Child Safeguarding
Practice Review Panel

Child Safeguarding Practice Review Panel: Guidance for Safeguarding Partners

June 2025

Contents

1. Introduction

1.1 This publication provides non-statutory guidance from the Child Safeguarding Practice Review Panel ('the Panel'). It should be read alongside the relevant statutory guidance set out in Working together to safeguard children 2023 (Working Together 2023).[1]

1.2 Every effort has been taken to ensure that this guidance is up to date and reflects current policy at the time of publication. The Panel recognises that the safeguarding system in England is the focus of significant changes. The guidance will therefore be subject to periodic review.

Who this publication is for

1.3 This guidance is for local safeguarding partners. It applies to all local authorities, integrated care boards (ICB), police and other organisations who have responsibility for safeguarding and promoting the welfare of children, with particular reference to education and childcare settings. It is relevant to all strategic and senior leaders as well as frontline practitioners involved in child safeguarding, and the relevant inspectorates. The guidance is pertinent to those involved in local child safeguarding practice reviews (LCSPR) including reviewers, review panel members, and those responsible for decision-making around reviews.

About this guidance

1.4. This guidance from the Panel:

- Sets out expectations of how the statutory guidance in chapter 5 of Working Together 2023 should be interpreted and implemented by safeguarding partners.
- Provides details on the processes of notification, rapid review and local child safeguarding practice reviews, the principles underpinning decision making, and what makes for good reviews.
- Outlines how the Panel works, including our approach to national reviews.

1.5 We use the term 'children' to refer to both children and young people throughout the guidance, reflecting the reality that those under 18 are legally recognised as children (Children Act 1989, section 105), which should always be kept in mind.

[1] Links to relevant supplementary guidance that practitioners should consider can be found in Appendix B of Working Together to Safeguarding Children 2023

We do understand and acknowledge that some young people (aged 16 and 17) might prefer not to be referred to as 'children.'

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

1.7 We use the term 'racism' to encompass all forms of racism, including structural, institutional and systemic racism, which may be discussed or observed within rapid reviews and LCSPR. We fully recognise the wide range of views that exist when referring to race, ethnicity and culture, and have published a thematic review addressing this.[2]

1.8 All practice examples used in this guidance document utilise pseudonyms and have been created for illustrative purposes.

Our approach

1.9 Through its work, the Panel plays a key role in children's safeguarding in England. This role is reflected by:

- System oversight: maintaining oversight of the system of national and local reviews and how effectively it is operating.
- 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.
- System leadership: identifying improvements to practice and protecting children from harm.

1.10 Safeguarding in England is a complex multi-agency system. The Panel has an important role in overseeing the review of serious child safeguarding incidents which, in its opinion, raise issues that are complex or of national importance.

1.11 Safeguarding partners are responsible for ensuring that there are effective multi-agency arrangements in their local area to meet children's needs. This accountability is equally shared by the three main safeguarding partners i.e. the local authority, the integrated care board (ICB) and the police.[3] They are also responsible for identifying and ensuring that improvements are implemented

[2] Child Safeguarding Practice Review Panel, "It's Silent": Race, racism and safeguarding children (2025)

[3] Children Act 2004, Section 16E

towards safeguarding and promoting the welfare of children. Proposals to strengthen existing legislation regarding the strategic and practice contributions of education and childcare settings exist are being progressed. These agencies play a key role in safeguarding children, therefore safeguarding partnerships should ensure they are included within local arrangements.

1.12 The Panel and safeguarding partners have a shared goal of identifying improvements in practice to protect children from harm and to promote their welfare. We aim to maintain an open and ongoing dialogue with safeguarding partnerships. This will help us to raise concerns, highlight commonly recurring areas needing further exploration, (whether or not this leads to a local or national review), and share learning, including from best practice, which could lead to improvements elsewhere. It is critical that systemic issues are identified, including if policy and practice changes are needed to ensure that the safeguarding system is dynamic and effective.

Introducing the Panel

1.13 The Panel was established under the Children and Social Work Act 2017 and operates under the relevant legislation and statutory guidance. The Panel has the power to commission reviews of serious child safeguarding incidents and to work with local safeguarding partners to improve learning and professional practice. Although funded by the Department for Education (DfE) and accountable to the Secretary of State for Education, it acts independently from Government.

1.14 The multi-agency make-up of the Panel reflects the focus on joint responsibility across safeguarding partners enshrined in law. Panel members are appointed by the Secretary of State for Education. The Chief Social Worker for children and families is a standing member of the Panel (ex officio). All other members are appointed through the Centre for Public Appointments procedure.

1.15 Panel members come from diverse professional backgrounds and have long-standing operational and strategic experience within the multi-agency network with responsibilities for safeguarding children, including local authority children's services, police, health and education.

1.16 Underpinning the work of the Panel is its vision that all children are protected from abuse, neglect, and harm through excellent safeguarding practice.

Learning from serious incidents

1.17 In addition to learning from serious incidents, agencies will also learn from other sources of evidence, including best practice. This learning may arise from local safeguarding partnership activity or be part of single agency responsibilities. This

will help to build a balanced picture about the quality of practice. This guidance is focused on statutory requirements for serious incidents.

1.18 A culture of system learning underpins the environment in which we work. That is, when a child suffers serious harm, safeguarding partners have a shared responsibility to reflect on what can be learned from that incident to help the system to prevent similar situations from happening again.

1.19 Working Together 2023 sets out the role of safeguarding partners to establish this multi-agency system of learning and reflection locally.[4] If a child suffers serious harm or death as a result of abuse or neglect, inside or outside the home, including online, safeguarding partners need to explore what happened and why. Reviews are designed to prevent or reduce the risk of recurrence of similar incidents.

1.20 Safeguarding partners have a shared responsibility for ensuring that rapid reviews and LCSPRs lead to effective learning which drives practice change. The impact of actions identified from local and national reviews and independent scrutiny, should be captured in their yearly reports.

1.21 Strategic leaders are responsible for creating a learning environment and culture that supports safeguarding partners to develop a shared insight into what system improvements are needed after incidents of serious harm and to create the momentum for implementation.

1.22 Whilst it is important to consider why the incident occurred for the child in focus, system improvement should focus on what the learning from the incident tells us about the way in which all agencies work together to protect children. Systems methodology builds upon the reflections of individual agency roles and responsibilities in relation to the incident and considers how effectively the systems and processes in place, enable robust multi agency working to protect children.

1.23 The key to successful learning is engaging people in decisions and activities that affect them. By reflecting on practice, all those involved will be able to identify why things happen, to stimulate practice, systems and cultural changes which they can implement to reduce the risk of recurrence.

1.24 The systems approach should consider the types of learning that might be needed at various levels of the system and in different agencies within the partnership.

[4] Department for Education, Working Together to Safeguard Children 2023, page 23

1.25 Identified improvement actions should align with any existing action plans that have been developed from previous learning activity. Where similar incidents have occurred locally, the partnership will need to review existing action plans to understand how effective these were in preventing the current incident from happening.

1.26 The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018 specify the agencies who need to engage in reviews where appropriate and have a role in safeguarding and promoting the welfare of local children.[5]

Strategic leadership and accountability

1.27 Strong, joined-up leadership and clear accountability are critical to effective multi-agency safeguarding, bringing together various organisations and agencies. Working Together 2023 specifies that accountability for statutory and legislative duties to safeguard and promote the welfare of children sits with lead safeguarding partners (LSPs) at Chief Executive level for local authorities and the ICB, and Chief Officers of police forces. Each LSP appoints their own delegated safeguarding partner (DSP) who is responsible for the delivery and monitoring of multi-agency priorities and procedures to safeguard children in their local area. They are also jointly responsible with the other two delegated safeguarding partners for the delivery of high-quality and timely rapid reviews and LCSPR.

1.28 The Child Safeguarding Learning Support and Capability Project draws attention to the structural and cultural differences between agencies which can create barriers to effective learning from serious incidents. Leaders have a responsibility to role-model multi-agency collaboration throughout the process which starts with identifying serious harm and ensuring that review panel members and reviewers are equipped with the knowledge and skills to utilise a systems approach to learning from serious incidents. The report can be found here.[6]

1.29 Commissioning reviews using focussed terms of reference, formally agreeing the scope with relevant questions and selecting the right reviewer with the skills and knowledge, will support managers and practitioners to engage in reviews and produce reports which capture key learning that promotes children's welfare.

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[5] The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018, Regulation 18

[6] Child Safeguarding Learning Support and Capability Project Smale, E., Cossar, J., Sorensen, P (2025)

Working Together 2023[7] sets out multi-agency expectations for strategic leaders, senior and middle managers and practitioners to:

Collaborate – have a shared vision for services which leads to shared practice approaches, constructive debate and analysis of information as well as ensuring children's voices are at the centre.

Learn – leaders, managers and practitioners use evidence from their individual fields and practice reviews to understand what is and is not working for children and families and create opportunities for managers and practitioners to engage in peer learning and share their diverse perspectives.

Resource – leaders are ambitious to improve outcomes for children and jointly prioritise and share resources so that managers and practitioners can share expertise, engage in reflection and supervision, and build strong relationships to ensure children are supported.

Include – leaders create an inclusive culture where diversity is understood and multi-agency work is celebrated; managers support staff to identify and challenge discrimination and practitioners are skilled at responding to children who experience adversity and face harm due to parental abuse and neglect.

Mutual challenge – leaders hold each other to account and are held accountable for the quality of partnerships and enable managers and practitioners to offer constructive challenge and seek to resolve differences of opinion in a restorative and respectful way.

[7] Department for Education, Working Together to Safeguard Children 2023, page 17

2. Notifications

2.1 There are three key stages in the process of learning from serious incidents:

- Serious incident notification to Panel shared with Ofsted and the DfE.
- Rapid review which should be completed within 15 working days of notification.
- Consideration of an LCSPR or national review.

Duty on local authorities to notify incidents to the Panel

2.2 The duty to notify serious incidents to the Panel sits with local authorities. When a notification is sent through the Child Safeguarding Online Notification System, a copy will automatically be sent to the Panel, DfE, and Ofsted.

2.3 Under the Children Act 2004, if a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if (a) the child dies or is seriously harmed in the local authority's area, or (b) while normally resident in the local authority's area, the child dies or is seriously harmed outside England.

2.4 Although the responsibility to notify rests with the local authority, all three safeguarding partners should agree which incidents should be notified in their local area. Where there is disagreement, safeguarding partners should follow their own local dispute resolution processes.

2.5 The Child Safeguarding Online Notification System must be used to report relevant incidents within five working days[8] of safeguarding partners becoming aware of the incident.[9] Only one notification is needed per incident, regardless of the number of children involved. The notification should provide information about the incident, the child/ren and their families, their contact with services, and about actions that have been taken to safeguard and protect any children involved. It is important that senior local authority managers have oversight of notifications made

2.6 Safeguarding partners should have effective systems in place to identify children who meet the criteria for notifications. Notifications should be submitted for all incidents that meet the criteria outlined in paragraph 2.3, followed by the submission of a rapid review within 15 working days. This process should be followed irrespective of whether or not it is believed it will yield further learning.

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[8] Department for Education, Working Together to Safeguard Children 2023, page 133

[9] See guidance on reporting the death or serious harm of a child or care leaver at www.gov.uk/guidance/report-a-serious-child-safeguarding-incident

2.7 The local authority, on behalf of the safeguarding partners, has a duty to notify the Panel about all serious incidents that meet the criteria. The number of serious incidents notified is not a reflection of local area performance. Making a notification will ensure that learning is identified and fed back into the system to prevent future harm or death.

Non-recent abuse / young people over the age of 18

2.8 Occasionally, local partnerships identify young people over the age of 18 who have experienced serious harm and neglect or abuse as a child, and information sharing suggests that there are learning opportunities for the local system. When the primary harm for an over 18-year-old is related to the abuse and neglect they experienced as a child, safeguarding partners should consider whether the adult or child safeguarding review process is the most appropriate to follow. In their considerations partners should take into account the time that has elapsed since the harm occurred, the opportunities for learning and whether the learning principally relates to adult or children's services.

2.9 The Child Safeguarding Online Notification System can be used to report this harm if partners decide to use the child safeguarding process, followed by a rapid review report.

2.10 When safeguarding adult reviews and domestic homicide reviews are completed, safeguarding partners should work in collaboration with children's services to ensure that the relevant learning and practice issues are captured and shared with partner agencies.

2.11 Sometimes safeguarding partners become aware of non-recent issues which would have met the criteria for notifying at the time, but practice has subsequently changed significantly. As the purpose of completing reviews is to generate learning for partnerships, it is up to local partners to decide if the learning is sufficiently relevant to justify the investment of resource that these rapid reviews and learning reviews would entail. Where serious incidents are notified to the Panel, the approximate date that the incident occurred should be included to evidence that the harm occurred during childhood.

2.12 The Panel only require one notification per incident, regardless of new information coming to light which alters the original decision for safeguarding partners. In this event partners should update the secretariat at Mailbox.NationalReviewPanel@education.gov.uk

Death of looked-after children

2.13 Local authorities must notify the Secretary of State for Education and Ofsted of the death of a looked-after child, whether or not abuse or neglect is suspected or known. This must be done within 5 working days of becoming aware of the incident by using the Child Safeguarding Online Notification System.[10]

2.14 All deaths of looked after children must be notified, including deaths by suicide, accidents and medical causes. However, unless abuse or neglect was known or suspected to have contributed directly to the death, these cases do not need a rapid review. It is recognised that the majority of looked after children will have experienced neglect or abuse, often as a precursor to the child being looked after. However, such abuse or neglect, unless it is felt to be directly linked to the child's death, should be considered as background information and not as a requirement to do a rapid review or LCSPR. Where a looked after child has experienced recent abuse or neglect, or criminal or sexual exploitation, that is linked to the death or serious harm, then a rapid review should be undertaken.

Care-leavers

2.15 The local authority should notify the Secretary of State for Education and Ofsted of the death of a care leaver up to and including the age of 24.[11] This should be notified via the Child Safeguarding Online Notification System. The death of a care leaver does not automatically require a rapid review or LCSPR. However, safeguarding partners must consider whether the criteria for a serious incident have been met. If the criteria for a rapid review or LCSPR is not met but local partners think that learning can be gained from the death of a looked after child or care leaver, they may wish to undertake their own internal multi-agency learning review.

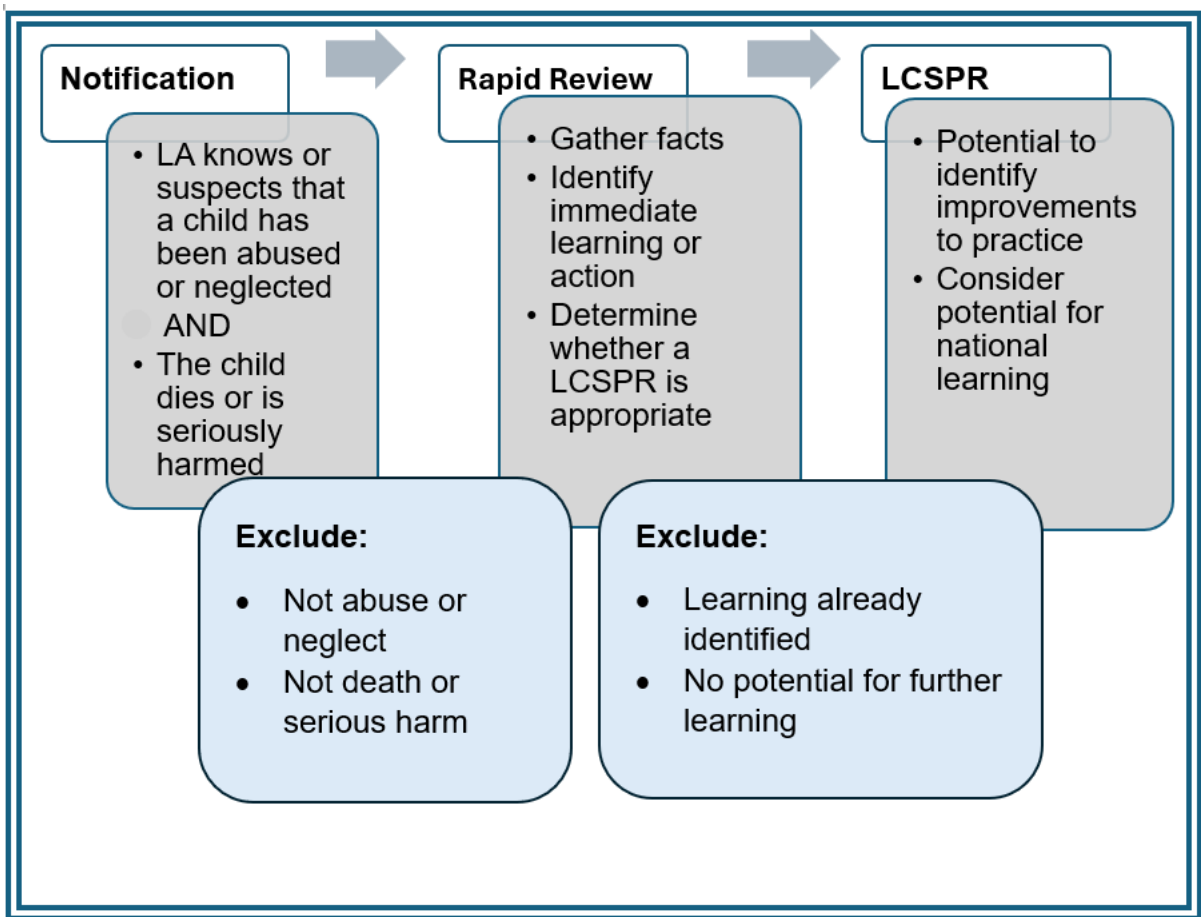
Decision-making around reviews

2.16 Figure 1 sets out the decision making for reviews which clarifies the criteria.

[10] Department for Education, Working Together to Safeguard Children 2023, page 133

[11] Department for Education, Working Together to Safeguard Children 2023, page 133, paragraph 332

Figure 1: Decision making around reviews



Reporting serious incidents

2.17 The judgement about whether the level of harm to a child is serious is often quite straight forward. This may be because the child has a life-changing physical injury, or an injury that is clearly life-threatening - for example, requiring resuscitation or intensive care treatment. It might also be because what has happened to a child is quite exceptional and the harm suffered will have severe long-term consequences for their health and well-being.

2.18 However, the judgement about some incidents may be less straightforward. It is important that safeguarding partners use their professional judgement to determine whether the harm to a child should be deemed serious.

2.19 Working Together 2023 describes serious harm as including (but not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development as a result of neglect or abuse.[12] It also states that when making decisions, judgement should be exercised where

[12] Department for Education, Working Together to Safeguard Children 2023, page 132, paragraph 329; The Children Act 2004, Section 16B(9)

impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may have still occurred.

2.20 The threshold for notification to the Panel is distinct from the threshold for children suffering "significant harm", as defined within the Children Act 1989[13], that may lead to, for example, time on a child protection plan or children becoming subject to public care proceedings. Whilst it is likely that many children who have suffered "significant harm" will live with the long term physical and emotional consequences of that, "serious harm" is a higher-level threshold for the exceptional incidents. Whilst this relates to the seriousness of the injury or harm, the context in which the injury or harm occurs will also be a relevant consideration.

2.21 What was known about the child and their family, or indeed the perpetrator(s), prior to the incident will also be an important consideration. For example, if a child or their siblings, were known either at the time of the incident or previously to be likely to suffer "significant-harm" or had been subject to public care proceedings, or the perpetrator had convictions for serious violence or sexual offences against children, then the incident, may be considered to be sufficiently serious to warrant a serious incident notification. It is not possible to provide a definitive list of situations or incidents that constitute a serious incident; multi-agency professional judgement should be used to decide if the circumstances meet the criteria.

Is it abuse or neglect?

2.22 Notifications must always be made if abuse or neglect is known or suspected to be a cause of, or a contributory factor to, the death or serious harm of a child.[14] The question of whether or not abuse or neglect was known or suspected has caused some difficulties for safeguarding partners. In essence we interpret this as meaning that there was sufficient reason to suspect that abuse or neglect was present and, at least in some way, caused or contributed to the death or serious harm.

2.23 If the event is in itself abusive, for example the child was murdered by a parent, carer, or other child, the criteria would have been met, regardless of whether or not there was pre-existing evidence of abuse or neglect.

2.24 Safeguarding partners do not have to wait until abuse or neglect is proven to make a notification. It is for local areas to determine which children's experiences should be submitted to the Panel based on local and contextual understanding. In determining this, safeguarding partners should consider the ability of the parents

[13] Children Act 1989

[14] Children Act 2004, Section 16C

or carers to provide a safe and nurturing environment for the child, the role of different agencies in supporting the child and family, whether the victim was known to children's services as well as the possible impact of multi-agency actions or omissions.

2.25 The Panel recognises that not all children who experience serious harm, and abuse or neglect is suspected, will be open to services. There will be circumstances when children experience serious harm or death, and they are not currently receiving services. These children should still be notified and a rapid review undertaken to identify learning for local areas.

3. The review process

Rapid reviews

3.1 The requirement for safeguarding partners to undertake a rapid review is set out in full in Working Together 2023, paragraph 343.[15]

3.2 When safeguarding partners notify the Panel about a serious incident they must undertake a rapid review of the child's experience within 15 working days, calculated from the date that the notification was sent to the Panel. One of the key purposes of a rapid review is to identify if there is any immediate action required to ensure children's safety, therefore meetings need to be held promptly. Safeguarding partners should also use this process to identify areas for learning and improvement in how agencies are working together, including whether the serious harm or death seen in this incident may be indicative of wider system problems at a local level.

3.3 Safeguarding partners should inform the Panel if rapid reviews will be delayed beyond 15 working days from the date of notification, including the reason for the delay and when the report will be submitted to Mailbox.NationalReviewPanel@education.gov.uk

3.4 Safeguarding partners may send the Panel a rapid review which has significant information pending, for example, toxicology results, criminal charges, or a long-term prognosis. In most circumstances, a rapid review can still be completed, not least because it is the multi-agency working which is the key focus.

3.5 Rapid reviews provide an opportunity for safeguarding partners to identify immediate learning and make changes to practice to improve outcomes for children. Well-conducted rapid reviews can form the basis of an LCSPR. They can identify the learning for partnerships and for some children, avoid the need for further review processes when learning is already comprehensively identified.

[15] Department for Education, Working Together to Safeguard Children 2023, page 136

Purpose of rapid reviews:

- To gather the facts about the child's experience as far as they can be readily established, including details of agency involvement and an analysis of key practice episodes.
- To discuss whether any immediate action is needed to ensure children's safety and share any learning appropriately.
- To consider the potential for identifying improvements to safeguard and promote the welfare of children.
- To understand the context of children's and families' lives including how racism and other inequalities related to other protected characteristics "including disability" may have influenced children's and families' experiences and the quality of practice.
- To decide what steps safeguarding partners should take next, including whether to undertake an LCSPR.

3.6 Where a child's experience involves services delivered across more than one safeguarding partnership, partners should liaise and agree which safeguarding partnership will lead the rapid review. Normally this would be the safeguarding partnership in the area where the child usually resides. When scoping the period to be covered within the rapid review or an LCSPR, safeguarding partners should take into account the relevance of previous history and the individual circumstances being reviewed. The determination of the time period to be considered is a matter for safeguarding partners, based on the circumstances of the case. Our experience shows that most safeguarding partners look back over a maximum 24-month period unless the review concerns young children, or the incident occurred at an earlier date.

3.7 Safeguarding partners do not have to progress to an LCSPR for all serious incidents. Many serious incidents will capture learning that is already known in the system through other local or national published reviews. We encourage safeguarding partnerships to reflect on the learning from national reviews and consider how this is being acted on locally. Where an incident reflects issues already explored, safeguarding partners should carefully consider what additional local learning is likely to be achieved through an LCSPR. Well-constructed rapid reviews can draw out significant learning that negates the need to proceed to an LCSPR.

Factors that rapid reviews should consider

The following information should always be included in rapid reviews:

- Date of birth, sex, ethnicity of family members, whether the child has any known disability.
- Immediate safeguarding arrangements for any of the children involved.
- The child's voice including a summary of their identity and characteristics and how these impacted upon their experiences.
- How children's vulnerabilities and risk of harm were recognised and responded to.
- Family structure and relevant history and background information, including details of all the children in the family, genogram, information about parents and any significant adults, including ages and any known physical or mental health problems or disabilities.
- Information about the alleged perpetrator of the harm, including involvement with relevant agencies
- A concise summary of the facts about the serious harm and relevant context.
- The agencies involved in the rapid review, explaining any gaps in agency involvement. Education services should be represented when children are of statutory school age. Childcare settings should be represented if children are attending this provision.

Rapid reviews should include an analysis of practice, including:

- Details and analysis of what happened, the involvement of different agencies, what actions were taken or omitted and why. This should include analysis of significant practice episodes, which should be summarised, avoiding long chronologies.
- The quality of assessment of needs and risk, and information sharing and communication within and between agencies.
- Analysis of the quality of individual and multi-agency decision making, highlighting what worked well and where improvements are indicated.
- How well practitioners understood and responded to children's lived experiences, how well the voices and experiences of children were sought.
- The quality of professional engagement with the family, including parents and carers.

- How well sex, race, ethnicity, faith, sexual orientation, disability, social and economic background and other protected characteristics were explored in practice and what impact they had on children's and families' experiences.
- The quality of support offered to children and their families, including support to address their cultural needs.
- Children's and families' experiences of services.
- How any disability, physical or mental health issues, or environmental factors such as poverty or caring roles impacted on children's and families' experiences.

The report should identify learning and recommendations, including:

- Information about the learning that has already been captured, and good practice and how this is being shared across the system.
- If any published national or local reviews or relevant research can be referenced and used to support local learning.
- If there are issues of national significance for the Panel to consider, including the rationale for any recommendations.
- Recommendations for creating the right conditions for good practice to flourish which are the responsibility of strategic leaders alongside manager and practitioners.
- An action plan with clear agency and partnership actions to take forward including timescales.
- A clear decision and rationale as to whether the criteria for an LCSPR have been met and on what grounds, and if not, why not.
- Key lines of enquiry for any LCSPR.

Involvement of families in rapid reviews

3.8 Whilst there is no expectation of involving families in the rapid review, safeguarding partners should consider informing relevant family members that a review is taking place.

3.9 On concluding the rapid review, consideration should be given to how any learning and recommendations arising from the rapid review should be shared with the family. This contrasts with the LCSPR process where the expectation from the outset is that families and, where appropriate, children, can be involved in and contribute to the review.

Involvement of practitioners in rapid reviews

3.10 In the Panel's experience, better quality rapid reviews are produced where practitioners are supported to effectively engage in the review process and are helped to reflect upon the events that led to the serious harm or death of a child. It is important to view learning as a continuous cycle which leads to practice and cultural change and adaptation. Good engagement of practitioners in reviews is an important way to understand why things have happened and help focus attention on the systems change required to ensure practice is improved.

3.11 Strategic leaders have an important role in creating an environment which enables open reflection to stimulate practice and organisational change, addressing the issues that emerge through this process.

Submitting the rapid review

3.12 As soon as the rapid review is complete, safeguarding partners should send a copy of their findings to the Panel. This should include:

- Rapid reviews should be signed off by the three statutory delegated safeguarding leads, who should provide their observations of the review, together with their decision and rationale for any decision.
- The submission should include a concise action plan that shows how immediate learning will be taken forward, by whom, within what timescales and how its impact will be evaluated. Consideration will need to be given to any pre-existing, relevant action plans. These may need to be reviewed to reflect new learning.

3.13 Any further review of children's experiences should normally be carried out as an LCSPR.

3.14 In addition to submitting the completed rapid review to the Panel, safeguarding partners should inform the Panel, Ofsted and the Department for Education of their decision, if they have agreed that the incident will proceed to an LCSPR.[16]

3.15 The Panel provide feedback to safeguarding partners on the decisions and quality of the review. Occasionally the Panel may question the decision to conduct an LCSPR if it feels that there is insufficient justification for further review. Similarly, the Panel may question a decision not to conduct an LCSPR if it feels that the rapid review has not adequately explored the learning, or if there may be further learning to be gained from an LCSPR.

[16] Department for Education, Working Together to Safeguard Children 2023, page 136, paragraph 344

3.16 Following publication of the Panel's thematic analysis "It's Silent": Race, racism and safeguarding children[17] the Panel will be clearer in response letters about their expectations of reviewers and local review panels for identifying and progressing learning that considers the specific impact of race, ethnicity and culture on practice and what has happened to children.

Local Child Safeguarding Practice Reviews (LCSPRs)

3.17 Safeguarding partners are responsible for deciding if a serious incident meets the criteria and guidance for an LCSPR.[18] There is no expectation that an LCSPR will automatically be carried out following a rapid review. Decisions on whether to undertake an LCSPR should be made collaboratively between safeguarding partner agencies. The rationale should be recorded and communicated appropriately, including to families.

3.18 Where a child's experience involves services delivered across more than one safeguarding partnership, partners should liaise and agree which safeguarding partnership will take the lead in conducting the LCSPR. Normally this would be the safeguarding partnership in the area where the child is usually resident.

3.19 Safeguarding partners must consider whether the child's experience may highlight:[19]

- Improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified.
- Recurrent themes in the safeguarding and promotion of the welfare of children which may require legislation or changes to guidance.
- Concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.

3.20 Safeguarding partners should also have regard to circumstances where:

- The Panel has considered the rapid review and has concluded a local review may be more appropriate.
- They have cause for concern about the actions of a single agency or lack of agency involvement.

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[17] Child Safeguarding Practice Review Panel, 'It's Silent": Race, racism and safeguarding children (2025)

[18] Children Act 2004

[19] The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018, regulation 11 (a), (b) and (c)

- More than one local authority, police area or ICB is involved, including examples where a family has moved around and there is evidence that this increases the family's vulnerability.

- The experience may raise issues related to safeguarding or promoting the welfare of children in institutional settings, including secure children's homes, young offenders' institutions and secure training centres, and all settings where children may be detained under the Mental Health Act 1983 or Mental Capacity Act 2005.

Undertaking LCSPRs

3.21 Safeguarding partners are responsible for commissioning and supervising reviewers for their LCSPR. Where LCSPR appointed reviewers are internal to the safeguarding partnership, assurance should be sought that they meet the requirements listed below.

Working Together 2023[20] details the full requirements for a reviewer

They should have:

- Professional knowledge, understanding and practice relevant to local child safeguarding practice reviews, including the ability to engage with practitioners, children, and families.
- Knowledge and understanding of research relevant to children's safeguarding issues.
- The ability to recognise the complex circumstances in which practitioners work together to safeguard children.
- The ability to understand practice from the viewpoint of the individuals, organisations or agencies involved at the time rather than using hindsight.
- The ability to communicate findings effectively.
- Not have any real or perceived conflict of interest.

3.22 The methodology should be agreed with the reviewer, taking into account the principles of systems methodology. Safeguarding partners are advised to produce terms of reference, which set out the scope and key lines of enquiry for the LCSPR. The Panel's analysis of LCSPRs shows that time and attention spent at this stage of a review to clarify scope and purpose, ensures that the LCSPR is

[20] Department for Education, Working Together to Safeguard Children 2023, page 139, paragraph 355

appropriately focussed and influences the quality of the completed report. Further useful information on undertaking LSCPRs can be found in the Child Safeguarding Practice Review Panel commissioned Learning Support and Capability Project.[21]

3.23 All LCSPRs should reflect the child's experience, perspectives and the family context. Safeguarding partners should ensure reviewers have the expertise to consider the impact of equality issues on children's experiences and provide appropriate challenge to agencies to understand how sex, gender, race, ethnicity, disability, social and economic background, including poverty and other characteristics, impacted their experiences. The impact of structural inequalities, for example, racism, ableism, homophobia, should be explored as necessary on the lives and experiences of children and families, as well as professional decision making and actions. The LCSPR should be proportionate to circumstances, focus on potential learning, and explain and suggest reasons why the incidents occurred as they did.

Factors that an LCSPR should explore

The following information should always be included in an LCSPR:

- Scope and key lines of enquiry for the LCSPR keep the review focussed and ensure the right ethos and culture are in place to maximise learning opportunities.
- Key lines of enquiry should be developed from the findings of the rapid review, building upon and progressing the identified learning.
- Contextual information that outlines the background to the child and family. This should allow the reader to understand issues whilst also protecting the identity of the child and family involved.
- A genogram if appropriate and an integrated multi-agency chronology focussed on key practice episodes.
- Where many professionals from a range of agencies are involved in a review, their involvement should be carefully summarised, and the review should then identify and focus on key practice episodes. This facilitates analysis of the relevant issues and avoids the submission of overly long chronologies. Setting lines of enquiry at the outset will help focus the review on key learning areas.
- The perspectives and lived experience of a child and where possible and appropriate, their voice, which should be dominant throughout a review.

[21] Child Safeguarding Learning Support and Capability Project. Smale, E., Cossar, J., Sorensen, P (2025) Learning Support and Capability Project (2025)

LCSPRs should include an analysis of practice, including:

- The quality of professional decision making, particularly at key moments in a child's life, or at key times when they engaged with services.
- How well practitioners understood and responded to children's lived experiences.
- The extent to which sex, race, ethnicity, disability, social and economic background and other characteristics impacted their experiences and were explored in practice.
- How the context of children's and families' lives including the impact of inequalities and factors such as racism, ableism and discrimination in relation to other protected characteristics[1] may have influenced children's and families' experiences and practice decision making.
- The quality of support and protection offered to children, particularly in relation to their social, emotional, and cultural needs.
- Children's and families' experiences of services.
- How any mental health issues, or environmental factors such as poverty or caring roles impacted on the child's and family's experience.
- How children's vulnerabilities were recognised and responded to.
- Knowledge about the alleged perpetrator of harm, including involvement with relevant agencies
- The impact of local context and system issues which may have affected practice, including workforce pressures, leadership challenges, among others.
- If any published national or local reviews or relevant research can be referenced and used to support local learning.
- If there are issues of national significance for the Panel to consider, including the rationale for any recommendations for a national review.

LCSPR recommendations:

- The report must include a summary of any recommended improvements to safeguard and promote the welfare of children. Recommendations should reflect and be based on the findings of the review. They should address the issues that have been identified from the analysis of any systemic or underlying multi-agency practice that contributed to the circumstances.
- The number of recommendations will vary according to the circumstances; however, more than 8-10 recommendations are unlikely to support effective implementation of learning and improvements. They should be specific,

address the issues, be workable and partnerships should be able to measure their impact and effectiveness.

- Recommendations should clearly state what is required of agencies to improve practice, both collectively and individually.
- Recommendations need to include actions for leaders, with consideration of the environment or culture that supports front line practice.
- Recommendations should be clear on which agency or organisation is responsible for the action and how impact will be evaluated.
- Recommendations should evidence that attention has been paid to the voice of the child and that their family.
- Often single agency action plans are developed and progressed following the rapid review. Where single agency actions form a significant part of a review, it is useful to provide context and an update within the LCSPR.
- The safeguarding partnership needs to assure itself that clearly written action plans are in place, showing how the learning process will be shared, monitored, reviewed and evaluated. Action plans do not need to be shared with the Panel or published alongside the LCSPR.
- The LCSPR report should include the learning that has already been captured, including good practice and how this is being shared across the system.

Involvement of children and families in LCSPRs

3.24 LCSPRs should aim as far as possible to integrate and address the voice and experiences of the child in the review, including details of their daily life so that the child's life and experience remains at the centre of discussion. Listening to and capturing the voice and experiences of a child is crucial to understanding their lives, their perspectives and views about their lives and what has happened to them.

3.25 In the Panel's experience, the involvement of children in LCSPRs, as appropriate, provides invaluable insights that will help safeguarding partners identify good systems learning. This needs to include understanding of the harm that results from racism, ableism, homophobia, sexism and other inequalities and which can be captured more clearly when reviewers use children's own words to describe their experiences.

3.26 Not all children are able to verbalise their experiences and views so reviewers should also consider the different ways a child may try to communicate. The effective use of professionals who have developed a trusting relationship with children may provide an insight into the lived experience of the child.

3.27 Safeguarding partners should also ensure that families, and where appropriate siblings, are invited to contribute to the LCSPR. Families should be supported to understand how they are going to be involved and have their expectations appropriately and sensitively managed. They should be kept updated and be prepared for and supported during the publication of a review.

Involvement of practitioners in LCSPRs

3.28 As outlined previously, the involvement of practitioners in rapid reviews and LCSPRs allows the full range of perspectives and contributions to be considered. LCSPRs benefit from including wider relevant evidence related to the circumstances. For example, the context of the local area, data and analysis relating to agencies and services can inform the identification of practice issues in reviews. It is important that LCSPRs explore why things happened to elicit learning that can be used to improve practice.

3.29 Analysis of the broader context within which practitioners work, for example workforce pressures, leadership challenges and thematic practice issues can support systems thinking and lead to better quality recommendations that strengthen practice. LCSPRs are also strengthened by incorporating key learning from research, other LCSPRs and national reviews.

3.30 In addition to involving practitioners during the investigation stage of an LCSPR, safeguarding partners need to consider how learning will be shared during the process. Facilitating a supportive learning environment that fosters more reflective learning, allows learning to become embedded and impactful. Strategic leaders are responsible for creating a multi-agency system that can build capacity and develop peer expertise to lead and deliver LCSPRs that explore why things may go wrong for children, to help drive systems change and practice improvements. Leaders need to promote and model learning cultures that enhance learning across the local safeguarding system.

Submitting LCSPRs

3.31 It is the responsibility of the delegated safeguarding leads (DSL) within a safeguarding partnership to ensure that the LCSPR is of a satisfactory quality and that timescales are met.[22] If there are delays in completing or publishing an LCSPR, safeguarding partners should, where possible, share learning that has already been identified, across the partnership and with other relevant agencies.

[22] Children Act 2004, Section 16F(3)(b)

3.32 The report should be completed and published within six months[23] from the date of the decision to initiate an LCSPR. The name of the reviewers should be included and published reports must be publicly available for at least one year.[24]

3.33 Safeguarding partners should ensure that LCSPRs are written with publication in mind; unnecessarily sensitive detail and identifying features should therefore be removed prior to submission.

3.34 Where a decision is made that the publication of an LCSPR would be inappropriate even with the removal of identifying features, safeguarding partners should ensure that the learning from the review is published and shared.[25] In response to an increase in the number of reports that were being published by the NSPCC "on behalf of an unnamed local safeguarding partnership", the NSPCC decided and agreed with the Panel, that from 1 July 2023, they will only publish LCSPRs anonymously in very exceptional circumstances. Panel agreement that anonymous publication is appropriate and necessary should be sought by local safeguarding partners before using this facility.

3.35 A copy of the full LCSPR report should be sent to the Panel (Mailbox.NationalReviewPanel@education.gov.uk) and the Secretary of State for Education (Mailbox.CPOD@education.gov.uk), no later than seven working days before the date of publication[26]. Executive summaries must be accompanied with the full LCSPR report to enable the Panel to undertake a comprehensive review of the completed work. Safeguarding partners are encouraged to provide these earlier than the deadline. Safeguarding partners should also share the LCSPR or details about improvements with Ofsted (SCR.SIN@ofsted.gov.uk) within the same timescale.[27]

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[23] Department for Education, Working Together to Safeguard Children page 141, paragraph 365.

[24] Department for Education, Working Together to Safeguard Children, page 140-141, paragraph 362.

[25] Department for Education, Working Together to Safeguard Children, page 140, paragraph 362

[26] Children Act 2004, Section 16F(3)(C) and The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018, Regulation 16.

[27] Department for Education, Working Together to Safeguard Children 2023, page 141, paragraph 364

4. Children's experiences

Thematic LCSPRs of children's experiences

4.1 Occasionally safeguarding partners choose to undertake a thematic review where multiple incidents occur with a common theme. When safeguarding partners choose this approach, it is important that children's voices remain at the centre of the review. There should be appropriate involvement of practitioners and families, and the report should be published within 6 months.[28]

4.2 This approach can enhance the learning for agencies, providing a more comprehensive and rounded analysis of practice. The following learning may be useful to safeguarding partnerships who are planning this approach.

4.3 It is important to ensure that the voice, experience and individual characteristics of each child and family are reflected within the review. Partners may benefit from undertaking a 'mini review' of what happened to each child before summarising their story in relation to the thematic review. This ensures that the valuable learning about what uniquely happened to each individual child is not lost.

4.4 Themes should be identified and analysed using information from the children's experiences, together with relevant research, national reviews, publications and local intelligence.

4.5 Reviews should be succinct and focus on key practice episodes to avoid overly long and complex documents.

4.6 The learning and recommendations should clearly address the issues that have been identified to prevent future harm to children in similar circumstances.

Intersectionality

4.7 Intersectionality describes the interconnected relationship of social categorisations such as race, sex, gender, disability and sexual orientation, together with an individual's vulnerability and the adversities they have experienced. It is important to consider the potential to learn from the intersection of sex, gender, race, ethnicity, sexual orientation, disability, social and economic background (including poverty) and other characteristics at each stage of the process. All notifications and reviews should include this information.

4.8 Evidence from rapid reviews and LCSPRs shows that children's age, sex, gender, race, ethnicity, disability, sexual orientation, faith, social and economic background

[28] Department for Education, Working Together to Safeguard Children page 141, paragraph 365

and other characteristics, and the impact of how these intersect, are not always well considered when completing reviews. The Panel's thematic analysis "It's Silent": Race, racism and safeguarding children[29] emphasises the need for change and improvement in how the identities of children with Black, Asian and Mixed Heritage backgrounds are understood within reviews, as well as how their experiences of involvement with professionals is considered and evaluated.

4.9 Reviews should consider the extent to which protected characteristics[30] and the cultural background of a child and/or family may have impacted on professional decision-making and responses. Reviews should identify how well services provided support to children and any gaps in services which might have made a difference. This is important in supporting intersectional analysis of children's lived experiences. It is also important to understand how well services helped and protected them.

4.10 Using an intersectional lens will help to identify and name barriers children can face and therefore help strengthen the learning from reviews. This will help to identify where there may be a need for system change that takes account of structural inequalities and discrimination. It will address practitioner bias and assumptions that may result in children not receiving the help and protection they need.

Race, ethnicity and culture

4.11 Racism, bias, stereotyping, or cultural misunderstanding operate at the individual, institutional and societal level, both consciously and unconsciously. This in turn may result in some children being more likely to come to the attention of child safeguarding services, while others may be less likely to receive the services they need. Equity is an important consideration for safeguarding services, in terms of both individual professional actions and the quality of multi-agency decision making. All reviews should use an intersectionality lens to consider how children and their families were affected by their experiences and how this influenced decisions and actions.

4.12 Reviews should always explore the impact of race, ethnicity and culture in safeguarding practice to understand children's and families' experiences and understand how they influenced the support offered or decisions made.

4.13 The Panel's report "It's Silent": Race, racism and safeguarding children identified a prevailing and powerful silence in talking about race and racism in reviews.[31] The

[29] Child Safeguarding Practice Review Panel, "It's Silent": Race, racism and safeguarding children (2025)
[30] Equality Act 2010, Section 4
[31] Child Safeguarding Practice Review Panel, "It's Silent": Race, racism and safeguarding children (2025)

analysis found that the safeguarding needs of children with Black, Asian and Mixed Heritage backgrounds were too often rendered invisible in both practice and the system learning from reviews, with relatively few learning points being identified to improve practice and policy. This inevitably limits our understanding about the experiences of children and families with Black, Asian and Mixed Heritage backgrounds and is a barrier to understanding what changes are needed to improve safeguarding responses for all children.

4.14 The thematic analysis identified a series of reflective questions for safeguarding partners, reviewers and practitioners to help improve the quality of analysis and identify relevant learning in reviews.

Questions for safeguarding partners:

- When commissioning reviews involving a Black, Asian, or Mixed Heritage child, what expectations do you hold for the review panel (in the case of rapid reviews) and for lead review authors (in the case of LCSPR) and how is this communicated and benchmarked? When selecting a reviewer, do you consider their expertise in matters of race, racism and racial bias?

- To what extent do you start – at the point of producing rapid reviews and commissioning LCSPR – from the position that children and families from Black, Asian and Mixed Heritage backgrounds will have experienced racism in their lives, regardless of whether they themselves recognise it or not? Starting from this position can enable more thoughtful consideration of their experiences within the safeguarding system.

- How do you create the conditions in which the rapid review panel and the LCSPR lead review author feel confident to explore issues concerning race, ethnicity and culture robustly and to identify and challenge racism when it occurs in practice?

- How are you assured that a focus on the impact of race, ethnicity and culture, on practice is embedded within the rapid review process and within terms of references for LCSPR? Do you have a quality assurance process in place to ensure the review has appropriately challenged practice responses where racism and racial bias are present?

- How open are you, and what processes do you have in place, to respond to challenges from the review panel or independent review author about practice that reflects racist or biased approaches?

Questions for review authors:

- Do you feel confident that you have the necessary skills and experience to author reviews where race, ethnicity and/or culture is a factor? Do you have the knowledge and skills to critically examine practice responses that may be rooted in racism and racial bias?

- When reviews involve children and families from diverse racial or cultural backgrounds, how do you ensure that this is robustly explored and considered within the report or meeting?

- How confident are you in identifying evidence of racism and racial bias demonstrated by practitioners? How confident are you in raising this with review panels and safeguarding partnerships, and that you will be listened to?

5. Interdependencies

The interface with other statutory processes

5.1 Serious incidents may trigger more than one statutory review process. It remains important for safeguarding partners to organise locally how these can successfully combine while still meeting the core purpose of each. Safeguarding partners should ensure that they have processes in place for how they contribute to other investigations, including domestic homicide reviews, independent investigation reports into homicide, multi-agency public protection arrangements or safeguarding adult reviews. There should be flexibility in the arrangements for completing LCSPRs to enable partners to design a review process that incorporates the needs of other processes.

Practice example of a notifiable incident where there is overlap with other processes

Finn*, a Black British child, aged 8 was living with his younger sister, Charlie* aged 2 and his parents when his mother was tragically killed by their father.

Partnership agencies recognised the overlap with different statutory processes and came together to agree a single process that included expertise from adult services to complete a joint review that met the needs of an LCSPR and Domestic Homicide Review.

The learning was enhanced for both agencies using the expertise of reviewers who understood the needs of the processes which resulted in a holistic overview of the circumstances leading up to the incident and richer learning about how agencies had not shared information.

The process reduced the burdens on, and anxiety for, the children and families concerned as well as uncertainty and duplication of effort.

The President of the Family Division

5.2 The President of the Family Division's guidance covering the role of the judiciary in serious case reviews should also be noted in the context of LCSPRs.[32] There is no

[32] See President's Guidance Judicial Cooperation with Serious Case Reviews

obligation for judicial participation in reviews. Any requests to participate should be made to the President's office where they will be considered.

Cafcass

5.3 There have been examples of rapid reviews and LCSPRs where there has been involvement with the family court system but engagement with the Children and Family Court Advisory and Support Service (Cafcass) is not noted in the report. The absence of this engagement can result in a loss of learning for the partnership and for Cafcass. Safeguarding partners should involve Cafcass in review processes where possible and appropriate to maximise learning potential across the whole safeguarding system.

Prevent[33]

5.4 Counter Terrorism Police (CTP) work in partnership with local frontline policing and children's services through the Channel programme to safeguard children who are vulnerable to being drawn into terrorism.[34] Agencies have a duty to support those children identified at risk of radicalisation to reduce vulnerabilities. There is a duty on agencies as set out in Schedule 26 Counter-Terrorism and Security Act 2015 to have due regard to the need to prevent people from being drawn into terrorism. Children open to Prevent can receive interventions over a lengthy period and it is important that any information held by CTP is included in reviews.

5.5 Local police review teams will request information for rapid reviews or LCSPRs direct from CTP on behalf of the safeguarding partnership. Whilst there is no requirement for safeguarding partners to make a direct request if they feel information is missing, the partnership should liaise with their local police team to make any further enquiries. More information can be found in the UK Strategy for Countering Terrorism.[35]

Interface with criminal investigations and proceedings

5.6 The LCSPR process can often run concurrently with ongoing criminal proceedings, and this should not delay the commencement of an LCSPR,

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[33] For further information see Prevent duty guidance: for England and Wales at www.gov.uk/government/collections/prevent-duty-guidance

[34] For further information see Channel duty guidance: protecting people susceptible to radicalisation at www.gov.uk/government/publications/channel-and-prevent-multi-agency-panel-pmap-guidance/channel-duty-guidance-protecting-people-susceptible-to-radicalisation-accessible

[35] For further information see CONTEST The United Kingdom's Strategy for Countering Terrorism 2023 available at www.gov.uk/government/publications/counter-terrorism-strategy-contest-2023

although it may delay the conclusion of the process. When considering whether to delay the LCSPR process, safeguarding partners should consider proposed key lines of enquiry. Where the learning is restricted to systemic weaknesses in multi-agency practice, then the LCSPR process and the implementation of learning should not be delayed.

5.7 To avoid compromising evidence or broadening the scope of a review, it is useful for safeguarding partners to establish clear terms of reference. This will allow the police to identify any likely points of risk or opportunity for the criminal investigation and the safeguarding review.[36]

5.8 Where there are potential overlaps in relevant timelines under consideration in the criminal and LCSPR processes it should still be possible to conduct the LCSPR (with clear agreed key lines of enquiry) and implement learning but delay publication of the LCSPR.

5.9 The Crown Prosecution Service has issued guidance about how any risks to criminal proceedings can best be managed and mitigated: Protocol for Liaison and Information Exchange when criminal proceedings coincide with Child Safeguarding Practice Reviews in England | The Crown Prosecution Service.[37]

5.10 In criminal proceedings the availability of witnesses is a commonly stated problem, but this should not prevent LCSPR work being undertaken, with any gaps in learning being addressed later. Often safeguarding partners wait many months, if not years, to speak to families only to be told that they do not wish to engage. Therefore, the review focus should be on prompt learning embedded into system and practice improvement.

5.11 Concerns about compromising witness statements can be avoided in rapid reviews and LCSPRs by using methodologies that enable reflection, analysis and system learning that does not focus on individual practitioner action or inaction but, helps to create the conditions for improved practice relevant to the theme.

5.12 The Panel is working with the Independent Office for Police Conduct (IOPC) to develop further guidance to assist safeguarding partners who are working with the IOPC's regional investigation teams.

5.13 It is important that both parties work together so that they can make an informed decision about any impact the LCSPR process may have upon an IOPC investigation, or any proceedings. In exceptional circumstances, if the IOPC decision maker overseeing the investigation is of the view that there would be

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[36] Major Crime Investigation Manual November 2021

[37] The Crown Prosecution Service, Protocol for Liaison and Information Exchange when criminal proceedings coincide with Child Safeguarding Practice Reviews in England (2020)

irreparable prejudice to the investigation if the LCSPR were to proceed, they will notify safeguarding partners of this.

5.14 If safeguarding partners are concerned about the timeline for publishing an LCSPR, they should contact the secretariat at Mailbox.NationalReviewPanel@education.gov.uk who can facilitate dialogue with the Panel.

Publishing reports

5.15 Further information on the publication of LCSPRs, including the anonymous publication of reports on the NSPCC website, can also be found under the heading 'Submitting LCSPRs' in this guidance.

5.16 There is an expectation that LCSPRs will be published to ensure that learning is shared and promoted both within the local area and beyond. Safeguarding partners should complete and publish the LCSPR report as soon as possible and no later than six months from the decision to initiate a review,[38] unless they consider it inappropriate to do so.[39]

5.17 Circumstances such as ongoing criminal or other investigations are not, of themselves, a reason to delay completion of the review. Safeguarding partners should consider the impact of publication on any criminal proceedings and liaise with the police and CPS about this matter.

5.18 When compiling and preparing to publish the report, safeguarding partners should ensure that reports are written in such a way so that what is published avoids harming or undermining the welfare of any children or vulnerable adults involved. Safeguarding partners should consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the review.[40]

5.19 If a local review raises issues of national importance, or recommendations for national government, the Panel will consider how to disseminate and embed the learning. Reviews should be shared with Panel at least seven working days ahead of publication date.[41] Please note that where partnerships require the Panel to be sighted on a review prior to publication, submissions should be made at least 14

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[38] Department for Education, Working Together to Safeguard Children 2023, page 141, paragraph 364

[39] In line with page 144 of Working Together to Safeguard Children 2023, full reports must be sent to the Secretary of State for education at mailbox.cpod@education.gov.uk and the Panel at mailbox.nationalreviewpanel@education.gov.uk no later than seven working days before publication.

[40] Children Act 2004, Section 16F(5)

[41] The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018, Regulation 16

days ahead of publication to give the Panel sufficient opportunity to consider the implications.

Tracking rapid reviews and LCSPRs

5.20 It is the responsibility of safeguarding partners to ensure that rapid reviews and LCSPRs are completed within the timescales set out in Working Together 2023.[42] Safeguarding partners should inform the Panel if rapid reviews will be delayed beyond 15 working days from the date of notification of the incident to the Panel, including the reason for the delay and when the report will be submitted.

5.21 Safeguarding partners should monitor the quality of, and the time being taken to conduct an LCSPR at regular intervals whilst the review is underway. Safeguarding partners may request specific information or a draft of the review from the author to assist with this.[43]

5.22 The Panel should be notified of any delay to publication. Safeguarding partners should provide a reason for the delay and when they expect to provide a copy of the report. The Panel secretariat will contact safeguarding partnerships if they do not receive a rapid review or LCSPR within these timescales and will request updates at regular intervals until the reports are received.

[42] Department for Education, Working Together to Safeguard Children 2023, page 144

[43] See The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018 Regulation 14, and Children Act 2004, Section 16F(3)(b)

6. National reviews

6.1 The Panel reviews and discusses all rapid review and LCSPR reports to support its work in providing oversight of the system of local safeguarding reviews following serious incidents. This enables the Panel to identify any recurrent themes or individual children's experiences that suggest that a thematic review or a national review should be undertaken by the Panel. Panel discussions will also identify any specific issues of concern that may need to be raised with government departments or other organisations, where change may be required to existing national guidance or legislation.[44] The Panel give due consideration to the views of local safeguarding partners and other stakeholders when deciding whether a thematic or national review is required.

6.2 The factors taken into consideration for national or thematic reviews include:

- Practice themes evidenced in notifications, rapid reviews and LCSPR that are frequently seen or are identified as important national issues.
- Reviews about individual children where their experiences have been of such significance or complexity that there are implications for national learning.
- Areas of practice of such complexity and concern that it is in the public interest to undertake a review. This may include emerging areas that require focussed attention.

6.3 The criteria that the Panel must take into account when considering whether to undertake a national review is set out in Regulation 3(a) 3(b) and 3(c) of the Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018.

6.4 In making decisions, the Panel considers a range of other evidence, including inspection, published reports and research. The Panel will contact the relevant safeguarding partnership promptly following receipt of a rapid review that may require consideration for a national review. The Panel will advise safeguarding partners about the further information required to support its decision-making and discuss next steps. This may include potential scope and methodology and how the Panel will engage with the partnership and those involved in the child's care.

6.5 The Panel notifies the Secretary of State for Education when it has decided to undertake a national review. Where national reviews are focussed on the lives of individual children, the Panel will inform the families concerned.

[44] The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

6.6 The Panel are subject to the same requirements as local safeguarding partners in terms of the publishing of national reviews;[45] these should be published within six months of the decision to conduct a review.[46]

6.7 If national reviews are unavoidably delayed due to other processes, the Panel will advise the Secretary of State for Education of the reasons. The Panel will also set out for the Secretary of State the explanation for any decision not to publish either a full report or information relating to improvements.

6.8 Where national reviews make reference to specific local areas the Panel ensures that information about any improvements that are needed within that locality are shared with the relevant safeguarding partner, together with others as applicable.[47]

6.9 The national Child Safeguarding Practice Reviews must be publicly available for three years.[48] A list of published national reviews is available at www.gov.uk/government/collections/child-safeguarding-practice-review-panels-reviews-and-briefings

6.10 Full reports including an analysis of any systemic or underlying reasons why actions were or were not taken are sent to the Secretary of State no later than seven working days before the date of publication.[49] National reports must include a summary of any improvements being recommended to safeguarding partners, or others, to safeguard and promote the welfare of children.

6.11 Where the Panel decides only to publish information relating to the improvements to be made following the review,[50] they also provide a copy of that information to the Secretary of State within the same timescale.[51]

6.12 The Panel also send a copy of the report or improvements to the relevant safeguarding partners and stakeholders.[52]

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[45] Children Act 2004, Section 16B(4) and (5)

[46] Department for Education, Working Together to Safeguard Children 2023, page 143, paragraph 374

[47] Regulation 8, The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

[48] Regulation 10, The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

[49] Regulation 9(1) The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

[50] Children Act 2004, Section 16B(5)

[51] Regulation 9 (2), The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

[52] Department for Education, Working Together to Safeguard Children 2023, page 143, paragraph 373

Inclusion of LCSPRs in national reviews or thematic analyses undertaken by the Panel

6.13 There will be instances where an LCSPR has been conducted by a safeguarding partnership which could then form part of a thematic review that the Panel undertakes at a later date. There may be other instances where a local review has not been carried out but where the Panel considers that the child's experience could be helpful to a future national review. In such circumstances, the Panel will communicate with safeguarding partnerships as needed.

Actions in response to local and national reviews

6.14 Safeguarding partners should take account of the findings from local and national reviews and consider how recommendations can be implemented locally. Learning from these reviews should also be considered by safeguarding partnerships when undertaking rapid reviews and LCSPRs. This is to ensure that the focus is retained on implementing and embedding learning from all reviews.

6.15 Improvement should be sustained by safeguarding partners through regular monitoring and follow up of actions so that the findings from these reviews make a real impact on improving outcomes for children.

6.16 The Panel disseminate the learning from national reviews through its communication networks as well as making use of briefing documents, webinars, podcasts, and newsletters to share key messages.

Safeguarding partnership yearly reports

6.17 Safeguarding partners are required to publish a yearly report at least once in every twelve-month period[53] as part of their partnership arrangements and send copies to the Panel Mailbox.NationalReviewPanel@education.gov.uk. Full details are available from paragraph 106 of Working Together 2023.

6.18 Yearly reports should demonstrate the leadership of local safeguarding partnerships and show how strategic priorities are determined and how learning from practice and reviews is disseminated.

6.19 Reports should articulate the learning identified from rapid reviews and LCSPRs, including actions taken, progress made, and assurance gained that related improvements have positively impacted upon outcomes for children.

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[53] Children Act 2004, Section 16(G)7

How the Panel operates

6.20 The Panel has a responsibility to identify and oversee the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance.[54] In discharging this function, we work with local safeguarding partners to identify such cases, and we maintain oversight of the system of national and local reviews. The Panel continues to undertake national and thematic reviews to identify learning for the safeguarding system, disseminating their findings through the provision of webinars, newsletters and practice briefings.

6.21 The Panel secretariat receives all notifications of serious incidents from local authorities and the subsequent rapid reviews from safeguarding partners. The Panel aims to make decisions promptly but sometimes needs to discuss matters directly with local safeguarding partners. The Panel usually meets every two weeks to consider all rapid reviews and LCSPRs and provides feedback regarding the quality of the review and the decisions made.

6.22 Since its inception, the Panel has sought to increase its communication and engagement with stakeholder bodies and safeguarding partners. This is currently achieved by issuing quarterly newsletters, publication of panel briefings and regular Panel events such as roundtables and webinars which afford the Panel the opportunity of hearing directly from safeguarding partners. This engagement informs the business planning process for the Panel and its prioritisation of thematic and national reviews.

6.23 Over time we have increased the reach of our communications channels and are providing more opportunities for engagement. There is an identified Panel member to link to safeguarding partners in each of the nine English regions. They are available for safeguarding partners to contact (via the mailbox) and discuss referrals, reviews, and any other questions you may have.

6.24 The Panel is supported by a secretariat comprised of civil servants from the Department for Education who can be contacted at: Mailbox.NationalReviewPanel@education.gov.uk

6.25 Safeguarding partners can contact the secretariat for points of clarification, although the secretariat cannot advise about the interpretation of statutory guidance. It is for safeguarding partners and statutory agencies to secure their own legal advice.

[54] Children Act 2004, Section 16B (1)

The data we collect

6.26 The data we collect helps us to understand common safeguarding practice themes and issues. We also collect a range of other data that allows us to interrogate what is happening, understand how well processes are working, and therefore to highlight relevant evidence about strengths and areas for improvement in multi-agency safeguarding practice. This includes:

- Demographic information about the children who are the focus of Serious Incident Notifications.
- The number of Serious Incident Notifications we receive.
- The primary cause of death and serious harm as evidenced in serious incidents.
- The proportion of rapid reviews received within the 15 working day timescale and our response time to local areas.
- How often the Panel agrees or disagrees with local area decision making.

6.27 Our annual reports present some of this data and are available at www.gov.uk/government/organisations/child-safeguarding-practice-review-panel

Pool of reviewers

6.28 The Panel must set up a pool of potential reviewers who can undertake national reviews, a list of whom are publicly available. If the Panel consider that there are no potential reviewers in the pool with availability or suitable experience to undertake the review, the Panel may select a person who is not in the pool.[55]

6.29 When selecting a reviewer, the Panel should consider whether they have any conflict of interest, real or perceived which could restrict their ability to identify improvements impartially. For national child safeguarding practice reviews, the Panel generally will follow the same guidance on procedure and supervision as that for local child safeguarding practice reviews.[56]

6.30 Panel recruit to the pool of reviewers periodically and notification of the process will be in the newsletter. The secretariat can provide more information at Mailbox.NationalReviewPanel@education.gov.uk

[55] Regulation 4, The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

[56] Page 142, paragraph 369, Working Together to Safeguard Children

7. Additional guidance on notification of serious incidents

7.1 This chapter provides additional guidance about the notification of serious incidents to support local authorities and their safeguarding partners in deciding whether to make a serious incident notification.

7.2 As indicated in chapter 2, Working Together 2023 sets out the criteria for notification and expectations of safeguarding partners.[57] It is important that there is appropriate consistency in decision making about serious incidents across local areas. When a child has died or been seriously harmed, there must be robust, transparent and effective review of what has happened. Safeguarding professionals have a responsibility to the child whose life is the focus of the incident to identify and secure relevant learning and improvements.

7.3 Safeguarding leaders have a responsibility, and are accountable, for overseeing and assuring the quality of local notification and review processes. Making a serious incident notification should not be seen as a reflection of poor or weak local practice; instead, it should be viewed as an opportunity for reflection on local multi-agency practice to enable improvement and best practice in the challenging and complex work of protecting children.

7.4 Data from serious incident notification also supports national analysis about the safeguarding system.

Death of a child

7.5 Where a child has died through abuse or neglect, then the criteria for notification will be met. This includes instances where a child has died because of harm by another child (including in an extra-familial context, such as through knife crime or criminal exploitation). Safeguarding partners do not need to have existing knowledge about prior abuse or neglect in order to submit a notification as the criteria will have been met.

Suicide

7.6 It may be difficult to determine if a child who has taken their own life has experienced abuse or neglect, or whether non-recent abuse or neglect has contributed to the death or serious harm. Local authorities, in discussion with their safeguarding partners may need to consider some of the following questions:

[57] Department for Education, Working Together to Safeguard Children page 133

- Was there any previous history of abuse or neglect that may have contributed to the child taking their own life?
- Was the child known to safeguarding agencies and other relevant agencies and, is there any evidence that the availability or non-availability of services may have contributed to what happened?
- Is there evidence of criminal action by others (for example online sextortion of indecent images) that may have contributed to the child taking their life?

Sudden unexpected death in infancy

7.7 Most deaths of babies as a result of sudden unexpected death in infancy (SUDI) are appropriately reviewed through the child death review process and do not require notification. However, where abuse or neglect is considered to be present and has contributed to the death (for example, examples of severe and persistent neglect or evidence of dangerous sleeping practice) then it should be notified and a rapid review undertaken.

7.8 The Panel published a national thematic review on SUDI, Out of Routine, in 2020.[58] We encourage safeguarding partnerships to reflect on the learning in that national review and how this is being acted on locally. When a notification is made, and where a rapid review of a child who has died through SUDI has progressed, safeguarding partnerships should reflect on the findings of this national review, and whether or not additional learning would be secured through a LCSPR.

Unexpected deaths in hospitals

7.9 These will be reported via the Child Death Overview Panels, but local authorities, with their safeguarding partners, should consider notifying instances to the Panel where there is evidence of the neglect or abuse of children. This includes institutional harm caused by systemic weaknesses in organisations.

Serious harm

7.10 Chapter 2 (sections 2.17 – 2.25) provides guidance on what constitutes serious harm, and some of the factors that may need to be taken into account when deciding on whether a serious incident notification should be made.

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[58] Child Safeguarding Practice Review Panel, Safeguarding children at risk from sudden unexpected infant death (2020)

Concealed pregnancy

7.11 When deciding whether to complete a serious incident notification for an infant who has died or experienced serious harm following a concealed pregnancy, local authorities, with their safeguarding partners, will need to consider whether abuse or neglect has occurred. There should be careful consideration about whether the serious harm or death was due to a lack of, or delay in, seeking appropriate medical assistance or an act of deliberate harm. If the mother is under the age of 18 years, she may need to be included on the notification as a child in her own right, particularly if have been concerns that she may have been abused or neglected.

Neglect

7.12 Sometimes there will not have been a specific incident to prompt notification, however, a notification may be indicated when there is evidence that children have experienced neglect and the definition of serious harm is met as set out in Section 2.

Sexual abuse within the family environment

7.13 Indicators of serious harm may include situations when a child has been sexually abused by a substitute carer, intergenerational sexual abuse, or a child has died through suicide as a result of sexual abuse, and/or when there is evidence that indicators of abuse had not been responded to appropriately by professionals. The harm from sexual abuse is likely to be intensified when combined with other adversities or multiple forms of maltreatment, or where it involves multiple abusers or organised networks.

Harm outside the home (extrafamilial harm)

7.14 Forms of extra-familial harm includes exploitation by criminal and organised crime groups and individuals, serious violence, modern slavery and trafficking, online harm, sexual exploitation, teenage relationship abuse and the influence of extremism which could lead to radicalisation.[59] In their consideration of what is serious, local authorities, and their safeguarding partners, should consider the definition of serious as set out in Section 2.

[59] Department for Education, Working Together to Safeguard Children 2023, page 67, paragraph 194

Abuse and neglect of children in care, education or other settings

7.15 Children can experience serious harm within provider organisations such as nurseries, schools, residential homes, educational settings, (including residential special schools, boarding schools), and hospitals, (including mental health providers or establishments that care for children as part of the justice system). The Panel's report on safeguarding children with disabilities and complex health needs in residential settings[60] highlighted the harm that occurs when system weaknesses lead to organisational cultures which create the conditions where those who seek or have the potential to harm and abuse children are enabled to do so.

7.16 Where serious harm occurs in a setting and abuse or neglect is suspected, safeguarding partners should collectively consider whether the criteria for a notification has been met and report the incident to the Panel.

7.17 Examples of notifiable incidents include deliberate harm caused by staff, family members or visitors and organisational cultures which create the conditions where those who seek or have the potential to harm and abuse children are enabled to do so.

[60] Child Safeguarding Practice Review Panel, Safeguarding children with disabilities and complex health needs in residential settings (2023)

8. Some issues to consider when undertaking reviews about specific forms of abuse and neglect.

8.1 This chapter addresses some of the issues that safeguarding partners may need to give attention to when undertaking rapid reviews or LCSPRs. The information provided below is drawn from analysis of rapid reviews and LCSPRs from safeguarding partnerships across the country, together with national reviews and thematic analysis published by the Panel.

Suicide

8.2 Where a notification has been made following a child's suicide, reviews will need to consider a range of issues including about the quality of multi-agency practice to safeguard and help the child and their family, the impact of prior traumatic events (including loss and bereavement), their experience of education, whether there were issues about gender dysphoria[61] that had failed to be addressed, the impact of social media and whether there was evidence of criminal behaviour from others that may have contributed to the child taking their own life.

Concealed pregnancy

8.3 There is no formal definition of concealed pregnancy. Legally, in England, women have the right to autonomy over their bodies, including during pregnancy. This means that women have the right to manage their pregnancy and the delivery of their infant without any medical or midwifery intervention if they wish. However, concealing the birth of a child who died before, at or after its birth is an offence under s60 of the Offences Against the Person Act.

8.4 A review of safeguarding partnership and local NHS guidance categorises three main groups of undeclared pregnancy:

- The pregnancy is concealed, when a woman is aware she is pregnant but chooses not to tell professionals, or in some cases her family and wider network.
- The pregnancy is denied, where a mother is unwilling or unable to accept the existence of her pregnancy.
- The pregnancy is unknown and undiagnosed with the mother not aware that she is pregnant until the onset of labour, or when the baby is born.

[61] Gender dysphoria is a condition where there is significant discomfort or distress caused by a feeling that one's assigned sex at birth does not match children's gender identity and this can cause mental health problems. See www.nhs.uk/conditions/gender-dysphoria/

8.5 Panel evidence shows that factors that contribute to pregnancies being concealed include:

- The mother being under the age of 18 years and therefore a child herself.
- The mother lacking mental capacity.
- Conception through rape or an abusive relationship.
- Fear of risks associated with the wider family or cultural context.
- Fear of removal of the infant related to current or historic circumstances.

8.6 Reviews by safeguarding partnerships may need to take account of forensic evidence which can impact upon the detail available in time for the rapid review process. In these circumstances the partnership should proceed with the rapid review process and keep the Panel updated on the progress and outcome of criminal and forensic investigations through the secretariat.

8.7 Concealing a pregnancy can mean that a woman is rejecting access to care and support at a uniquely vulnerable time for her and her infant. Safeguarding partners may need to carefully consider the reasons for this and liaise with colleagues in adult safeguarding where broader familial and cultural concerns are raised by the incident.

Child neglect

8.8 The Children Act 1989 sets out a definition of neglect that has been expanded in government safeguarding guidelines: 'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development'.[62]

8.9 Neglect may occur during pregnancy as a result of maternal substance abuse or domestic abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment).
- Protect a child from physical and emotional harm or danger.
- Ensure adequate supervision (including the use of inadequate caregivers).
- Ensure access to appropriate medical care or treatment.
- Provide suitable education.

[62] Working Together to Safeguard Children 2023, page 160

8.10 It may also include a failure to respond to a child's basic emotional needs.[63]

8.11 When undertaking rapid reviews and LCSPRs, agencies need to look beyond single incidents and review the cumulative impact of trauma over time, including how the persistent or intermittent but recurring harm has impacted upon the daily life of children. This approach can also assist safeguarding partners when considering whether to notify incidents to the Panel. Safeguarding partners should consider the points made in chapter 2 and in chapter 7 in determining whether the neglect has caused serious harm which should trigger a notification and rapid review.

8.12 Reviews should consider the quality of assessments of the impact of neglect on children's physical, social and emotional development including whether children have experienced a chronic impact from entrenched patterns of neglect. Safeguarding partners should also consider the impact of cumulative harm on children and its long-term effect on their health and well-being.

Practice example of a review about neglect

Felix*, aged 6, has mixed Asian and White British ethnicity and has one sister aged 4. They have experienced the impact of chronic neglect. The children have a number of health conditions which had deteriorated because they did not receive timely medical attention. Neither child attended school or nursery, and both have very limited speech and communication skills. The children lived with their mother who had severe mental health issues, and the family were extremely isolated. Services experienced difficulty in engaging with the children and family. When the children attended hospital for an appointment, health professionals were concerned about their appearance. Their clothes were stained and inappropriate for the season, and they appeared unkempt. Neither child was able to talk clearly to health professionals which raised concern about developmental delay. The children went to live with foster carers where alarming information was shared about their experiences.

The safeguarding partners decided to complete a LCSPR due to concerns that agencies had not identified that the children were living in chronic neglect and that there had been a delay in raising the alarm.

[63] Working Together to Safeguard Children 2023, page 160

Sexual abuse within the family environment

8.13 Children may experience serious harm when they are sexually abused within the family. “I wanted them all to notice”, the Panel’s national review into child sexual abuse within the family environment, found there was significant harm to children’s emotional and physical health, and in some examples, lifelong impact resulting from this abuse.[64] The review noted that children who are victims of sexual abuse within the family are frequently not identified by practitioners, nor do they receive the response needed for their ongoing safety and recovery.

8.14 While there is no single agreed definition of child sexual abuse within the family environment (also referred to as intrafamilial child sexual abuse), this is broadly understood as sexual abuse by a relative or someone closely linked to the family. The national review identified that intrafamilial child sexual abuse often overlaps with other forms of sexual abuse and this often leads to serious harm and suicide. These children are under-represented in child protection plans.[65]

8.15 In addition to the definition in the previous paragraph, indicators for serious harm include sexual abuse from a substitute carer, intergenerational sexual abuse, or children dying through suicide as a result of being sexually abused. The harm from sexual abuse also tends to be compounded when it is combined with other adversities or multiple forms of maltreatment, or where it involves multiple abusers or organised networks. Children with disabilities are particularly vulnerable to sexual abuse.

Practice example of a review of a child who had been sexually abused

Jessica* is 14 and White British and has experienced extensive harm with a history of sexual abuse within her foster family. There was cause for concern about the way in which agencies acted to safeguard Jessica and the other foster children who lived with the foster carers over a 15-year-period.

The safeguarding partnership agreed to complete a LCSPR focusing on key areas including:

- how concerns about Jessica’s wellbeing and medical symptoms were responded to
- the assessment, supervision and review of the foster carers and
- how allegations about standards of care were reviewed, including by the Fostering Panel

[64] Child Safeguarding Practice Review Panel, "I wanted them all to notice" (2024)

[65] Child Safeguarding Practice Review Panel, "I wanted them all to notice" (2024)

Harm outside the home (extrafamilial harm)

8.16 Neglect and abuse can occur online or outside the home and children may experience this type of harm from other children and/or from adults.[66] Forms of extra-familial harm include exploitation by criminal and organised crime groups and individuals (such as county lines and financial exploitation), serious violence, modern slavery and trafficking, online harm, child sexual exploitation, teenage relationship abuse, and the influences of extremism which could lead to radicalisation.[67]

Child sexual exploitation

8.17 Child sexual exploitation is a form of harm that can affect any child or young person under the age of 18 years, including 16- and 17-year-olds who can legally consent. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child into sexual activity.[68] The victim may have been sexually exploited even if the sexual activity appears to be consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology. This is a complex form of abuse which can be difficult to identify.

8.18 Many children who are sexually exploited may have been victims of other forms of abuse; the 'grooming' methods that may be used can mean that children who are sexually exploited do not always recognise they are being abused, which can also affect identification and detection rates. Child sexual exploitation may be linked to other crimes and practitioners should be mindful that a child who presents as being involved in criminal activity may also be being sexually exploited.

8.19 There are known vulnerabilities that children can experience that make them more susceptible to child sexual exploitation. Safeguarding partners should assure themselves that these factors are understood and that learning from practice is shared to reduce harm to children.

8.20 Reviews will need to consider issues such as:

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[66] See more information about extrafamilial harm in the Panel's national review: 'It was hard to escape' – a national thematic review of child criminal exploitation (2020)

[67] Extremist groups may make use of the internet to radicalise and recruit and to promote extremist materials. Any potential harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism should also be considered. For further information see Prevent duty guidance

[68] Department for Education, Child sexual exploitation: Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation (2017)

- Whether the incident raises issues of concern about the scrutiny and reporting of group-based offending and child exploitation which highlights system learning?
- How well agencies assessed, understood and responded to the risks of harm and the quality of interventions and support offered to protect and help the child.
- Were the actions that were taken proportionate and child centred?
- Whether the right agencies were involved in investigating and responding to harm and were there any systemic failures in how agencies worked together?
- Has there been necessary scrutiny of whether any biases such as those related to sex, sexuality, ethnicity or social background adversely influenced decision making?
- Was there evidence of 'adultification' of children, particularly with Black, Asian and Mixed Heritage children?
- What evidence was there of criminal action by others (including online sextortion of indecent images or evidence of organised exploitation); was robust and necessary action taken to bring offenders to justice; is deeper review merited?

Practice example of a review of a child who had been sexually exploited

Katie*, aged 15, with White European ethnicity was sexually abused for 3 months online and pressured into sharing nude images. She was coerced into sharing her contacts with a man who posed as a 15-year-old boy, who also persuaded her into meeting him with her friends. She and her friends were systematically harmed by this man and his friends, who used cigarettes, drugs and alcohol to increase their vulnerability. They were sexually abused and exploited over several months by different men. The children were seriously harmed over a 12-month period and their engagement in school and family life was seriously impacted by the abuse.

The rapid review identified that the harm was serious as it involved an organised network who sought to exploit and abuse young girls. The safeguarding partners were required to make one notification for all children involved.

Serious youth violence

8.21 The joint targeted area inspection report into serious youth violence described the serious harm to children caused by youth violence.[69]

[69] See further information on multi-agency responses to serious youth violence: working together to support and protect children available at https://www.gov.uk/government/publications/multi-agency-responses-to-serious-youth-violence

8.22 Other issues to consider in these reviews are listed below.

Sex

- It is important to highlight the danger of hidden harm to girls in the context of serious youth violence. Was there any evidence of female children being overlooked in assessments of risk for serious youth violence or blamed for 'risk-taking' behaviour when they were being coerced or sexually exploited?

Known vulnerabilities and risks of harm

- Should any of the children involved been offered services to support them with their vulnerabilities and risk of being harmed by serious youth violence?
- Were the risks of being associated with 'gang activity' known and considered in any decisions about their support?
- Were there particular risk of harm factors noted for any child involved in serious youth violence including whether the children were attending education or training?
- Was there any indication that either child had been subject to county lines exploitation, groomed, coerced, or exploited by anyone including adults associated with gangs? Has necessary action been taken in relation to possible offenders?
- Did the children involved or harmed by serious youth violence have known vulnerabilities including, but not limited to having special educational needs and/or disabilities, a neurodivergent diagnosis or were awaiting a neurodevelopmental assessment?

Support and multi-agency working

- Did agencies act appropriately and respond to children when they were harmed and were safeguarding actions taken in a timely and proportionate way?
- If children were arrested and brought to custody for an incident relating to serious youth violence, were there appropriate child-centred approaches with children's vulnerability identified and responded to?
- What was the quality of engagement of services to support and protect children and young people, including the involvement of youth justice services. Were appropriate transition arrangements in place to support children and young people into adulthood?
- Is there any evidence that there were barriers to effective multi agency working? Why did these occur?

Ethnicity, race and culture

- Were the children involved of specific ethnic groups that are disproportionately represented among those harmed by serious youth violence?
- We know that poverty, racism and inequality can make children more vulnerable to school exclusion and entering the criminal justice system. Was there any evidence that a either child's life and experience has been affected by these wider structural issues?

- Was there evidence that either child had been ‘adultified’ or criminalised as a result of a failure to assess their special educational needs or recognise that they were a victim of exploitation or racism?

Practice example of a rapid review about a child who was seriously harmed as a result of serious youth violence

Sam* is a 17-year-old, White British child, who lived with his mother and younger siblings. The rapid review identified that Sam was a vulnerable child who had experienced serious harm and acknowledged that the neglect he experienced as a child had not been recognised. He had been drawn into crime over a two-year period, with his offending increasing in severity and violence. He was prosecuted several times , including carrying a knife and possession of drugs with intent to supply.

Sam rarely attended college and the services available to support him had difficulty in finding a way to engage him. Sam’s episodes of going missing increased and he was increasingly vague about his whereabouts. His mother rarely reported him as missing, so agencies were unaware of the risks he was exposed to.

Sam was charged with causing serious harm to two other people and sent to a Youth Offending Institution.

The rapid review concluded that there was key learning for safeguarding partners to improve practice.

The safeguarding partners made one notification which included both Sam and his child victims whose needs were also considered in the LCSPR.

9. Appendices

Appendix A – How to notify a serious incident, rapid review, and local child safeguarding practice review

Serious Incident Notification

All serious child safeguarding incidents must be notified to the Panel.

Notifications should be sent within five working days of the local authority becoming aware of the incident.

Notifications are made through the Child Safeguarding Online Notification System, which is accessible 24 hours a day.

The rapid review

Rapid reviews should be submitted to the panel within 15 working days of the date that the notification was submitted to the Panel.

Rapid reviews should be submitted to the Panel secretariat, at Mailbox.NationalReviewPanel@education.gov.uk.

Local child safeguarding practice review

These reviews should be completed within six months of the decision to undertake one. Full reports must be sent to the Panel and the Secretary of State for Education no later than seven working days before the date of publication.

Final reports, information relating to improvements to be made following a review, and reasons for any delay, should be notified to

Mailbox.NationalReviewPanel@education.gov.uk and Mailbox.CPOD@education.gov.uk

In addition, final reports and information about improvements should also be sent to Ofsted SCR.SIN@ofsted.gov.uk.

Appendix B – Useful resources for safeguarding partners

A list of Child Safeguarding Practice Review Panel national reviews and briefings

NSPCC - National Case Review Collection: a repository of published reports

Vulnerability, Knowledge and Practice Programme – Publications and Reports

Research in Practice - Triennial analysis of serious case reviews

Wales Safeguarding Repository

Child Safeguarding
Practice Review Panel

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