THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Annual review of LCSPRs and rapid reviews

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Disclaimer

The views expressed in this report are the authors' and do not necessarily reflect those of the Child Safeguarding Practice Review Panel.

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Executive summary

Introduction

The system of rapid reviews and local child safeguarding practice reviews (LCSPRs) was established in 2018, to replace the previous system of serious case reviews. For a while the two systems ran alongside each other, but since October 2019, only the new system can be used. The Child Safeguarding Practice Review Panel (the Panel) published practice guidance in 2019 and its first Annual Report in 2020 (covering 2018-19).

This present study, the first independent review of rapid reviews and LCSPRs, was undertaken by a joint team from the University of East Anglia and the University of Birmingham. Our aims were to provide an overview of key themes, issues and challenges for practitioners and agencies; draw out implications for policy makers and practitioners; assess how well the rapid reviews and LCSPRs achieve the tasks required of them; analyse the sample of LCSPRs available to us in order to increase understanding of the root causes of systemic strengths and vulnerabilities within local practice; and generate findings and questions for local safeguarding partners and the Panel to support them in their work to improve child protection practice.

Methods

Our methodology reflects the aims of the new system, in that we have tried to look beneath the surface of what happened in individual cases, to explore deeper system issues. We drew on the model of 'Pathways to harm, pathways to protection' that we used in our triennial reviews of SCRs (Sidebotham, Brandon et al, 2016; Brandon, Sidebotham et al, 2020). The sample, provided by the Panel, included 135 rapid reviews and 33 LCSPRs. The 135 rapid reviews included 27 reviews matched to LCSPRs.

There were two elements to the study:

- In-depth analysis and development of themes in the rapid reviews and LCSPRs, including those that appear to persist and any new issues.
- An appraisal of the quality of the rapid reviews and LCSPRs (that is to say, how well they met the requirements) and an exploration of the 'added value' of the LCSPR compared to the rapid review in the pairings that we had.

Findings

Pathways to harm, pathways to protection

We looked at the sequence of identification and referral; case management; engagement with families; and case closure.

Close to half of all reviews identified problems with either early identification of risks, or agencies not responding adequately to referrals, or both. There were often concerns about the quality and timeliness of referrals, often compounded by the use of unclear language and jargon.

Case management issues were linked to limited access to appropriate services; receiving information about children and families but not acting on it; and the importance of recording, sharing and acting on multi-agency meeting decisions.

Reviews also highlighted difficulties in engaging children and families but there was less evidence of consideration as to *why* families may not be engaging. Engaging fathers and men in families remains a problem for practitioners and agencies. Lack of engagement could too easily lead to closure of cases before relationships can be built. Progress was not always evidenced prior to closure.

Overall, we found that reviews rarely address *why* things happen*, why* practitioners make certain decisions or *why* children and families may respond negatively to interventions.

Key themes and new themes

The qualitative analysis found that rapid reviews and LCSPRs often identified well-known themes in child safeguarding practice. Key themes were opportunities to be curious, resources, inter-agency communication and sharing, policies and protocols, and training. We also found new themes that would benefit from further exploration: working with families during a pandemic, peer-on-peer abuse, young people's gender and sexual identities, and trafficking of children.

A lack of 'professional curiosity' is a cliché used by reviewers. Further inquiry into why practitioners did not always ask 'the second question' was usually missing. Work with adolescents, babies, fathers and men in families, and families from diverse cultures often showed the impact of stereotypes and assumptions that left issues unexplored.

Resource issues were not explicitly mentioned in many rapid reviews, but the theme was more developed within LCSPRs (eight cases). Issues included lack of specialist services as well as shortage of personnel within agencies.

Shortcomings in inter-agency communication and information sharing continue to be a barrier to safeguarding children across all agencies.

Practitioners are expected to know, understand and follow a range of policies and procedures as part of their job and when they were not followed, recommendations invariably pointed towards further training. Training was also focused on specific topics, practice skills and approaches.

Rapid reviews and LCSPRs: links, themes and quality

Most rapid reviews appeared to follow set templates, with the best reviews being documented on templates that helped them to include all the key information required. The best rapid reviews ranged from 6 to 16 pages, with a mean of 10.

The weakest rapid reviews tended to be very short, suggesting that there is a minimum amount of information necessary to provide the detail and context needed to satisfy the requirements of *Working Together 2018* and the Panel's practice guidance. Falling below this is likely to reduce the quality of the review, but there appears to be a point at which extra detail does not increase, and may even reduce, quality. Commonly missing was the ethnicity of the child and their family.

Our appraisal of LCSPRs found evidence that local partnerships were still coming to terms with the new requirements, and the concept that any further form of inquiry should be regarded as an LCSPR was taking time to become familiar. Reviews employ a range of methodologies and there is a wide variety of reports, in terms of structure, style and length. There is relatively little guidance on what the report of an LCSPR should contain.

Three notable features of LCSPRs are specified in the *Working Together 2018* guidance: these are the goals of publication, capturing the views of children and the families, and the involvement of practitioners. Although referred to as local reviews, learning from LCSPRs will likely be picked up by other safeguarding partnerships and possibly other agencies, therefore bringing national value for the child protection system. It was therefore of concern to learn how few reviews have been published so far.

Families' views were missing from over a third of the LCSPRs. There are many reasons why families cannot or will not be involved in reviews. It would be useful for LCSPRs that cannot include the family's views to include a statement detailing the reasons why.

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

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

Conclusions and suggestions for safeguarding partnerships and the Panel

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

Reviews are called on to identify ‘good practice’ in the cases they are examining, but these serious incident cases may not be the best way to do this. We suggest the Panel should consider commissioning a review or other work to identify and analyse good practice in cases outside those notified as serious incidents.

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

The Panel and safeguarding partnerships need to tackle the reasons for delay and non-publication of LCSPRs. Without publication, learning is not shared, and the system is fundamentally undermined.

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

We suggest that the Panel and local partnerships work together to consider what is reasonable to expect from rapid reviews, including the possible benefits of a national template; and to clarify understanding about the nature and range of LCSPRs, and publish clear, agreed guidance about them.

In addition, we suggest that the Panel should consider commissioning and publishing two new studies:

1. A study of implementation and impact of the learning and recommendations of rapid reviews and LCSPRs as this is a major knowledge gap currently.
2. A study of the *practice* of rapid reviews and LCSPRs, to uncover what actually happens and why. This could identify common sticking points and produce ‘best practice guidance’ for reviewers and partnerships.

Chapter 1: Introduction and methodology

A joint team from the University of East Anglia and the University of Birmingham was commissioned by the Child Safeguarding Practice Review Panel to conduct a qualitative analysis of all completed local child safeguarding practice reviews (LCSPRs) in England received in the period 1 October 2019 - 31 December 2020 (total of 33 LCSPRs). A sample of 135 rapid reviews (approx. 25%) completed in the period January - December 2020 was also analysed.

The system of rapid reviews and local child safeguarding practice reviews (LCSPRs) was established in 2018, to replace the previous system of serious case reviews. For a while the two systems ran alongside each other, but since October 2019, only the new system can be used. The Child Safeguarding Practice Review Panel (the Panel) published practice guidance in 2019 and its first Annual Report in 2020 (covering the period 2018-19). This present study, the first independent review of rapid reviews and LCSPRs, is being published at the same time as the Panel's second Annual Report (link to Panel's Annual Report). Two other reports have also been commissioned: one to give a quantitative analysis of the data from the notifications, rapid reviews and LCSPRs, and the other (from the What Works Centre for Children's Social Care) to review the annual reports of local child safeguarding partnerships.

The overall goals of our study were to distil and analyse themes arising from the reviews with a focus on learning for practice and policy, in particular to:

- Provide an overview and understanding of the key issues, themes and challenges for practitioners and agencies, working collectively and singly, that have been identified in the reviews.
- Draw out implications from the analysis for both policy makers and practitioners.
- Assess how well rapid reviews and LCSPRs achieve the tasks required of them, notably in terms of information, analysis, and clear recommendations.
- Carry out an in-depth analysis of a sample of LCSPRs to increase understanding of the root causes of systemic strengths and vulnerabilities within local practice, in particular where there are emerging or entrenched problems which are evading remedial efforts locally, regionally or nationally.
- Generate findings and questions for local child safeguarding partners and the Panel, to support them in their work to develop a better understanding of why agencies do not always protect children from serious harm and death, and how lessons can best be learned from such cases about system dynamics and the role of human error.

Background

The impetus for a new system of reviewing and learning from cases where children have died or suffered serious harm because of abuse or neglect, came from the Wood review

of the work of local child safeguarding boards (DfE, 2016). Wood observed that serious case reviews often seemed to be about finding someone to blame rather than identifying ways to improve practice, and that '*the recommendations tend to be predictable and/or banal, unfocussed and not addressed to specific individuals or organisations, e.g. better information sharing; more communication between partners; more curious inquiry; do more to engage the young person/family*' (DfE, 2016: 51). He was also critical of the high cost of some reviews and the proportionality to the lessons learned.

Wood called for the creation of a new 'national learning framework', building on a system of rapid inquiries and local learning inquiries. His recommendations were accepted by the government and introduced by the Children and Social Work Act 2017, amending the Children Act 2004 (HM Government, 2017). Statutory guidance on the purposes and criteria for rapid reviews and LCSPRs is published in *Working Together 2018* (HM Government, 2018).

Rapid reviews should be completed within 15 working days of the notification of a serious incident to the Panel. If an LCSPR is then commissioned, it should be published within six months but as we discuss later, this is not being met in the majority of cases.

The 2019 practice guidance from the Panel commented on the great variety of rapid reviews they had already seen, and held that '*rigorous and comprehensive rapid reviews can offer a new mechanism through which the key learning may be identified and disseminated quickly … A well-conducted rapid review … may avoid the need for an additional lengthy process with limited additional learning'* (CSPRP, 2019: 14).

The practice guidance also set out the Panel's expectations for a good rapid review. These include '*a concise summary of the facts, so far as they can be ascertained, about the serious incident and relevant context; this should give sufficient detail to underpin the analysis against the Working Together criteria, but does not require lengthy detailed chronologies of agency involvement that can obscure the pertinent facts*' (p 14). They should also have a clear decision on whether the criteria for a local child safeguarding practice review have been met; identify any immediate learning and plans for its dissemination; and the potential for additional learning (p 15).

The first annual report from the Panel was critical of many rapid reviews for being overly long and descriptive, not focusing on the key questions (CSPRP, 2020a). However:

> In the best rapid reviews, there has been thoroughness that has meant there has been no need for a further local safeguarding practice review and those areas have been able to move quickly to implement the learning across their system. These reviews feature: a concise statement of what has happened; the key questions which emerge from an appraisal of the case; a detailed and sufficient analysis which addresses those key lines of enquiry; and clearly related learning with actions to address any weaknesses. (CSPRP, 2020a: 22)

The *Working Together 2018* guidance gives flexibility for local safeguarding partnerships to decide how learning may be best generated and disseminated. Even if the criteria are met, it is not automatic to hold an LCSPR: *'It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice*' (HM Government, 2028: 87). The interpretation and application of this guidance was still evolving over the period of our review, which is an issue we discuss more fully in Chapter 4.

Aims and methodology

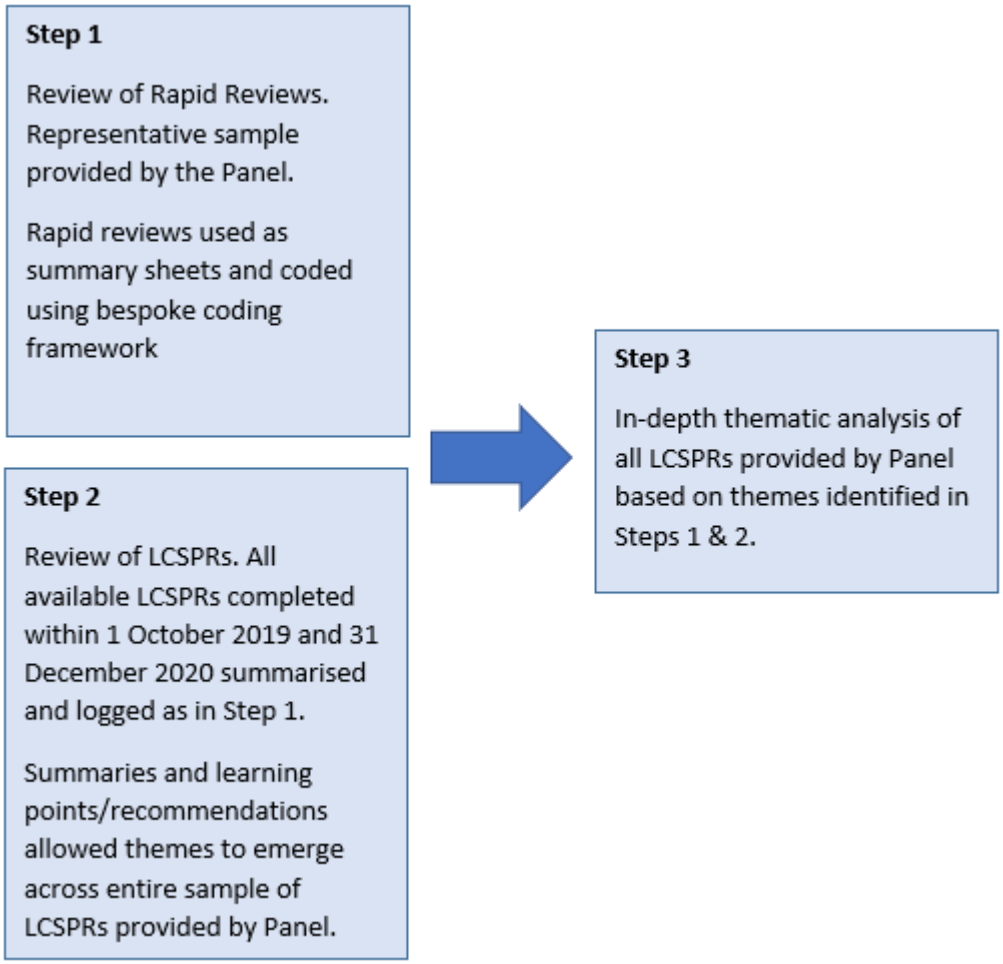
Our aims were to identify common themes and trends across all the LCSPRs and rapid reviews provided, by analysing factors such as child and family circumstances; the characteristics of each case; the nature of agency involvement; and the nature of any learning points and recommendations. We also aimed to assess the relationship between rapid reviews and LCSPRs, and what 'added value' could be discerned in them, through a closer analysis of the LCSPRs.

Behind all this were the objectives listed in the introduction: to draw out the implications for practitioners and managers in local child safeguarding partnerships, and for policy makers, on emerging or entrenched problems; and to identify challenges and raise questions for local partners and the national Panel, about the strengths and areas for development in the new system of rapid reviews and LCSPRs.

Our methodology reflects the aims of the new system, in that we have tried to look beneath the surface of what happened in individual cases, to explore deeper system issues. We drew on the model of 'Pathways to harm, pathways to protection' that we used in our triennial reviews of SCRs (Sidebotham, Brandon et al, 2016; Brandon, Sidebotham et al, 2020). We outline the approach later in this report, but its benefits are that it directs attention to the opportunities for intervention both at case level and system level.

Our analysis of the rapid reviews and LCSPRs was undertaken using a three-step approach as set out below (Figure 1).

Figure 1: Three-step approach to analysis



Analysis of rapid reviews

We were provided with a sample of 135 rapid reviews (see Appendix 1 for details of the sampling process). These related to 81 cases of serious harm and 54 deaths. The sample included 27 rapid reviews linked to the 33 LCSPRs analysed (that is to say, each of the LCSPRs for which rapid reviews were available). Reasons for the six rapid reviews not being available to the researchers when the LCSPR was available were:

- No record of case being notified to the Panel prior to LCSPR.
- Incident notified retrospectively.

A bespoke coding framework was developed based on guidance from the Panel, with a focus on learning points and recommendations within the reviews. In addition to this top-down approach, rapid reviews were coded for shared and emerging themes; these are described in Chapters 2 and 3.

Analysis of local child safeguarding practice reviews

A similar bespoke framework as for the rapid reviews was used to analyse 33 LCSPRs available to the researchers. Our brief from the DfE had expected there to be up to 90

LCSPRs from which a sub-sample would have been selected for the Step 3 analysis shown above. In the event, we were supplied with all the completed LCSPRs that were available on 31 January 2021, which was 33.

Reasons for LCSPRs not being available to the researchers were:

- Not yet completed.
- Not sent to the Panel.
- Decision to undertake an LCSPR changed and alternative arrangements made.

Further thematic analysis

After initial coding, further in-depth analysis was undertaken of the 27 pairings of rapid reviews and LCSPRs. We also developed two checklists for appraising the rapid reviews and LCSPRs. These were based on the requirements in *Working Together 2018* and the Panel's practice guidance (CSPRP, 2019) and unpublished advice from the Panel to local partnerships (discussed more fully in Chapter 4).

We therefore have two major elements to the study, as follows:

- In-depth analysis and development of themes in the rapid reviews and LCSPRs, including those that appear to persist and any new issues (Chapters 2 and 3).
- An appraisal of the quality of the rapid reviews and LCSPRs (that is to say, how well they met the requirements) and an exploration of the 'added value' of the LCSPR compared to the rapid review in the pairings that we had (Chapter 4).

Advisory group consultation

We invited practitioners and managers to join in a virtual group discussion to explore:

- Their understanding of the criteria for undertaking local child safeguarding practice reviews.
- Their awareness of learning points from rapid reviews and local child safeguarding practice reviews.
- The fit between learning and recommendations.

Participants included a special needs education practitioner (1), safeguarding partnership business managers (2), police (1), Trust Director of Practice (1), Head of Safeguarding (1), a designated doctor for child protection (1).

We have also benefited from discussions with members of the national Panel, and the Panel secretariat. Information and comments from the advisory group and the Panel were very helpful and have informed our commentary and analysis; but the analysis is ours and of course we take responsibility for any errors of fact or interpretation.

Chapter 2: Pathways to harm, pathways to protection

The framework of 'Pathways to harm, pathways to protection' offers a number of dimensions for identifying and beginning to understand where things might have 'gone wrong' for an individual child – where actions or decisions were taken that moved them along a trajectory leading to eventual harm, or where the chance was missed to take actions or decisions that might have led to better outcomes. Of course, in a study of this nature, we do not have a 'control sample' of cases which have gone well, successfully finding a pathway to protection. A full study of the child protection system would have that element. Rapid reviews and LCSPRs focus on the cases which have ended sadly; and although they do, from time to time, identify 'good practice', this inevitably begs the question why was it not good enough in this case to change things. But we know from other research that it is often difficult for cases to 'change track', for practitioners to make the shift from seeing it as, for example, a 'child in need' and 'family support' case, to seeing it as a 'child in need of protection' and safeguarding case (e.g. Munro, 1999).

The pathways approach can be used to look at the actions of families and young people, and the actions of practitioners and agencies; and it can be used to look at recent events and older ones.

We have used the pathway approach in this four-dimensional way in our review of the rapid reviews and LCSPRs and suggest that those conducting such reviews could use it too. It is most likely to be useful to frame the analysis of the recent events that led to the incident in question – for example, if it is found that an assessment was undertaken that could have identified the risks to the child, but did not do so. This was a missed opportunity to have moved the child along a pathway to protection; instead, they were moved along a pathway to harm. An initial omission or mis-reading of the situation can have knock-on effects that lead to harm, quickly or gradually – for example, not to ask about the father and his family, or to form a view too quickly that a partner or a grandparent is a protective factor. Equally, of course, forming a view too quickly that they pose a threat can lead to harmful outcomes – the harms of a coercive intervention that might not have been necessary.

If applied rigorously, the pathways approach always points to the next question – what was the pathway for that practitioner and that agency that led to the omission? Why was it that the questions were not asked about the father? Why was it that a conclusion was reached so quickly, on evidence that we can now see as deficient? The answers to these questions might point to lack of training and understanding, but also to the pressures of such heavy responsibilities, fear, inadequate supervision, limited time and – possibly – a commitment to 'strengths-based practice' or 'relationship-based practice' that has missed the subtleties of those notions, that strengths *and* weaknesses have to be identified and addressed, and relationships built through honesty and difficult conversations. Another element could be the impact of wider pressures to reduce the number of child protection plans being made, care proceedings or children in care, possibly creating a mind-set in

frontline practitioners and managers that tries too hard to keep cases out of formal safeguarding processes.

The pathways approach can also be used to look back at the older events that led to the family or the young person being in a situation of risk. Even if the victim is a very young baby, there will still be a backstory – as examples, the mother's and father's history, or the upbringing of older siblings. What pathways have the family followed, perhaps over many years, and what learning is there as to why the risks were not addressed earlier or, if they were addressed, why that was not successful, or why the lessons were not applied to the new child? And how have wider factors, beyond the family or the immediate actions of individual practitioners, shaped the pathway of that family's life – poverty, poor housing, discrimination? The current approach to rapid reviews and LCSPRs focuses on the recent event, and of course it is too late now to change the longer pathway for that family and that child; but without detracting from the proper focus on the more recent events, reviews do give a chance to learn about the bigger picture, to help change the pathways for others.

Findings

Identification and referral

Close to half of all reviews identified problems with either early identification of risks, or agencies not responding adequately to referrals, or both. Examples included undervaluing information from anonymous sources; misconceptions about sharing information (what, when and how); not undertaking satisfactory 'whole family' assessments or not taking historical information into account; and not recognising when risks for one child may have implications for others. Shortcomings were also identified in referring cases onwards, timeliness of assessments and assessments that were not adequately informed by understandings of the long-term impact of early trauma (i.e. that did not explore and appreciate the pathways that led to the current behaviour). For example, adolescents' patterns of behaviour, which could indicate risk of exploitation, such as going missing, were not always investigated. Reviews often assert that assessments need to be holistic, including historic information, to enable practitioners to build a more complete picture of the children and families as well as their environment. We found examples of a social worker not prioritising researching the history of parents to inform the impact of trauma on their parenting capacity; a multiagency hub not making basic agency checks and consideration not given to previous referrals for siblings. *Why* this did not happen is not usually addressed but some reviews referred to lack of information sharing, delay in access to information from other agencies and changing IT systems resulting in records not being merged.

Learning points and/or recommendations were often predictable. One example was when practitioners were reminded about the importance of listening and responding to views of children and young people, in the review of a case where that had not happened. The review recommended an audit of case records regarding speaking and listening to

children, and the recording of conversations in case notes and assessments. This is a way of finding out how often this activity is recorded, but the review did not explore why the child's views were not ascertained in this case.

There were other examples of recommendations leading to specific work to try to prevent recurrence of a problem. For example, one rapid review identified a lack of robust pre-birth assessments, which triggered work between children's social care and health, to develop joint training and pre-birth assessment guidance. Within the rapid review there was a link to the new guidance about pre-birth safeguarding which included resources and support for practitioners. What we cannot tell from the rapid review is how successful it was.

Within reviews, quality and timeliness of referrals were highlighted as problems. Recommendations included training for school staff in completing referrals to ensure the right information was provided succinctly, and in one case changes were recommended to shorten the multi-agency referral form.

In a case where there were delays in appointments for children with mental health problems and delays in completing assessments, the LCSPR recommended reviews of referral and appointment processes, fast-track pathways for children and young people in most need of mental health support, and the use of escalation processes for high risk cases. These recommendations were clear and gave explicit direction for change rather than vague or implicit comments.

The importance of using clear and accurate language was addressed within some reviews. Examples were practitioners using phrases such as '*children doing well'*, '*thriving*' or '*mother relaxed and at ease'*. These sort of well-worn phrases, without clear evidence and balanced assessment, were considered to reflect a lack of inquisitive practice, and too easily give false assurances when interpreted by other practitioners.

However, our assessment of rapid reviews and LCSPRs is that they often fall into the same trap of using ready catchphrases, such as asserting the need for '*holistic*', '*whole family*', or '*trauma-informed*' assessments, but do not get to the heart of what was missing, why, and how change is to be achieved. The term 'professional curiosity' is a prime example, discussed further in Chapter 2.

Service provision: case management

Reviews regularly commented on issues to do with case management within and across agencies. These included matters such as information being obtained on risk factors but not acted upon, the lived experience of children not being sought, and poor management of missed appointments. There were also difficulties in securing the appropriate services for children and their families. Examples included access to mental health services or providing universal rather than 'universal plus' services. Problems were identified with not

using escalation processes when these could have provided a useful way to resolve inter-agency differences.

There was also reference to multi-agency meetings when managing cases:

- Meetings themselves are not enough. They need to be recorded properly and any planned actions duly taken, to manage the case and avoid drift ('review, analyse, reflect and take charge').
- The right people must be at the meetings and practitioners involved with cases, particularly complex cases, need to have management oversight and effective supervision.
- Actions need to be recorded and any decisions shared with others.

Service provision: when engagement with families is difficult or not working

Difficulties with engaging some children and families were identified in reviews. These included barriers to engagement that services themselves might create, such as lack of follow-up after non-engagement or minimal engagement not being 'flagged' as a cause of concern. Possible solutions included putting alert processes in place so that GPs are aware when children miss tests, having a key worker with an overview of the case to identify patterns of engagement, and professionals' meetings to discuss engagement. These solutions address the problem at a technical level, but do not ask the harder question why the family may be reluctant or mistrustful, and how practitioners can be supported to overcome this, whilst recognising the difficulties and not blaming them if they do not achieve this.

Lack of engagement with fathers in the safeguarding process continues to be an issue; one review stated that '*those who cause the most harm are also those who are the least engaged, understood, confronted or worked with'*. However, as discussed further in Chapter 3, men and their extended families can also be sources of protection and support. In one review agencies were recommended to identify how they intend to measure and improve practitioner engagement with men.

In relationships dominated by domestic abuse and coercive control, it may be very hard, even impossible, for a parent to engage with services. Likewise, when a child is neglected or abused, they may be too frightened to engage with interventions offered. Patterns of engagement and withdrawal should prompt an escalation of concern, and not closure of the case. Refusals of offers of support should be recorded and assessed.

Some reviews found that practitioners need to explore different approaches when working with children and families who are not engaging with services, including ten reviews that mentioned the use of '*trauma-informed'* approaches. However, it was not possible to ascertain what reviewers meant by such approaches and how they might be

embedded across agencies; and neither was it clear how such approaches would actually promote engagement.

Case closure

Fourteen reviews discussed the closure of cases. Repeated opening and closing of cases, as in one case where children had been sexually exploited, did not facilitate the building of effective relationships when the case was allocated, leading to poor engagement, leading to inappropriate closure of the case, which then had to be re-opened, and so on. There were other examples of cases that were closed too soon when families and/or children did not engage. A key message is that services should consider the *reasons* for non-engagement – in the family and in the response of practitioners and agencies – and *how* to engage, rather than close due to non-engagement. Progress should be evidenced prior to closure, the reasons for closure should be clear and closure should not be viewed simply as the end – that is, there should be clarity about what to do if new concerns emerge.

Chapter 2 summary points

- Our ‘Pathways to harm, pathways to protection’ approach looked at identification and referral; case management; engagement with families and case closure.
- Close to half of all reviews identified problems with either early identification of risks, or agencies not responding adequately to referrals, or both. The importance of quality and timeliness of referrals also permeated learning and recommendations as did the need to use clear and accurate language rather than well-worn phrases which did not get to the bottom of a problem.
- Reviews regularly commented on case management issues across and within agencies. Those included limited access to appropriate services, receiving information about children and families but not acting on it, and the importance of recording, sharing and acting on multi-agency meeting decisions.
- Recognition of difficulties in engaging children, young people and families were highlighted. There was less evidence of consideration as to *why* families may not be engaging. Engaging fathers and men in safeguarding continues to be a problem for practitioners and agencies.
- Repeated opening and closing of cases can occur when families do not engage and there is not enough time to build relationships. Progress was not always evidenced prior to closure and there was often insufficient clarity about what to do when new concerns emerge.
- Reviews rarely address *why* things happen*, why* practitioners make certain decisions or *why* children and families may respond negatively to interventions.

Chapter 3: Key themes and new themes

This chapter looks more closely at a selection of key themes to emerge from our analysis of the reviews. These develop the analysis that we began to put forward in Chapter 2. We draw particular attention to the frequent use of the term '*professional curiosity'*; lessons regarding work with babies, adolescents, fathers and families from different cultural backgrounds; and 'high level' themes such as resources, inter-agency communication, knowledge and application of policies and procedures, and the routine calls for 'more training'.

The second part of the chapter draws attention to four aspects where 'new learning' was identified (the Covid-19 crisis, peer-on-peer violence, working with transgender young people and with trafficked young people) – although our analysis would be that the learning was not really 'new', rather a case of needing to apply well-known lessons in new circumstances.

Opportunities to be curious

It was noticeable that reviews, at times, used ready clichés as much as they were critical of practitioners for doing so; the most striking example is the phrase 'professional curiosity'. Although used extensively within reviews, the term is fraught with controversy and ambiguity (e.g. Burton & Revell, 2018; Sidebotham, Brandon et al, 2016). The task and challenge for front-line practitioners is to develop authentic relationships with children and families in order to effect positive change, and to do that it is necessary to be curious and ask '*the second question',* as one review put it. It went on to suggest that:

> Labelling that as 'professional curiosity' can have the (unintended) consequence of separating it out as a specific and separate task or skill rather than being the job itself.

Reviews show that at times practitioners were not suitably curious or challenging. One report described this as '*laissez-faire practice, taking the path of least resistance and conflict avoidance'* in response to blood on a baby's face. Taking what parents were telling professionals at face value rather than employing '*respectful scepticism'* could lead to case drift and ultimately serious harm. Reviews identified that this was exacerbated by parents telling professionals what they wanted to hear because they were aware of the potential consequences for their family otherwise, resulting in a cycle of professionals not really listening or exploring difficult issues and parents not speaking up about the issues, giving the impression that progress is being made. Overall, there was rarely exploration within the reviews as to *why* practitioners were not sufficiently curious. Instead, reviewers also omitted to ask '*the second question'*.

When practitioners work with families over longer periods of time and those families have a long history of agency involvement, it is necessary to step back and review practitioners' thoughts and feelings about the case, to avoid 'fixed thinking'. This can be

done in professional supervision, and through supported conversations and exploration with team and inter-agency colleagues. A recommendation in one review was to 'stress-test' the level of objectivity in assessment, planning and intervention through network meetings with partners from different agencies. Learning in another LCSPR focused on the need for a culture of openness when working with hostile families to allow practitioners to ask for support when needed:

> This includes ensuring a culture that accepts no intimidation or bullying from service users or colleagues. A 'buddy' system within teams may be considered as a way of supporting professionals. Professionals must feel safe to admit their concerns knowing that these will be taken seriously and acted upon without reflecting negatively on their ability or professionalism.

But the primary questions, of *why* practitioners may not feel safe to admit their concerns, *why* they are concerned about this being interpreted negatively, *why* professional supervision does not give a space for this, were not addressed.

Adolescents

Limited 'professional curiosity' was sometimes evident in relation to adolescents who could be viewed as 'troublesome' rather than 'troubled', and the cause of the trouble was not always fully explored, rather put down to the age of the child. This was explicitly mentioned in three adolescent cases, and one of them noted that the narrative of a 'troublesome child' could then change the focus to support for the parent – which may of course be much needed – but without a full assessment of this it left the underlying issues unexplored. One young person who had been criminally exploited was viewed as a perpetrator rather than a victim. The LCSPR suggested that '*reflective curiosity'* is necessary to avoid the gender bias that views girls as victims and boys as perpetrators but did not indicate how reflective curiosity could be supported. Lack of curiosity and fixed views could also lead to experiences and levels of care being too readily accepted as 'good enough', not just from parents but from agencies too. That was evident in one review around low expectations at pupil referral units (PRUs).

An issue with adolescent reviews is that they usually only focus on the recent past and consider at most the last 2-3 years. Much of the harm in adolescents relates to previous childhood trauma and neglect, so that it may be exceptionally difficult to change things for them by the time, for instance, they move into residential care. The key decisions for supporting families when effective preventive action could have been taken falls outside of the review, so we cannot learn from it. There needs to be consideration of how we can ensure full learning from adolescent reviews.

Babies

Some reviews found that limited curiosity about the development of babies led to acceptance of explanations when a baby presented with an injury incompatible with their

stage of development, such as bruising in a pre-mobile baby. This was the case for medically qualified staff and social care staff. One review highlighted supervision as an important space for being curious about cases and to offer opportunities for analysis; but why a trained medical practitioner would not demonstrate such curiosity in the moment, when seeing the child, was not explored. And supervision does not automatically deliver learning: there were examples of limited reflection within supervision and actions not completed post-supervision.

The apparent lack of knowledge and curiosity about child development does not seem to fit with the sort of training that one might expect practitioners in health and social care to have received. However, research by Brandon and colleagues (2011) found that child development training was patchy for both professions. That finding is a decade old now, so this might be an issue for local partnerships, or even the national Panel, to investigate.

The impact of substance misuse and domestic violence when parenting a baby was not adequately explored in one case, where the review commented:

> There was a lack of professional curiosity identified throughout the period of time reviewed. There was limited exploration of mother's history of domestic abuse and alcohol misuse. There was also an over reliance on mother's self-reporting.

Unfortunately, the rapid review itself lacked exploration as to *why* there was no apparent curiosity about the mother's experiences and how that practice may be encouraged or addressed.

Fathers and men in families

Practitioners are well placed to probe and explore the histories and backgrounds of fathers and men and, if it is appropriate, to inform the mother of the risks. It could also be the basis for helping the men. Curiosity about fathers and men should also explore their supportive and caring capacity and is an important step towards avoiding the binary view of men as either good or bad, as expressed in one review:

> Fathers are often seen in a completely binary way - either good, supportive and caring or bad, a threat and a risk and to be avoided. Typically, we do not develop rounded balanced assessments of them and their histories, their abilities and willingness to be a good parent, their challenges, support networks like we would more normally do with mothers.

Another rapid review stated in the summary of learning that '*all professionals need to be more inquisitive and ask questions about fathers, not waiting to be informed by other professionals.* There is no suggestion as to how professionals may do that or why it has not been happening.

In one LCSPR reviewing two cases where babies had a non-accidental injury, it was noted that '*the biggest issue reported by health visitors in regard to involving fathers is a*

lack of time, and that currently it is not a mandated contact or currently expected'. The review went on to acknowledge that '*it would take flexibility in the system and a change in the commissioning of the service to ensure that fathers and secondary carers are fully involved…'* Yet the problems with involving men in child protection work have been known for at least twenty years (e.g. Daniel and Taylor, 1999; 2001) and the recommendation is only that safeguarding partners '*take the learning from the next national CSPR when it is published and explore further what can be done to improve the involvement of fathers in work undertaken with families where there is a new baby…*'.

Culturally competent practice

Cultural competence is a necessary aspect of understanding and thinking about families and the behaviour of adults and children, but details about the ethnicity of children were often missing from the reviews. Awareness can aid practitioners to explore the impact of parental cultural beliefs on mental health difficulties or parenting practices. One review reiterated the requirement for all agencies to record evidence of their actions to address the problem that '*assessment and planning did not always take into account what it is like to be a minority, what it is like to be a child of minority or mixed ethnicity in a local environment that is not ethnically diverse*'. In addition, it was noted that consideration should be given '*to identify what further action should be taken to suitably equip carers, professionals and children's settings to identify and respond to racism when they encounter it*'. The subsequent LCSPR recommended that agencies provide evidence and evaluation of both the above points. We cannot say whether that happened or how effective it was.

Resources

Resource issues were mentioned in nine rapid reviews but the theme was usually more developed within LCSPRs (in eight cases). For example, there was a rapid review which mentioned that there is '*some evidence that financial pressures across the public sector is limiting the ability to respond speedily and comprehensively to children at risk*', whereas an LCSPR might be more specific about where the pressures are, for example that services for children with mental health issues are not responding fast enough. There were, within LCSPRs, recommendations and learning related to lack of suitable placements for young people with complex needs, including mental health needs, availability of housing for large families, and funding for mother and baby units.

Work pressures and heavy caseloads were discussed in some reviews and one held that they could lead to a '*reluctance of some agencies to occupy the lead professional space*', particularly when a complex case is not open to social work. In one review, the reviewer commented on the '*strong narrative that was repeated and re-told about how difficult it was to work in the area with high levels of poverty and deprivation, coupled with high volumes/numbers of safeguarding cases, and a high level of vacancies in both health and social care services'*. The review found that the reputation of the area made it difficult to recruit, and the focus had been on recruiting rather than assessing and improving the

effectiveness inter-agency working; but of course, there is a wider debate about how much agency structures and leadership can mitigate the effects of deprivation (e.g. Bywaters et al, 2018; Hood et al, 2019). In some cases, the impact of resource deficits was linked to a specific agency or even individual: for example, one LCSPR found that a social worker had got distracted and side-tracked due to their high workload. In other cases, the problem of resources appeared more extensive. But a closer analysis of this, and proposed ways of dealing with it, were not forthcoming.

Other gaps in services were identified including in health visiting services, services for children with a learning disability who have mental health needs, and services for adults with lower-level mental health needs or less serious substance misuse issues. Both factors that can present risks to children. One LCSPR stated that within the criminal justice system there were delays in 'achieving best evidence' (ABE) interviews due to lack of qualified staff. A recommendation was that children's services and the police set out how they would work together when planning and undertaking joint ABE interviews and present a report to the safeguarding partners. This might help improve practice but does not appear to address the lack of qualified staff.

Inter-agency communication and sharing

Much has been written about the continuing barriers to sharing information between safeguarding partners and we found that those issues remain and were highlighted in almost half of all reviews. Issues included relying on other agencies to make social care referrals, not valuing information from third sector organisations and different IT systems in health which limited information sharing between trusts. There were also the longstanding difficulties around what to share, when to share and how to share.

One review drew attention to the role of the courts in sharing information and safeguarding children. It considered a case where the mother had suffered domestic abuse, and there had been close inter-agency working. The local authority supported the mother in her application for divorce and a restraining order. The father's contact arrangements were also determined during the proceedings. The review found that safeguarding partners were not aware of what had been disclosed in court or what the outcomes were. It recommended that the national panel '*remind court officials of their safeguarding responsibilities in relation to private court proceedings where information is disclosed that may indicate safeguarding risks to the child/ren'*. The report is not clear who these 'officials' are or what their responsibility is vis-a-vis the court, which does have the power to make a referral to the local authority under s.7 or s.37 of the Children Act 1989. These findings reflect wider national concern about the harms of domestic abuse in private law cases (see Hunter, Burton and Trinder, 2020).

Overall, recommendations had little to add to what is already known about sharing, as one review said:

> Issues of data sharing and confidentiality have been well-rehearsed and need not be reiterated here; the ‘golden rules’ on information sharing are easily accessible and should be recirculated to all and should be routinely recirculated to all agencies on an annual basis.

There are examples of good information sharing in the reviews, but unfortunately there are many more where sharing is still patchy or not taking place at all. Multiagency safeguarding hubs (MASHs) are designed to facilitate information-sharing and decision-making (HO, 2014), but in eight reviews, there were specific concerns about the local MASH.

Policies and protocols

Many learning points and recommendations (almost a quarter) referred to policies, protocols or processes that need reviewing as part of the identified learning or recommendations from the rapid reviews or the LCSPRs. Included here were policies related to information sharing and escalation when there are professional disagreements, both issues identified in other reviews of serious case reviews (e.g. see Brandon et al, 2020). Procedures around attendance at school and children ‘not brought’ to appointments were highlighted and although in place, they were not always adhered to. Other policies were referred to, including recommendations related to children ‘released under police investigation’; strengthening and revising policies relating to the use of texting to communicate with young people; management of parental suicide attempts; concealed pregnancy; restraint of children; and management of low birth weight.

It was not always clear what the blocks to following procedures and policies may be, but there was often seen to be a need for further training and awareness raising. Again, the language used (e.g. ‘strengthening’) did not offer any concrete support for practitioners dealing with many policies and procedures day-to-day.

Training

In almost a third of all reviews, there were learning points or recommendations related to training. This seems to be a standard response and there is an important place for it. Certainly, there are heavy demands on practitioners, who are expected to understand and retain a large amount of knowledge, from individual procedures on specific topics to more general approaches to working; and of course, there are always new practitioners coming in who need training for the first time. But as we have seen, the more general lessons about underlying practice are already well known; quite why more training – ‘more of the same’ – will lead to different outcomes is not explored.

The involvement of fathers in safeguarding and child protection was highlighted frequently, begging the question of why such a well-known issue is still such a problem for practice – a question that was not addressed in the reviews in our sample. The need for further and continuing training was also flagged up for intrafamilial sexual abuse and

child exploitation. Relevant training for practitioners to be confident in dealing with disclosures of sexual abuse, listening to the voice of the child and using risk assessments that are evidence-based was emphasised. One rapid review identified '*a significant gap in expertise across the multi-agency workforce in responding to child exploitation with robust risk mitigation and effective impact*', which could be considered another example of an unclear, rather clichéd expression. It recommended that there should be a multi-agency review of workforce development needs related to the exploitation of children, without delay. Other rapid reviews identified the need for learning around risks from peer groups, and training related to children with learning disabilities that might increase their susceptibility to exploitation. Similarly, there was seen to be a need for some practitioners to receive training and guidance on responding to children and young people who are deemed victims of modern slavery.

Rapid reviews and LCSPRs identified many other areas for further training and development. Some were topic-focused, for example, understanding of concealed pregnancies, eating disorders, autism, self-harm and suicide, witnessing domestic abuse and long-term neglect. Other training suggestions were related to ways of working with children, families and other professionals. Those included training to challenge other professionals, disclosing information confidently, seeking the voice of the child, trauma informed practice, working with hostile families, recognising trigger points for shaken babies, children of ethnic minority who are looked after, working with parents who have learning disabilities and the Mental Capacity Act, including Liberty Protection Safeguards as they apply to 16-18 year-olds. In addition, training must be updated, sometimes annually.

Training recommendations were directed towards all safeguarding partners but also other practitioners such as those working in the voluntary sector, housing, foster carers and elective home education advisors. Time and availability for training was not considered within reviews despite a survey finding that, for social workers, less than one in ten have their workload covered when they do training (Stevenson, 2019). The repetitive call for 'more training' within reviews should be assessed alongside what is possible, both for the individual and the agency. There should be consideration of other ways of gaining knowledge and expertise, such as through supervision, peer support, or special points of contact who are highly trained in certain topics and available for consultation.

New themes for further development and learning

The analysis of rapid reviews and LCSPRs identified some new challenges where learning and change are required. Four issues identified here are the impact of Covid-19, peer-on-peer abuse, working with transgender young people and delay in responding to the potential trafficking of a child. Whereas there were a number of reviews concerning the impact of Covid-19 and peer-on-peer abuse, our sample had just one case each about transgender identity and the suspected trafficking of a child, but we have included

these two issues because we consider they reflect wider social changes and are likely to become more frequently seen in child safeguarding work.

Working with families during Covid-19 pandemic

The Panel requested that safeguarding partnerships considered whether, and to what extent, the current Covid-19 crisis may have impacted either on the circumstances of the child or family or on the capacity of services to respond to their needs. It is, therefore, not surprising that comments appeared in rapid reviews and LCSPRs. We note though that the first three months of our sample was prior to the Covid-19 period, and therefore not all the cases in our sample could have referred to the impact of the pandemic.

Thirty-six of the rapid reviews identified the impact of Covid-19, highlighting issues with delivery of services or the impact on children and families, or both in 13 reviews. Another eight reviews specifically stated that Covid-19 either did not have an impact on the services provided to the family, or services were adapted so that there was no adverse impact on children and families. For example, after telephone triage, a GP still saw the child face-to-face as it was established that it was necessary and for a mother, all routine and additional antenatal and post-natal appointments were completed face-to-face as normal.

Where services had been adapted, such as replacing some face-to-face visits by health visitors with telephone or video calls, reviews indicated that Covid-19 had not impacted adversely on the outcome, although it is conceivable that it was much harder for the practitioner to make a full assessment of the situation on a remote call. The two agencies where the impact on families was most evident were education (actions lost or not followed) and maternity/health visiting services, but there was also reference to youth offending institutions and unsupervised contact.

There was, however, evidence of services being affected, particularly during the lockdowns when face-to-face appointments were not possible which led to adverse outcomes. There was discussion around the impact of virtual meetings and reduced involvement, and encouragement for agencies to use the same online platforms to promote engagement. How risk assessments were affected by Covid-19 was raised as an issue, and in one case a school risk assessment did not involve multi-agency discussions during lockdown, which may have affected the outcome of the assessment. One case raised the need for clear guidelines, but another identified that Covid-19 guidelines were not followed. These issues are similar to those identified in other recent research (e.g. CSPRP, 2020b; Neil, Copson & Sorensen, 2020).

The lockdown did offer opportunities for some positive changes – for example, in one case phone appointments were seen to be better for a young person who became very anxious during face-to-face appointments. Further, the lockdown could have afforded agencies the opportunity to visit the homes of vulnerable young people who were not attending school, but these opportunities were not always taken. Good practice was

identified in one case with the school providing regular contact with the family during lockdown. A common recommendation was for a review to be carried out as to how Covid-19 had impacted the delivery of services. One review specifically questioned whether the impact of Covid-19 was understood, particularly the impact on decision-making. Changes in protocols and procedures in one agency had an impact on others. Examples included police being unable to respond to domestic abuse effectively due to restrictions on hospital ward access, or children's social care relying on other agencies to be the 'eyes' on children where home visits had been scaled back. A result of the changes, in these cases, appeared to be better inter-agency working.

There was evidence of agencies drawing up guidelines to respond to the Covid-19 pandemic, but guidelines varied and were not always applied consistently. In one case, non-attendance at appointments was attributed to Covid-19-related lockdown and so was not followed up, whereas in another, non-attendance was not followed up contrary to Covid-19 guidance. For families who are reluctant to engage, the pandemic was thus a chance to avoid appointments. That was the case for a mother whose non-attendance for antenatal care occurred during the peak of Covid-19 but was not identified as a cause for concern.

The effects of Covid-19 on young people and families were identified in five reviews related to the death of a child and in 15 related to cases of serious harm. Issues included:

- Young people feeling isolated during the Covid-19 lockdown, but releasing of restrictions led to a young person feeling agitated *after* lockdown.
- Challenges of balancing childcare and work arrangements during lockdown, especially with younger teenagers.
- Relocation during lockdown to an area with no family connections.
- Households not being able to mix and consequent lack of support and monitoring by social networks.
- Delay in seeking support because of fear of the virus and the risk of infection.
- Weight loss coinciding with non-attendance at school during lockdown for a child suffering severe neglect.
- Financial impact.

Peer-on-peer abuse

Peer-on-peer abuse was an identifiable feature in thirteen reviews related to adolescent harm and death. Safeguarding children from harm by other children requires a new model of safeguarding young people beyond their families, in a range of social contexts and communities. A definition of peer-on-peer abuse is set out in *Keeping Children Safe in Education 2020* (updated 2021). Peer-on-peer abuse can take many forms, including, but not limited to, bullying (including cyberbullying); physical abuse such as hitting, kicking, shaking, biting, hair pulling, or otherwise causing physical harm; sexual violence; sexting and initiation/hazing type violence and rituals (DfE, 2020: 10)

The reviews involved children and young people who had experienced peer bullying, peer sexual abuse, physical abuse including knife and gun violence, and exploitation either as victims or perpetrators, or both. Some young people had died, and some had been seriously harmed. Learning and recommendations focused on the impact of school exclusions, the need for preventative work with young people, the impact of early adverse experiences (e.g. domestic abuse, family criminality, substance misuse), thresholds for intervention, promotion of social/friendship networks for children who are in the care of the local authority, placements out of borough, referral of multiple young people and parental support when the harm is outside the home.

It is of note that in three reviews concerning peer-on-peer abuse, one reason for not proceeding to an LCSPR was given as the Panel's recent report on safeguarding children at risk from criminal exploitation (HM Government, 2020). However, the Panel's report does not directly address issues around peer-on-peer abuse.

Young people's gender and sexual identities

Although not a new issue, working with transgender young people and consideration of how young people wish to identify may be new to some professionals. Awareness of how support can be coordinated, and mental health services accessed for young people who are transitioning, was identified as learning in one rapid review. AN LCSPR was not undertaken but the safeguarding partners chose to undertake 'a single agency (health) review' and findings were shared with the multi-agency panel.

Trafficking of children

In one case, there was delay in recognising that a child had been trafficked into the UK, which highlighted the need for wider multi-agency safeguarding, including with the UK Visas and Immigration service and with housing providers. The young person was posing as an adult, and the circumstances did not initially appear coercive. The safeguarding partnership commissioned an LCSPR which explored whether pathways for managing cases of children and adults who may have been trafficked, are transparent and embedded into local practice. Recommendations included the need for professional curiosity about the age and developmental stage of a presenting person and the use of dispute resolution processes. The LCSPR offered extra lessons for practice beyond those in the rapid review, including for agencies that may consider themselves on the periphery of child safeguarding such as UK Visas and Immigration service when immigration documents are issued outside the UK.

Protection of trafficked children is of course an important topic to address, but this review is another example of the routine use of the phrase 'professional curiosity', and also raises the issue of why dispute resolution processes may exist but not be used – another 'why?' question that is not investigated.

Chapter 3 summary points

- The key themes found from the qualitative analysis of rapid reviews and LCSPRs concerned *opportunities to be curious*; *resources*; *inter-agency communication and sharing*; *policies and protocols* and *training*.
- New themes that would benefit from further development and learning were working with families during a pandemic; peer-on-peer abuse; young people's gender and sexual identities; and trafficking of children.
- A lack of 'professional curiosity' was often identified in reviews, but the term had become something of a cliché. Further inquiry into why practitioners did not always ask 'the second question' was usually missing. Work with adolescents, babies, fathers and men in families and families from diverse cultures often showed the impact of stereotypes and assumptions that left issues unexplored.
- Resource issues were mentioned in nine rapid reviews, but the theme was usually more developed within LCSPRs (in eight cases). This included lack of specialist services as well as shortage of personnel within agencies.
- Inter-agency communication and sharing continues to be a barrier to safeguarding children across all agencies. Multiagency safeguarding hubs (MASHs) are designed to facilitate information-sharing and decision but in eight reviews, there were specific concerns about the local MASH.
- Practitioners are expected to know, understand and follow a range of policies and procedures as part of their job and when they were not followed, recommendations invariably pointed towards further training.
- Training recommendations were present in almost a third of reviews. Proposed training could be focused on particular topics, practice skills and approaches, or knowledge of policies and procedures. They could be single as well as multi-agency.

Chapter 4: Rapid reviews and LCSPRs: links, themes and quality

Introduction

In this chapter we focus on the 'added value' of undertaking an LCSPR and the quality of the LCSPRs we reviewed. It is important to bear in mind, however, that our comments on LCSPRs are based on a relatively small sample, the total that had been completed and submitted to the Panel by 31 January 2021. In order to get a wider picture, therefore, it is necessary to start with a discussion of the quality of the rapid reviews and the process of moving from a rapid review to an LCSPR.

If a decision is made to undertake an LCSPR, it should be completed and published within six months of the decision to initiate it (HM Government, 2018). This timescale is not being met in the majority of cases. We understand that 220 LCSPRs were initiated between 1 October 2019 and 31 December 2020; the timing of our study meant that we could not expect reports on any from the second half of 2020. Our brief from the DfE spoke in terms of there being up to 90 LCSPRs, but in the event, we received 33, all that had been submitted to the Panel by 31 January 2021. We understand that 10 LCSPRs had been published by 31 December 2020, although more have been published since.

We assessed the rapid reviews and the LCSPRs against the requirements identified in *Working Together 2018*, the Child Safeguarding Practice Review Panel practice guidance (CSPRP, 2019) and unpublished advice from the Panel to local child safeguarding partnerships. Our aim was not to rank the reviews, but rather to investigate the key features of a good review, and conversely a poor one, and whether the core requirements are demonstrably met in the written reports. We intend this as a contribution to discussion between local safeguarding partners, reviewers and the Panel.

Rapid review appraisal

The minimum requirements for a rapid review are set out in *Working Together 2018* and the 2019 practice guidance (CSPRP 2019: 14-15). They include specifying which agencies have been involved in the review and who has been involved in the decision-making process; relevant identifying details of the child and family; the immediate safeguarding arrangements for any children involved; a concise summary of the facts, giving sufficient detail to underpin the analysis but without lengthy detailed chronologies 'that can obscure the pertinent facts'; a clear decision as to whether the criteria for an LCSPR have been met and on what grounds, any immediate learning already established and plans for dissemination; and the potential for additional learning.

Assessed against these criteria, the quality of the rapid reviews was variable. There were noticeable omissions in many of the reviews, e.g. no identifying details of the child, their family or who participated in the review. Commonly missing was the ethnicity of the child

and their family. This does not necessarily mean that it was not known to the reviewers or taken into account; it is worth remembering that we only have access to the written reports. But the omission is of some concern, given the known importance of culturally competent practice and the potential impact of inappropriate services or discriminatory practices in child protection; and it is important more broadly, as an acknowledgement of the equality and diversity agenda (Keddell and Hyslop, 2019).

The level of analysis and reflection was an issue for many reviews, as we have discussed in earlier chapters. Fewer than half provided a clear and concise account of the analysis and reflection on the incident and surrounding issues. Those that did not either had missing detail, meaning that analysis and reflection was not reported, only provided limited detail, or were unnecessarily verbose and repetitive. There may have been an expectation that reviews where an LCSPR was recommended would have left the fuller analysis and discussion to that stage, but in fact we found similar numbers of reviews with good levels of analysis that went on to recommend an LCSPR as those with missing or weak analysis.

In some cases, the conclusion did not follow logically from the analysis or the facts presented. For example, a baby with a Child in Need plan due to domestic abuse, drowned when left unsupervised in the bath. There was no criminal prosecution for neglect, and the review concluded this was a tragic accident rather than neglect so an LCSPR was unnecessary. Even though there was no prosecution this was a one-off neglectful decision which had devastating consequences, and there may have been the chance for significant learning, which was therefore missed. Other cases with limited analysis seemed to ignore important aspects; for example, a review following a concealed pregnancy did not consider why the mother felt unable to tell her parents which was particularly concerning given that they were current foster carers to other children. Another review relating to the suicide of a young person undergoing gender transition did not consider the impact of them having to leave home for supported accommodation because their parents did not support their decision to transition.

There was some association between the length of rapid reviews and their quality. The best rapid reviews ranged from 6 to 16 pages with a mean of 10. One of the weaker reviews was 176 pages, but overall, the poorest reviews tended to be shorter with a mean of 7 pages and a range of 2 to 19. This suggests that there is a minimum amount of information that is necessary to provide the detail and context needed to meet or exceed requirements and falling below this reduces the quality of the review. Moreover, there appears to be a point at which extra detail does not increase, and may indeed reduce, the quality of the review. Many of the longer reviews had sections which appeared to be cut and pasted from the *Working Together* guidance, which added little value.

We know that many local partnerships have devised their own templates for rapid reviews, and most reviews appeared to follow a template. The best reviews were documented on templates that ensured all the key information was included, but there is

a wide range of templates, and not all did this. We are aware that there are differing views about whether a national template would be helpful. We have heard it said that a template might too quickly become a routine checklist, with items simply to be ticked off. That is possible, but it seems to us that a carefully designed template could help reviewers and panels to identify key information and gaps, to effectively employ a systems or pathways approach, to think things through and to ask the ‘second question’. We would suggest further discussions about this between local partnerships and the Panel.

Rapid reviews mostly had immediate learning and actions, often to safeguard siblings and protect the child in cases of serious harm. Some rapid reviews included enough analysis to put forward potential learning and areas for further exploration but other than recommending an LCSPR, or not, recommendations were usually not a feature of rapid reviews. This may not be surprising given that very little time has elapsed since the incident and information is still being gathered, particularly in complex cases involving many agencies, sometimes several children and parallel processes.

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

Progression from rapid review to LCSPR: a case example

Death of a 15-year-old child

The rapid review gives background to the child and family as well as the significant incident. There are clear areas for learning locally which include learning for GPs in relation to opportunities for measuring height and weight, policies around older children not brought for consultations and tests, GP awareness of children who are home educated, being seen by a different GP at each surgery attendance and the importance of the voice of the child. There is also learning for home education advisors, stressing the need for a broader assessment that includes psychological and social development even when the child is excelling academically, as in this case. Training and actions for the two groups of practitioners are recommended. The rapid review suggests that there is learning relevant to the local context but also national learning regarding home educated children 'lost to services' which may require legislative change to resolve.

The LCSPR develops the findings further and looks at the transition from school to home education status, information not available in the rapid review. Whilst still at school, the child started to look gaunt and pale and their attendance was dropping. Poor attendance was reported by parents to be due to illness. Scrutiny of the child's school record, during the LCSPR process, added to the understanding of potential opportunities to intervene, for example, for teachers, school nurse and friends.

Within the LCSPR there is learning for all the areas identified in the rapid review with specific suggestions and guidance for improving some areas of practice. There are six recommendations with intended outcomes related to practitioners' understanding of anorexia and implications/monitoring of children home educated. The LCSPR states that '*a lack of professional curiosity is a golden thread which was a feature in all agency reports. The barriers to professional curiosity and how systems are used to support professional curiosity need to be considered across the partnership'*.

The incident took place late summer 2019, the rapid review was submitted within the required timescale and the LCSPR, written in a publishable format, was completed the following year (late summer 2020).

We have identified two rapid reviews which exemplify the strengths (Rapid review case study 1) and weaknesses (Rapid review case study 2) of rapid reviews.

Rapid review case study 1: Death of a 3-day-old infant

This rapid review was one of the strongest we saw. It makes good use of a template, which means that no relevant information is missed. There are tables of the people who participated in the review, with columns for name, job title and agency/organisation, and of the details of the child and their family with columns for name and address, relationship to the child, date of birth, legal status and ethnic origin.

The review is divided into logical sections, the first being 'Case Background' which includes a brief summary of the incident. Section 2, 'Consideration of Case, Criteria and Guidance', comprises subheadings for 'Immediate Action', and 'Additional information' which includes details of domestic abuse (possibly triggered by the use of a tick box asking if domestic abuse is known or suspected), whether Covid-19 has had an impact on the case and a tick box list to identify improvements to safeguarding and promoting the welfare of children. The last part of this section is 'Rapid Review Discussions'. Within this there is a succinct summary of the involvement of each of the agencies/organisations involved in the case. The key point here is that the summaries are concise and relevant to the case, providing all the context necessary to understand the incident and the circumstances leading to it. Furthermore, there is clear evidence of analysis and reflection, rather than simply a description of involvement by the various services and agencies. This ends with the decision summary, which demonstrates that the review clearly considered the child and the impact of the incident on their sibling, taking a holistic view of the case. It identifies where the case could have been better managed and areas for improvement.

The review ends with the recommendation that the criteria for an LCSPR were met, but that the issues that were identified are evident in previous SCRs and LCSPRs. They found, therefore, that there was not likely to be any new learning and it would be more useful to scrutinise implementation of the previous learning, to see whether it is being embedded in practice. This conclusion appeared to be based on reliable evidence and a thorough analysis. Nevertheless, the case did progress to an LCSPR on the Panel's advice.

Overall, there was a good balance of description and analysis, whilst remaining succinct (10 pages long), providing enough detail to give context and meaning to the case without becoming verbose.

It is worth noting that we could have chosen one of two reviews from the same safeguarding partnership, both of which were excellent. Both used the same template and many of the participants were present at both, including the Chair.

Rapid review case study 2: Concealed pregnancy

This was a poor rapid review of a case involving a concealed pregnancy culminating in a birth with no medical assistance and the infant being placed in foster care. It had significant missing information, with the information that was provided being across two separate documents, the minutes of the rapid review and a letter summarising the case and outcome. The minutes provide a full list of who attended the meeting, their role and organisation, but not details of the child or their family. The date of birth and name of the child are stated in the letter but there are no further details of the family given in either document, other than that there is a sibling who is in care.

From hereon we will describe both documents together. There is some detail of the incident but this is lacking, and there is no contextual background detail. The focus of the meeting appeared to be on the reason that the case was missed by relevant agencies, without any exploration of the experience of the infant or their family. There was minimal analysis and reflection around the wider issues of the case, with the focus concentrated on a missed email. Despite highlighting a number of points where communication within and between agencies failed, the finding of the review was that the issue was a single individual misinterpreting correspondence rather than a systemic issue. For this reason, despite the account of failures in the review, the recommendation was that the criteria for an LCSPR were not met.

This review did not appear to use a template, the subheadings being questions that were discussed in the review; using a template might have ensured that relevant detail was not missed. For example, if there had been a box for the background then some information might have been provided. Moreover, this would have ensured that all relevant information was contained in a single document. This review was 8 pages altogether, 6 pages for the minutes of the meeting and 2 for the letter, but there is some duplication across these documents without which the review would have been much shorter.

Moving on to a local child safeguarding practice review

The guidance for safeguarding partners on whether or not to undertake an LCSPR is set out in *Working Together to Safeguard Children 2018* (HM Government, 2018), shown in the box below. A reminder of the guidance is included in many of the rapid review templates developed by safeguarding partners, although this is not a requirement.

The grounds for an LCSPR in *Working Together 2018*

The criteria which the local safeguarding partners must take into account include whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified;
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children;
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children;
- is one which the Child Safeguarding Practice Review Panel have considered and concluded a local review may be more appropriate.

Safeguarding partners should also have regard to the following circumstances:

- where the safeguarding partners have cause for concern about the actions of a single agency;
- where there has been no agency involvement and this gives the safeguarding partners cause for concern;
- where more than one local authority, police area or clinical commissioning group is involved, including in cases where families have moved around;
- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings (HM Government, 2018: 87-88).

But the statutory guidance also says:

Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice (p. 87).

Working Together 2018 grants local partnerships discretion on whether or not to call an LCSPR, as shown in the box, but if the rapid review has identified that there is further local learning to be had, then that inquiry should be done under the auspices of an LCSPR. The partnership may use a range of methodologies to do this (there are a variety of terms such as multi-agency review, appreciative enquiry and so on), but whatever the approach, the Panel guidance is that it should be considered an LCSPR. The point here is that an LCSPR does not have to be a full-scale inquiry along the lines of an old-style

serious case review. Shorter, more focused types of investigation into what lessons there are for practice may well be more appropriate.

This gives room for creativity in how the learning is uncovered, analysed and then disseminated, but does make it harder for reviewers to evaluate LCSPRs, because they may not all be doing, or intending to do, the same sort of things. We discuss this variety and the challenges it raises later in the chapter.

We found evidence that local partnerships were still coming to terms with the new requirements, and the concept that any further form of inquiry should be regarded as an LCSPR was taking time to become familiar. As an example, one rapid review concluded that '*it would be useful to use the opportunity for multi-agency learning, outside of the formal parameters of a Child Safeguarding Practice review'.*

We understand that the 220 LCSPRs initiated between October 2019 and December 2020 include 17 that were initially notified as 'no LCSPR', but were changed to 'yes' after Panel advice, and two that went the other way, from 'yes' to 'no LCSPR'. In the LCSPRs that we reviewed we found a wide variation of terminology, not all referring to the exercise as an LCSPR. In one, for example, the introduction states that the rapid review had concluded that '*the case did not meet the threshold for an independently led CSPR. The members agreed that a multi-agency table top review would be the appropriate methodology to extract any further learning'.* The fact that it was submitted to us as an LCSPR shows that the classification had been changed at some point.

Despite this evidence of uncertainty, we found that overall, when looking at the rapid review/LCSPR pairings, the lines of enquiry suggested within the rapid review were commonly taken up and developed by the LCSPR.

Three notable features of LCSPRs that distinguish them from rapid reviews are specified in the *Working Together 2018* guidance: these are the goals of publication, capturing the views of children and the families, and the involvement of practitioners. We consider each of these in turn.

Publication

Rapid reviews are not written for publication as they contain detailed information about the incident, the child and family members. It is therefore not possible to use those reviews for learning beyond a local audience without producing an alternative format or report that can be made more widely available, such as this annual review. In contrast, LCSPRs should be written for publication, after suitable anonymisation, making them available to all practitioners and the wider public. Of the reviews in our sample that had not been published, it appeared that some were ready but waiting for criminal proceedings to be completed, and others would be published once the review had been checked.

The legal basis is in the Children Act 2004 as amended by the Children and Social Work Act 2017 (HM Government, 2017). This establishes the presumption that safeguarding partners publish LCSPRs '*unless they consider it inappropriate to do so'* (Children Act 2004, s. 16F (4)). If it is not considered appropriate, then safeguarding partners '*must publish any information relating to the improvements that should be made following the review that they consider it appropriate to publish'* (Children Act 2004, s. 16F (5)). Partnerships may aim to do this through their annual reports, but if an LCSPR is not going to be published there should be a clear 'audit trail' for the Panel to this more general information.

The availability of a review that evaluates an incident and safeguarding practice not only offers an opportunity to improve child safeguarding practice but may also have the benefit of demonstrating to the wider public efforts to change and thereby improve public confidence. The real value of the LCSPR is the publication of learning as opposed to the rapid reviews where publication cannot be an option. Although termed *local* reviews, the learning will likely be picked up by other safeguarding partnerships and possibly other agencies, therefore bringing national value for the child protection system.

Views of children and families

Rapid reviews do not include the views and experiences of services from the child and family but LCSPRs are required to do so whenever possible. However, with publication in mind (see above) it is important that the child and/or family are not identifiable, if this is possible. This may not always be the case, for example, if there has been media coverage of a criminal trial; but whatever the circumstances it is essential to treat families with respect so that no unnecessary or harmful material is included.

There were ten reviews that gave a detailed account of the family's views, another ten gave a limited account, and there was nothing about it in the other 13 reviews. There are many reasons why families may not be involved in a review; the six-month timeframe might limit engagement, or if there are ongoing legal proceedings family involvement might not be possible. Further, families may choose not to be involved in the review. It might be useful for LCSPRs that cannot include the family's views to include a statement detailing the reasons why.

The experiences of children and families, and in some cases communities, are important for exploring how the safeguarding system works in practice for those who need it. There were good examples of engagement with children in LCSPRs and a determination by independent reviewers to hear the voice of the child. In some cases that meant giving the child a list of questions when it was not possible to speak face-to-face. One review which included three children and separate incidents, had summaries of the experiences of the children and their concerns about the support they had received. They explained that they did not feel supported during their early childhood whilst experiencing neglect and domestic abuse in the home and they were fearful of support coming to an end once they entered adulthood. This is an important point about the child protection system and

transitioning into adulthood whilst still requiring support and one that needs to be considered at all levels of the system.

In some reviews, parents were very reflective and able to articulate where they felt things may have gone wrong. For example, a parent explained that after her child had been excluded from school, she was not able to support him with his home learning and she would have preferred a more collaborative approach. In contrast, she spoke positively about the whole family support she had received from a non-statutory agency.

Such comments, direct from those who have experience of the system, are evidently important and add to the power of learning for those who safeguard children (Morris et al, 2012; 2015). Just as for the comments of practitioners and managers, they need to be triangulated against the range of information and evidence about what happened in the case. The challenge for reviewers is to show 'professional curiosity' with sensitivity and readiness to learn.

Involvement of practitioners

Another point of difference between rapid reviews and LCSPRs is that the former mostly relied on information from agencies and tended to have managers present during the process. There was rarely evidence of individual practitioners being involved in rapid reviews. In contrast, the LCSPRs did demonstrate practitioner involvement, often through practitioner events. Such events intended to provide a way of getting practitioners who had worked with the child and family together to discuss the case. It is likely that such events allow practitioners to reflect on the case, learn for future practice and also connect with multi-agency partners and establish better working relationships; this may be valuable to them, but whether it effectively leads to systemic change is harder to assess. We heard from participants in the advisory group that practitioners who had not had direct contact with the case were sometimes approached to explore the case, rather than those with immediate involvement.

In one of the rapid review-LCSPR pairings, it was clear from the rapid review that there were many multi-agency issues to explore including quality of referrals, escalation of professional disagreements and working across boroughs. Such complicated issues could not be explored within the rapid review due to the timescale but they were usefully identified and later explored in an LCSPR by holding a 'practitioner event' with key staff who had worked with the family and knew them well. As often is the case, the recommendations included many that have been voiced before but with this case, it was clear that the role of housing in statutory child protection processes needed to be understood better, including the effectiveness of notifications to boroughs when families move. Housing and frequent moves had been a suggested line of enquiry in the rapid review and the LCSPR allowed the in-depth exploration and understanding of the system and processes as expressed by practitioners. Unfortunately, this positive step did not seem to be taken forward effectively; the recommendations mainly suggest that the

safeguarding partnership investigate the various issues more fully, and there is no clear guidance as to how things could be changed for the better.

LCSPR appraisal

We examined 14 LCSPRs where the index child had died and 19 where the focus was on serious harm. *Working Together 2018* specifies that the final report of an LCSPR should include an analysis of any systemic or underlying reasons why actions were taken or not, and a summary of any recommended improvements. It also states that practitioners should be involved, and families if possible. Reports should be written for publication but take care to consider the likely impact of publication on all involved.

The Panel's 2019 practice guidance does not give detailed guidance about LCSPRs. We therefore also drew on the principles of the Wood review and the criticisms of SCRs that it sought to resolve. In addition, we referred to unpublished advice that we have seen from the Panel to safeguarding partnerships. The key elements are that LCSPRs should be focused and succinct, with relevant, clear content from which the analysis, learning and conclusions logically and explicitly flow. They should not contain personal and intimate details about those involved such that they become unpublishable. They should speak to both front-line practice and to the contribution of leaders and senior managers. In summary, there is relatively little guidance about what the report of an LCSPR should contain; this, together with the breadth of objectives and learning methodologies that could be used in a review, means it is not straightforward to compare the reports.

Our appraisal uncovered the wide variety of the reports, and wide variety of ways in which they might have met some requirements but not others. There was a range of methodologies, although not all were clear and not all were helpful. For example, one used appreciative enquiry, which participants spoke about highly, but it did not appear to offer much in the way of analysis of what had happened or new learning. However, the author of the LCSPR concluded:

> The facilitators worked hard to avoid falling into more familiar, old-style SCR practice and recognised that they succeeded in part and failed in part, which is what we should expect in trialling a new methodology. They have reflected on the challenge of examining the system and the conditions conducive to good practice through the lens of cases, without falling into the trap of an examination of the deficits in practice in the case.

There was some association between quality and length, with weaker LCSPRs tending to be shorter. One review, described as a '7-minute briefing', was one page and contained only minimal information. A single page summary might be a good way of getting the messages out to practitioners, but as it stands, we are unable to comment on how well grounded those lessons are. Looking back to the rapid review in this case, it was not clear how the LCSPR had added anything to the learning or analysis that was already there. It may have done for those involved, but the report did not show how. Whilst

brevity was an issue for some reviews (see LCSPR case study 2 as an example) it is harder to state with any certainty what the maximum length of an LCSPR should be, and to do so may actually limit some reviews which by their nature have to be longer due to more issues being discussed or more cases being included. As an example, the longest review, of 65 pages, included five different families with an in-depth exploration of the issues for each of them; this was one of the best reviews we saw.

As noted earlier, the views of the family were completely missing from over a third of the reviews, with minimal information in ten, and only ten providing a detailed account. However, there are many reasons why that may be the case, and it does not necessarily mean that there was no effort to obtain it. LCSPR case study 1 exemplifies how family involvement can be done well.

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

One LCSPR specifically explored why learning from previous reviews had not been implemented in practice. This concerned responses to cases of self-harm, and one learning point was that '*further promotion of the local self-harm referral pathway is required to raise professionals' awareness'*. A logical recommendation, one of several within the LCSPR, steered safeguarding partners towards ways of raising awareness: '*An audit should take place 12 months after [promotion of the self-harm pathway] is completed to compare its usage prior to and since the recommendation was made*'. In addition, a proposed outcome was stated: *'Knowledge and use of the self-harm referral pathway is enhanced across the authority and young people are referred when support is needed'*. The clear process of learning from the incident, recommendations for future learning and working, and a proposal to measure the outcome is a good example of the additional benefits accorded by the LCSPR in this case. Of course, what is not known to us is whether that audit occurred and if so, what it found.

Some LCSPRs had many learning points or recommendations. In one LCSPR there were 31 learning points listed, one being: *Consideration should be given to de-escalating to a Team Around the Family plan if low level concerns still need to be addressed when a decision is made to close a Child in Need plan*. The point summarises the learning from the incident, but it is not necessarily helpful in supporting practitioners to change their practice, in the absence of a clear recommendation about this. Another learning point was that: '*An authoritarian parenting style is likely to exacerbate behavioural problems in children'*. This may be the case, but again, is clearly different from a recommendation for changes in policy or practice. In contrast, another LCSPR had five very clear recommendations based on learning from an incident, for example: '*CAMHS should review the current referral process to ensure that it is child and young person focused, and that any new process has the confidence of professionals working in the county'.* This is a clear statement of what needed to be done; but again, our study does not allow us to say whether this happened, or how well it worked.

It was not always possible to separate learning points from recommendations, although the better reports did do this. Some concluded with a range of open-ended questions that were occasionally useful reflective points, but sometimes added little to help with what should follow next. All made recommendations or observations that applied at both a local and national level and many (but not all) made observations about good practice. However, good practice examples were often those where people appeared to be doing the job they were supposed to do. For example, one found that the medical care was excellent, with provision of timely and comprehensive reports, shared information and good communication, all of which should be standard practice. It was unclear at times why the decision to undertake an LCSPR had been made. One LCSPR was used to investigate a clinical medical error, which would normally be investigated using the NHS Serious Incident Framework. This may have happened in addition, but it was not referred to; this review is examined in more detail in LCSPR case study 2.

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

LCSPR case study 1: Death of a 16-year-old male

This was an example of a good LCSPR. It concerned the case of a 16-year-old male, found dead in his bedroom by his mother, with insufficient evidence that he had intended to end his life. This review provided a clear and concise executive summary of the key points from the review, briefly describing the incident, findings and conclusion, and detailing questions considered by the review, the key learning, and local and national recommendations.

The format of the review allows for identification of all the key elements expected of the review laid out in a clear and easy to read structure. It begins with a foreword, which concisely details the purpose of the report whilst setting it in the wider context and is written in a manner that is sympathetic to the family. The first section details the reason for conducting the review, giving the purpose as a bullet point list. Second is what the review found, summarising the findings into three themes: criminal exploitation, education and working together, again with bullet point lists. One of the major strengths of the review is the following sections which look at the young person's story and the perspectives of the family and community. These demonstrate that the voice of the young person and family were at the forefront of this review and including the community perspective gives insight into wider community issues that affect children and young people across the area. The next section is a summary of the themes, and again these are described and analysed from the perspective of the young person. This section provides enough detail to give the context and background to the incident from multiple agencies without becoming repetitive or verbose.

Most of the remainder of the report, over 20 pages, is taken up with the key learning within each of the three themes. The learning shows extensive analysis of a wide variety of contextual issues surrounding the case, and again is written with the young person at the forefront. The review ends with clearly laid out national recommendations, and local recommendations with accompanying action plans. These clearly relate to the key learning detailed in the previous section and include areas that should receive particular attention in the action plan.

LCSPR case study 2: Death from sepsis

This was a less effective LCSPR. It related to the death of a child from sepsis who was on a Child in Need plan for neglect due to home conditions. The death was recorded as due to natural causes and no police action resulted. Home conditions were poor, but these did not contribute to the death and the family sought medical attention appropriately. Arguably it is unclear whether an LCSPR was necessary, but the safeguarding partnership felt that there was important potential local learning based on the circumstantial factors in the case. The diagnosis of sepsis was missed by medical staff when the child was sent home from hospital two days before. The medical management should have been reviewed using the NHS Serious Incident Framework, referring to appropriate medical guidelines and standards; if this had occurred there was no reference to it.

The review was 39 pages long, covering a period of 33 months prior to death, with a detailed 10-page chronology documenting, for example, weeks prior to death that ‘he attended a mini sports day but missed a reptile party...’. This level of detail does not add to the quality of the review and makes it difficult to identify the key information.

The review identified weaknesses in the Child in Need process with healthcare staff often not invited to contribute to plans or meetings, professionals not recognising the impact of poverty, and the potential benefits of using tools such as Graded Care Profile 2 more frequently to accurately quantify neglect. Although an LCSPR is not the appropriate mechanism to investigate a medical error such as a missed diagnosis, there was useful learning from missed opportunities earlier in the child’s life.

Chapter 4 summary points

- We received 33 LCSPRs for our analysis and we were able to obtain matched rapid reviews for 27 of them.

- Analysis of rapid reviews suggested that there is a minimum amount of information that is necessary to provide the detail and context needed to meet or exceed and falling below this is likely to reduce the quality of the review. Commonly missing was the ethnicity of the child and their family which is of some concern, given the known importance of culturally competent practice.

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

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

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

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

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

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

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

Chapter 5: Conclusions and suggestions for safeguarding partnerships and the Panel

This independent review of rapid reviews and local child safeguarding practice reviews (LCSPRs) was commissioned by the Child Safeguarding Practice Review Panel in late 2020, with a deadline of 31 March 2021 so that its publication could coincide with the publication of the Panel's second Annual Report. Our brief was to conduct a qualitative analysis of all LCSPRs completed in England and received by the Panel in the period 1 October 2019 - 31 December 2020. In the event, we were supplied with 33, up to the end of January 2021. We were also asked to review a sample of 135 rapid reviews completed in the period January-December 2020 (approx. 25%). This included 27 rapid reviews that were linked with the 33 supplied LCSPRs.

The aim of the new system of rapid reviews and local practice reviews was to overcome some of the shortcomings of the old system of serious case reviews. These had been highlighted by the Wood Review (DfE, 2016), notably that they were too often about allocating blame rather than identifying ways to improve practice, and that the recommendations were too often predictable and banal. The new system aimed to put the focus firmly on learning, rather than describing and reviewing for its own sake, and in particular to identify and disseminate *new* learning. The new system also introduced a 'filter', the rapid reviews, to identify any new or local learning quickly, and thus reduce the number of larger reviews.

As regards the point about blame, we have found that reviews are careful not to identify individuals as culpable; that is welcome, although arguably a consequence of this caution has been the notable shortcomings of reviews not pursuing the really hard questions about 'why?' There is too often a gap, not going beyond *what* happened to *understanding* it, by asking 'the second questions', about the family's history and circumstances, about the practice of individuals and the various agencies, about the organisational, social and policy contexts. We found this specifically with regard to the frequent use of the term 'professional curiosity'. This has become a cliché in the reviews, but it does not tell the reader exactly what was missing, and why that individual – or more likely, group of individuals (worker, supervisor, other agencies) – did not use it, or how that can be improved. We found that the weakest reviews themselves displayed a lack of professional curiosity – and that itself should be a cause of 'second questions': why is that? Certainly, we are not arguing for a re-introduction of the blame culture; rather for deeper analysis and explanations.

As for the point about predictability and banality, it is still the case that many of the same messages come round again and again. For example, the challenges of engaging with troubled young people and families, fathers, problems with information sharing, poor assessments, missed or slow referrals, policies that are not known, not understood or not applied. Three points are worth making.

First, the work is desperately difficult, with competing imperatives: safeguarding children and supporting families; investigative duties and powers versus family autonomy; providing an excellent service for this family and saving time and resources for work with all the other families, and so on – all the well-known dilemmas. The new practice review system has not changed that, so it is unlikely to find any new solutions. If it were easy to do it, it would have happened a long time ago. That is not to suggest defeatism, but rather realism, and everyone working in the field deserves the recognition of how difficult it is. Furthermore, lessons always have to be re-learned. People change – a new generation of practitioners comes in every year; a new cohort is promoted to their first managerial jobs and so forth. Of course, they should know the lessons from their training – but one usually has to do a thing first, live it, to properly learn it. The challenge in this work is to get it right first time, every time – but that is hard in such highly pressured jobs where successful outcomes depend as much on what others do as on one's own actions.

Second, it is important always to remember that we are focusing on the 'hard cases', the ones where children have suffered serious harm or died. Once again, this is the same for the new review system as the old. These are awful cases and everyone has to try to learn from them; but they are the small minority of cases. The messages from them must be balanced with other learning – from successful cases and from cases where there does not seem to be much change, and from wider research, service users' views, practitioners in other agencies, campaign groups, policy analysis and so on.

We note that reviews are called on to identify 'good practice' in the cases they are examining, and as we have found, some do – although it was generally hard to see what made it 'good', as opposed to what should have been usual practice. But if the Panel and others want to get a clearer picture of 'good practice', looking only at the hard cases may not be the best way to do it, and we would suggest a wider review of a fuller range of cases, especially where there are apparently successful outcomes for children and families in similar situations – these are most likely to illustrate examples of good practice.

Third, it is also important to remember that we were only looking at the review reports – written documents, with all the usual caveats that apply to data obtained from documents (see Prior, 2003). They are only summaries of information and discussions, and there are bound to be omissions. Indeed, the goal of conciseness means that some degree of omission is effectively a requirement – we commented on this in regard to the lack of information about the backgrounds of adolescents. There may well be mistakes, they are written under pressure and with particular readerships in mind, and it is not always fair to judge them by a different set of expectations. What is recorded is significant, but so is what is not recorded – for example, the longer-term history, but also all the exchanges that took place before the review, or alongside the review but not formally part of it. Again, this is the same for the new system as the old and would be the case for *any* review system.

Furthermore, we need to remember that our sample of LCSPRs is relatively small, and they all come from the earlier time period of the new system. The experience of conducting and writing them is still very limited. Our 33 reviews came from just 27 partnerships (four had completed two, and one had completed three). Although the name of the author was not always given, we could only see two authors who had completed more than one. Learning from the experience of doing an LCSPR is therefore not widespread. Our sample is a snapshot of a new system bedding in, and it ought not to be too surprising to see old approaches still in place, and signs of uncertainty about the new requirements.

So, from the data we have examined, what can we say about how well (or not) the new case review system is working? Any answer must be cautious – experience and understandings of the new system are still evolving, and of course there has been a global pandemic to contend with.

A main message for practice is about the importance of staff in all agencies asking the second question, probing behind the first information or first answers they are given, whether from service users or other practitioners. There is a key role here for management, supervision and consultation in all agencies. That message applies as much to the reviews themselves as to the practice they are investigating; but also, it is important to have realistic expectations of practice and of the reviews.

Significantly, very few LCSPRs have yet been published. Without publication of the LCSPRs, learning is not shared and the system is fundamentally undermined. It is important for the Panel and safeguarding partnerships to work together to understand and tackle the reasons for the delays in completing LCSPRs, and to increase the number that are published in a timely manner.

We also suggest that the Panel and local child safeguarding partners work together to clarify understanding about the nature and range of LCSPRs, and publish clear, agreed guidance about them. Given the range of activities that could count as an LCSPR, we suggest that the discussions should consider how flexible expectations should be to take account of this variability, and should also address the circumstances in which an ‘alternative’ to an LCSPR might be acceptable. The aim should be for a shared understanding of ‘quality’ and its different dimensions.

Most of the learning is now in the rapid reviews, which are not intended for publication, and so are hidden from wider view. Publication and dissemination of an annual review of rapid reviews is essential, to share this learning. We suggest that the Panel and local partnerships should consider together what is reasonable to expect from rapid reviews, given their 15-day timescale, learning from the best reviews. They should also consider whether a national template could assist in helping reviewers gather the relevant evidence, or at least, try to gather it, and to analyse it and come up with clear recommendations.

Furthermore, we do not have any information on how the learning from either type of review is actually being disseminated - reviews give the plans, but we do not know what happened, or what impact it has had. Partnerships may refer to the actions in their annual reports, or they may be mentioned in agencies' individual reports; but that does not give an independent assessment of how well they have gone or their longer-term effectiveness. We therefore suggest that the Panel considers commissioning and publishing a study of the implementation and impact of the recommendations of rapid reviews and LCSPRs.

Finally, we suggest that the Panel considers commissioning and publishing a study of the *practice* of rapid reviews and LCSPRs; that is to say, to look behind the products – the reports – to uncover the processes, what actually happens and why. This would include interviews with those involved about their roles, understandings and priorities, observing meetings, following the stages of establishing the review, preparing for and conducting it, involving practitioners and families, writing the report, deciding on the recommendations, submitting it to the Panel and responding to their advice. It could identify common sticking points and produce 'best practice guidance' for reviewers and partnerships.

Chapter 5 summary points

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

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

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

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

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

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

- We suggest that the Panel and local partnerships work together to consider together what is reasonable to expect from rapid reviews, and the possible benefits of a national template; and to clarify understanding about the nature and range of LCSPRs, and publish clear, agreed guidance.

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

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Appendix 1: Sample Selection

From the serious incident notification (SIN) data provided by DfE at end October 2020, there were 347 notifications for which rapid reviews had been submitted; a further 88 rapid reviews were received in November and December 2020, giving a total of 435. These related to notifications from 18.7.19 to 26.10.20 and incidents from 18.5.18 to 14.10.20.

These cases were ordered by SIN type (death/harm/other) and age group and for each block a 25% sample was identified by using a random number generator to give a number from 1-4 and then taking every fourth case. For categories with expected less than four cases in an age group/type, all cases within that category were included.

This gave a sample size of 107 (25% of all rapid reviews with notifications received) plus 7 cases (114 total) from small cells as shown in the table below. We then added a further 21 cases to match up with the 27 LCSPRs (six of them were already in the sample of 114). This gave a total of 135 rapid reviews.

Age group	**Death**	**Serious Harm**	**Other**
<1 year	16 (14.0%)	20 (17.5%)	1 (0.9%)*
1-5 years	6 (5.3%)	14 (12.3%)	2 (1.8%)*
6-10 years	2 (1.8%)	4 (3.5%)	1 (0.9%)*
11-15 years	7 (6.1%)	13 (11.4%)	1 (0.9%)
16-17 years	9 (7.9%)	13 (11.4%)	2 (1.8%)
18+ years	1 (0.9%)*	0	0
unknown	2 (1.8%)*	0	0

* expected cell size <4, all cases included.

Comparing the selected sample with the remainder, the following proportions were observed:

Variable		**selected sample (n=114)**	**Remainder (n=321)**	**Total (n=435)**
Incident Type				
	Death	43 (37.7%)	123 (38.3%)	166 (38.2%)

	Serious Harm	64 (56.1%)	190 (59.2%)	254 (58.4%)
	Other	7 (6.1%)	8 (2.5%)	15 (3.4%)
Age Group				
	<1	37 (32.5%)	110 (34.3%)	147 (33.8%)
	1-5	22 (19.3%)	59 (18.4%)	81 (18.6%)
	6-10	7 (6.1%)	22 (6.9%)	29 (6.7%)
	11-15	21 (18.4%)	61 (19.0%)	82 (18.9%)
	16-17	24 (21.1%)	69 (21.5%)	93 (21.4%)
	18+	1 (0.9%)	0 (0.0%)	1 (0.2%)
	Unknown	2 (1.8%)	0 (0.0%)	2 (0.5%)
Gender				
	Male	64 (56.1%)	169 (52.6%)	233 (53.6%)
Ethnicity				
	Asian	8 (7.0%)	24 (7.5%)	32 (7.4%)
	Black	10 (8.8%)	30 (9.3%)	40 (9.2%)
	Mixed	12 (10.5%)	37 (11.5%)	49 (11.3%)
	White British	61 (53.5%)	178 (55.5%)	239 (54.9%)
	White Irish/White Other	11 (9.6%)	15 (4.7%)	26 (6.0%)
	Other	1 (0.9%)	8 (2.5%)	9 (2.1%)
	Not declared	11 (9.6%)	29 (9.0%)	40 (9.2%)

There were no statistical differences on any of these variables between the 25% sample and the remainder of the notifications.

The notifications came from a total of 128 local authorities; those of the selected sample came from 62 different local authorities, representing 48% of all notifying local authorities.

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