focus on multi-agency approaches to safeguarding infants, of which some will focus on supporting male carers or care leavers who become young parents.

- Financial support over two years awarded to Police and Crime Commissioners to increase availability of interventions for perpetrators of domestic abuse.

- Continuing to look at how the Family Hubs and the Supporting Families programme better address concerns about service engagement with male carers.

- Asking local authorities, through Family Hubs, to better engage fathers and male carers by making services more accessible with an emphasis on whole family working, making maternity and neonatal care safer, and a more personalised and more equitable for mothers and fathers.

## Child Criminal Exploitation

### Why did the Panel choose this theme?

*8.9* In March 2020 the Panel published its first national review into child criminal exploitation*:* It was hard to escape which aimed to identify 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. The Panel completed further analysis in 2021 to identify whether the findings and conclusions of the first report continue to apply, and if there are any additional findings and conclusions.

### What did we do?

8.10 The follow up work included an analysis of 100 rapid reviews notified to the Panel between April 2019 and May 2021, along with published Serious Case Reviews and LCSPRs; a survey questionnaire distributed to safeguarding partners and practitioners and a roundtable forum event with key stakeholders.

### What did we find / next steps

8.11 This work suggests that the findings and conclusions of *It was hard to escape* remain relevant to safeguarding partners. The challenges and barriers identified are still present and are impacting on the safeguarding workforce's ability to effectively protect children and young people from criminal exploitation. The messages set out below provide a framework for partnerships to use in evaluating their own practice and will also be used by the Panel to inform their ongoing work programme.

- **Exclusion from education** is continuing to play a part in the escalation of vulnerability among young people who become victims of exploitation and the role of education is key in ensuring a more holistic and earlier intervention.

- **Relationship-based practice is vital but is an area for further development.**

- **Disruption activity continues to be important, but this is often being implemented via a single agency rather than a multi-agency approach** and partners tend to focus upon victim-initiated investigations rather than intelligence-led investigations aimed at disrupting perpetrators.

- **Contextual safeguarding principles are underpinning approaches to practice, but local areas are clearly at varying stages of their journey in implementing this framework**. Processes such as assessments or multi-agency meetings may be followed, but with little assessment of the impact or outcome, both in relation to the child and in relation to disrupting suspects/perpetrators.

- **The National Referral Mechanism (NRM) is only being used as a safeguarding intervention in a small number of cases**, even where there is clear evidence of trafficking. Where it is used, delays in decision making mean safeguarding responses may be stalled while waiting for the outcome of an NRM referral. There were, however, some examples given of steps taken to implement the NRM, for example through delivering training on the NRM, developing best practice guidance, and introducing multi-agency NRM meetings.

- **Housing and accommodation continue to be a concern**. Where there is good liaison between children's services and housing departments this can assist in moving children quickly and can facilitate an improved outcome for families.

- **Transitions continue to be an area for practice development** as in nearly all cases reviewed, crucial transition points were overlooked. This can be further compounded at age 18 when safeguarding and support services transfer to adult services.

- **The role of mental health, trauma, and childhood adversity in our understanding of, and response to, criminal exploitation is an area for developmen**t. In many cases it was not clear how partnerships were responding to trauma experienced by young people, adults, and their families.

## Elective Home Education

**Why did the Panel choose this theme?**

8.12 In 2020 the Panel identified the need to look in more depth at the circumstances of children who had been notified to the Panel and were described as electively home educated. An initial analysis of 19 rapid reviews had found that the children in this cohort had suffered significant abuse and were largely "invisible" as they were not at school and not visited at home. Where these children had been visited by elective home education practitioners, the practitioners did not always consider the child's circumstances from a safeguarding perspective and identify risk of harm.

8.13 A roundtable discussion with representatives from local Partnerships, discussions with key stakeholders and with government confirmed the Panel's view that this was an area of practice that needed further analysis, including exploring good practice examples. More in-depth analysis commenced in 2021 and learning will be shared when concluded.

**What did we do?**

8.14 27 rapid reviews involving 41 children were evaluated using a standard audit tool. In 15 cases an LCSPR had also been completed and the findings from the LCSPR were considered alongside the learning from the rapid review. As well as the case audit, a

roundtable discussion was held with safeguarding partnerships who had carried out an LCSPR. The analysis was based on a small sample as there was limited information about the details of electively home educated children in many rapid reviews.

**What did we find / next steps**

8.15 The analysis identified issues and questions which have been used in a call for best practice. Partnerships have provided information which will be further analysed in 2022 on the following areas:

- Policies and procedures that support practitioners in identifying vulnerability at the stage that parents decide to educate their child at home. This may be at the point children enter full time education or those outside of school.
- Initiatives to support and equip elective home education staff with the knowledge and skills to work at the interface of elective home education and safeguarding.
- Good practice examples of capturing the voice of the child at the point of decision to electively home educate and throughout their engagement with home education.
- Good practice examples of the use of school attendance orders that have had a positive outcome for children educated at home.
- Examples of initiatives designed to develop constructive relationships and engagement with the elective home education community.

## Risk assessment and decision making

**Why did Panel choose this theme?**

8.16 Weaknesses in risk assessment and decision making had been identified by partnerships as an issue in many rapid reviews. This was also a common theme identified by the Panel in their analysis of both rapid reviews and LCSPRs and we wished to explore the underlying systemic factors and ways in which the effectiveness of risk assessment and decision making could be improved.

**What did we do?**

8.17 A tool was developed for a systemic audit of 44 cases using a framework which identified the factors that affect risk assessment:

- Systems and processes
- Practice and practice knowledge
- Leadership and culture
- Wider service context

8.18 The initial analysis was shared and tested with 10 safeguarding partnerships through roundtable discussions with groups of practitioners, managers and strategic leaders.

**What did we find / next steps?**

8.19 Risk assessment in child safeguarding is complex. A key consideration is the extent to which systems of safeguarding practice enable practitioners in all agencies to exercise professional judgement confidently. Therefore, the review team adopted and adapted the following systems framework in order to analyse the learning from the reviews. The Panel also utilised this framework in its national review into the deaths of Arthur Labinjo-Hughes and Star Hobson, and feel it is a useful tool for all safeguarding partners when analysing and understanding serious incidents.

## UNDERSTANDING EFFECTIVE RISK ASSESSMENT AND DECISION MAKING

## A SYSTEMS FRAMEWORK

### Systems and Processes

*(including key decision points on continuum of care pathway, sharing information, use of specialist assessment)*

• The importance of robust multi-agency arrangements for contact, referral and assessment, including high quality inter-agency discussion

• Thresholds or levels of need to be understood by practitioners across all agencies and consistently applied.

### Practice and Practice Knowledge

*(incorporating the Panel's 'Key Practice Themes to Make a Difference')*

• The importance of relational practice models that promote purposeful direct work with children and families.

• Practitioners apply critical thinking to their work, reframing their understanding of risk in the light of changing circumstances.

• Practitioners have the requisite professional knowledge to identify risk in particular safeguarding contexts such as risk outside the home. A key gap in professional knowledge relates to cultural competence as absence of cultural competence can lead to inaccurate assessments and decision making.

### Wider Service Context

*(including workforce development, commissioning strategy, funding, match of resources to priorities, impact of socio-economic factors)*

• The impact of wider socio-economic factors such as poverty and inadequate accommodation.

• The provision of early help services to support families in helping themselves.

• Workforce development – effective recruitment and retention of staff, with appropriate caseloads

•Using data effectively to respond to changing patterns of demand and need.

### Leadership and Culture

*(including vision and values, partnership relationships, multi-agency working, quality of supervision, management oversight, challenge between professionals, timely and appropriate escalation)*

• Supervision is crucial to risk assessment and relies on effective leadership to create the learning culture within which effective supervision can thrive.

• Leaders promote wider values to underpin the relationships between professionals across the partnership, and in the work with families.

# 9. Reflective questions for safeguarding partners

9.1. The following questions are derived from our overarching analysis of all the information received by the Panel in 2021. At the end of 2021, the Panel commissioned work to review incidents that feature poor management of risk and decision making. This included an analysis of rapid reviews to establish some of the factors behind effective and strong child protection practice. We have drawn upon this systems framework to set out the following reflective questions for safeguarding partners. They are by no means exhaustive but are aimed at providing some thoughts to help partnerships develop their work programmes.

**Risk assessment and decision making review**:

| Wider Service Context | Practice and Practice Knowledge |
|---|---|
| Have we developed a positive approach to the scrutiny of safeguarding practice?<br><br>How do we recognise and respond to the impact of wider socio-economic factors such as poverty and inadequate accommodation?<br><br>How do we review the strategic use of funding to invest in early help provision and innovative services to support families in helping themselves?<br><br>How do we match priorities to resources including the effective use of data and intelligence to respond to changing patterns of demand and need? | Do practitioners hear the voices of children, explore their identity and understand their lived experience? Do they consider the influence of race, culture and ethnicity?<br><br>Do practitioners listen and hear the views of family members and have the skills to work with complex family situations?<br><br>Are practitioners confident to offer professional challenge including across agencies boundaries and in their own practice, for example, how their biases and prejudices may influence their work?<br><br>Do practitioners have the necessary professional knowledge and understanding about different communities and cultures to support good, accurate assessments and decision making? |

| Systems and Processes | Leadership and Culture |
|---|---|
| How can barriers to information sharing be addressed so practitioners develop a comprehensive understanding of the child within their family/care network?<br><br>Is there a clear expectation that all records, assessments and plans document and analyse the impact of a child's racial, ethnic and cultural context?<br><br>Do adult-facing systems such as MARAC, probation, substance misuse and mental health services work effectively with child safeguarding processes?<br><br>Are men included in all stages of engagement and work with children and their families?<br><br>Is there a clear risk assessment framework which is understood and owned across agencies, and does risk assessment identify vulnerability at critical moments of a child's life – particularly the vulnerability of babies? | Does leadership and culture support practice which:<br>• Promotes multi agency working<br>• Is culturally considerate<br>• Supports practitioners to develop practice skills including work with families in complex situations?<br><br>Is there a supervision culture across all agencies which supports positive challenge and provides an opportunity for the exploration of biases and assumptions that might be driving practice decisions?<br><br>Do senior leaders promote a culture that welcomes criticism, acknowledges the potential for bias and recognises the importance of challenge to drive improvement? |

# 10. How multi agency safeguarding partner arrangements are working

10.1. This chapter considers the analysis of safeguarding partner's annual reports and how well these provide an understanding of the work undertaken locally to improve safeguarding partnership arrangements and safeguarding practice. Published annual reports provide the Panel with an insight into the overall progress that has been made in implementing the new arrangements and addressing local safeguarding challenges.

10.2. The Panel commissioned What Works for Children's Social Care (WWCSC) to undertake the annual analysis of a sample of safeguarding partnership yearly reports from 2020-21. In summary, the analysis is based on desktop deep-dive audits of a sample of 18 annual reports for the year 2020-21, submitted to the Panel and WWCSC by 1st June 2022 using an integrated audit tool.

10.3. A separate report setting out the approach, findings and recommendations has been published alongside this annual report.

**Key learning:**

- As of 1 June 2022, the Panel had received an annual report for 2020-21 from 49% of partnerships. Of those received, we selected 18 for our analysis.
- The most common priority for partnerships was neglect
- The most common safeguarding priorities by practice theme were learning from reviews (6/18), information sharing (3/18) and trauma informed practice (2/18).
- All reports described activities but few included information about the impact that this work is having on children and families.
- It was positive to see that some reports identified challenges and highlighted actions taken to try to overcome lack of progress.
- There is descriptive evidence of some variation in how the leadership of safeguarding partnerships and independent scrutiny are managed. Reports would benefit from further analysis of the impact of different arrangements to help partnerships learn from the experience of others.
- Analysis found that the majority of reports (13/18) included reference to independent scrutiny, though it is concerning that five of 18 did not mention their independent scrutiny arrangements at all or refer to independent scrutiny of the report.
- Training and quality assurance were evident as a result of local learning activity and case reviews although there was limited information on impact, including the views of children and families.

## Learning from the analysis

10.4. Overall, the analysis suggests the need for yearly reports to have a sharper focus on impact, evidence, assurance, and learning.

10.5. The year 2020-21 represents only the first full year of reporting. The Panel were encouraged to see the steps taken in many areas to embed new partnership arrangements, particularly against the difficult backdrop of the COVID-19 pandemic. It is also clear that some areas have improved their approach to reporting, based on the feedback from last year's analysis of reports, with a greater focus on learning and the use of evidence.

10.6. Overall however, this second review of these reports found many of the same concerns that were highlighted last year. There is significant variation in the content and quality; reports were largely descriptive and there is still a need to move away from naratives that focus on detailing actions rather than impact. Future reports should set out clearly the rationale behind priorities, the evidence behind approaches and their impact on children and families. The Panel were concerned that only 49% of Partnerships had produced their Annual Reports for 2020/21 by June 2022 but recognised that the impact of operational priorities for partners during the COVID-19 pandemic will have had a significant impact .The Panel itself recognises the impact of competing demands given this Annual Report for 2021 has also been delayed, in part due to the two major national reviews we have undertaken in the last 12 months.

## Examples of practice

10.7. In one report there was discussion of how the leadership manages differences of opinion between partners. One safeguarding partnership developed additional guidance to support practitioners following a case review finding that there were issues about effective escalation of cases when there are differences of opinion.

10.8. A number of reports also highlighted the role of their Independent Scrutineer in evaluating governance arrangements as they can provide an impartial view about the quality of the leadership arrangements and independent challenge.

10.9. Several of these reports also highlighted the actions they had taken to try to overcome lack of progress. One report highlighted the "significant efforts" being taken to help enable frontline practitioners to develop better working relationships with children and families and to fill other gaps in the system. Another report discussed how they had applied for additional funding from the Department for Education to help improve engagement. A further report highlighted that the safeguarding partners had developed a toolkit to address victim blaming language.

## Areas of development

10.10. There is a need for the reports to move beyond simply describing governance structures so that instead they provide evidence of the added value of these arrangements, using a range of evidence perfrmance measures, such as data, audits, and feedback from families and professionals. This will help promote a strong and shared culture of learning from what is going well and where improvements need to be secured.

10.11. Partners should include their independent scrutiny arrangements in the annual reports and should also consider evaluating and reporting on the effectiveness of scrutiny approaches to help other partnerships learn from their experience.

10.12. Safeguarding Partners should be more open about where there is a lack of progress in their work, the barriers to progress and what might help to improve multi-agency working to ensure that reports are a useful tool for identifying areas where partnerships would benefit from additional support/focus.

## Conclusion

10.13. The Panel has provided safeguarding partners with clear guidance to consider when drafting future annual reports to help ensure they include the most relevant and helpful information, building on the analysis in this report and the report from 2020. The findings from this analysis will contribute to further development work with safeguarding partners.

10.14. The Panel's recent *Child Protection in England* report published in May 2022 highlighted the need to strengthen the work of local safeguarding partners. Recommendations in this report are relevant. Firstly, the Panel intends to offer greater facilitation to enable safeguarding partners to learn from each other and provide more hands-on, practical support. There may also be scope to encourage and incentivise better self-assessments. Therefore, the Panel have recommended that a national learning support capability for safeguarding partners is developed to disseminate learning about effective practice, however, this work would necessarily and importantly be co-led with all key stakeholders.

10.15. Secondly, the Panel recognises that multi-agency inspection should play a stronger role in ensuring all areas are held to account for their multi-agency partnership working, both operationally and strategically. The Panel has recommended that the inspectorates draw up proposals for a more genuinely integrated and comprehensive model of multi-agency inspection, adequately resourced by all partners, and integrated into the ongoing work of each inspectorate. We look forward to the publication of the Government's forthcoming Implementation Strategy which will set out further details about how this will work in practice.

# 11. The Panel at work

11.1 The Panel plays a key leadership role within the English child protection and safeguarding system. This chapter describes how the Panel fulfilled this role during 2021.

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

**11.2** The Panel receives all rapid reviews produced by safeguarding partners and provides feedback on the decision whether to conduct an LCSPR. This helps to ensure consistency across the system. On occasions, the Panel disagrees with a partnership's decision or considers that there is insufficient evidence in the rapid review to draw a similar conclusion. In such cases, the Panel engages with local safeguarding partners to understand and help with their decision-making processes.

**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**.

11.3 The Panel does this by commissioning national reviews and thematic analyses based on trends from rapid reviews. For example, in the years 2020-21 it commissioned and published a national review of non-accidental injury in under 1s. As more LCSPRs are completed and published, the thematic analysis of learning from LCSPRs will become an increasingly important feature of the Panel's work. Towards the end of 2021 the Panel began work on two national reviews (Safeguarding children with disabilities and complex health needs in residential settings, and the review into the deaths of Arthur Labinjo-Hughes and Star Hobson).

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

11.4 The Panel disseminates evidence, insights and learning from local and national reviews through an extensive communication and stakeholder engagement programme. This includes hosting regional as well as thematic roundtables to listen to feedback from safeguarding partners. For example, following the review on non-accidental injury in Under 1s, the Panel held a webinar with key stakeholders and safeguarding partners to ensure learning was cascaded back into frontline practice. Nationally, the Panel works in a cross-governmental context and with a range of other stakeholders to contribute to and influence the development of research and policy on child safeguarding practice.

## Progress on the Panel's commitments as set out in the Annual Report 2020

11.5 To address the key issues identified in the 2020 annual report, the Panel committed to further develop its system leadership role in making the safeguarding system more effective and more efficient. The intention was to distil and disseminate learning from rapid reviews and LCSPRs in a more meaningful ways to influence policy and practice. Three specific actions were agreed to support this ambition which have, in the most part, been delivered.

| | |
|---|---|
| **The Panel committed to increase communication and engagement with stakeholder bodies and safeguarding partners** | Throughout 2021 the Panel has continued to engage with a broad network of stakeholders as well as safeguarding partners. This has been achieved through, a variety of methods including meetings with stakeholders such as government ministers and senior officials, thematic events, quarterly newsletters and webinars that have attracted over 250 participants. |
| **A Panel member will be linked to each of the nine English regions to engage with safeguarding partnerships on issues of mutual interest as well as offering additional support where necessary** | This has successfully been implemented, with regional links as follows:<br><br>**North West** – Jenny Coles<br>**North East** – Dale Simon<br>**Yorkshire and the Humber** – Annie Hudson<br>**West Midlands** – Peter Sidebotham<br>**East Midlands** – Peter Sidebotham<br>**East of England** – Susan Tranter<br>**South West** – Sally Shearer<br>**South East** – Dale Simon<br>**London** – Renuka Jeyarajah-Dent and Jahnine Davis |
| **We will gather, analyse and share data and learning quarterly from rapid reviews and LCSPRs, so that valuable insights and practice themes can be disseminated more quickly to support improvements locally and nationally.** | Learning from the analysis of serious incident notifications, rapid reviews and LCSPRs has been used to inform this annual report as well as the revisions to the Panel's guidance, Panel newsletters and thematic reviews. We aim to implement a more regular data sharing cycle in the coming year when we have established an 'in house' data analysis function for Panel. This function will work closely with safeguarding partners to gather intelligence and support local and national learning. |

## Assessing the impact of the Panel

11.6 Quantitative and qualitative analysis was undertaken by YouGov working with safeguarding partners and frontline practitioners from June to September 2021 to assess the impact of the Panel. Specifically, the Panel wished to understand the perceptions of the Panel among key audiences, whether their recommendations around child safeguarding practice have been communicated to local areas, and what are the most effective avenues of communication to engage key audiences.

11.7 Analysis methods:

- Quantitative survey of 139 safeguarding partners and business managers
- Qualitative interviews and focus groups with safeguarding partners from 27 local areas
- Quantitative survey of 307 individuals working in a frontline professional role across social work, health, policing and education

11.8 A full summary of findings from the You Gov survey can be found at Annex D. The following is a summary of the headline findings of the survey.

**What do safeguarding partners think about the Panel?**

- **86%** of safeguarding partners agree that the Panel's work helps to identify improvements to multi-agency safeguarding practice
- **70%** of safeguarding partners agree that the Panel's work is improving the safeguarding system
- **74%** of safeguarding partners agree that the Panel's feedback on rapid reviews for serious child safeguarding incidents is useful
- **77%** of safeguarding partners are aware of the criminal exploitation review. **72%** of these have made changes to their local safeguarding practice as a result
- **72%** of safeguarding partners are aware of the national review into sudden unexpected death in infancy. **67%** of these have made changes to their local safeguarding practice as a result.
- **37%** of frontline professionals are aware of the Panel's reviews. This is much higher among social workers and low among police, health, and education.

**Priority areas for development**

- Engagement of frontline professionals - half of frontline professionals surveyed have heard of the panel (49%), but awareness varies significantly by job role. Three in 10 frontline professionals report knowledge of the Panel's thematic reviews. (28%).
- Safeguarding partners overwhelmingly think the Panel should be independent of government (90%), but a lower proportion think that its work is currently independent (60%).

**Conclusion and next steps**

11.9 The learning from this work and the highly valuable feedback from the sector has led to increased engagement and improved communication with safeguarding partners. This includes hosting 10 regional roundtable events attended by 448 representatives from 148 safeguarding partnerships which provide an opportunity for Panel to hear directly about practice issues and areas for improvement. A summary of the feedback received from the regional roundtable events and the Panel's response/further action can be found at Annex C.

11.10 The Panel will continue to develop their regional engagement with safeguarding partners. An ambitious programme of webinars, roundtables, newsletters, and conferences will help the Panel to disseminate findings of national and thematic reviews as well as learning from incident notifications, rapid reviews and LCSPRs.

11.11 We also continue our important national role, working with key stakeholders and government (including the Child Protection Ministerial Group) to provide independent, expert advice on safeguarding issues of national significance.

# 12. Priorities and 2022 work programme

12.1 We are clear in our mission for children to be protected from abuse, neglect and harm through excellent safeguarding practice and continue to support the safeguarding system to achieve this. At the end of 2021, the Panel identified four important priorities to shape its workplan in 2022. These priorities were brought to the fore in the context of the two national reviews undertaken in 2022 and wider policy debates about how to strengthen systems for helping and protecting children. The four priorities are outlined below.

### Promote child centred practice, ensuring the voices and perspectives of children, families and communities inform child protection and safeguarding practice and policy

12.2 We have made clear in this report that the voices of children, families and carers should be at the heart of the reviews. We know from our analysis that this is not always consistently achieved, and we will continue to work with the system to promote child centred practice, including through the Panel's own reviews where the lives of the children will be at the centre of our work. We will also be an advocate for children and families on a national level, in our work with Government to improve the system.

### Tackle perennial and complex barriers to effective practice

12.3 The Panel's oversight of safeguarding practice reviews provides insight into issues that are of a national importance. These issues can be perennial problems that exist within the safeguarding system which impede effective safeguarding practice by practitioners up and down the country.

12.4 We will tackle perennial and complex barriers by:

- Undertaking further thematic analysis where we have identified trends and themes in reviews that need further exploration. This will include:
    - expanding our elective home education work which began in 2021,
    - domestic abuse
    - intra-familial child sexual abuse
- Delivering two major national reviews that will explore issues of national importance. The first will explore the tragic deaths of Arthur Labinjo-Hughes and Star Hobson; the second examining safeguarding of children with disabilities and complex needs in residential settings.
- Working with Government to ensure improvements to the child protection system are made in a timely manner and fit the reality of working in the multi-agency

system.

## Use evidence and data to drive system improvement and learning through high quality reviews

12.5 Rapid reviews and LCSPRs provide the Panel with rich, unique insight into the child protection system. We will continue to monitor every single review to identify trends and themes that are of national importance.

We will use this information to:

- Commission qualitative and quantitative analyses of rapid reviews and LCSPRs that will identify learning for safeguarding partners to use as they develop their systems and processes.
- Explore potential themes of interest in local practice to determine whether a national review is required.
- Provide the baseline evidence for thematic analyses listed above.
- Inform our work with Government to shape policy development on behalf of the system – including the forthcoming Implementation Strategy.
- Disseminate learning to safeguarding partners and practitioners about effective practice.

## Encourage system learning and sharing of best practice to promote the behaviours and culture necessary for excellent child protection and safeguarding practice

12.6 We will continue to strengthen our relationships with safeguarding partners across England to gather intelligence from the system as well as disseminating the Panel's learning. We will achieve this by:

- Hosting a series of regional roundtables with safeguarding partnerships.
- Offering online webinars to safeguarding partnerships and practitioners on a range of themes including the findings of thematic and national reviews.
- Hosting a one-day national conference for the sector which will feature high-profile speakers, share learning and examples of effective practice and prompt thought. provoking debate.
- Publishing regular newsletters for safeguarding partners that provide timely insight.
- Publishing briefings for safeguarding partners that distil the learning from thematic analyses.

# ANNEX A: Breakdown of categories of fatal incidents

| Category of Death | Definition | Number | % |
|---|---|---|---|
| Overt Filicide | Deaths where a child is killed by a parent or parent figure using overtly violent means, or with no attempt to conceal the fact of homicide, and where there appears to have been some intent to kill or harm the child. | 6 | 3.8 |
| Covert Filicide | Deaths where a child is killed by a parent or parent figure but using less overtly violent means, and with some apparent attempt to conceal the fact of homicide. | 1 | 0.6 |
| Fatal Physical Abuse | Deaths following severe physical assaults (non-accidental injuries) where the suspected perpetrator is a parent or parent figure, and where there is no clear intent to kill or harm the child. | 6 | 3.8 |
| Severe, Persistent Child Cruelty | Deaths where a child dies as a result of a physical assault or neglect, and in which there is evidence of previous severe and persistent child cruelty. | 3 | 1.9 |
| Extreme Neglect / Deprivational Abuse | Deaths where the child dies as a result of severe deprivation of his/her needs with evidence that this has been deliberate, persistent or extreme. | 0 | 0.0 |
| Extra-familial Child Homicide | Deaths where a child is killed by someone other than a parent or parent figure using overtly violent means, or with no attempt to conceal the fact of homicide, and where there appears to have been some intent to kill or harm the child. | 16 | 10.3 |

| | | | |
|---|---|---|---|
| Extra-familial Fatal Assaults | Deaths following severe physical assaults where the suspected perpetrator is someone other than a parent or parent figure, and where there is no clear intent to kill or harm the child. | 5 | 3.2 |
| Deaths Related to Maltreatment | Deaths which are felt to be related to maltreatment, but in which the maltreatment cannot be considered a direct cause of death. | 82 | 52.6 |
| Not maltreatment related | Deaths for which there was no evidence of any maltreatment as a cause or contributory factor. | 31 | 19.9 |
| Not Clear | Deaths where there was insufficient information to enable any categorisation. | 6 | 3.8 |
| **Total** | | **156** | **100.0** |

Of the fatal incidents where maltreatment cannot be considered to be a direct cause of death (82) and those that are not maltreatment related (31), the category of death can be broken down further.

| **Category of death** | **Number** |
|---|---|
| Sudden Unexpected Death in Infancy (SUDI) | 38 |
| Suicide | 43 |
| Accident | 13 |
| Medical | 10 |
| Risk-taking Behaviour | 2 |
| Poisoning | 1 |
| Late consequences of abuse | 1 |
| Other | 5 |
| **Total** | **113** |

# ANNEX B: Breakdown of categories of serious harm

| Category of Serious Harm | Definition | Number | Percentage |
|---|---|---|---|
| Non-fatal physical abuse | Cases where there has been evidence of severe but non-fatal physical abuse (acute or chronic). | 89 | 36.8 |
| Non-fatal neglect | Cases of chronic neglect, or where neglect is the predominant form of maltreatment. | 29 | 12.0 |
| Emotional abuse | All forms of emotional abuse where this has been the predominant form of maltreatment, or the incident which led to recognition or notification. | 1 | 0.4 |
| Child sexual abuse – intra-familial | All forms of sexual abuse where this has been the predominant form of maltreatment, or the incident which led to the notification and where the suspected perpetrator is a parent, primary carer or member of the immediate family. | 16 | 6.6 |
| Child sexual abuse – extra-familial | All forms of sexual abuse where this has been the predominant form of maltreatment, or the incident which led to notification and where the suspected perpetrator is NOT a parent, primary carer or member of the immediate family. | 7 | 2.9 |
| Child sexual exploitation | Cases where there is evidence of child sexual exploitation as opposed to isolated intra- or extra-familial sexual abuse. | 13 | 5.4 |

| | | | |
|---|---|---|---|
| Non-fatal assault – extra-familial | Physical assaults where the suspected perpetrator is someone other than a parent or parent figure, includes gang-related and peer-on-peer violence. | 27 | 11.1 |
| Serious harm related to but not directly caused by maltreatment | Includes risk taking or violent behaviour, attempted suicide/deliberate self-harm, accidents, poisoning and other incidents where maltreatment was felt to be a contributory factor. | 40 | 16.5 |
| Serious harm not related to maltreatment | Other incidents with no evidence that maltreatment contributed to the serious harm. | 17 | 7.0 |
| Unclear | | 3 | 1.2 |
| **Total** | | **242** | **100.0** |

# ANNEX C: Regional roundtable feedback

| Feedback | Panel Response |
| --- | --- |
| The challenge involved in meeting the expected timescale for rapid reviews. | The Panel recognise it is a challenge but overall, timescales are improving and more safeguarding partnerships are now managing to meet the 15 day timeframe. Of those rapid reviews seen by the Panel, we don't believe quality is impacted by submitting within 15 days. In fact many of the best rapid reviews we have seen were submitted on time. As a reminder, the purpose of a rapid review is to gather the facts, consider immediate action, consider potential for improvements, decide whether to proceed to LCSPR. It is not expected that children and families would be involved at this stage. |
| The impact of reviews on system and practice change has in some instances been limited – is there a danger that learning is simply repeated in future reviews? | The Panel agrees that safeguarding partners should not be commissioning LCSPRs where there are findings and recommendations from existing reviews which can be drawn upon. For example, the Panel would suggest utilising relevant national reviews when issues relating to non-accidental injuries in children under 1, sudden and unexpected death in infancy or child criminal exploitation are being considered. Safeguarding partnerships do not need to reinvent the wheel. |
| The challenge completing and publishing LCSPRs within 6 months due to ongoing criminal investigations. | Given the difference in the focus of a criminal investigation and that of the LCSPR, it should usually be possible to conduct the LCSPR while the criminal investigation is ongoing. This issue is covered in the updated 2022 Panel guidance. |
| What detail to include in a published LCSPR when criminal proceedings are still ongoing? | The Panel believe LCSPRs should be written in a way so that they are publishable but also recognises that the child's experience can be lost due to anonymisation. Context is important to make sense of what happened to a child but the primary focus should be on learning and system improvement. This issue is covered in the updated Panel guidance to be published in 2022. |

| | |
|---|---|
| Safeguarding partnerships may choose to undertake and "alternative learning review or use other terminology to describe difference approaches to review. | The Panel supports and encourages different methodologies and approaches to reviews; however, any further review of a case should be referred to as an LCSPR and should meet the requirements of an LCSPR, including the appropriate involvement of practitioners and families and the expectation that the report will be published. |
| Extra-familial harm – the need to understand the experience of the child throughout their lives, including the impact of domestic abuse and the relationship for some children between criminal exploitation and long-term neglect. | The Panel has undertaken a further piece of work exploring criminal exploitation and the learning will be used to inform our work in the coming year. |
| Mental health, suicide, and access to tier 4 beds. Several safeguarding partnerships noted an increase in incidences of suicide and questioned how to draw the learning and improve practice from these cases, particularly ones that don't meet the criteria for a rapid review (i.e., no suspected abuse or neglect). | We recognise that these are priority issues for the system and continue to monitor cases to track trends and themes. We will also continue to raise the profile of these issues through our links with government departments including the Department for Health and Social Care |
| What constitutes 'persistent failure' (as per the Working Together 2018 definition) and how should this be applied in relation to different ages (new-born as opposed to older child) and / or different needs (for example a child with complex health needs)? | The Panel recognises that, in general, the adverse effect of neglect on children is cumulative. Most typically this occurs when parents/carers persistently fail to meet the child's physical or psychological needs. Many parents will, from time to time, be unable (for a range of reasons) to meet the specific needs of the child, however, when this happens in the context of otherwise nurturing and loving care, then it is unlikely to result in significant harm to the child. |
| Information sharing – Safeguarding partners raised that rapid reviews and LCSPRs often cite poor information-sharing, or misunderstandings around what information can be shared, as a key systemic failure. | The Panel is keen to identify barriers to timely and appropriate information sharing and is seeking to explore this further as part of the implementation of the recommendations following the Panel's national review into the deaths of Arthur Labinjo-Hughes and Star Hobson. |

# ANNEX D: Summary of the findings of the YouGov survey on Panel impact

**Perceptions of the Panel**

- Most safeguarding partners surveyed report a good understanding of the Panel's remit and activities (87%).
- A similar proportion of safeguarding partners report being well informed about the Panel's current activities (87%), and many think their knowledge has improved compared to a year ago (64%).
- Almost nine in 10 safeguarding partners surveyed see the Panel as a trusted source of information and think it identifies improvements in how areas can work together (both 86%).

**Impact of thematic reviews and annual reports**

- Most safeguarding partners surveyed generally know at least a fair amount about the two thematic reviews (as at September 2021) (76%).
- Over two thirds of safeguarding partners aware of the reviews say their organisation has already implemented changes to local safeguarding practice as a result of a review (72% criminal exploitation, 67% SUDI).
- Large proportions of frontline professionals aware of the thematic reviews consider them useful in their day-to-day role (86% criminal exploitation, 81% SUDI). Frontline professionals generally find out about the Panel's reviews from their organisation or local safeguarding partnership.
- Overall, the vast majority of safeguarding partners surveyed have read some of the Panel's annual report (84%). A similar proportion think the recommendations are understandable and actionable (87%).

**Improving safeguarding knowledge**

- Most safeguarding partners surveyed think the Panel's activities are beneficial for local safeguarding practice (86%), but they are less convinced about whether the Panel's information and communication improves their local safeguarding practice (64%).
- Overall, around three-quarters of safeguarding partners surveyed think that it is easy to find information about the panel (78%) and that the gov.uk website is useful (73%). However, many noted that they would initially use a search engine that then routes them to the gov.uk website rather directly going to gov.uk itself.
- Three-quarters of safeguarding partners who took part in a rapid review found the Panel's feedback useful in improving their local practice (75%).

**Areas of development**

- Engagement of frontline professionals- half of frontline professionals surveyed have heard of the panel (49%), but awareness varies significantly by job role. Three in 10 frontline professionals report knowledge of the Panel's thematic reviews. (28%).
- Safeguarding partners overwhelmingly think the Panel should be independent of government (90%), but a lower proportion think that its work is currently independent (60%).
- Safeguarding partners generally receive information directly from the Panel's letters (60%) or emails (58%). There is marked appetite to potentially receive information via the Panel's newsletter (66%) or webinars (59%).

# ANNEX E: Acronyms and glossary

**Acronyms and abbreviations**

| | |
|---|---|
| **CPP** | Child Protection Plan |
| **CSC** | Children's Social Care |
| **CSPR** | Child Safeguarding Practice Review |
| **DA** | Domestic Abuse |
| **DfE** | Department for Education |
| **EH** | Early Help |
| **EHE** | Elective Home Education |
| **GP** | General practitioner |
| **LCSPR** | Local Child Safeguarding Practice Review |
| **N/A** | Not Available |
| **NEET** | Not in Education, Employment or Training |
| **RR** | Rapid Review |
| **SIN** | Serious Incident Notification |
| **SMART (action plans)** | Specific, Measurable, Agreed, Realistic, Time Bound |
| **SUDI** | Sudden Unexpected Death in Infancy |
| **The Panel** | The Child Safeguarding Practice Review Panel |
| **YOT** | Youth Offending Team |

**Glossary of terms**

| | |
|---|---|
| **Adultification** | The practice of authority figures being less protective of and more punitive towards children of racial minorities. |
| **Extra-familial harm** | Risks to the welfare of children that arise within the community or peer group, including sexual and criminal exploitation. A key element of extra-familial 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. |
| **Intra-familial 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. |
| **Minoritise** | To make (a person or group) subordinate in status to a more dominant group, its members or another person |
| **Safeguarding partners** | Local safeguarding arrangements are led by three statutory safeguarding partners: the local authority, the police and the integrated care board. |