Briefing for frontline practitioners National reports – Key points and considerations

1. Introduction

The national Child Safeguarding Practice Review panel published two reports in Spring 2021. This briefing will summarise and outline the key points and any considerations for frontline practitioners working with children and families.

The national reports are:

1. The annual review of Local Child Safeguarding Practice Reviews (LCSPRs) and rapid reviews, Child Safeguarding Practice Review Panel, March 2021
2. Child Safeguarding Practice Review Panel Annual Report 2020 Patterns in practice, key messages and 2021 work programme

2. Key points and considerations

2.1 Annual review of LCSPRs and Rapid Reviews: Child Safeguarding Practice Review Panel March 2021

The system of rapid reviews and local child safeguarding practice reviews (LCSPRs) was established in 2018, to replace the previous system of serious case reviews. For a while the two systems ran alongside each other, but since October 2019, only the new system can be used.

The first independent review of rapid reviews and LCSPRs, was undertaken by a joint team from the University of East Anglia and the University of Birmingham.

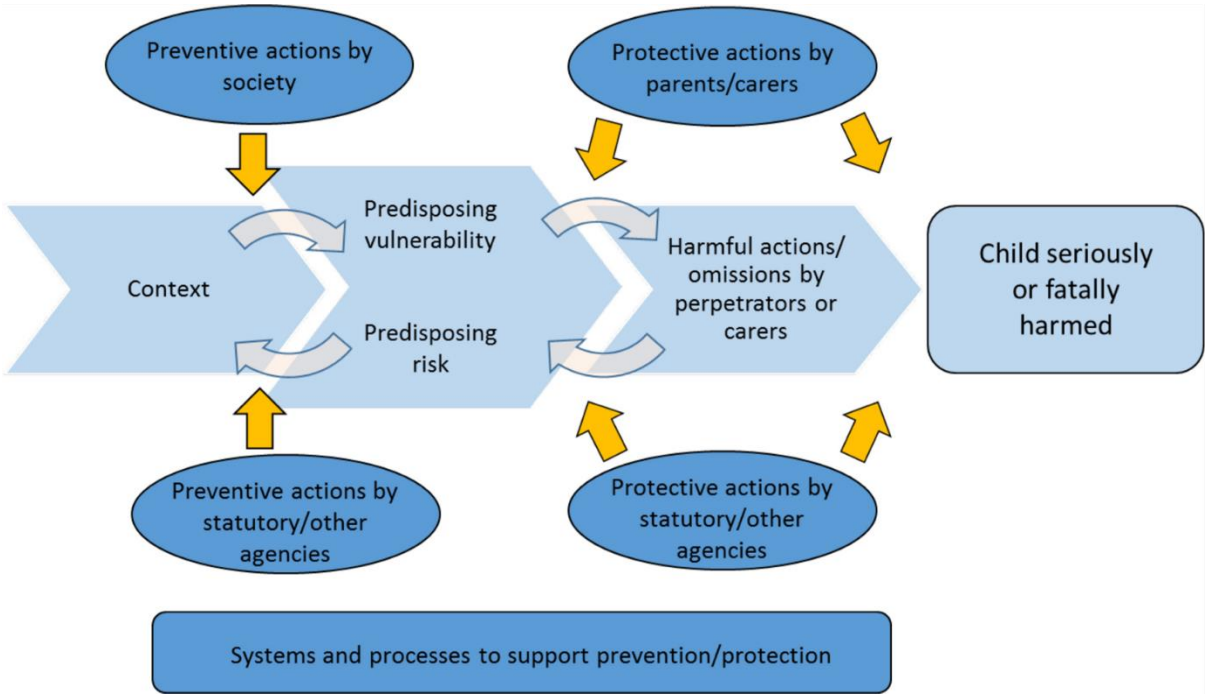
The aims were:

- to provide an overview of key themes, issues and challenges for practitioners and agencies
- to draw out implications for policy makers and practitioners
- to assess how well the rapid reviews and LCSPRs achieve the tasks required of them
- to analyse the sample of LCSPRs available to the team in order to increase understanding of the root causes of systemic strengths and vulnerabilities within local practice
- to generate findings and questions for local safeguarding partners and the Panel to support them in their work to improve child protection practice

The 'Pathways to harm, pathways to protection' approach was used to look at identification and referral; case management; engagement with families and case closure.

Pathways to harm, prevention and protection is an analytic framework drawing on systems methodology and a previous approach to identifying relevant themes within serious cases. The framework of 'Pathways to harm, pathways to protection' offers a number of dimensions for identifying and beginning to understand where things might have 'gone wrong' for an individual child – where actions or decisions were taken that moved them along a trajectory leading to eventual harm, or where the chance was missed to take actions or decisions that might have led to better outcomes.

Pathways to harm, prevention and protection



- Close to half of all reviews identified problems with either early identification of risks, or agencies not responding adequately to referrals, or both. The importance of quality and timeliness of referrals also permeated learning and recommendations as did the need to use clear and accurate language rather than well-worn phrases which did not get to the bottom of a problem

- Reviews regularly commented on case management issues across and within agencies. Those included limited access to appropriate services, receiving information about children and families but not acting on it, and the importance of recording, sharing and acting on multi- agency meeting decisions

- Recognition of difficulties in engaging children, young people and families were highlighted. There was less evidence of consideration as to *why* families may not be engaging. Engaging fathers and men in safeguarding continues to be a problem for practitioners and agencies

- Repeated opening and closing of cases can occur when families do not engage and there is not enough time to build relationships. Progress was not always evidenced prior to closure and there was often insufficient clarity about what to do when new concerns emerge

- Reviews rarely address *why* things happen*, why* practitioners make certain decisions or *why* children and families may respond negatively to interventions.

The key themes found from the qualitative analysis of rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs) concerned opportunities to be curious; resources; inter-agency communication and sharing; policies and protocols and training:

- New themes that would benefit from further development and learning were working with families during a pandemic; peer-on-peer abuse; young people's gender and sexual identities and trafficking of children

- A lack of 'professional curiosity' was often identified in reviews, but the term had become something of a cliché. Further inquiry into why practitioners did not always ask 'the second question' was usually missing. Work with adolescents, babies, fathers and men in families and families from diverse cultures often showed the impact of stereotypes and assumptions that left issues unexplored

- Resource issues were mentioned in nine rapid reviews, but the theme was usually more developed within LCSPRs (in eight cases). This included lack of specialist services as well as shortage of personnel within agencies

- Inter-agency communication and sharing continues to be a barrier to safeguarding children across all agencies. Multiagency safeguarding hubs (MASHs) are designed to facilitate information-sharing and decision but in eight reviews, there were specific concerns about the local MASH

- Practitioners are expected to know, understand and follow a range of policies and procedures as part of their job and when they were not followed, recommendations invariably pointed towards further training

- Training recommendations were present in almost a third of reviews. Proposed training could be focused on particular topics, practice skills and approaches, or knowledge of policies and procedures. They could be single as well as multi- agency

Rapid reviews and LCSPRs: links, themes and quality

- 33 LCSPRs were received for analysis and matched to 27 rapid reviews

- Analysis of rapid reviews suggested that there is a minimum amount of information that is necessary to provide the detail and context needed to meet or exceed and falling below this is likely to reduce the quality of the review. Commonly missing was the

ethnicity of the child and their family which is of some concern, given the known importance of culturally competent practice

- The best rapid reviews ranged from 6 to 16 pages. They were also documented on templates that ensured all the key information was included

- There is relatively little guidance about what the report of an LCSPR should contain. There is a wide variety of reports, given the breadth of objectives and learning methodologies that could be used in a review, which means that it is not straightforward to compare them

- Analysis of LCSPRs found evidence that local partnerships were still coming to terms with the new requirements, and the concept that any further form of inquiry should be regarded as an LCSPR was taking time to become familiar

- The real value of the LCSPR is the publication of learning as opposed to the rapid reviews where publication cannot be an option. Although termed local reviews, the learning will likely be picked up by other safeguarding partnerships and possibly other agencies, therefore bringing national value for the child protection system

- LCSPRs are required to include the **views of children and families** whenever possible. The experiences of children and families, and in some cases communities, are important for exploring how the safeguarding system works in practice for those who need it. There are many reasons why families cannot or will not be involved in reviews and we found that families' views were missing from over a third of the LCSPRs. It would be useful for LCSPRs that cannot include the family's views to include a statement detailing the reasons why

- There was rarely evidence of individual practitioners being involved in rapid reviews. In contrast, the LCSPRs did demonstrate practitioner involvement, often through practitioner events

- LCSPRs have further learning in most cases and some are excellent at linking that learning to specific recommendations for change but often not *how* the changes might come about or *how* to measure the effectiveness of any change

The report provides an example of the process from rapid review to a published LCSPR in the case of a child who collapsed at home and could not be revived. In this case, the LCSPR developed the initial findings presented in the rapid review, suitably anonymised the family and circumstances to allow for publication (available on the NSPCC repository) and specifically addressed areas of practice. While the child died as a result of anorexia, the review recognised the significance of children being home educated and often invisible to services and called for a national review about elective home education:

Progression from rapid review to LCSPR: a case example Death of a 15-year-old child

The rapid review gives background to the child and family as well as the significant incident. There are clear areas for learning locally which include learning for GPs in relation to:

- Opportunities for measuring height and weight
- Policies around older children not brought for consultations and tests
- GP awareness of children who are home educated
- Children being seen by a different GP at each surgery attendance
- The importance of the voice of the child

There is also learning for home education advisors, stressing the need for a broader assessment that includes psychological and social development even when the child is excelling academically, as in this case. Training and actions for the two groups of practitioners are recommended. The rapid review suggests that there is learning relevant to the local context but also national learning regarding home educated children 'lost to services' which may require legislative change to resolve.

The LCSPR develops the findings further and looks at the transition from school to home education status, information not available in the rapid review.

Whilst still at school, the child started to look gaunt and pale and their attendance was dropping. Poor attendance was reported by parents to be due to illness. Scrutiny of the child's school record, during the LCSPR process, added to the understanding of potential opportunities to intervene, for example, for teachers, school nurse and friends.

Within the LCSPR there is learning for all the areas identified in the rapid review with specific suggestions and guidance for improving some areas of practice. There are six recommendations with intended outcomes related to practitioners' understanding of anorexia and implications/monitoring of children home educated.

The LCSPR states that '*a lack of professional curiosity is a golden thread which was a feature in all agency reports. The barriers to professional curiosity and how systems are used to support professional curiosity need to be considered across the partnership*'. The incident took place late summer 2019, the rapid review was submitted within the required timescale and the LCSPR, written in a publishable format, was completed the following year (late summer 2020).

Within the report, two rapid reviews were also identified which exemplify:

The strengths of rapid reviews - Rapid review case study 1	The weaknesses of rapid reviews - Rapid review case study 2
Rapid review case study 1: Death of a 3-day-old infant This rapid review was one of the strongest we saw. It makes good use of a template, which means that no relevant information is missed. There are tables of the people who participated in the review, with columns for name, job title and agency/organisation, and of the details of the child and their family with columns for name and address, relationship to the child, date of birth, legal status and ethnic origin. The review is divided into logical sections, the first being 'Case Background' which includes a brief summary of the incident. Section 2, 'Consideration of Case, Criteria and Guidance', comprises subheadings for 'Immediate Action', and 'Additional information' which includes details of domestic abuse (possibly triggered by the use of a tick box asking if domestic abuse is known or suspected), whether COVID-19 has had an impact on the case and a tick box list to identify improvements to safeguarding and promoting the welfare of children. The last part of this section is 'Rapid Review Discussions'. Within this there is a succinct summary of the involvement of each of the agencies /organisations involved in the case.	**Rapid review case study 2: Concealed pregnancy** This was a poor rapid review of a case involving a concealed pregnancy culminating in a birth with no medical assistance and the infant being placed in foster care. It had significant missing information, with the information that was provided being across two separate documents, the minutes of the rapid review and a letter summarising the case and outcome. The minutes provide a full list of who attended the meeting, their role and organisation, but not details of the child or their family. The date of birth and name of the child are stated in the letter but there are no further details of the family given in either document, other than that there is a sibling who is in care. From hereon we will describe both documents together. There is some detail of the incident but this is lacking, and there is no contextual background detail. The focus of the meeting appeared to be on the reason that the case was missed by relevant agencies, without any exploration of the experience of the infant or their family. There was minimal analysis and reflection around the wider issues of the case, with the focus concentrated on a missed email. Despite highlighting a number of points

The key point here is that the summaries are concise and relevant to the case, providing all the context necessary to understand the incident and the circumstances leading to it. Furthermore, there is clear evidence of analysis and reflection, rather than simply a description of involvement by the various services and agencies. This ends with the decision summary, which demonstrates that the review clearly considered the child and the impact of the incident on their sibling, taking a holistic view of the case. It identifies where the case could have been better managed and areas for improvement. The review ends with the recommendation that the criteria for an LCSPR were met, but that the issues that were identified are evident in previous SCRs and LCSPRs. They found, therefore, that there was not likely to be any new learning and it would be more useful to scrutinise implementation of the previous learning, to see whether it is being embedded in practice. This conclusion appeared to be based on reliable evidence and a thorough analysis. Nevertheless, the case did progress to an LCSPR on the Panel's advice.	where communication within and between agencies failed, the finding of the review was that the issue was a single individual misinterpreting correspondence rather than a systemic issue. For this reason, despite the account of failures in the review, the recommendation was that the criteria for an LCSPR were not met. This review did not appear to use a template, the subheadings being questions that were discussed in the review; using a template might have ensured that relevant detail was not missed. For example, if there had been a box for the background then some information might have been provided. Moreover, this would have ensured that all relevant information was contained in a single document. This review was 8 pages altogether, 6 pages for the minutes of the meeting and 2 for the letter, but there is some duplication across these documents without which the review would have been much shorter.

As with the rapid reviews, the report identifies two LCSPRs to illustrate what makes a stronger (LCSPR case study 1) and a less informative (LCSPR case study 2) review. Both are of similar length (38 and 39 pages respectively), and both are described as LCSPRs.

The strengths of LCSPRs - LCSPR case study 1	**The weaknesses of LCSPRs - LCSPR case study 2**
LCSPR case study 1: Death of a 16-year-old male This was an example of a good LCSPR.	**LCSPR case study 2: Death from sepsis** This was a less effective LCSPR.

It concerned the case of a 16-year-old male, found dead in his bedroom by his mother, with insufficient evidence that he had intended to end his life. This review provided a clear and concise executive summary of the key points from the review, briefly describing the incident, findings and conclusion, and detailing questions considered by the review, the key learning, and local and national recommendations. The format of the review allows for identification of all the key elements expected of the review laid out in a clear and easy to read structure. It begins with a foreword, which concisely details the purpose of the report whilst setting it in the wider context and is written in a manner that is sympathetic to the family. The first section details the reason for conducting the review, giving the purpose as a bullet point list. Second is what the review found, summarising the findings into three themes: criminal exploitation, education and working together, again with bullet point lists. One of the major strengths of the review is the following sections which look at the young person's story and the perspectives of the family and community. These demonstrate that the voice of the young person and family were at the forefront of this review and including the community perspective gives insight into wider community issues that affect children and young people across the area. The next section is a summary of the themes, and again these are described and analysed from the perspective of the young person.	It related to the death of a child from sepsis who was on a Child in Need plan for neglect due to home conditions. The death was recorded as due to natural causes and no police action resulted. Home conditions were poor, but these did not contribute to the death and the family sought medical attention appropriately. Arguably it is unclear whether an LCSPR was necessary, but the safeguarding partnership felt that there was important potential local learning based on the circumstantial factors in the case. The diagnosis of sepsis was missed by medical staff when the child was sent home from hospital two days before. The medical management should have been reviewed using the NHS Serious Incident Framework, referring to appropriate medical guidelines and standards; if this had occurred there was no reference to it. The review was 39 pages long, covering a period of 33 months prior to death, with a detailed 10-page chronology documenting, for example, weeks prior to death that 'he attended a mini sports day but missed a reptile party...'. This level of detail does not add to the quality of the review and makes it difficult to identify the key information. The review identified weaknesses in the Child in Need process with healthcare staff often not invited to contribute to plans or meetings, professionals not recognising the

This section provides enough detail to give the context and background to the incident from multiple agencies without becoming repetitive or verbose. Most of the remainder of the report, over 20 pages, is taken up with the key learning within each of the three themes. The learning shows extensive analysis of a wide variety of contextual issues surrounding the case, and again is written with the young person at the forefront. The review ends with clearly laid out national recommendations, and local recommendations with accompanying action plans. These clearly relate to the key learning detailed in the previous section and include areas that should receive particular attention in the action plan.	impact of poverty, and the potential benefits of using tools such as Graded Care Profile 2 more frequently to accurately quantify neglect. Although an LCSPR is not the appropriate mechanism to investigate a medical error such as a missed diagnosis, there was useful learning from missed opportunities earlier in the child's life.

Conclusions and suggestions for safeguarding partnerships and the Panel

1) The aim of the new system of rapid reviews and local practice reviews was to overcome the shortcomings of the old system of serious case reviews. It is still too early to judge its success, especially given the extra challenges of Covid-19 over the last year

2) The fundamental challenges of safeguarding work remain the same for all the agencies involved, and it is important to recognise that wider context. There are no simple solutions to such complex problems

3) A main message for practice is about the importance of staff in all agencies asking '*the second question'*, probing behind the first information or first answers they are given, whether from service users or other practitioners. That message applies as much to the reviews themselves as to the practice they are investigating

4) Reviews are called on to identify 'good practice' in the cases they are examining, but these hard cases may not be the best way to do find this. We suggest a wider review of a fuller range of cases, especially where there are apparently successful outcomes for children and families – these are more likely to illustrate examples of good practice

5) Without publication of the LCSPRs, learning is not shared, and the system is fundamentally undermined. It is essential for the Panel and partnerships to tackle the reasons for delay and non-publication of LCSPRs

6) Most of the learning is now in rapid reviews, which are not intended for publication, and so are hidden from wider view. Publication and dissemination of an annual review of rapid reviews is also essential, to share this learning

7) The Panel and local partnerships should work together to consider together what is reasonable to expect from rapid reviews, and the possible benefits of a national template; and to clarify understanding about the nature and range of LCSPRs, and publish clear, agreed guidance

8) The Panel should consider commissioning and publishing two new studies: (1) a study of the implementation and impact of the learning and recommendations of rapid reviews and LCSPRs as this is a major knowledge gap currently; and (2) a study of the *practice* of rapid reviews and LCSPRs, to uncover what actually happens and why. This could identify common sticking points and produce 'best practice guidance' for reviewers and partnerships.

2.2 Annual report 2020 patterns in practice: key messages and 2021 work programme Child Safeguarding Practice Review Panel

This report has three important messages:

1) The Panel's analysis of practice brings into sharp relief once again the importance of using our very best resources and skills to give a real and strong voice (and influence) to children We fail too often to grasp and make sense of the intrinsically unique identities and life experiences of children. 'Reading between the lines' of what children and families say and communicate (as well as what they do not say) involves time, imagination and the most proficient of relational skills. We all have responsibility for creating the conditions in which the talents and resources of practitioners can prioritise understanding what life is like for children

2) The urgency of addressing what might be described as stubborn and perennial problems in multi-agency child protection practice. Issues such as weak information sharing, communication and risk assessment have, over decades, impeded our ability to protect children and to help families. The English child protection system has generally proved to be extremely adaptive and resilient, but despite the best of intentions (and very many inquiries), professional systems and cultures have not successfully tackled some of these deep-seated challenges. We need to question and challenge ourselves when we talk about issues such as poor 'risk assessment', 'disguised compliance' and weak 'professional curiosity', thinking carefully what we mean and why these issues are coming about.

3) The need to understand and evaluate robustly the impact of learning from rapid reviews as well as local and national practice reviews. There is increasing evidence that the

safeguarding 'system' is developing its capacity to reflect and learn. Although the Panel still sees examples of old ways of thinking, it has also discerned real and evidenced shifts in the way that reviews are moving from an emphasis on 'reporting about' to 'inquiring into and learning from'. This is positive, but it also means that together we need to develop ways of systematically evaluating the effectiveness and impact of learning.

The report highlights six key practice themes to make a difference in reducing serious harm and preventing child deaths caused by abuse or neglect. These themes are not new, but they are amongst the most urgent, and also the most difficult. Underpinning all of them is the importance of effective leadership and culture:

1. Understanding what the child's daily life is like
2. Working with families where their engagement is reluctant and sporadic
3. Critical thinking and challenge
4. Responding to changing risk and need
5. Sharing information in a timely and appropriate way
6. Organisational leadership and culture for good outcomes

<table>
<tr><td colspan="2">Theme 1 – Understanding what the child's daily life is like
Understanding what a child sees, hears, thinks and experiences on a daily basis, and the way this impacts on their development and welfare, is central to protective safeguarding work. The complexity of situations in vulnerable families can lead to a particular focus on parental needs, which can get in the way of professionals understanding risks faced by the children. It is essential to explore the child's experience of living with neglect, domestic violence, and substance misusing parents and to understand how these harms impact on their safety, health and overall development. The child's views should inform analysis and assessment so that intervention is appropriate to address key concerns and needs.</td></tr>
<tr><td>Key Learning from case reviews
It is important for practitioners to build a trusting and respectful relationship with the child, which goes beyond listening and recording the child's views, to critically reflect on what the child is trying to communicate through their behaviour, interaction with others and physical presentation.
Look to ascertain children's views in a variety of ways, using structured tools to support the process.</td><td>Case study: Read between the lines
Child B had been in a kinship care placement for four years when she disclosed that she had been sexually abused by her male carer. Practitioners had found her chatty and engaged in their regular LAC and health assessments, both of which included direct statements from her. Professionals from all agencies accepted the child's views, often expressed in front of her carers, without further exploration. Child B contributed to the review following the case and spoke of how changes in her presentation, behaviour and eating were not recognised as distress signals.</td></tr>
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• Recognise that challenging or help-seeking behaviour may well reflect harm and distress. • Be aware of and challenge circumstances where children seek to minimise potential risks of harm and show reluctance to accept support.	
Theme 2 – Working with families where their engagement is reluctant and sporadic Reviews often refer to 'lack of engagement' by vulnerable families, citing patterns of missed appointments, cancelled home visits, and offers of support not taken up. This is sometimes characterised as 'disguised compliance' or 'resistance'. It is important to understand the underlying issues giving rise to reluctant or sporadic engagement, particularly where professionals are 'working with consent'.	
Key learning from case reviews • Relationship-based practice recognises the importance of effective relationships and connections between practitioners and families in creating the motivation and opportunity for change. • An understanding of adults' own experiences is essential to addressing concerns about their lack of engagement. • Motivational interviewing provides a strong framework to initiate difficult conversations. The model of question, affirmation, reflection and summary enables practitioners to maintain a balance between being directive, supportive and non-judgmental. • Non-engagement may be better understood as 'closure' – a response in circumstances of unresolved adverse childhood experiences or socio-economic pressures, where individuals believe that what is happening to them is largely outside their locus of control and this may mitigate against their	**Case Study: T family** Partner agencies, including the children's school, reported mother's behaviour to be erratic and, on occasion, hostile. Assessments had not identified or addressed mother's trauma from mother's childhood experiences. Practitioners focused on mother's non-compliance with safety plans, particularly around contact with a partner who was the apparent perpetrator in domestic abuse incidents. A more strength-based, trauma informed approach could have enabled better support for mother and reduced harm to the children from emotional abuse. **Case Study: K family** The K family were offered early help with concerns about low-level neglect, including the poor physical home environment. After the parents' initial consent to an Early Help Assessment, a 'Team Around the Family' found it difficult to arrange home visits and other appointments were missed. Work through a single Family Support Worker enabled a one-to-one relationship, during which disclosures about debts and possible criminal exploitation came to light.

capacity for behavioural change. Effective relationship-based work with families is essential to enable a better understanding of the way that closure interacts with other risk factors. • Some parents find difficulty in engaging with a large number of professionals and may have limited capacity to understand the different roles and their contribution. This indicates the importance of a single lead practitioner with a key relationship with the family. • Missed appointments, blocking of communications and cancelled visits are all indications of avoidant behaviour and require proactive follow-up.	
Theme 3 – Critical thinking and challenge Reviews frequently highlight a lack of 'professional curiosity' and 'over optimism'. Assessments and plans for support are framed by underlying assumptions that remain unchanged in spite of continuing or spiralling risk. This is particularly so where there has been intervention over a number of years. These circumstances are often combined with a lack of challenge between professionals and a reluctance to escalate concerns.	
Key Learning from case reviews ▪ Practitioners should be confident in using the authority of their role to promote authentic 'support and challenge' relationships between practitioners and children and young people. This is essential in creating a climate of trust for courageous conversations about difficult issues, creating the motivation and opportunity for change. The capacity to build relationships in this way, and to apply critical thinking, can be limited for practitioners in situations where there are high and complex caseloads, with poor quality supervision. ▪ To help families identify goals and build on strengths to overcome difficulties,	**Case Study: Baby N** Baby N was aged 11 weeks when his mother found him floppy and unresponsive, having earlier gone to sleep with the infant next to her on the sofa. At initial booking of her pregnancy, mother had stated she had previously participated in treatment for substance misuse but was no longer using cannabis. Practitioners built a positive relationship with her and wanted her and the new baby to do well. A lack of critical thinking meant that incidents of low-level neglect were rationalised. Mother's self-reporting that she had stopped the use of cannabis was not challenged in spite of limited evidence of her motivation to change and reported concerns from the local children's centre.

practitioners need to test assumptions about resilience and ensure appropriate support is in place. ▪ Positive self-reports of change need to be considered alongside reports and information from other practitioners. ▪ Strategy meetings, core groups and case reviews are contexts to analyse and challenge. Decisions to close cases, step down, or maintain at the same level need to be based on evidence of the positive impact of previous interventions or reducing risk. ▪ Critical thinking, particularly as part of reflective supervision, provides a framework for practitioners to exercise analytical skills to reframe and reassess their work with children, young people and families. ▪ Practitioners are often aware of escalation protocols but reluctant to invoke them. Where escalation protocols work more effectively, safeguarding partnerships have provided opportunities for practitioners to understand their different roles and promoted challenge as a key part of multi- agency working.	**Case Study: Family M** Family M were engaging with early help after the school had noted that the children were coming to school poorly presented and hungry. A 'Team Around the Family' meeting identified inadequate temporary accommodation as the key issue and sought to resolve the housing difficulty. This continued to be the main focus in spite of the emergence of other safeguarding issues. Some practitioners considered that the work with the family could be stepped up to children in need. When the decision was taken to close the case, their professional differences were recorded but not escalated as they were not confident of management support. The case review found that reflective supervision could have enabled practitioners to reassess their work with the family.
Theme 4 – Responding to changing risk and need Weaknesses in risk assessment feature in the majority of case reviews. In many cases, initial assessments of risk have not been reviewed and updated in response to changing circumstances or taken sufficient account of the potential risk to children arising from known information about factors such as parental mental health concerns, adverse childhood experiences or criminality.	
Key learning from case reviews ▪ A mindset of 'respectful uncertainty' supports the effective identification of risk factors and the mitigation of risk, underpinned by comprehensive assessment. This goes beyond the	**Case Study: Child H – Use of risk tools** Child H disclosed that she had been the victim of a series of sexual assaults following an alert to police by a minicab company. Previously, a CSE risk tool had been completed and the case was referred into the multi-agency child

immediate presentation and takes account of any prior involvement with the family (for example if a previous child had been taken into care). Information from parental self-reporting needs to be triangulated. • Up-to-date and appropriate evidence-based risk tools support assessment but they require critical reflection about the evidence to inform next steps. • Pre-birth assessment is a 'reachable moment' to assess and mitigate risk, with co-ordinated support. • In assessing risk in adolescents, it is important to understand and observe a 'risk trajectory'. Be aware of the possible impact of childhood trauma or prior neglect. • Concerns about domestic abuse, parental mental health concerns and substance misuse are not sufficiently taken into account in assessing risks to children. • Holistic family assessment needs to take account of any changing risk factors arising from extended family members (for example an adult joining the household following release from prison). • The role of fathers/adult males is not sufficiently understood or taken into account in assessing risk. Practitioners should explore previous histories and involvement with children's social care, either in childhood or as parents, and inform the mother of the risks if appropriate. Consideration of fathers' supportive and caring capacity avoids a binary view of men as either good or bad.	exploitation (MASE) process. The response to the escalating risks for Child H may not have been as proactive as it needed to be as practitioners focused on adherence to completion of the MASE process rather than linking it with wider child in need planning. **Case Study: Baby R - Pre-Birth Assessment** Baby R died in hospital after suffering non-accidental injury a few weeks after her birth. Mother had been under the care of mental health services since early adolescence. Father was being supervised by the community rehabilitation company. A decision to initiate the process was deferred as practitioners felt that the parents were cooperating with support plans. Earlier initiation could have brought together key information, holistic assessment of risks, and ensured an effective multi-agency plan to safeguard the unborn baby. **Case Study: Child G - Role of male carer** Child G was brought to hospital after ingesting tablets prescribed for an adult. Mother had recently formed a relationship with a new male partner who was spending time in the household. He had a previous history of substance misuse and suicide ideation. Contact with his children from an earlier relationship was limited by court order. Although a number of professionals working with the family were aware of the relationship, there was no coherent understanding of his role and any assessment of the risks that he might present in his involvement with the family.

Theme 5 – Sharing information in a timely and appropriate way

Information sharing is a basic tenet in Working Together 2018. Constraints in systems and processes for accessing and sharing information between agencies are noted in national and local reviews. Lack of appropriate and timely sharing of information (particularly about siblings, domestic violence, substance misuse and mental health concerns) means that the nature of risk to the child is not recognised or acted upon. As a result, agencies act in isolation on the basis of known but incomplete information.

Key learning from case reviews

Thresholds for when to share information are not consistently understood and applied. Basic training for all practitioners needs to address a concern that GDPR and data protection regulations limit when information may be shared. This issue will be addressed in the forthcoming update to Working Together 2018.

- Lack of access by practitioners to IT systems outside their professional role limits sharing of information and can lead to a lack of accurate cross-service chronology. This is evidenced particularly in relation to health records held by GPs, health visiting, midwifery, CAMHS and adult mental health services.
- The development of information sharing capability between IT systems in partner agencies has the potential to offer a system-wide solution through the use of 'flags' and 'triggers' that prompt information sharing.
- Poor quality recording, inaccurate and out-of-date information result in partial understanding of the needs of the child. Considerations of risk are based on circumstances that may no longer apply.
- Timely circulation of minutes from multi- agency meetings provides reference points for chronology, decision-making, plans and evidence of

Case Study: Child L

After the father's conviction for sexual offences against his own child (Child L), a review of the circumstances revealed that there had been concerns about the father's harmful sexual behaviour when he was an adolescent. Practitioners supporting the parents pre-birth and afterwards were not aware of father's previous history. A key learning point for practitioners was that the children's right to protection overrode father's rights in relation to confidentiality.

Case Study: Baby Z

Baby Z's mother had a history of mental health concerns in adolescence and received support from the Peri-Natal Mental Health Team. A few weeks after Baby Z was born his mother began to experience mood swings and bouts of depression. One of these episodes led to an attempted overdose and emergency admission to hospital. Inaccuracies in the information at booking meant that mother's previous records were not accessed and her previous history of mental health concerns was not known. Mother minimised the seriousness of what happened and was subsequently discharged with no formal mental health assessment. A short time afterwards Baby Z was presented at hospital with injuries indicating that he had been shaken. This case showed the importance of accurate information, which was needed to trigger alerts to the GP and health visitor.

progress to address safeguarding concerns. • Information in reports about the observed circumstances of children needs to be jargon-free and avoid using generic phrases such as 'children doing well'. Inaccurate use of language does not support critical thinking and can give false assurances when viewed by other practitioners.	
Theme 6 – Organisational leadership and culture for good outcomes Effective organisational leadership within individual agencies, and across multi-agency partnerships, provides for the enabling systems processes and workforce development to support a practice culture that contributes to good outcomes. Senior leaders take a personal interest in learning and improvement activities and their impact. Funding constraints, high levels of vacancies and turnover, and high caseloads can make it more difficult for practitioners to sustain the direct work on cases to make an impact.	
Key learning from case reviews • Case reviews are an opportunity to identify and act upon improvements required in relation to key systemic enablers such as: improving practitioner and service capacity; the consistent use of shared, evidence-informed practice methodologies; and developing holistic approaches to assessment. • Changes intended to improve practice and working cultures need to be supported by robust arrangements for implementation, particularly in support for workforce development and the associated systems and processes. • Drift and delay in completing assessments and decision making are common features in case reviews. Wider system learning should also consider the impact of IT systems for recording and retrieving relevant information, and the extent to which administrative arrangements allow	**Case Study: Embedding change** Following a recommendation from a previous case review, a safeguarding partnership looked to put in place more systematic early help arrangements. The transformational intent was to give practitioners more time for direct early intervention work and reduce the costs of expensive statutory interventions. Participation in a multi-agency development programme for the role of lead professional was good. The evaluation and follow-up of the impact of training was limited. A case review found that eighteen months on from the original initiative the lead professional role was not consistently understood and embedded in practice – a finding later confirmed from multi-agency audits commissioned by the partnership following the case review. The lack of an appropriate IT system for accessing information and case recording, and limited business support, were found to be key barriers to the take-up and effectiveness of the lead professional role.

more time for direct work with children and families. • Case reviews highlight the importance of management oversight to promote and assure practice standards. Reflective supervision has a pivotal role to support professionals in applying critical thinking, particularly in situations of high caseloads when practitioners can experience distress and loss of analytical capacity. • Perceptions by practitioners about assumed service pressures (for example, high case numbers and limited staff capacity) can lead to a practice culture of working norms that are outside procedures, with reluctance to escalate concerns.	**Case Study: Child J** At the time of his suicide Child J was receiving targeted mental health support organised through his secondary school, linked to a Children in Need (CiN) plan to address his increasingly erratic and challenging behaviour at home and in school. High staff turnover and vacancies limited management oversight. Access to high quality reflective supervision could have helped practitioners to keep an even keel, cope better with the pressures of completing tasks, and apply critical thinking.

The report provides a strong message that one of the principle aims of the panel is to work with local strategic leaders to develop and embed a learning culture where:

- Agencies at every level are honest when things go wrong
- Partners are properly held to account without scapegoating
- There is time and determination to reflect and learn
- That learning translates quickly into policy and practice

Areas of analysis within the report

Ethnicity	**Cultural competence**	**Gender identity and transgender young people: Co-ordination of support and access to services**
In a number of rapid reviews, the ethnicity of the family does not feature in the characteristics described, even when the information has been included in the original serious incident notification to the panel. There is a concern that issues relating to ethnicity and	Culturally competent practice places children's well-being and protection within their cultural context. Absence of cultural competence can lead to inaccurate assessments and decision making. Evidence from practice reviews suggests that the impact of culture on parenting is not always overtly considered or evidenced.	Although this is not a new consideration, working with transgender young people and consideration of how young people wish to identify may be new for some practitioners. Thematic analysis of notifications relating to children who had committed suicide noted that gender identity issues had emerged as a

cultural competence are not being addressed if they are not recorded.	Practitioners need to be supported through training and supervision to feel confident in addressing issues of culture in the families that they work with, and to be clearer about the potential impact of cultural assumptions and norms in relation to safeguarding risks. Learning from reviews highlights the importance that practitioners recognise their own cultural identity and its impact on others. Practitioners need support and training to identify and respond to racism when they encounter it.	significant factor in seven of the incidents in the sample.
Safeguarding adolescents at risk of criminal exploitation	**Impact of domestic abuse**	**Preventing self-harm and suicide**
Known risk factors around adolescent vulnerability do not always act as predictors of risk of criminal exploitation. Moving children away from the local area is not an effective long-term solution to protect them from the reach of criminal gangs. Exclusion from school can escalate the risk of manipulation by criminal networks Relationship-based practice and making use of the 'reachable moment', such as arrest, school exclusion and physical injury, are critical for this group of children. The combination of domestic violence and substance misuse appears particularly	Domestic Abuse, Stalking and Harassment (DASH) assessments and other risk tools tended to focus more on risks to adults rather than children. Insufficient co-ordination between Multi- Agency Risk Assessment Conference (MARAC) processes and children in need planning. A high degree of variation in the types of programmes commissioned by local authorities and safeguarding partnerships to address domestic abuse. Responses to incidents of domestic abuse were most effective where there was: ▪ A robust analysis of risks to the victim and support for them ▪ Swift action to ensure safety of the children and provide on-going support in recognition of emotional abuse ▪ Purposeful work with the perpetrator, followed up to monitor the extent of sustained	In 2020 the Panel commissioned a thematic analysis of Serious Incident Notifications where the child had committed suicide. A sample of 98 notifications was examined. The themes in the lives of the children reflected the common themes identified in the University of Manchester's 2017 report, 'Suicide by Children and Young People': ▪ Abuse or neglect from others ▪ Bereavement ▪ Relationship issues ▪ Substance misuse ▪ Children missing from home ▪ Bullying in an educational setting A fifth of all the cases involved children who were, or had previously been, involved with Children's Services, including looked after children and care leavers. Practitioners can contribute to suicide prevention through:

strong, accounting for 24% of all incidents. Parental mental ill-health or substance misuse in the absence of any reported domestic violence was less common. Important that these factors are not treated in a deterministic way in assessing risk in families. They need to be considered in the specific circumstances of a household including parental age, quality of housing, employment status and identity factors, such as ethnicity.	engagement and positive outcomes Domestic Violence Prevention Orders or Notices (DVPO/DVPN) had limited impact where they were not accompanied by a robust support plan. Domestic abuse is a key feature in the case sample for the Panel's national thematic review of Non-Accidental Injury (NAI) in children under one, which is still underway. There is currently no national system to track males who have previously had domestic abuse/ violence convictions and later move in with other partners.	▪ Greater awareness of the range of factors that may add to risk, and of the 'final straw' stresses that can lead to suicide ▪ Agencies required to work together and jointly unravel the complex interplay of the risk factors ▪ Recognise that clear evidence of harm and stress may not always be visible Practice that takes account of contextual risk issues (for example, peer-to-peer sexual abuse or debt slavery) is required across all safeguarding agencies.
Recognising and responding to neglect	**Looked-After Children (LAC)**	**Adult mental health**
The recognition of cumulative neglect and its impact continues to be a key challenge for practitioners, with incidents of neglect too often treated in isolation The use of evidence-based risk tools and assessments of parenting capacity can support professionals in their assessment of neglect, ensuring a common framework and shared understanding between practitioners Often, practitioners are working with families where neglect features in combination with other risk factors such as parental substance misuse and domestic abuse	From a sample of 89 cases where LAC had died or suffered serious harm, the analysis focused on 48 incidents where children became looked after as a result of abuse or neglect. Children were coming into care in adolescence having experienced long-term parental abuse and neglect, with significant trauma Where adolescent children came into care owing to previous involvement in gang-related activities or criminal exploitation, these continued once in the care system. Historic trauma experienced by these children led to high incidence of risk-taking behaviour as perpetrators or victims, and self-harming behaviour	Fieldwork for the national review of NAI found many fathers had a variety of mental health issues whether ADHD, anger management, anxiety or depression Therapeutic work is rarely offered or accepted, either when young through CAMHS, or by adult mental health provision when the focus is not on their role as parents but as adults The issue of emotional dysregulation needs better understanding across the system Learning from local reviews suggests that maternal mental health concerns were sometimes not recognised and factored into the overall assessment of risk. This was particularly so in cases of neglect where the impact of poor mental health was reflected in mood swings, lack of recognition of

Important not to focus on a single issue (e.g. lack of suitable housing) Professionals can become desensitised to the impact of adverse socio-economic circumstances. In working with families where neglect is a presenting concern Specific understanding and analysis needed of adverse socio-economic circumstances on parenting capacity and the daily life of the child These issues warrant greater consideration as part of the learning in rapid reviews and LCSPRs	High levels of placement breakdown occurred as a result, with children placed in emergency unregulated placements. Mental health and other support were disrupted Findings highlighted the importance of commissioning and sufficiency of high quality residential and foster placements for LAC displaying high risk and challenging behaviours	children's needs and difficulty in keeping routines Training need for non-mental health practitioners to understand the mental health risks in parenting capacity, and pathways to access mental health support Tired parents on medication for mental ill health sometimes exacerbated the risk of falling asleep with an infant in unsafe circumstances
Serious Incident Notifications and rapid reviews	**National review of SUDI in families where the children are considered at risk of harm**	**A sense of new working arrangements**
The COVID-19 outbreak continues to present a situational risk for vulnerable children and families, with the potential to exacerbate pre-existing safeguarding risks and bring about new ones. Notifications to the Panel in the period April to September 2020 were 27% higher than the same period in 2019 (the increase in notifications was less significant when compared to the 2018 data).	Families living within a context of recognised background risks (such as, deprivation and overcrowding, domestic violence or poor mental health) are at heightened risk of losing a baby to SUDI. All those working with families need to recognise this and work together, this is not just an issue for midwives and health visitors. Flexible and tailored approach to prevention needed that is responsive to the reality of people's lives.	Evidencing the added value of the new governance arrangements, and the impact of the partnership's work programme overall, are key areas for development in safeguarding partnerships. The evaluation of the impact of learning (including training) is a key area for development across safeguarding partnerships. This will be a focus for the Panel in 2021. The Panel asked What Works Children's Social Care (WWCSC) to evaluate the extent to which the published reports from safeguarding partnerships (see section 2.3).

The concentration of serious safeguarding incidents was greatest (39% of all notified incidents) for children living in the 20% most deprived areas of England. Just 5% of all notified incidents were for children living in the 20% least deprived areas.	The best local arrangements for promoting safer sleeping involve a range of professionals as part of a relationship-based programme of support, embedded in wider initiatives to promote infant safety, health and well-being. The review has identified a number of issues that have helped inform the development of a 'prevent and protect' practice model If embedded in practice, this model has the potential to improve the way safeguarding partners work with families to reduce the risks of SUDI, and beyond that, to address a much wider range of risks to their children's health, safety and development.	Overall, our analysis suggests the need for yearly reports to have a sharper focus on impact, evidence, assurance and learning.

Priorities and 2021 work programme

The Panel has agreed a number of priorities which will inform and shape its work programme over the next one to two years:

- Explore how best to make sure that the voice and perspectives of children and families are at the heart of safeguarding reviews and system learning
- Enhance appreciation of the impact of culture, race and ethnicity on safeguarding practice
- Extend ways in which the Panel engages with local and national leaders and policy makers, maximising influence through timely and effective communications
- Assess impact of the panel for better understanding of the difference it makes and how it can enhance contribution.
- Develop, with others, the approach to learning and change, so that learning is effectively embedded