Executive Summary:

Annual Report 2020
May 2021

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Executive Summary

The Child Safeguarding Practice Review Panel's second Annual Report covers our work from 1st January to 31st December 2020. It sets out our views about how effectively the system of national and local child safeguarding practice reviews is operating. We recognise that this was a year like no other, with the unique challenges presented by the COVID-19 pandemic.

The impact of the COVID-19 pandemic

1. Agencies working in child safeguarding faced major challenges during the pandemic and needed to adapt practice quickly to maintain support and protection for vulnerable children and families. Safeguarding partners have had to respond to changing patterns of need whilst ensuring COVID-19 safe practice.

2. Using an analytical model derived from published commentary and stakeholder research, the Panel identified four key factors that increased vulnerability and risk for children and young people during the pandemic.

3. Parental and family stressors were a strong factor in escalating risk, particularly in incidents involving babies under 12 months old. Disrupted routines and overcrowding increased pressures and tensions in households, with increased incidence of domestic violence and mental health concerns.

4. Learning from the impact of school closures in the first lockdown period in 2020 reinforced the crucial role that schools play in child safeguarding. Some vulnerable children remained 'below the radar' as school was not available as a source of support or trusted environment to disclose concerns. Being away from the support of friends, trusted adults and school appeared to have a particular impact on children and young people's mental health and was evident in all cases of suicide.

5. Adaptations for COVID-safe practice meant that home visits were often replaced with telephone contact or virtual visits. Where these worked well, practitioners were able to observe the family and home environment and assess changing risk and need. Partnerships are identifying opportunities to take forward the learning from these adaptations into a more blended approach to work with families through a combination of visits and remote support, appropriate to needs and risk.

'A window on the system'

6. The Panel received notification of 482 serious incidents which occurred between 1 January and 31 December 2020, relating to 514 children. Of those 482 notifications, 206 were in relation to child deaths and 267 related to serious harm.[1]

7. Of the 514 children involved in the incidents notified, 274 (53%) were male and 238 (46%) were female. There were two transgender young people. The age distribution showed a predominance of infants under the age of one (35%) and a second peak in 15-17 year-olds (30%).

8. The majority of children (69%) were of White British ethnicity. However, compared with the ethnic breakdown of the 0-17 population in the 2011 census, there was a higher proportion of ethnic minority children among the cases notified to the Panel. This was particularly marked among black teenagers and among mixed ethnicity children of all age groups. Those from Asian ethnic groups were under-represented in all age groups compared with the general population.

Child deaths

9. Of the 206 fatal incidents, 36 (17%) were caused by maltreatment within the family, 17 (8%) were extra-familial assaults or homicide, 63 (31%) were sudden unexpected deaths in infancy (SUDI) and 42 (20%) were suicides. A further 20 (9.7%) were related to, but not directly caused by maltreatment. Domestic abuse featured in 41% of fatal cases and neglect was a feature in 35%. SUDI formed the most common category of fatal cases and was the focus of the Panel's second national thematic review, published in July 2020.

10. Suicide in young people remains an important issue, accounting for 20% of all incidents. Young people's feelings of isolation during the COVID-19 lockdown were a contributory factor in a number of incidents. More generally, it was not always clear whether a suicide was linked to suspected abuse or neglect. Often there was not a single trigger event.

Serious harm

11. Non-fatal physical abuse, such as unexplained bruising or fractures, was the most common form of non-fatal serious harm (22%), followed by young people involved in risk-taking or violent behaviour (11%) and child sexual abuse (10%).

12. Neglect was the primary form of serious harm to children in 7% of incidents. However, it was an underlying feature of 35% of fatal incidents and 34% of non-fatal incidents.

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[1] Nine notifications were for other issues, including six where the young person was a perpetrator of harm, two in which the young person was subject to criminal exploitation and one where the young person had engaged in risk taking or violent behaviour.

Learning from practice reviews tells us that the recognition of cumulative neglect and its impact continues to be a key challenge for practitioners.

13. Domestic abuse was recognised in over 40% of incidents. This predominantly involved the father as perpetrator and mother as victim (74%). In 2021 the Panel will be commissioning a national practice-based review of cases involving domestic abuse. We will be giving particular consideration to working with men, women and children from diverse backgrounds.

14. Parental mental ill-health was a characteristic in 146 incidents, the majority relating to mothers (78%). There was a lot of overlap in parental and family risk factors, indicating a degree of cumulative harm in many of the families.

15. The combination of domestic abuse and substance misuse appeared to be particularly strong, accounting for 24% of all incidents. Learning from case reviews shows that these concerns are not sufficiently taken into account in assessing risks to children.

16. In 16% of the notified incidents, the child had experienced mental ill-health. These issues have taken on greater significance given the evident concerns about children and young people's mental health and emotional well-being during the COVID-19 pandemic.

17. In 51 incidents in which young people were involved in risk-taking or violent behaviour, 75% of them had evidence of gang violence or county lines activity. Child criminal exploitation (CCE) was the focus of the Panel's first national thematic review, in March 2020. We are now following this up with a 'Phase 2' examination of CCE cases received by the Panel since the report was published.

Key practice themes

We have highlighted six key practice themes to make a difference in reducing serious harm and preventing child deaths caused by abuse or neglect. These themes are not new, but they are the most urgent, and also the most difficult. Underpinning all of them is the importance of effective leadership and culture – dimensions which too often are left unexplored in the case reviews that we see. We expect these six themes to be a focus for shared learning with safeguarding partnerships, and nationally, to improve the safeguarding system.

Six key practice themes to make a difference

- Understanding what the child's daily life is like

- Working with families where their engagement is reluctant and sporadic

- Critical thinking and challenge

- Responding to changing risk and need

- Sharing information in a timely and appropriate way

- Organisational leadership and culture for good outcomes

Section 5 of the full report provides an extended outline of each theme, with learning drawn from reviews and illustrative case studies. These themes reflect the findings in a qualitative review of 135 Rapid Reviews and 34 Local Child Safeguarding Practice Reviews (LCSPRs) undertaken for the Panel by a team from University of East Anglia and University of Birmingham.

A sense of the new working arrangements

18. We continue to reflect on how local leaders have risen to the challenge of new multi-agency arrangements for child protection. We are interested in the extent to which safeguarding partners are facilitating effective and timely dissemination and embedding of learning.

19. Safeguarding partner arrangements, combined with some sub-regional multi-agency working, has enabled a sharper focus on a smaller number of priorities and practice themes, with a greater emphasis on quality assurance and learning. To demonstrate a new model of tripartite leadership, typically partners have established a pattern of high-level strategic meetings focused on problem solving 'wicked issues' and the dissemination of learning from audits and local reviews.

20. Evidencing the added value of the new governance arrangements (including independent scrutiny) and the impact of the partnership's work programme are key areas for development.

21. Safeguarding partners are looking to establish innovative learning and improvement cycles, building on the foundations of multi-agency audits and programmes of training. The evaluation of the impact of learning (including training) is a key area for development across safeguarding partners. This will be a focus for the Panel in 2021.

22. Working Together 2018 (WT 2018) requires safeguarding partners to publish a report at least once in every twelve-month period and send copies to the Panel and the What Works Centre for Children's Social Care. An evaluation by the What Works Centre found that 49 reports of the 68 reports published by January 2021 fully or partly evidenced WT 2018 requirements. We have found considerable variation in the length of report and the detail provided. Overall, our analysis suggests that the requirements for Yearly Reports set out in WT 2018 would benefit from revision to enable a sharper focus on impact, assurance and learning.

Quality of reporting and reviews

23. Most local areas (43%) notified the Panel of between three and six cases per year. The variation in the number of notifications between areas to some extent reflects their differing socio-economic contexts and child populations. There continues to be considerable variation in the way that local areas interpret the criteria for serious harm. This is a complex issue and we will engage with partnerships to understand the issue better.

24. The timely completion of rapid reviews (within 15 days of serious incident notification) was affected by the COVID-19 pandemic, in recognition of which the Panel authorised an extended submission for the period between April and September 2020.

25. Full year figures for 2020 showed 65% of rapid reviews completed within 25 days (1-15 days, 21%). Excluding the extended period, 70% of rapid reviews were completed within 25 days (28% in 15 days).

26. Well-conducted rapid reviews, with challenge and direction from senior leaders, identify immediate learning and how and when it will be disseminated across the partnership. There is a clear rationale for the decision to initiate an LCSPR and sufficient analysis to identify areas for further exploration. We have seen good examples of partnerships using the learning and reflective questions from national reviews as a starting point to inform their own analysis. Unfortunately, in too many of the rapid reviews that we see the analysis does not either inform immediate learning or provide a clear rationale for the aspects to review in an LCSPR.

27. LCSPRs provide an opportunity to explore the analysis and practice themes from rapid reviews in more depth. Effective LCSPRs build on the initial findings presented in the rapid review, incorporating the views of children and families and involving practitioners. The learning from the review is linked to SMART recommendations. Many of the LCSPRs seen by the Panel to date are structured and read like Serious Case Reviews with insufficient focus on learning. Too often the narrative focuses on what happened rather than why. Rapid reviews sometimes suggest an alternative process to an LCSPR. The detailed arrangements for these alternative review processes are not always clear nor how their impact will be evaluated. If a rapid review has indicated that there is more multi agency learning to be gained, safeguarding partnerships should move to an LCSPR. There are no other types of review needed or allowed in WT 2018.

Looking forward – System leadership, learning and improvement

28. The Panel will develop further its system leadership role through its communication and stakeholder engagement programme. To date it has done this through a quarterly newsletter, creating a Twitter account, and running a series of webinars. In the next year, we will build on that work by increasing the reach of our communication channels and providing more opportunities for engagement through quarterly practice briefings and Panel-run virtual events, as well as stakeholder channels. We will continue to assess and adapt our communication style to share learning in a way that is agile and responsive to changing circumstances.

29. Working with safeguarding partners and other stakeholders, the Panel has an important role in supporting the development of an effective learning culture. This is where agencies at every level are honest when things go wrong, where partners are properly held to account without scapegoating, where there is time and determination to reflect and learn, and where that learning translates quickly into policy and practice. We invite everyone involved in protecting children to engage with the themes and issues identified in this report. Below we set out some reflective questions for local leaders to encourage effective learning in the interests of children and families.

Reflective questions for local leaders

1. How do safeguarding partners model personal leadership of, and accountability for, the dissemination and embedding of learning in their local area?

2. How do you know that the new system of learning is making an impact? What are the key barriers? How can the Panel work with you to address them?

3. How can we make better use of national reviews to support learning and improvement in your area?

4. How can we work together to give practitioners a sense of confidence, support and progress in addressing the stubborn challenges in child safeguarding?