Child Safeguarding Practice Review Panel Learning Support and Capability Project

Research in Practice, in partnership with the University of East Anglia and Vulnerability Knowledge and Practice Programme

May 2025

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Foreword

This report, commissioned by the Child Safeguarding Practice Review Panel, sheds valuable light on how we can best learn from tragic incidents where children have died or been seriously harmed because of abuse or neglect. Safeguarding professionals, the Panel and those in Government need to reflect carefully on the findings and recommendations in this report.

A key intention of the Children and Social Work Act, 2017 was to strengthen how agencies yield the best possible learning from serious incidents. It was clear that there needed to be diminished focus on 'blaming' individuals or organisations for what had happened and correspondingly greater emphasis on securing deep systemic learning about what may have happened and, very crucially, why. This research suggests that we are only part way along that journey and that we must work differently to engender sustained and meaningful changes in safeguarding practice.

There are many rich insights in this report about our current approach to child safeguarding practice reviews, but three over-arching messages stand out. Firstly, we must get better at asking 'why' seemingly perennial problems, such as information sharing, or assessing risk, persist. This involves us being more creative and courageous when candidly reflecting on the impact of assumptions, values, approach, and context on how we work with children, families, and other professionals.

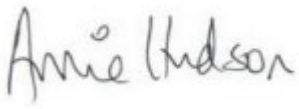
Secondly, multi-agency practice learning should be seen as a continuous and complex endeavour. Change will often be messy and non-linear; most crucially perhaps national and local leaders must strive to create multi-agency practice environments where practitioners can feel safe in reflecting on their practice and on how they might work differently in future.

Finally, the report also highlights the imperative for reviews to give deeper attention to the effects of complex structural and organisational culture issues on both the lives of children and families and on practice responses. Equity, equality, diversity, and inclusion issues should be central threads in every review; however, this research has, disappointingly, revealed a continued lack of system confidence and capability. This finding echoes the Panel's recently published thematic analysis about race, racism and safeguarding children. Remaining silent on these issues serves to preserve and perpetuate discrimination and inequality, and most importantly, it severely inhibits our collective ability to protect children.

The research makes plain that good learning is underpinned by truly joined up multi-agency leadership of learning and practice. Professionals and organisations invariably bring distinct cultures, customs, priorities, and ways of doing things. Such differences can get in the way of learning and improvement, but they can also become a crucible for healthy challenge and thinking differently about protecting children.

This report is being published in the context of major multi-agency safeguarding practice reforms, including the establishment of a Child Protection Authority (CPA). This context is important and exciting, providing opportunities for working differently in the interests of children. The Panel, Government and safeguarding partners must now reflect on this research and the six proposed priorities for change and how best these can be taken forward. There are undoubted capacity and resource implications, but these must not become an excuse for doing nothing.

Finally, I would like to thank, on behalf of the Panel, colleagues in Research in Practice, University of East Anglia and the Vulnerability, Knowledge and Practice Programme who have brought great research expertise and knowledge to this work. Thanks are due too to the many others who contributed their insights and experience to help us learn more and better from serious incidents involving abuse and neglect to children.



Annie Hudson

Chair, Child Safeguarding Practice Review Panel

Executive summary

Introduction

The Panel commissioned this project to find out more about the current approach to safeguarding reviews and how learning can be generated from them to better protect children and young people. It explored the value Safeguarding Partnerships (SPs) place on learning and improvement from serious incidents and how they viewed Local Child Safeguarding Practice Reviews (LCSPRs) as part of that.

The Panel were interested in developing ways to better support Safeguarding Partnerships to deliver high quality reviews, addressing concerns about their rigour and timeliness and whether LCSPRs identify additional learning beyond that found in rapid reviews (RR). It was the Panel's intention to use findings from the project to design a Phase 2 to test improved ways to support multi-agency learning and delivery of high-quality reviews. Involving a group of SPs, Phase 2 is an opportunity to further develop new ways of working, outlined in the proposed options for change in this report.

The findings and recommendations in this report should be considered by national Government as part of the work to establish a Child Protection Authority announced in the Tackling Child Sexual Abuse - progress update[1].

A review of the literature and policy review was followed by interviews with Safeguarding Partnerships and independent reviewers, families and practitioners, along with focus groups with health and policing professionals. A series of collaborative workshops involved testing out ideas for recommendations and options for change.[2]

Key findings

Minimal infrastructure to support safeguarding professionals and independent reviewers to enact a 'systems approach'.

- Development of ways to approach child practice reviews which draw on 'systems thinking' and safety science, have long been called for. Findings suggest that a 'radical' shift is still needed[3].

[1] In this update, the Government committed to consulting this year on a roadmap to the creation of a Child Protection Authority, using the Panel as a foundation from which to build. The aim of this work is to make the system clearer and more unified. The Government has also committed to taking immediate steps to give the Panel additional resources in 2025/26 to increase its analytical capacity and capability. The aim of this is to support ongoing improvement and learning through effective evidence-based support.
[2] Whilst this project involved a relatively small qualitative sample, the methodology allowed for the development and iteration of knowledge; building relationships with stakeholders and deeper exploration of the issues over the course of six months (see annex C methodology section for more details).
[3] Munro, E, Munro review of child protection: final report - a child-centred system - GOV.UK Department for Education 2011. Professor Munro recommended a move to a 'systems approach' adopted by the NHS for child safeguarding reviews, noting that shifting to a systems approach would require a 'radical reconceptualisation of the task', paragraph 4.47, page 66.

- In contrast to other sectors, there is no framework to help identify contributing factors to serious incidents and drive improvement through action at national, regional and local levels of the system[4].

- Consequently, the learning from reviews is often focused only on 'what happened' and so drives action plans that are based on practice issues without a focus on the system in which practice occurs.

- Rather than move to prescriptive 'one size fits all' approach which is unlikely to be successful, a new shared framework would help to clarify the why of reviews for multi-agency partners and outline how multi-agency and system wide learning can be generated. This involves boosting capabilities, ensuring that SPs can align and maximise resources, and have appropriate flexibility to adapt to local context.

A systems approach*: '*explicitly focuses on a deeper understanding of why professionals have acted in the way they have, so that any resulting changes are grounded in practice realities. It provides a clear theoretical framework for understanding professional practice in context'. The approach moves away from methods that 'reinforce prescriptive approaches to practice, focusing instead on professional learning and increasing professional capacity and expertise' (Munro, 2011)[5].

Emphasis on learning for practitioners and learning outputs is counter to a need for continuous learning and adaptation within a complex multi-agency safeguarding system. Opportunities for deeper learning which might examine fundamental values, beliefs and purpose, are more limited and have implications for capacity and learning culture.

Learning was nearly always presented in terms of further training, updated tools, changes to process or new or adapted polices. Participants aspired to:

- Go beyond 'defensive reasoning' which inhibits or prevents learning from happening

- Create psychologically safe spaces to reflect on how personal biases can influence decision making, and to better address inequities and discrimination

[4] The NHS was judged to have become a 'world pioneer in the field of patient safety', drawing on knowledge developed by the engineering sector about how to learn from serious incidents and accidents. Munro, E, Munro review of child protection: final report - a child-centred system - GOV.UK Department for Education 2011, paragraph, paragraph 4.28, page 61. The NHS's Patient Safety Incident Response Framework (PSIRF) web hub provides access to a range of tools and videos explaining the aims and steps in the PSIRF. It includes details on the theory and evidence behind the PSIRF, and step by step guides for professionals. This model might provide a framework for a similar resource focused on safeguarding reviews.

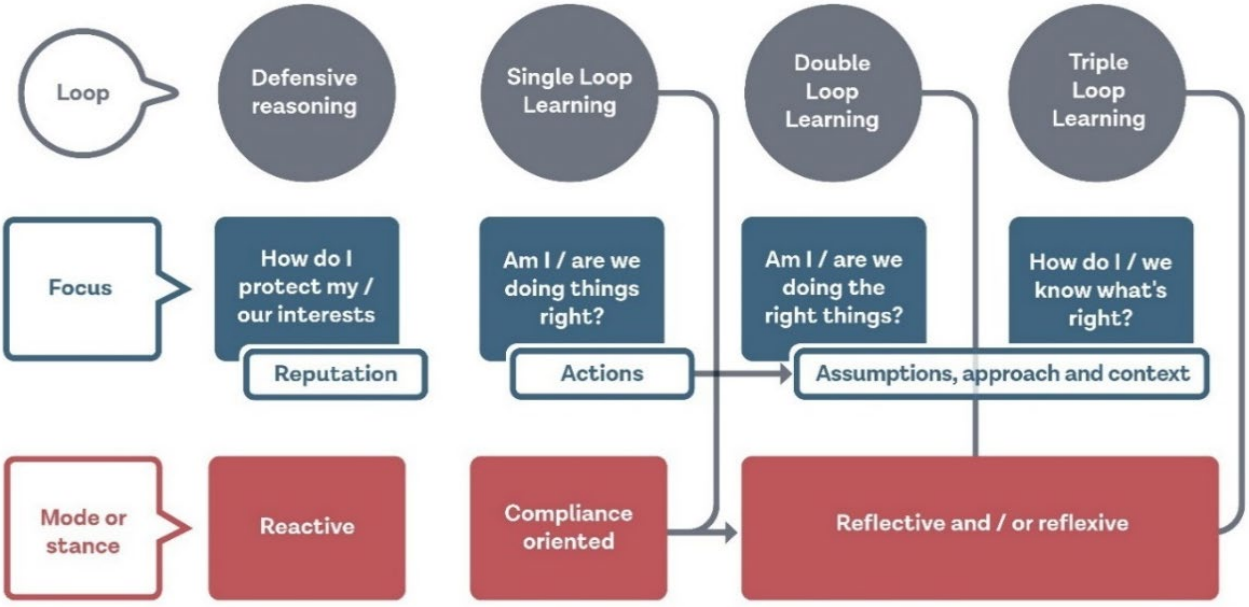
[5] Munro, E, Munro review of child protection: final report - a child-centred system - GOV.UK Department for Education 2011. See paragraph 4.30, page 61.

- Complement learning activities, like training (which can be more focused on 'doing things right' such as following prescribed guidance (single loop learning, Fig 1) with more opportunities to critically examine factors that might influence certain practices and ways of doing things (double loop learning, Fig 1). Learning that opens the possibility of changing existing norms and structures (triple loop learning, Fig 1) has implications for capacity which is already constrained, and taken up by delivering rapid reviews and LCSPRs.

"…we talk about learning from reviews and that lends us towards thinking there's a knowledge gap and we churn out training, 7-minute briefings, comms briefings and it isn't that. It's not about knowledge... **It's the implementation of learning to practice we're talking about** that's a completely different sort of field of work when we're talking about the space that we're asking practitioners to work in: culture, leadership, resource capacity" (health focus group participant).

Figure 1: Learning Loop Framework

Adapted from New Philanthropy Capital's (NPC) Learning Loop Framework which draws on the work of Joan O'Donnel and the original Double Loop Learning Framework created by Argyris and Schön (1978)[6]. The framework offers a way to support learning in individuals and teams. It shows different learning modes called learning loops which can occur simultaneously at different times. None of the loops are intrinsically bad. The aim is to achieve balance between the three loops.



[6] Adapted from the NPC graphic https://www.thinknpc.org/resource-hub/systems-practice-toolkit/triple-loop-learning/.which draws on the work of Joan O'Donnel which itself draws on the original Double Loop Learning Framework created by Argyris, C., & Schon, D. (1978). Organizational learning: A theory of action perspective Reading, Mass; London: Addison-Wesley.

Risk of insufficient attention to more complex, structural issues because of a preference for SMART recommendations. Re-focusing on identifying and responding to learning at every level of the system (local, regional, national), is more likely to generate opportunities for tackling complex and pervasive problems.

- Whilst recommendations have become 'smarter', this may be leading to recommendations that locate change only in 'frontline' professional practice and generate further layers of prescriptive activity. Ensuring deliverable and SMART recommendations is in tension with a constantly changing, complex multi-agency system and desire for impact.

- Professionals were aware of these risks and of the complexity of the system they are part of. There was debate and 'healthy challenge' about the types of recommendations made in reviews, including needing to understand what was achievable:

    - a distinction was made between findings highlighted by LCSPRs that could be addressed locally and 'bigger ticket issues' such as Tier 4 (footnote 7) placement availability, tackling unregulated children's homes, and home education monitoring.

    - some SPs and reviewers reported that they do not shy away from making national recommendations or from highlighting systems issues, yet ambivalence was expressed about the value of doing so because of perceptions that Panel were not receptive to recommendations that highlighted national issues. Others described how they assumed such issues were already known about, and therefore not made explicit in reviews.

    - a perceived lack of action at a national level appears to act as a disincentive to including recommendations which have implications for national and regional system leaders.

Learning is emergent and occurs throughout the process, including from the time of an incident and notification. Impact on outcomes is hard to demonstrate and capture in view of the complexity and the changing nature of multi-agency systems and activity. **There is a clear need to describe and enable learning differently, so that it is more attuned to the messy, reality of how change occurs in complex systems.**

- Implementation of learning is underway, according to participants, prior to final LCSPR report and publication. Some LCSPR reports will include information on changes already made.

- However, children and family members, and practitioners are not routinely involved at an early stage or kept informed about LCSPR publication or outcomes. SPs are not informed by Panel and / or national Government about how national recommendations or system wide issues will be considered or acted upon.

- Safeguarding Partners talked about how causes and effects are hard to distinguish, when considering how reviews impact upon improvements in practice. Safeguarding children requires working in systems that are beyond the control of any one of the actors in the system.

- Partners highlighted the challenge of implementing multi-agency recommendations, when leadership, policy, resourcing and staff levels are ever changing.

- It is proposed that, building a shared understanding of the challenges and solutions in the context of wider multi-agency improvement activity, should include:

    - opportunities for SPs to connect at regional level to identify and collaborate on thematic learning and improvement across multi-agency boundaries.

    - enhancing SP capacity to better involve and co-produce learning with children, families and practitioners as a core part of SP functions, to ensure that there is a better understanding of areas where ongoing learning is needed and impact.

    - stronger mechanisms for national Government and Panel to feedback to SPs on how national and system level recommendations are considered.

Realising opportunities for shared and equal responsibility across multi-agency safeguarding partnerships requires greater recognition of the structural and cultural differences between agencies.

- Multi-agency partnerships must navigate single agency professional cultures and norms, duties and processes. Although many SPs stated that they have a culture of healthy challenge, there were different opinions across agencies regarding the value of reviews. Concerns about achieving equality in decision-making were expressed.

- Geography is an important contextual factor for strategic safeguarding leaders and practitioners alike. Integrated Care Board (ICB) and police geographical boundaries are rarely coterminous with those of local authorities and often cover more than one local authority area. The specific structures, disconnect and fragmentation in police and health services adds to the complexity of representation and involvement in the RR and LCSPR process.

- Greater recognition of different structures and learning practices across local authorities, health and police and the relative strengths of different agencies, might help to evolve opportunities for multi-agency learning. An approach which promotes a dialogue between every level of the system, would require a shift in learning cultures across agencies.

Equity, Equality, Diversity and Inclusion (EEDI) is an area needing significant improvement, reducing the ability to learn from reviews or implement systems learning. If the process for generating learning to better protect children from harm currently contributes to perpetuating bias and discrimination rather than disrupting it, then leadership is urgently required at all levels to address this.

- Findings suggest a lack of confidence and capabilities regarding how issues of EEDI are understood and addressed within reviews.

- Whilst there is some promising practice and an openness to further learning about EEDI, the findings are indicative of deeper systemic failings to address inequities and discrimination impacting children and families.

- SPs require support to ensure that EEDI is central to decision-making and considered at every point in the RR and LCSPR process. An EEDI protocol would provide impetus and clarity, alongside intentional effort to create opportunities for continuous learning and reflection, to avoid a tick box approach.

Involving children, families and practitioners in review processes needs to be strengthened so that their expertise and lived experience shapes and informs learning from reviews as part of wider improvement. This should involve developing resources for SPs to maximise opportunities for strengthening communication, the range of methods and trauma informed approaches.

- Participation of family members in reviews was valued and seen to add to learning. Experiences varied amongst the family members and practitioners who participated in the project; despite involvement in developing recommendations, feedback provided to them was limited about what happened because of a review and / or their involvement.

- Some practitioners appear to associate the review process with blame and worried about professional consequences. In some cases, there was little therapeutic support and follow up after taking part in reviews and events.

There is variability in the capacity and capabilities across Safeguarding Partnerships impacting scope for learning. Greater connectivity and alignment of resources is needed to help partnerships work in more equitable, creative and impactful ways.

- A lack of familiarity about review processes amongst statutory partners can impact the effectiveness of the process, particularly when there is no core team undertaking reviews. Variable levels of preparedness and knowledge about the process, including about the reasons for a review, was reported by participants.

- How business units are resourced was reported to vary widely. The capacity and capabilities within review groups influence how far areas for 'further learning' with potential importance locally and nationally can be identified.

- Partnerships talked about how capacity to learn is limited where resources are stretched and diverted to undertaking reviews. Professionals report feelings of 'overwhelm' from the volume and emotional impact of reviews (particularly RRs), as well as from parallel processes they can also be involved in.

- SPs also described 'fatigue' from a constant stream of recommendations in view of the volume of reviews, with frequent overlap and repetition.

- Building on national thematic reviews and Annual Reports from the Panel which are valued by SPs would be one way of streamlining effort more effectively:

    - sharing learning regionally and nationally was identified as important by SPs
    - information about themes and trends, increased availability of data and insight helps SPs to make decisions about where 'further learning' is needed

Implications and recommendations

Overall, to fulfil the purpose of child safeguarding case reviews, learning needs to be identified and responded to at every level of the system. Realising impact must be a collective and systemic endeavour. Working Together (DfE, 2023 (Page 131) makes the purpose of a child safeguarding practice review clear:

"The purpose of serious child safeguarding case reviews, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. Learning is relevant locally but has a wider importance for all practitioners working with children and families and for the government and policymakers".

The recommendations proposed should be taken as a package as they require development at local, regional and national levels. The areas are inter-connected and inter-dependent. This means change at local level will require enabling structures and behaviours at sub / regional level change, and Panel / government level change.

Practical constraints must not limit ambition. Shifting the system to learn better and differently will challenge long-held assumptions about *how* learning and change occur. Panel and national government should:

- pursue a developmental approach by adopting the priority recommendations first, as these will underpin wider improvement

- involve multi-agency leaders, practitioners, children and families, reviewers and scrutineers in the process of implementation

- create regular opportunities to review implementation and engage in dialogue about what needs to iterate and adapt, given that trying out new ways of working can throw up new insight and learning

- respond to learning from implementation of PHASE 2 of this project which will test out a different and potentially transformative approach.

Principles for change

Repeating themes emerged throughout the fieldwork and workshops. Drawn together, these provide useful principles to guide future thinking about the change required to make the system improvements set out below. These are:

- Shared multi-agency purpose and approach.
- Change is emergent in complex, adaptive and dynamic systems.
- Continuous learning.
- Proactive rather than reactive.
- Meaningful collaboration with children, families, professionals and between agencies.
- Systems stewardship.

Six priorities for change

These are critical first steps and must be adopted to catalyse positive change.

Priority 1: National Government should increase capacity in Local Child Safeguarding Partnerships using existing regional improvement structures. Significant pressure on public finances and proposed re-organisation of parts of health system, will impact upon the capacity of multi-agency partners. It is critical that driving improvement to better safeguard children is made a priority. Political leadership should support local areas to embrace emerging opportunities for collaboration and innovation.

Next steps: Identify opportunities to build capacity in consultation with SPs and multi-agency leaders, including how to build on existing improvement initiatives[7] and communities of practice. Consideration should be given to how promising practice in individual SPs can be elevated and shared to maximise resources. The wide variation in SP resources will need to be considered to identify mutually beneficial arrangements at local and regional levels.

[7] Northwest Regional Improvement Pilot Programme (RIPP), Partnership Workstream.

Outcome: More opportunities for SPs to connect across localities, maximise resources, provide professional development opportunities and peer support. Greater connectivity for thematic learning and improvement across regional contexts.

Priority 2. National Government and Panel must introduce an approach to recruitment, accreditation, professional development and support of independent reviewers to address gaps in expertise and attract new professionals to the role, helping to diversify the current pool of independent reviewers. The current lack of reviewers is a barrier for SPs to commission and delivery timely and high-quality reviews. This change should happen in tandem with development and implementation of Learning Framework to drive up the quality of reviewing activity.

Next steps: Consult with reviewers, scrutineers, SPs and practitioners and children and families with experience of the review process about what is needed.

Outcome: SPs can engage a diverse pool of qualified reviewers through:

- a single mechanism for identifying reviewers
- stronger recruitment policy and process
- review of relevant qualifications and CPD, including how reviewers are supported through supervision and communities of practice.

Implementation of priority 1 and 2 will underpin effective implementation of priority 3 (Learning Framework), priority 4 (EEDI protocol) and priority 5 (co-production and participation).

Priority 3: The Panel should develop and implement a 'Learning Framework'. A broad framework that sets out how systems learning needs to be identified and enabled at every level of the system i.e. recommendations that identify change at local, regional and national levels.

Next steps: Commission further work to develop a Learning Framework.

Outcome: A Learning Framework will enable learning and change at every level of the system. It will support decision-making so that the review process is focused on effective implementation of learning from the start, such as deciding whether to notify an incident, undertake a review, commissioning and setting terms of reference, through to identifying recommendations and testing out learning. It will set clear expectations around systems learning and implementation. SPs would be required to use the framework to:

- identify and make decisions about learning at each level of the system
- test out recommendations involving children, families, practitioners
- ensure EEDI considerations are incorporated throughout the process
- align plans with wider improvement activity across multi-agency partners.

The Panel could also use the Learning Framework to identify and make decisions about national and thematic reviews.

Priority 4: The Panel must establish an EEDI protocol so systemic learning and reviews incorporate EEDI, demonstrated through tangible examples of various aspects of activity, e.g. commissioning.

Next steps: Panel should commission development of a protocol along with a toolkit to help guide and enhance SP practice in collaboration with children and families and professionals. The protocol should be tested and refined by a smaller group of SPs.

Outcome: Increased confidence, skills and capabilities in respect of EEDI and decision making, helping to strengthen analysis and learning from reviews.

Priority 5: Share power with children, families and practitioners.

5a. The Panel must role model clear expectations for Safeguarding Partnerships to strengthen participation and co-production by:

- requiring SPs to inform families and practitioners about RRs
- requiring SPs to keep families and practitioners informed throughout the RR and LCSPR processes and about publication and impact
- supporting SPs with dedicated ‘how to’ and good practice resources
- establishing an ‘Expert Group’ made up of representatives from SPs, family members and practitioners from each of the regions, to inform Panel activity.

Next steps: Strengthen Panel guidance. Assess the practicalities of setting up an Expert Group, such as criteria for recruitment, support and development opportunities and governance framework, informed by best practices in co-production (ensuring tokenism is avoided).

Outcome: Stronger emphasis and capacity across the system for children, families and practitioners to be meaningfully involved in reviews. Greater connection between Panel and operational and lived experience perspectives.

5b. SPs should strengthen participation and co-production practice through:

- early and regular communication and feedback as part of reviews
- systematic involvement of children, families and professionals in learning activity as a core part of SP’s work.

Outcome: The development of participation and co-production with children and families and practitioners should form a core part of SP activity (not limited to specific reviews and opportunities). For example, Safeguarding Partnerships should deploy young scrutineers, or methods of child and young person scrutiny within the local independent scrutiny arrangements.

Priority 6: National government should respond annually to key recommendations for government in national and thematic reviews. The government's response should be reported by the Panel in their annual reports. This will address the current gap in response to issues of national importance and complex, system wide issues. A narrow focus on local practice improvement, whilst important, is unlikely to shift structural and systemic issues.

Next steps: Government to work with Panel to agree how to respond to key recommendations in national and thematic reviews. Panel should play a convening role and consider how to create discrete opportunities for national, regional and local stakeholders to come together to discuss progress on key themes.

Outcome: Increased dialogue and connectivity between systems leaders to support systemic and structural change.

Taken together, these SIX priority recommendations should lead to improvements in the quality and impact of reviews. To enable and support these changes, the following should also be considered: We propose that national Government, the Panel and Safeguarding Partners act as 'System Stewards'[8] to bring about a change in the way learning is valued and approached through child safeguarding practice reviews.

National Government should create and sustain a healthy system in which learning is valued, enabled and promoted and role modelling the change needed. Government should:

- send a clear signal that government departments share responsibility for safeguarding children and jointly own the learning from reviews, starting by jointly responding to recommendations in this report

- provide leadership on Equity, Equality, Diversity and Inclusion, including through implementation of a national leadership programme to address specific challenges around EEDI, sending a bold signal to the rest of the system

- enable multi-agency leadership development, such as through a Joint Executive Leadership development programme which addresses a gap around multi-agency development at executive level aimed at strengthening capacity of core Safeguarding Partnership functions, including learning from reviews. This should include components to strengthen co-production and participation practices across partnership activities.

[8] Institute for Government. (2011). System Stewardship | Institute for Government. [online] Available at: https://www.instituteforgovernment.org.uk/publication/system-stewardship-future-policy-making

What is Systems Stewardship?[9] The work of creating healthy systems[10] has been referred to as 'Systems Stewardship'. The role of a Systems Steward is a person (or people) who take responsibility for bringing about desired System Behaviours[11]. It requires brave leadership, as it requires leaders to assume responsibility for systems without seeking power over them.

Systems Stewards are essentially seeking to improve the quality of relationships and interactions between actors in a system of interest. Undertaking this role requires those actors to believe that the person(s) playing the stewardship role have legitimacy in doing so. Therefore, the Systems Stewardship role requires some form of (at least tacit) consent and agreement'[12]. Child reform facilitators within Education, local authorities, NHS England and the Police have undertaken a similar role: we can learn from this approach.

[9] Hallsworth, M. Systems Stewardship. The future of policy making? Working paper Institute of Government 2011.
[10] Lowe, T and French, M. Public Service for the Real World Centre for Public Impact and Collaborate. 2021, Chapter 3. The HLS Principles: Systems. Toby Lowe and Max French explain that outcomes are not produced by organisations, but by whole systems (this is core to the Human Learning Systems approach). If we want better outcomes for people and communities, we need to create the conditions for healthy systems. It is proposed that healthy systems: Are learning systems in which people collaborate and learn together; are based on relationships of trust; diverse systems to realise better outcomes for people with diverse lived experience; systems that tackle inequalities of power which is a necessary part of enabling diversity. See also the work of the Lankelly Chase Foundation about behaviours in a healthy system.
[11] The role of a Systems Steward also contains strong connections to the role of Systems Convenor, as articulated by Wenger-Trayner, B and Wenger-Trayner, E, Systems convening - the art of convening diverse voices across difficult boundaries (viewed on 12 December 2024).
[12] Public Service for the Real World Centre for Public Impact and Collaborate. 2021, Chapter 3. The HLS Principles: Systems.

PHASE 2

The Panel must implement PHASE 2 of this project to test out a new approach to multi-agency learning from reviews. SPs valued flexibility to target and align limited resources in areas where learning is most needed.

Next steps: Panel should commission PHASE 2 and involve SPs, independent reviewers and scrutineers in the design of the programme to ensure alignment with existing structures, local and regional priorities. Implement PHASE 2 using action learning to test out options for new ways of working. It should involve a small group of mature partnerships within a single regional footprint, alongside a partnership with boundary complexities. Criteria for participation could be developed as part of an open application process.

The Panel would be directly involved in the project, playing the role of Systems Steward, alongside national government, regulators and safeguarding partners.

Outcome: Test and learn about key areas identified by this project as potentially transformative. Identify a further set of changes, such as:

- **Allow SPs to select priority areas for RRs and LCSPRs within a given year**. This could involve testing out a 'Learning Framework' to help identify priorities and include at least one thematic review. It should help to streamline and focus reviewing activity and / or result in an SP undertaking fewer reviews (dependent on context). Where capacity is freed up, SPs can focus on learning activities, undertake reviews focused on when things go well, and enable greater participation and co-production with practitioners and families.
- **Undertake more thematic reviews** (streamlining opportunities across regions for deeper learning where it's needed). Using the Learning Framework to help guide decision-making; develop criteria for identifying themes and mechanisms for multi-agency partners to identify and agree shared priorities.
- **Promising practice to centre lived experience**. Implement trauma informed approaches for collaboration with children, families and practitioners, so that they are more active participants; they will advise SPs and help drive improvement as part of review processes, audit and impact activity and test out the EEDI protocol.
- **Focus on when things go well**, moving from a deficit to a strengths-based approach and incentivising professionals to engage positively in the process. Developing and testing out appropriate methodologies and levels of partner and practitioner engagement.

Acknowledgements

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1. Introduction

1.1. The Learning and Capability project aims to address gaps in understanding about the process of conducting high quality reviews, or how to enable them to take place across a range of Safeguarding Partnerships and situations.

1.2. In commissioning this project, the Panel noted that: 'Understanding of the LCSPR system would benefit from an in-depth study of the process, not only the outputs. This should include the ways that 'methodologies' and 'methods' are understood and used, the roles of the reviewers, and how day-to-day practice is addressed'.

Refer to the Annex A for definition of the terms used in this report.

Background and scope

1.3. The Panel believe that 'reviews should be driving improvements in practice to ensure that, wherever possible, the mistakes or poor practice that are identified within the reviews are not repeated. SPs do this initially through a rapid review, but during this process, they may decide to conduct a longer Local Child Safeguarding Practice Review (LCSPR). These two types of review are vital to the Panel achieving its mission of improving professional practice, and the Panel provides feedback to SPs on these reviews'.[13].

1.4. The Panel have expressed concerns that many of the LCSPRs the Panel receive are of 'poor quality.' While 'some LCSPRs are of good quality and many impact positively on practice, the Panel are concerned that where a review is of insufficient quality and rigour, it leads to important learning from serious incidents being missed. This reduces the impact learning activity can have, missing opportunities to protect children from harm and neglect.'[14]

1.5. These concerns chime with analysis conducted for the Panel's 2021 Annual Report[15], which identified some issues in the way LCSPRs are delivered, including:

- the median length of time to complete an LCSPR after the rapid review was 58 weeks. The longest case [in the sample examined] took over 2.5 years (Dickens and others, 2022: page 6)

- analysis identified that (in the sample reviewed) 'only half of LCSPRs identify 'additional learning' beyond that found in the rapid review' (Dickens and others, 2022: page 50)

- feedback to Panel Members suggested variation across the country in how much value practitioners and Safeguarding Partnerships place on conducting LCSPRs

[13] As outlined in the ITT (invitation to tender) for this project.
[14] As outlined in the ITT (invitation to tender) for this project.
[15] CSPRP (2022a). Child Safeguarding Practice Review Panel: annual report 2021. [online] Available at: https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2021.

- ‘wide variation in style of writing, length of reports, grounding in evidence, analytic detail and ‘clarity of learning’ in LCSPRs’ (Dickens and others, 2022: page 7)
- there is little consistency in the methodologies used for reviews
- they do not always sufficiently represent and analyse the experience of children and young people, families and practitioners.

Key questions

The Panel commissioned this project to build a detailed understanding of how to support Safeguarding Partnerships to conduct high-quality learning in response to serious incidents, continuously improve their practice and better protect children and young people from harm.

The Department and the Panel sought to understand four key themes:

- the value local Safeguarding Partnerships place on learning and improvement from serious incidents and how they view LCSPRs as part of that.
- the current LCSPR process and how it is delivered, including how choices around approaches and methodologies are made, and how Safeguarding Partnerships work with independent reviewers when conducting LCSPRs.
- what is working well in the process, examples of good practice, as well as the current challenges, at all levels, including local practice, leadership and management, system issues and challenges at a national scale.
- how recommendations are made and the consideration given to ensure recommendations will be deliverable and impactful and then included in the Safeguarding Partnership’s Annual report.

What was included in the exploration of the ‘process’

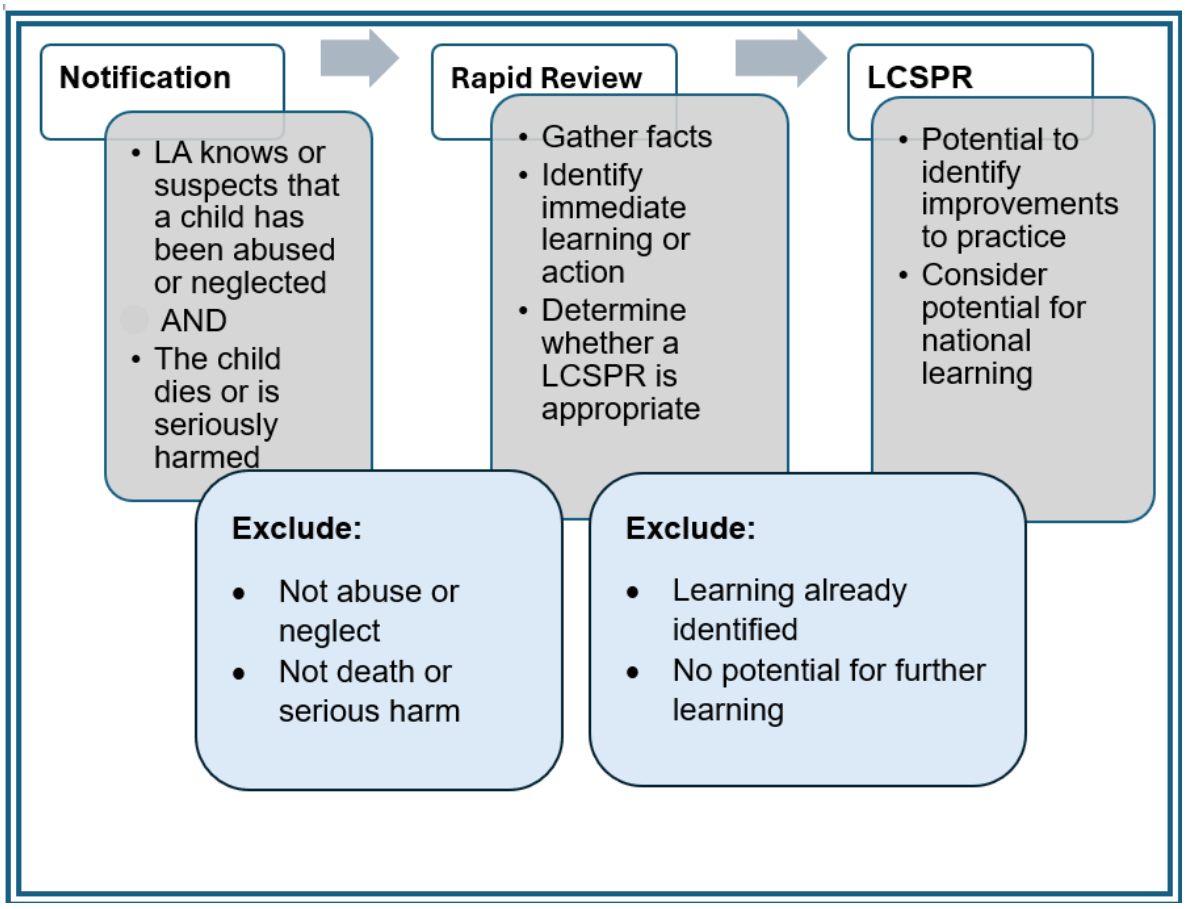
1.6. The initial aim was for this project to focus on LCSPRs in view of concerns about their quality. Early in the project, the Panel agreed to expand the lines of enquiry to include Serious Incident Notifications (SINs) and rapid reviews (RRs) because:

- The rapid evidence review raised questions about what actions should be considered as part of the review process and where learning takes place. There is more focus in the literature on the end of the process: the implementation of recommendations from reports. There has been less exploration of the wider learning that takes place throughout the review process. For example, learning that takes place around the time of a serious incident or death. To understand the ‘value local Safeguarding Partnerships place on learning and improvement from serious incidents and how they view LCSPRs as part of that’, it was

apparent that we would need to examine how safeguarding partnerships are approaching the whole process from the earliest points of a referral, through to rapid review and LCSPR.

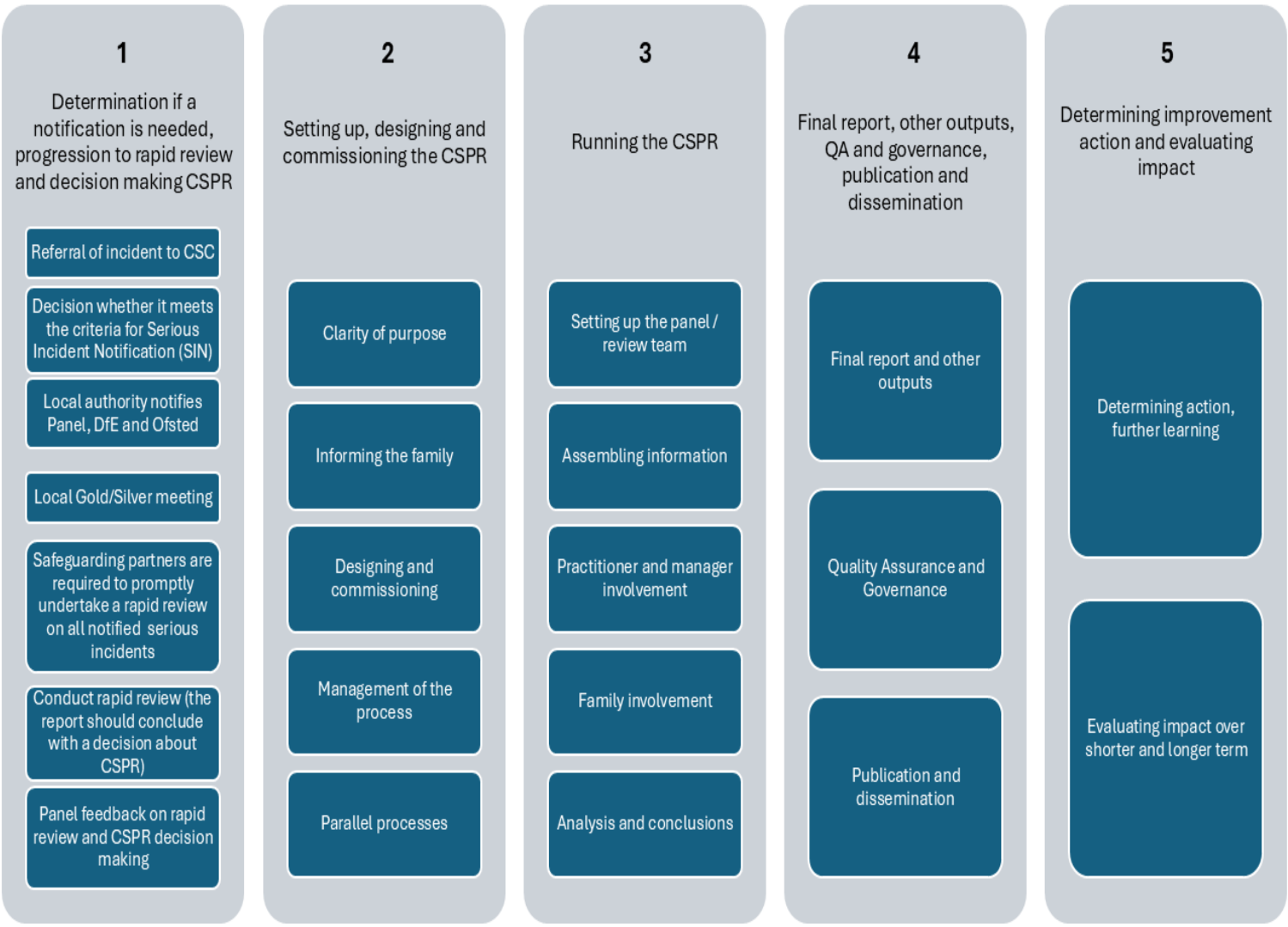
- In the scoping stages of the project, it became clear that there were varied understandings of the 'LCSPR process' and there were differences depending on professional background or prior knowledge**.** Having established that there was no ready resource that could be easily referenced, we created a 'Process Map', Figure 3 which we used as a reference point for the interviews and focus groups. A version of Figure 3 was shared with the participating partnerships. Interviewees confirmed that there was a lack of clarity amongst safeguarding professionals and suggested that simple materials on the process would be helpful to share with different agencies, children and families and practitioners.

Figure 2: Decision making around reviews[16]



[16] Child Safeguarding Practice Review Panel guidance for safeguarding partners, page 7

Figure 3: Process Map[17]



[17] This process map is a modified version of the process map originally created by Research in Practice (re-designed for final publication)

2. Methodology

2.1 The project adopted a 'double diamond' approach[18] to guide an iterative process of Discover, Define, Develop, Deliver.

- a rapid evidence review (Annex G) and policy scoping formed the first stage to Discover what we already know;
- define this knowledge in the context of the experiences of SPs, reviewers, the Panel, multi-agency professionals and families with experience of the LCSPR process through fieldwork;
- develop hypotheses and collate evidence from the fieldwork, explore challenges and identify existing effective practice through the workshop series;
- finally coproducing final report findings to Deliver project learning to the Panel and identify key recommendations for the next phase.

Equity, Equality, Diversity and Inclusion (EEDI) Framework

2.2 We developed and adopted an Equity, Equality, Diversity and Inclusion (EEDI) Framework to provide a clear stance on the project's EEDI approach to instil confidence and good practice, and to embed and support the mainstreaming of EEDI across all project levels to enhance outputs' quality, depth, and relevance. All project activities and fieldwork sought to apply Intersectionality, Critical Race Theory, Queer Theory and Disability Theory where appropriate. More details can be found in the EEDI Framework in Annex F.

Fieldwork

2.3 The fieldwork comprised single agency focus groups and multi-agency interviews as well as individual interviews with different stakeholders in the LCSPR process. This allowed the project to gather different data sets reflecting differing perspectives. These were first analysed separately and then combined to allow triangulation of the data. A total of ten Safeguarding Partnerships participated in group interviews.[19] Each Safeguarding Partnership was interviewed twice in relation to an 'index case', a child who had been the subject of an LCSPR in the last 12 months. The first semi-structured group interview covered the different stages of the LCSPR *process* and had a focus on EEDI. The reviewers for eight of the cases took part in a separate individual semi-structured interview focusing on their role in the process. Finally, the third interview was a group interview involving the SP and the associated reviewer. The third interview focused on learning.

[18] https://www.designcouncil.org.uk/our-resources/framework-for-innovation/

[19] Findings are presented thematically drawing upon all the data. Where quotes are used the source of the data will be identified (SP participant, reviewer, family member, practitioner, focus group/workshop participant).

Focus groups

2.4 Existing research and other evidence highlighted that much more was known about the views of social care professionals than professionals from health and the police. We wanted to understand more about the police and health professional perspectives to make sure that their views were clearly represented as well as undertake a range of interviews with specific professional from local areas. Single agency focus groups with health and police were conducted to capture professional perspectives specific to each professional group. A further 15 interviews were undertaken with frontline practitioners who had been involved in a LCSPR from across health, local authority social work, youth work, housing, police, and education. Four family members who had been involved in a child safeguarding practice review completed within the previous 12 months were interviewed - a grandmother, a child, a father, and a mother.

Workshops

2.5 After preliminary analysis of the interview and focus group data a series of five national workshops were undertaken. The first four of these used a combination of presentation of preliminary findings with further breakout groups and discussion. These allowed participants from the interview study to come together with representatives from a wider range of SPs. The final workshop was an opportunity to test out findings and recommendations from the project.

See Annex C for more detail on the methodology.

3. Findings

The current process: a high degree of variability across all stages

3.1. Variability emerges from the very start of the overall process in a number of ways: from interpreting the criteria for 'serious harm' to decision making about notifications and proceeding to rapid reviews (RR).

Progression from SIN to RR to LCSPR

3.2. Each of the Safeguarding Partnerships (SPs) in this study operated a triage system for incidents, demonstrating multi-agency cooperation. Applying the criteria for determining 'serious harm' is not seen to be straightforward and inevitably involves professional judgement, particularly when the harm may be cumulative such as in neglect, and / or the impact is psychological: "…if it's not kind of lasting harm to a child or serious harm to what we've deemed serious harm to a child, we probably wouldn't notify [the] Panel." (SP interviewee). Although the Panel Guidance provides further explanation of 'serious harm' to help SPs in their decision-making, there is evidence of variability in how that is applied.

3.3. In addition, a few SPs described using the criteria of potential for further learning, which according to guidance applies at the point of deciding whether to progress from RR to LCSPR, to determine whether to make a notification / undertake a RR "you're thinking is this something we need to learn from. Yes, it's an incident…. It's not just an 'I must inform somebody' and we're getting to thinking a little bit about why we need to inform people and what we could get from that, would be my view" (SP participant).

3.4. The latest SIN data published for the period April 2023 to March 2024[20] showed a marked drop in notifications related to serious harm. It is not clear if this is due to fewer incidents occurring or fewer incidents being notified. The Panel report noted the need for further analysis, and the evidence from the fieldwork reinforces this.

3.5. The findings raise questions about consistency in the way that guidance is applied, with implications for transparency about which incidents and circumstances are being screened out at an early stage impacting upon potential learning and identifying local, regional and national trends. The number of SPs involved in the project means it would be beneficial to explore these questions further. Rather than moving to further prescription, there is a case for exploring the various routes for referral and decision-making on local reviews in more depth. It should be noted that the sample size in this study was small, and further exploration is needed to understand more about the variability in decision-making at the early stages of the process. Safeguarding Partners expressed an interest in understanding more about national trends in

[20] https://www.gov.uk/government/statistics/serious-incident-notifications-2023-to-2024

referrals, conversion rates to SINs/RR and LCSPR. If this data is available and can be shared, it would help SPs have a better sense of how they are working compared to others.

3.6. Without an overview of activity deemed to fall short of SIN it is difficult to assess the extent to which 'near misses' are being explored, although several SPs spoke about keeping track of themes of referrals that do not meet the criteria for SIN and capturing learning from those cases. Working Together (DfE 2023, page 383), does make provision for LCSPRs to be undertaken to learn from near misses/good practice in cases not meeting the threshold for SIN, but LCSPRs were not mentioned in such circumstances in the present study.

Rapid reviews

3.7. Rapid reviews are approached in varying ways. They are valued by some SPs as an opportunity to 'get all the learning', "not sort of just a gateway to whether we do a CSPR" (workshop participant). An advantage expressed by several partnerships was that learning from rapid reviews was timely and avoided drift and delay. Participants talked about the local processes being developed and improved to support the rapid review process, such as redesigning templates so that questions about learning were at the beginning.

3.8. Several SPs spoke of how demanding the RR process is due to the resources needed and the short timescale. It was notable that several participants suggested that the work involved was on top of their 'day job', indicating the time pressure and workload involved, and the fact that the workflow is unpredictable. Some SPs said that they use independent reviewers to undertake rapid reviews as standard, believing that senior managers were more likely to listen to learning from rapid reviews as a result.

3.9. In one of the workshops, it was suggested that the distinction between rapid reviews and LCSPRs was becoming blurred, and this was viewed as problematic if expectations of RRs overreached their original aims. This prompted some debate amongst participants about the stated aim of RRs[21].

3.10. Whilst a good RR may obviate the need for an LCSPR[22], SP interviewees highlighted the amount of work going into the RR process. With limited capacity and the requirement that a RR should happen for every SIN (the Panel received 330

[21] The stated purpose of the RR in WT is to gather the facts; decide upon immediate action to ensure children's safety and share learning appropriately; consider the potential for identifying improvements to safeguarding and the welfare of children; and decide whether an LCSPR should be undertaken (WT: para 20).

[22] The 22/23 Panel report includes an analysis of the quality of rapid reviews suggesting most are of good quality but that there is a need to focus on the 'why' as well as 'what' happened and explore the wider perspectives of the child and family, and the context, history and lived experience of the child. In addition, the RR could 'consider the possible impact of race, ethnicity and culture on the child, their family and practice responses'. (p50: para 4.11 and 4.12).

RRs in 2023-2024), it raises questions about ensuring the RR process is proportionate.

3.11. Managing capacity might impact on decision-making about whether to make a SIN, since notification automatically leads to a RR. One SP interviewee suggested that the expectation of what could be done in 15 days was at times unrealistic[23].

3.12. There is also a risk centred around the limitations linked to the timeframe to complete the rapid review. Limitations of rapid reviews included:

- the capacity of the review panel to collate the relevant information and learning so that a robust decision can be made about whether to progress to LCSPR
- the rapid review report not being published and available to the public
- engagement with children and families is not part of the process

3.13. The potential for 'further learning' is at the heart of the decision to progress to LCSPR. SPs described examples of the ways in which they identified existing learning to aid their decision-making:

- development of a mechanism to track all learning so the SP did not commission a review on themes already covered by an LCSPR or national review.
- assessment of the potential further learning in the context of how well action plans from previous reviews had been implemented.

Progressing from RR to LCSPR

3.14. There was a suggestion by SPs that, at times, rapid reviews may be undertaken in place of LCSPRs, with potential implications for depth and breadth of learning if this is the case.

3.15. Decision making on when to progress to LCSPR was noted as inconsistent, particularly by some participants who worked in agencies that covered more than one SP area. This discussion may include a debate about whether sufficient learning had already been collated through the rapid review process to negate the need for LCSPR, as well as discussion about costs, capacity and proportionality.

3.16. Feedback on RR from the national Panel was valued by some SPs, acted upon and used for subsequent reviews. Some SPs felt that as the new system has become

[23] The 15-day window is non-statutory requirement (although published guidance creates a legitimate expectation). It is interpreted by some SPs as being a statutory deadline.

embedded, they have grown in confidence in challenging the national Panel and making their own decision about whether to progress to LCSPR, however others felt that you could not really say 'no' to the Panel.

3.17. A subtle distinction was made between a decision to proceed to LCSPR or move to 'disseminate learning' after a rapid review.

3.18. Fieldwork evidence identifies that some SPs undertake 'local reviews' or 'reviewing activities' that are not subject to serious incident notification or called LCSPR. An example was inviting practitioners to bring their own current cases to a peer workshop, based on a theme that had been identified in a referral for SIN, but where a notification had not been made.

Resourcing, capacity and capabilities in safeguarding partnerships

3.19. The capacity and capabilities within review groups to undertake analyses about further learning with potential importance locally and nationally is key. If a business unit is constrained by the volume of serious incidents and RRs, and/or limited by capacity, then the quality of analysis at rapid review stage might be impaired and limit decision-making about areas that require further exploration through an LCSPR.

3.20. The following list summarises the key points raised about capacity to deliver RRs and LCSPRs during the fieldwork and workshops:

- The quality of the RR is seen to have improved[24] but it is evident that it remains variable. The reasons for this include:
  - limits in business unit capacity
  - inexperience of participants
  - capacity of those undertaking the RR
  - may not involve practitioners
  - usually not undertaken by someone independent
  - SPs indicated that training for those who do not regularly attend the meetings would be helpful.
- Professionals are often responsible for multiple review types with different criteria and demands. Participants expressed feelings of 'overwhelm' and 'learning fatigue'. RRs and LCSPRs take place along with multiple parallel processes and other types of review.

[24] The Annual Report 2022/23 by The Child Safeguarding Practice Review Panel (published January 2024) discusses quality of rapid reviews.

- Business units were reportedly resourced differently and unequally between statutory partners: there is wide variation in the capabilities, capacity and expertise/qualifications of business managers, and in how resources are deployed to inform decision making, undertake rapid reviews and commission reviewers.

- It was reported that capacity issues affected the ability to create time and space for learning, and for measuring impact or 'to look back and check it works'.

- How SP costs should be shared between statutory partners, is not clear. In some instances, the local authority was reported to meet the main share of the cost. Fieldwork and workshop participants suggested that Working Together (DfE, 2023) could have set out the resourcing implications more clearly and provided guidance on how this should be calculated. This would help ensure that Business Units had sufficient capacity and establish consistency of how SP funding is calculated and shared amongst the statutory partners.

Independent reviewers, contracting and methodologies

3.21. Despite previous recommendations to address the qualifications and professional competencies of reviewers (Munro, 2011) and (Wood, 2016), there has been no change to the accreditation of reviewers; contracting processes are often informal but lengthy, and a dearth of reviewers can add delays and pressure into the LCSPR process.

3.22. The independence of reviewers is complex as while the review process is collaborative, the SP has a role in quality assurance of their work. One reviewer described it, saying

> "So, you know, you're independent, you're collaborating. That's a contradiction". While another said, "I'm child centred…I'm here for the child. That's my independence, isn't it? That's all".

3.23. SPs valued the independence and expertise that a good reviewer brought to the LCSPR process, not only regarding their expertise regarding producing the report, but in some cases their expertise regarding the process. However, both SPs and reviewer interviews highlighted concerns about consistency. There was some evidence of tensions arising between reviewers and partnerships about the quality of reviewing activity indicating the importance of clear processes and protocols. One reviewer suggested training and development are 'out of step with Domestic Homicide Reviews' (DHRs) which was perceived to be more comprehensive, and concerns were expressed by business managers about reviewers engaging with children and families without relevant qualifications (and support). Reviewers themselves identified a need for greater peer connection and professional development and felt disconnected from the national Panel.

3.24. Methodology (overall design, approach and framework) and method (techniques and procedures for collecting and analysing data) were referred to interchangeably; reviewers are using a combination of methodologies, tools and approaches. Variability, together with a lack of professional framework, is likely to be leading to a lack of consistency in the 'quality' of the analysis in LCSPRs.

3.25. Whilst the guidance refers to 'systems methodologies', The Panel does not provide a framework for adopting a systems approach or for helping professionals to think through the types of learning that might be needed at different levels of the system, and different agencies within the partnership, to realise change. It would be useful if SPs were supported to understand the differences between different review methodologies and the conditions in which any particular methodology might be most applicable.

Variability in how shared responsibility and decision-making are enacted

3.26. Challenge and scrutiny in multi-agency decision making panels remains a contested area. Many SPs stated that they have a culture of healthy challenge. Although, it is not possible to generalise from the small number of participating SPs, there was also a suggestion of different opinions across agencies regarding review. One business manager told us that in terms of decision making, they broadly found that:

> "Our health colleagues tend to say yes and want to review everything. Children's social care colleagues tend to say no and don't want to review anything. And our police colleagues, somewhere in the middle, tend to side with whoever speaks first."

3.27. Health professionals in the focus groups talked about the importance of three-way challenge. It was described how multi-agency decision making panels are in place, enabling professional challenge, scrutiny and escalation. Escalation policies for disagreements between partners in the LCSPR process are in place in some SPs, but not others.

The quality of relationships between agencies

Key factors identified which participants viewed as significantly influencing shared responsibility and decision-making include:

3.28. The quality of relationships was viewed as central to effective collaboration through the rapid reviews and LCSPR process. In some places, high turnover resulted in additional challenges for developing effective multi-agency arrangements.

3.29. Whilst it was evident that professionals are working hard to develop relationships and shared policies and protocols, concerns about achieving equality in decision-making were expressed. Some participants suggested that the expertise and perspectives of health and police professionals may be underutilised.

- Some workshop and focus group participants perceived that the local authority usually determined when serious harm had occurred.

- Health professionals felt that they are not always seen as equal partners, and that the education sector's exclusion as a statutory partner limits its contribution to the process.

- There was general agreement from focus group participants that they did not always feel that 'health' expertise was given the same 'weight' within decision-making, and that decisions on serious harm did not fully consider the health representative's views (despite the protocols for shared decision making noted above).

- Police professionals referred to shared responsibilities being unequal in practice, citing exclusion from key decision-making points such as setting terms of reference and scope, commissioning independent reviewers and chairing of local panel meetings.

Business units and managers

3.30. Business units were found to play a significant role in managing the LSCPR process once a decision is made to progress. The critical role of the business unit was a strong theme. Usually situated in local authorities, there is a reliance on the business units to coordinate efforts, but they may not have sufficient authority or independence to balance representation from all agencies. One business manager commented:

> "you're sat right in the middle of the partnership dealing with three massively different cultures and the 4th with education and the fifth with relevant agencies. You have to have a good structure behind you to be able to do that. Otherwise, things will just fall apart. They just won't happen". (SP, business manager)

The impact of geography, culture and organisational structures

3.31. Geography is an important contextual factor for strategic safeguarding leaders and practitioners alike. Working Together (DfE, 2023) states:

> 'Although the geographical boundaries for the three safeguarding partners may differ in size, multi-agency safeguarding arrangements should be based on local authority areas.' Working Together (DfE, 2023: 4.1 Chapter 2).

3.32. ICB and police geographical boundaries are rarely coterminous with those of local authorities and often cover more than one local authority area. This can impact on equal representation and shared responsibility and creates an inevitable tension

within the safeguarding system. For example, policing's strategic requirement for consistency, capacity, and capability at a force level might not always have the flexibility to meet bespoke, place-based safeguarding arrangements.

3.33. The geography of organisational boundaries also informs the perspectives of policing and health professionals, who are more likely to have an overview of reviewing activity across SPs. In the police focus group, participants talked about how review findings, recommendations and action plans of different SPs within their locality repeat the same findings, leaving some police and health professionals frustrated with a lack of coherence, or join-up, across localities. This suggest that a lack of consistency in the LCSPR process across SPs leads to variations in review quality.

3.34. Professionals noted that each local authority may use its own forms and templates for requesting police information, potentially causing confusion where boundaries are not coterminous. To counteract this, at least one police force standardised their own template to promote consistency. Comparisons were made with other types of review e.g. Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs), Patient Incident Reviews where the processes were viewed as being more consistent.

3.35. Recognising the structural and cultural differences between agencies[25] can help to unpick the barriers and bottlenecks that exist. Health and police are structured as universal services, and this impacts their 'flexibility' to engage with review processes and bring the right balance of strategic oversight and operational knowledge. Tensions were identified in the review process when there are disconnects between professionals located in operational teams with knowledge of local contexts and the involvement of strategic professionals, located in the Central Review Unit (police) or ICB (health).

3.36. A further challenge is service fragmentation. The diversity of health provision, such as acute services, primary care and school nursing, complicates its ability to act as a single agency. A theme highlighted by health professionals is that 'health' is referred to as monolithic agency. They suggested that the way in which 'health' is referred to within Working Together (DfE, 2023) could be improved as it is not reflective of the fragmented landscape of health and its many components.

3.37. A lack of knowledge about review processes amongst statutory partners can impact the effectiveness of the process, particularly when there is no core team undertaking reviews. Variable levels of preparedness and knowledge about the process, including about the reasons why a review was needed was reported by participants. There is high reliance on experiential learning. As an example, many police professionals could not identify any formal training that they had been provided with for their role, nor were they aware of any:

[25] See Annex D for more details on the roles and structures in health and policing.

> "there's a kind of an assumption that people go into these processes, and they know what they need to do and so on and so forth. But actually, I think sometimes it really does help just to say to a review panel, this is the expectation, this is the process".

3.38. 'Overwhelm' and 'learning fatigue' amongst professionals was clearly evidenced throughout this work. Professionals who contribute to rapid reviews reported they are often responsible for multiple other reviews with different 'thresholds' and demands. The emotional impact for those involved within review processes was highlighted, often compounded by the parallel processes practitioners might be involved in simultaneously, such as Child Death Reviews and criminal investigations.

3.39. The specific structures, disconnect and fragmentation in police and health services adds to the complexity of representation and involvement in the rapid reviews and LCSPR process. It may be useful to consider whether national and local guidance sufficiently takes account of single agency operational realities and structures, and parallel processes.

Strategic oversight and scrutiny

3.40. Arrangements for independent scrutineers to replace or come alongside independent chairs were still being developed in some partnerships during the fieldwork period. Mostly, scrutiny was used at decision-making points such as reviewer commissioning and the draft report stage. Research participants did not reference scrutiny of the 'collective decisions and actions of the three formal safeguarding partners', a gap also identified by (Wood, 2016: page 8), although one partnership described scrutiny of their case review group's decision after rapid review.

3.41. We saw evidence of possible disconnect between review processes and senior and executive level knowledge and engagement. In some areas, it was evident that achieving consensus and sign-off can be challenging, with strategic input often occurring at the 'eleventh hour' in the LCSPR process[26].

3.42. Given the emphasis on shared and equal responsibilities amongst the statutory partners, and extended role for education in Working Together (DfE, 2023), there is an opportunity to ensure these duties are understood and taken up so that the intended benefits of multi-agency arrangements are realised. Leaders need to role model multi-agency collaboration and articulate the shared purpose of reviews to drive positive improvements in safeguarding children. These leaders also play a vital role in setting expectations for the wider system; for example, through strong leadership to address systemic inequalities. This leadership extends beyond those

[26] We were unable to engage with many strategic and executive level representatives through the fieldwork and workshops, so this gap should be addressed as part of the next phase of this work.

directly involved in the SP or review process to strategic and operational leaders in partner organisations who need to be engaged, responding and supporting the learning to be embedded into core governance and working practices.

Significant gaps in knowledge, skills and confidence regarding EEDI

Consideration of EEDI across the review process was a key line of enquiry.

'Invisibilisation' of minoritised and marginalised children

3.43. The rapid evidence review highlighted that understanding or paying attention to diversity and the intersection of gender, race, ethnicity, sexual orientation, disability, class and other characteristics, reduces the ability to learn from reviews.

3.44. Recording of information may be inconsistent or unclear. In previous LCSPRs it has been noted that ethnicity is not always recorded although this had improved by the latest annual report of the Panel (CSPRP, 2024b). The latest annual report of the CSPRP (CSPRP, 2024b) also comments on the recording of disability and sexuality. It points out that 7% of the children in rapid reviews had a physical disability, though it was often not clear what this was. There is a need to develop more consistent recording practices, since the absence of an attribute being recorded does not mean it is not present in the case (CSPRP, 2024b). This makes it harder to understand and analyse the risks to a person or a particular group. HMIC, 2024 report specifically highlights the impact of this in practice: 'Important information, such as disability, ethnicity and nationality, is also routinely missing from reports. This makes it much harder for the force to understand and analyse risks to a person or particular groups' (page 14).

3.45. Issues of recording may affect different marginalised groups in different ways. Whilst guidance for rapid reviews suggests that demographic factors such as gender, sex, ethnicity and disability should be recorded, sexual orientation is not mentioned[27]. This may result in LGBTQ+ young people being hidden in review processes, although elsewhere the guidance does suggest considering sexual orientation as part of a discussion of intersectionality[28]. This may also be indicative of heteronormative frames of reference being perpetuated.

3.46. Allnock (2020) suggests that lack of information can obscure learning for all agencies about communities that may face disproportionate levels of harm and

[27] Child Safeguarding Practice Review Panel guidance for safeguarding partners

[28] Intersectionality serves as an organising concept, analysing the interplay of categories like race, gender, social class, age, sexual orientation, disability, and other defining elements of oppression (Crenshaw, 1989). Widely recognised as a crucial critical approach, intersectionality provides conceptual tools to better understand experiences rooted in race and class-based inequalities. This understanding extends to their impact on system behaviour, capacity, and ability to respond to child protection issues that impact minoritised children and families.

therefore lead to knowledge gaps about practice and engagement with marginalised groups and communities.

3.47. Dickens and others (2022) argued that reviews sometimes did not mention or discuss race, ethnicity and culture, even when they could have been relevant factors. The latest Annual Report (CSPRP, 2024b) found that in 95% of the rapid reviews (2022-2023) ethnicity was reported although 'this did not always translate into the review considering its impact on a child's life and on practice' (p10).

3.48. Recent work by the Panel on race, racism and racial bias CSPRP Briefing 4, 2024c builds on this and makes clear the need for change and improvement in how Black, Asian and Mixed Heritage children's identities are understood within reviews. The concept of 'invisibilisation' is helpful here, conceptualised by Hope and others[29] as 'a lack of positive attention to the identity characteristics of racialised and minoritized groups by those in authority' [30].

3.49. Invisibilisation is also relevant to other children including LGBTQ+ children experiencing serious youth violence who may avoid disclosing their need for support to professionals (Open Innovation Team, 2023). Disabled children are at a disproportionately higher risk of experiencing significant harm leading to a serious case review, particularly during adolescence (Franklin and others, 2022; Brandon and others, 2020). However, 'Attitudes, which could be defined as disablist and discriminate against disabled children, can render disabled children invisible, and/or seen as better protected than their non-disabled peers which can lead to greater risk.' (Franklin and others, 2022: page 3).

Findings from fieldwork

3.50. The group interviews with SPs included questions about EEDI. Participants varied in their interpretation of the question. When responding to a general question about EEDI, responses focused on the child and family were often expressed in terms of 'needs', and there was less discussion of practitioners, leadership and organisational factors. There was also little to no reference to structural inequalities and factors such as racism, and how these are considered within review processes, but also within the operation and make-up of the Partnership overall.

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[29] Dickens, J., Taylor, J., Cook, L., Garstang, J., Hallett, N., Okpokiri, C. and Rimmer, J. (2022). *Annual review of local child safeguarding practice reviews.* [online] University of East Anglia. Available at: https://research-portal.uea.ac.uk/en/publications/annual-review-of-local-child-safeguarding-practice-reviews, P33.

[30] The term 'invisibilisation' is used here to mean the lack of positive attention to identity characteristics. The term is also used in relation to: The ways in which risk and vulnerability are considered by practitioners can result in invisibilisation; the dichotomy of a child who may be 'hyper visible' while at the same time being 'invisible' (i.e. their perpetration/offending may be visible, but their safeguarding needs not). See, Child Safeguarding Practice Review Panel (CSPRP). (2024c). '*It's Silent': Race, racism and safeguarding children. Panel briefing 4.* Race, racism and safeguarding children - GOV.UK

3.51. In a few cases the response to the general question about EEDI suggested that the SP did not feel there was diversity within their local population and so EEDI was not really an issue for them. Where this is the case, it is possible that decision-making from the start of the LCSPR process might hide and reinforce inequalities. If certain incidents are not notified, or a rapid review determines that there is no 'further learning' relating to the intersectional identities of children, families or professionals, then a route for valuable learning is missed. Bias may influence whether LCSPRs are commissioned and compound limits to learning from incidents involving disabled/racialised/LGBTQ+ children (see Health Management and Policy Alert, 2020 for a discussion of the numbers of SCRs commissioned relating to peer violence).

3.52. Even where an LCSPR has been commissioned, intersectionality may receive insufficient attention. In one example a lack of curiosity left EEDI unexplored in the case of a child who was of mixed heritage but identified as white British: "Well, then you wouldn't necessarily have thought that given the heritage of grandparents". How services worked with him and how he perceived himself and services was not explored. Using an intersectional lens, it may have been possible to explore how the child might have experienced bias, oppression and privilege based on the interaction of multiple identities (Simon and others, 2022). Research consistently demonstrates that discriminatory experiences for children and young people are multifaceted and have complex impacts (Tinner & Curbelo, 2024; Bernard & Harris, 2019).

What helps or hinders effective engagement with EEDI in LCSPRs

3.53. LCSPRs should promote more insight into the lived experience of the child than rapid reviews and are an opportunity to explore intersectionality and intersecting identities.

3.54. The reviewer interviews indicated a more sophisticated understanding of intersectionality than the SP group interviews, discussing not only the importance of understanding the experiences of the child and family, but in some instances also understanding how that might impact on the family's relationship with services. Some SPs appreciated the expertise and analysis of independent reviewers, who prompted new thinking. For example, one review explored community tension, mental health and schooling together with issues around neurodiversity in a way which "hadn't been thought about previously" by the SP.

3.55. Examples were given of attempts to consider EEDI within the LCSPR process, including:

- having an EEDI tab on assessments leading to greater understanding of the importance of discussing EEDI considerations with families and in supervision.
- including EEDI considerations in rapid review templates. In one case this had developed from asking for sex and ethnicity, to include asking for information

on protected characteristics for both child and family members. Other SPs requested deprivation centile, and information about communication needs.

- coopting specialists onto rapid review panels and reviewers where relevant, for example a specialist in SEND to be on the panel if the child has an EHCP. In one example an academic was recruited to contribute to the report in relation to a minority faith. The SP had considered including a community faith organisation but had concluded that the family might be identifiable because the faith community was very small.
- including intersectionality in the terms of reference for reviews.
- trying to work with local communities, in one example engaging the community in the areas where the LCSPR involved the child of a particular heritage. "We engaged the whole community in the area… and we worked with community groups and venues… and held events with that group to get their feedback. So, involving them right from the beginning and then feeding back to them at the end".

3.56. There were other examples of reflection on and learning about diversity gained through undertaking a full LCSPR:

- In relation to trans young people: Updating letters to GPs around gender change because GPs were updating the NHS spine[31] resulting in children being lost from medical screening programmes relating to their birth sex; ensuring gender was recorded accurately and consistently on systems; ensuring multiple names of a child were checked on all systems when their name had changed. [32]
- Class: Exploration of how the perceived affluence of parents might have influenced practitioner's work with family; challenging an assumption about class in written recording by an Independent Reviewing Officer (IRO), ''these families have a strong social bond … although it looks like things are going badly wrong…", which could lead to the lived experience of the child being overlooked.
- Cultural context: Considering work with a family from Eastern Europe who were not used to free health care and wondered if they'd have to pay, "people hadn't taken into account those things would affect how they responded to the health service".

Discussion of protected characteristics and aspects of diversity

[31] Spine - NHS England Digital

[32] Since this project was undertaken, the Secretary of State for Health and Social Care has directed that the process for changing gender markers and NHS Numbers in relation to gender amendments for children and young people under 18 is stopped.

3.57. There was more discussion of the protected characteristics[33] and aspects of diversity pertaining to children and families than there was reflection on EEDI within the workforce or organisations and how this might impact on the work. One reviewer reflected on an issue brought to their attention during a practitioner event by a practitioner in the group:

> "We were sitting in a group and the team manager said, you know, I need to actually talk about the fact that this is a Black child. The majority of the social work team's Black. I'm a Black manager. The doctor who is raising a challenge about him is white middle class. So, we had a good discussion about that". (reviewer).

3.58. In relation to practitioner identities and possible bias, a reviewer reflected on the sensitivity of raising these issues, and not wishing their analysis to lean too heavily towards "practitioner learning issues as opposed to … systems". However, the extent to which bias might be linked to wider systems issues or structural inequalities was not examined.

3.59. Interestingly there was no discussion about EEDI in terms of strategic leadership and very little about wider organisations. One SP did refer to a 'disproportionality and inequality steering group' undertaking wider work on structural inequalities within the partnership. Another referred to a need to consider organisational factors across different agencies and geographic footprints. Some SPs spoke of developing policies and procedures relating to EEDI, but this was limited and still in development. One SP had undertaken a piece of work to look at EEDI strategies across different agencies in the partnership but found this task difficult, "and in terms of how they interact, I'm not sure that they do. And I think we struggled to know with how to continue that piece of work as well once we had the information".

3.60. Clearly, not understanding or paying adequate attention to diversity and interplay of gender, race, ethnicity, disability, class, and other characteristics, and the systemic oppression and inequalities relating to these characteristics, such as racism and ableism, reduces the ability to learn from reviews or implement systems learning. If both practitioners and reviewers ignore those intersections, then progress will not be made in safeguarding overrepresented, minoritised and marginalised groups of children.

3.61. For example, if the issue of adultification is not attended to, ethnically minoritised children will continue to experience a criminal justice response rather than a child protection response (Davis, 2022). Awareness of adultification will help ensure that ethnically minoritised young people are responded to as vulnerable children (Marsh and Davis, 2020; Dickens and others, 2022). As there is no consistent training for reviewers, it is not clear how they are supported and equipped to bring an intersectional lens to reviewing activity. It was noted by one reviewer that

[33] Equality Act 2010

intersectionality was foregrounded in Domestic Homicide Review training as a point of contrast.

3.62. A more in-depth exploration of the issues was afforded by a workshop facilitated as a reflective space. The workshop was welcomed by participants as a space to discuss sensitive issues, including white privilege and unconscious bias. Participants talked about:

- How it is easier to see absence of race, but other characteristics may not be visible in reviews: e.g. sexuality, learning difficulty or disability, mental health.
- There are implications for an absence of lived experience in the review panels and amongst reviewers for appropriately considering EEDI and understanding local communities.
- Cultural biases were deemed important but hard to surface.
- EEDI is unlikely to be addressed well if it becomes a 'tick box' or procedural approach.
- EEDI issues should be embedded in all the safeguarding partnerships' work, not just in the reviews.

3.63. Whilst there is some promising practice and reflection and openness to further learning about EEDI, no doubt the findings are indicative of deeper systemic failings to address inequalities and discrimination impacting children and families. If the process for generating learning to better protect children from harm, currently runs a risk of perpetuating bias and discrimination rather than disrupting it, then leadership is urgently required at all levels to address this. There is a need and appetite for further training and awareness building for partnerships and senior managers in EEDI. Participants commented on the importance of senior leadership modelling that they take EEDI seriously. An EEDI Framework is an output from this project. This will be useful in encouraging people in all parts of the system to reflect on the extent to which they understand and actively promote EEDI in practice and leadership. See Annex D for details.

Engaging families and practitioners

Practitioner involvement

3.64. Practitioner involvement in the process is an important source of information for review (SCIE, n.d.) . It needs to be handled sensitively to elicit an understanding of the contextual factors surrounding practice 'without fear of being blamed for actions they took in good faith' (DfE, 2023: page 140). Practitioner voices and perspectives were identified as 'crucial for learning' by safeguarding partners interviewed and seen to 'add to learning'. One partnership stressed the importance of learning *from*

rather than *for* frontline practitioners, something that is ideally part of the review process when practitioners are consulted, usually through a group event or meeting.

Practitioner events

3.65. This section of the findings draws upon interviews with SPs, reviewers and 15 frontline practitioners with recent experience of an LCSPR. During the review process, multi-agency practitioner events were the norm, supplemented with individual interviews. These were used to gather and test out hypotheses. It was evident that practitioners invited to practitioner events were not always those who were involved with the family, often due to staff turnover or sick leave. In some instances, it was more difficult to identify appropriate multi-agency practitioners to attend events. For example, police professionals do not 'work' with families in an ongoing way and may just have been called to the home for an isolated incident.

3.66. According to partnerships and reviewers, the practitioner event process was generally positive for practitioners. Practitioners also talked about the benefits of gaining new perspectives, seeing how colleagues work in other agencies, and even networking opportunities.

3.67. There was broad agreement that preparation and follow up was important. For practitioners this meant having time and support to prepare before an event and having clarity about what an event was for: it meant they could respond effectively if directly challenged by the reviewer or other agencies. Reviewers recognised the need to sensitively engage and prepare practitioners, such as through providing an agenda and an overview of the case beforehand and a short presentation on the purpose of an event. Smaller, focused events were seen as helpful by practitioners compared with larger groups (sometimes reported as over thirty). These were perceived as curtailing opportunities for reflection and instead putting practitioners under pressure to 'perform'. Several practitioners suggested that it would have been more helpful to have the opportunity to speak to the reviewer alone, or as a small key group of professionals, to include those who had most contact with the family.

3.68. There was recognition that practitioner events benefit from skilled facilitation. One SP talked about the importance of "skilful facilitators that don't go in with an investigative stance but going with a reflective stance, that allows people to feel vulnerable" (SP interviewee). In-person events were seen as preferable by reviewers and practitioners, but it was not always possible for practical reasons, including being involved in several reviews at once.

3.69. Some reviewers were creative about gathering practitioner input sensitively. A reviewer who was aware of the emotional response to a difficult case, decided to hold a reflective event for anybody who wanted to be there "in order to provide a space to share memories of Child B or to talk about the review itself". The feedback

was good, and practitioners felt their voices were heard. A second event was planned to follow up on systems issues and check emerging findings.

3.70. Practitioner events were also held outside of the LCSPR process. Two SPs spoke of holding learning events outside of the LCSPR process – either after a RR as part of disseminating learning, or for cases that did not meet criteria for serious harm. It was argued that holding these events outside of the formal LCSPR process made it easier for practitioners to feel that it was a reflective space.

Anxiety and blame

3.71. It seems that it is difficult to eliminate anxiety about blame from the LCSPR process. Practitioners talked about feeling anxious when they are made aware that a review is taking place, and they were involved with the family: “Oh my God, what's going to happen? And you'd be thinking of your registration… I think it's across every professional group as well.” (Practitioner)

3.72. Frontline practitioners expressed more diverse views about their experience of practitioner events in contrast to the positive accounts given by SPs and reviewers. There was talk of hierarchies at play during events with some people feeling inferior or even scapegoated. Preparedness for participating in practitioner events varied between agencies. Generally, professionals outside of children’s social care had less idea of what to expect when attending a practitioner event and there was reliance on CSPR experienced colleagues. ‘De-mystifying’ the process was deemed to be important. As one health practitioner put it, “it does feel a bit of a blame game. What happened, what do you know, what did we miss? But actually, the focus towards the learning is really helpful.” (Health practitioner).

3.73. From practitioner participant perspectives, multi-agency discussions were interesting but could also feel threatening for some. It was more likely that a practitioner had felt uncomfortable during the discussions if they had a major role or involvement with the family or if their agency had struggled to work with the family. Unsurprisingly, those with a peripheral role experienced the discussions differently. There needs to be sensitivity to power dynamics. One reviewer explained that managers should only attend because they have been involved in decision making, not to monitor the input of their practitioners.

3.74. Safeguarding partners highlighted the importance of paying attention to practitioner wellbeing during the process, or at least around the time of the practitioner event. However, that did not chime with the experiences of some practitioners. Experiences of support around participation in the LCSPR process were variable and highly dependent on the culture and practice within the practitioner's organisation. Some relied on the partnership business manager for support, others had managers in their agency who could offer support but did not always do so. Some found that support was forthcoming from colleagues or designated leads.

Support from members of staff who had mental health and counselling training, provision of clinical supervision or a culture of psychological support were also mentioned.

3.75. The potential impact on practitioners highlights the need to think about how they are told that a review will take place (or an incident has been notified). Yet, there was not much attention paid to the initial conversation with practitioners. SPs talked about the importance of keeping practitioners up to date at the end of the process and when a review is published. However, practitioners suggested that they are not always kept up to date with progress. In one interview, the practitioner asked the researcher for an update on the LCSPR.

Involvement of children and families

3.76. The expectation of family engagement is set out in Working Together (DfE, 2023: page 140), as a duty, and safeguarding partners should ensure that:

- families, including surviving children (in order that the child is at the centre of the process) are invited to contribute.
- families understand how they are going to be involved and have their expectations appropriately and sensitively managed.

3.77. It was only possible to speak to a small number of family members (see methodology section, annexe 3). However, there are positive signs that family engagement is being seen as central importance to the review process, described as '*invaluable'* by SPs and reviewers. Overall, there was more of a focus on engaging parents rather than children although there was some evidence of independent reviewers engaging with adolescents and at times, wider family members. There was some discussion of the merits of community involvement, although this is not part of the guidance.

3.78. There was some evidence of a move towards earlier engagement of families in the process. Some reviewers and partners have learnt from the DHR process (GOV.UK, n.d.) which involves the family very early on, at the point when they have agreed the terms of reference with the independent reviewer. One reviewer author spoke to a family member through a prison link early on in the process.

3.79. It was acknowledged that involvement needs to be handled with care and sensitivity; engagement takes time, requires trust, clear communication of the review aims and using a range of methods. Partnerships and reviewers described going to great lengths to involve family members which could involve lengthy travel to meet face to face, video calls or telephone calls. In some cases, a list of questions was provided if the family/child did not want to engage otherwise.

3.80. There was consideration given to the right person to contact a family. Joint engagement with a partnership officer and reviewer was seen to be beneficial. One partnership explained that an allocated worker contacts the family to tell them that

there will be a review and that they will be contacted by the business unit. There was sensitivity to how families might perceive contact made via the Business Unit as they have local authority IDs and email addresses. SPs mentioned avoiding contact coming directly from the independent reviewer. But there were also instances where the family were comfortable for the reviewer to engage directly (as they valued independence from the SP).

3.81. The process of involvement was perceived positively by some family members, but this was not a universal experience. One grandmother gave a positive account of involvement and described reasonable adjustments being made to involve her autistic son (the father of the child) in the LCSPR. This contrasted with how she felt children's services had engaged with him prior to the incident that led to the review, making insufficient efforts to be inclusive and take account of his needs. It was felt to be important to show family members how their contributions have been considered, for example going through the final report with them. However, by contrast, one father and his child told us that they did not feel that their views were incorporated. They had no feedback or sight of the draft report but simply received the final report in the post without warning.

3.82. It was not clear how reviewers were equipped or supported to involve children and families by SPs, other than by drawing upon their professional expertise. One reviewer mentioned the value of having a social work background for engaging with children and families, but there was no evidence of any formal requirements or expectations e.g. through accreditation of trauma informed training. Involvement was often brief, leaving reviewers concerned about the impact on family members. As one reviewer reported:

> "When you start meeting families and particularly the parent in these circumstances actually, I'm left feeling who's going to support them after I've had this conversation. I felt really uncomfortable about raising particular concerns and issues for her, which clearly were impactful. And then I would just leave."

3.83. Although recognised by some reviewers, there was little mention by partnerships of how families may be supported after speaking to a reviewer or participating in the process. The grandmother we interviewed echoed the need to offer support repeatedly since the family member might not be able to access it at the time it was offered. She could not remember being offered bereavement support at the time and had ongoing caring responsibilities for the family to manage. In another example, a bereaved mother had not wanted to access support immediately after the incident as she stated that she was in denial and wanted to believe her child was still alive. The reviewer suggested that by "providing a kind and compassionate space" during the LCSPR the mother was able to start the grieving process.

3.84. The concerns of these family members underline the need for support during and after the review process. There is clearly a need for flexibility and adaptability to

maximise engagement that is trauma-informed and timely. Careful thought needs to be given to the impact of publication, as well as to the changing needs of surviving children. There are opportunities for strengthening communication and feedback throughout, and after the review is completed. There was limited discussion of consideration of EEDI in planning engagement activities with children or families. For example, examining the diverse representation at events or adopting inclusive options for engagement. Yet, flexibility and adaptability for engaging children and family members is clearly important.

3.85. There is an opportunity for SPs to look to use more diverse methods and routes for participation. Using a range of methods and trauma-informed approaches when engaging families in review processes should be a priority for SPs, building on some examples of promising practice. Where participation is handled sensitively it is possible for it to be experienced positively by family members:

> "I thought very carefully about the impact for me [of LCSPR process]. And revisiting that. But it was worth it for the impact for others, and strangely, it's quite… therapeutic to look at and see where things could have been put right … it helped me … to realise because I've got a lot of guilt about what I should have done. But I couldn't have done it because I didn't know. And that [LCSPR] helped because it identified in the different places where someone could have acted any differently and why they didn't." (Grandmother)

Family members contribution to learning

3.86. CSPRP (2024a) underlines the need to be straightforward about the reasons for engaging with children in discussion about multi-agency systems, especially if there is little prospect of their input resulting in change for children. The same could be said of other family members. Involving family members is an expectation of the guidance and in accord with many participants' professional value base. There were many examples of how engaging family members in the process contributed to learning in the LCSPR:

- A mother drew attention to the fact that the father was absent in the report, resulting in a shift in perspective:

  "The wealth of info we got was about mum… and when we went to mum… and we shared the first draft with her she was like, 'well, this is all about me. What about dad?... He was there too'… And actually [x] and I came away from that… and went 'She's got a point actually'… so actually it was another opportunity for us to grow in the way that we consider fathers and partners… it did make us step back and think we could do this a bit better".

- Input from families helped to identify inaccuracies. Simple facts such as dates of birth/age may not be recorded accurately in notes and speaking to families can rectify that. In one case a comment made in an early police report had been circulated and become viewed as a fact, until challenged by the mother.

- Interviewing parents highlighted an issue about lack of interpreters, which had not been picked up on earlier in the case.

3.87. Overall SPs reported valued family involvement and reported thoughtful ways of approaching and engaging with families. This research was only able to speak with a small number of children and family members with mixed experiences they felt able to share. There were many examples of family involvement contributing to learning. It is telling that many of these highlight issues relating to diversity and inclusion. Engaging with family members, when done well, can be a powerful way of ensuring their intersectional lived experience feeds into the review process and contributes to improvements in practice. It also highlights the need for a focus on EEDI to improve safeguarding practice. It should not be the responsibility of children and families to highlight these issues.

The value placed on learning

Learning is continuous, not at output that emerges at the end of the process

3.88. There is a distinction made between early, quick learning from RR that is perhaps the most obvious learning (for example a new way of recording consultations) and the learning that comes from the LCSPR which may be harder to implement as it is more complex, covers several agencies and sometimes involves regional collaboration, or national policies.

3.89. Implementation of learning is underway, according to participants, prior to final LCSPR report and publication. Some LCSPR reports will include information on changes already made. Throughout the process, review panel members are taking back emerging findings and developing recommendations to their senior managers and teams. For example: Learning is also captured from ‘cases’ that do not reach the criteria for serious incident notification, and themes are examined.

3.90. Rapid reviews were seen to initiate swift changes to practice or single-agency policies. An example of quick action in relation to learning from an RR was for GPs to check the exact relationship an adult has with a child, which was taken to GP forums and filtered into local surgeries. During the lengthier LCSPR, changes can be initiated and progressed, like rewriting policies and procedures, even if they take a while to fully action or complete.

3.91. It was expressed that LCSPRs add to ‘multi-agency learning’ gained from RR, by drawing upon the wider research and specialist expertise of independent reviewers. The involvement of families and professionals was also identified as key to how LCSPRs add to learning. However, some participants questioned whether there was sufficient additional learning coming from LCSPRs compared to rapid reviews.

3.92. The first annual review of LCSPRs and RR (Dickens and others, 2021) found that LCSPRs evidenced further learning in most cases. However, the subsequent

analysis the following year found that only around half of the in-depth sample of LCSPRs identified additional learning compared to the RR (Dickens and others, 2022). This may reflect an improvement in the quality of RR as the changes to the system bedded in and RR processes have been improved. It would be worth continuing to track the extent to which LCSPRs lead to further learning compared with the associated RR.

Going beyond a linear thinking about learning and change

3.93. The emergent continuous process of change and opportunities for learning through the process, suggests a need to go beyond a linear idea of learning. Learning is not an output that emerges at the end of the review process, but a continuous, cyclical process. The prevailing logic is that we simply need to find a solution and do more of that – 'embed' learning – and (hopefully) move on. This framing, also referred to as a simplistic improvement paradigm means that learning is largely top down and mandated and contrasts to an understanding that learning is dynamic, never linear[34].

An emphasis on practitioner learning

3.94. There is value placed on practitioner learning or improvement and recommendations that locate change in professional practice, through training or policies. When discussing learning it was nearly always presented in terms of further training, updated tools, changes to process or new or adapted polices. This is not to say that professionals weren't aware of these risks or of the complexity of the system they are part of. There was debate and 'healthy challenge' about the types of recommendations made in reviews, including needing to understand what was achievable.

3.95. Making 'learning' (or learning outputs) applicable to practice and relevant and useful to practitioners was referenced as being important. SPs are primarily sharing learning through practitioner events and materials, such as quarterly briefings based on reviews and audits, thematic learning briefings, 7-minute briefings, videos, sound files and executive summaries.

3.96. Described as "the cottage industry of learning" by one participant, there was marked consistency in the approach taken by SPs, consisting of producing LCSPRs (and other reviews), acting on recommendations by producing learning materials and events; then checking if that has been received and how that may be used in practice. The cycle continues with every review and action plan.

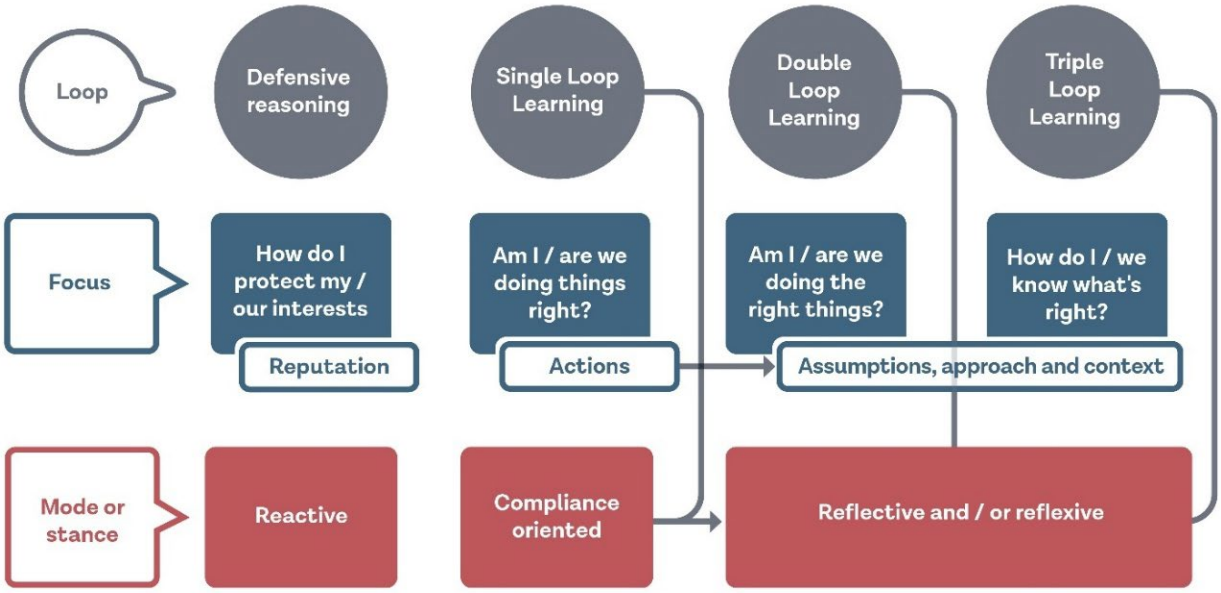
3.97. The focus on practice learning - by which we mean learning for practitioners – might be attributable to LCSPRs which do not take a systems approach (given the current lack of quality assurance and variability in quality of independent reviewers, this is conceivable). It might also be the result of compliance to timescales (in the case of RRs) which means that there is a tension between extracting learning quickly and

[34] Public Service for the Real World

having sufficient time to explore the 'why'. As a result of either of these scenarios, a partnership's ability to 'dig deeper' and to explore the 'why and how' not just the 'what' is limited. Consequently, the learning is often focused on 'what happened' and this drives action plans that are based in practice issues without a focus on the conditions in which practice occurs.

3.98. Learning loops are a helpful framework here. The diagram below was used in the workshop on learning, to explore whether reviews are 'stuck' in single loop learning, focused more on 'correcting' actions and 'doing things right'. It was discussed whether rapid reviews could ever go beyond single loop learning. The step before the single loop, is defensive reasoning (not a loop). As reported, reputational issues and questions of blame continue to run through some practitioners' experiences of reviews.

Figure 4: Different learning cultures[35]



3.99. Agency learning cultures that support reflective and / or reflexive learning (double and triple loop learning) are not necessarily experienced by professionals. In policing, for example, the focus groups raised whether policing is overly focused on compliance and the process of LCSPRs rather than learning.

[35] Adapted from NPC graphic which draws on the original Double Loop Learning Framework created by Argyris, C., & Schon, D. (1978). Organizational learning: A theory of action perspective Reading, Mass; London: Addison-Wesley. https://www.thinknpc.org/resource-hub/systems-practice-toolkit/triple-loop-learning/.

3.100. Participants were alert to the limits of training and how it may leave little room for professional judgement. For example, training designed to raise awareness of co-sleeping with babies and risks of overlay, was perceived to be misplaced because it didn't get into the complexity of the issue. This example highlights the potential benefit of more double or triple loop learning, going beyond 'acquisition of knowledge' about what needs to be done, to opportunities to examine professional assumptions and context:

> "For me, it's important about the use of language, so we talk about learning from reviews and that lends us towards thinking there's a knowledge gap and we churn out training, 7-minute briefings, comms briefings and it isn't that. It's not about knowledge. **It's the implementation of learning to practice we're talking about**. That's a completely different sort of field of work when we're talking about the space that we're asking practitioners to work in: culture, leadership, resource capacity. It's too easy then to go down sort of the training, knowledge-based action plans rather than looking at some of the systemic challenges that are obviously really hard and bigger than one provider". (Health focus group participant).

3.101. The efficacy of relying on training individual professionals as a way of effecting change has been queried. (Jackson and others, 2015) argue that CPD programmes in nursing presume the efficacy of training individual practitioners and then returning to the workplace to implement what is learnt. By contrast they argue for the development of the workplace as the main place of learning, development and innovation, with attention paid to bottom-up learning based on the insights of patients and frontline professionals (Jackson and Manley, 2021). It is suggested that top-down approaches can lead to resistance to change, and it is more likely to be accepted when professionals are involved and driving it (Braithwaite, 2018).

3.102. More reflective and reflexive learning, however, has implications for leadership and nurturing learning culture. There was wide agreement across workshop participants about the need for opportunities for more reflective and relational learning. The EEDI workshop highlighted a specific need for psychological safety. Throughout the project, stakeholders have underlined the importance of strong relationships and trust between professionals for delivering high quality reviews. Confident leaders who place trust in the workforce and are open to experimentation and learning is a pre-requisite for innovation and organisational change.

SMART objectives versus tackling structural issues

3.103. Partnerships express a preference for SMART (Specific, Measurable, Achievable, Relevant, and Time-Bound) recommendations that can be more easily tracked, audited and reported on. Recommendations were reported to be developed collaboratively throughout the LCSPR process, including through practitioner events, interviews / meetings with family members and lots of conversations between the reviewer and the review panel. Reviewers suggested consideration is

given to the context of the local authority. Some may be undertaking improvement activities after an Ofsted inspection or there may be restructuring on-going. Recommendations consider activity already happening to improve services and practice and are developed collaboratively, with several opportunities built in to allow conversations between the reviewer and the panel.

3.104. Reviewers emphasised a need to understand what was achievable and ensure a reasonable number of recommendations. This sometimes had to be negotiated with SPs and required 'being brave'. But there was agreement that a constant stream of recommendations wasn't helpful in view of the volume of reviews.[36]

3.105. SPs and reviewers referred to healthy challenge about recommendations, but this required a good relationship between the reviewer and SP. There were two examples of relationship break down between the reviewer and SP in the sample and clearly tensions arose elsewhere which would have had implications for how findings, recommendations and action plans were identified. One example was a draft passed back and forth for adjustments to the wording, when the reviewer felt it had already been consulted on and agreed.

3.106. One area of tension and disagreement was about SMART recommendations viewed by some as too 'simplistic'. Reviewers were less keen on SMART recommendations but acknowledged that recommendations needed to be workable, as they are the stimulus for action planning. The distinction between recommendations and action planning was more often made by reviewers. A recommendation may not easily translate into a simple action but that must be accepted, according to one reviewer who made a distinction between recommendations and the resulting action plan:

> "What I try and do is specify the result they need to get to, which some practitioners aren't terribly keen on … one recently where I've asked them to find a way of increasing practitioners' confidence, knowledge and understanding of something. And they want to write a policy, and they want to change it to write a policy. And I'm saying no, if you choose to, your policy won't fix this. It might help, but it won't fix it. So, you can put what you like in the action plan, but I'm not changing the recommendation".

3.107. One focus group participant expressed their frustration around recommendations involving training as it is not a 'golden bullet' and suggested that changing culture or providing more resource or capacity would have more of an effect. A lack of consideration of structural issues, and not just practice issues, was referenced. Another professional working in the health service said:

[36] The number of recommendations has reduced over time from an average of 47 per SCR in the 2009-2010 study (Brandon and others, 2012) to seven in the periods 2011-2014 and 2014-2017 (Brandon and others, 2020).

> “So, I think sometimes, although I'm very keen on actions being SMART, I do think sometimes there's an issue round them being unable or unwilling to engage with real systematic change on a national level.” (Health professional)

3.108. Importantly, a distinction was made between findings highlighted by LCSPRs that could be addressed locally and ‘bigger ticket issues’ such as Tier 4 placement availability, tackling unregulated children’s homes, and home education monitoring. Whilst some SPs and reviewers reported that they do not shy away from making national recommendations or from highlighting systems issues (one reviewer noted that a methodology encourages national recommendations), there was ambivalence expressed about the value of doing so.

3.109. Some reviewers felt that the Panel were not receptive to recommendations that highlighted national issues. It was recognised that recommendations might be for different parts of government, from the Home Office to the Information Commissioner’s Office. But a perceived lack of action at a national level, appeared to act as a disincentive to including national recommendations at all. SPs indicated that in some cases, this would mean an issue wasn’t highlighted, although it was relevant, such as lack of suitable adolescent mental health placements, “in this case it wasn’t mentioned because it’s a given”. (Health focus group participant talking about a lack of suitable placements). Another ‘elephant in the room’ was said to be capacity and resources.

3.110. There were examples of seeking to get purchase regionally on challenging issues, such as accommodation for children in complex circumstances, bringing together the CEO and senior leadership team from an ICB to look ‘how to do things differently’ across health and local authorities. But, as with other issues highlighted, there were elements of the problem that required national input, leaving the SP ‘still hampered’.

3.111. Overall, where there were efforts to address systemic issues and consider national change in LCSPRs, there appear to be few mechanisms for ‘feedback’ or further exploration of how system issues can be tackled, including by system leaders at local, sub/regional, or national level.

Learning and impact in a complex multi-agency system

3.112. Partnerships communicated that impact is hard to demonstrate and capture in view of the complexity and changing nature of multi-agency systems and activity. There can be tensions between single and multi-agency action plans. Mostly impact was assessed after a set period, 6-9 months or longer for new practice procedures to bed in. Progress reports from agencies, audits and learning events were a mechanism for checking if things were being done differently. They expressed a need for further support to assess impact, observing that change “happens constantly” including throughout review processes.

3.113. Interviewees highlighted a distinction between tracking action plans (sometimes a paper exercise) which might "result in a tick box mentality" with a more nuanced task of assessing impact, including the role of meaningful feedback from children and families, and understanding the overall effectiveness of safeguarding partnerships.

3.114. Partnerships queried having scope for deeper learning which might take longer and require further opportunities for reflection and exploration. They talked about how capacity to learn is limited where resources are stretched and diverted to undertaking reviews. As discussed earlier, learning cultures also vary between agencies. Limited capacity to learn was also down to competing priorities: "And it's a competition sometimes, isn't it? You know you're working with different regulatory bodies and different requirements" (SP participant).

3.115. High staff turnover was seen as a further challenge for partnerships considering the reach and impact of learning from reviews. Previous studies have found that turnover of staff and resulting 'depleted organisational memory' (Brandon and others, 2020: page 22) means that the same learning must be repeated (Sidebotham, 2012; Brandon and others, 2020). Persistent systemic issues, such as resource gaps, high caseloads, and fragmented systems, hinder the ability to turn learning into sustainable improvements. Reviewers said it can be demoralising to return to a SP after a number of years and find that there is no organisational memory of the issues they highlighted.

Building capacity and capabilities at every level of the system to enable 'high quality' learning

Human Learning Systems (HLS)[37] theory suggests that in complex environments, continuous learning drives performance improvement. Continuous learning and adaption aren't divorced from data or gathering evidence, but allow professionals to practice possible solutions, experiment and explore further, make sense of experiments in the specific services, place or context. HLS proposes that 'learning cycles' involve people from the community and are enabled by 'Systems Stewards'. These systems leaders are responsible for creating capacity for continuous learning and for monitoring its effectiveness. A shared purpose and understanding of how to address issues starts to emerge.

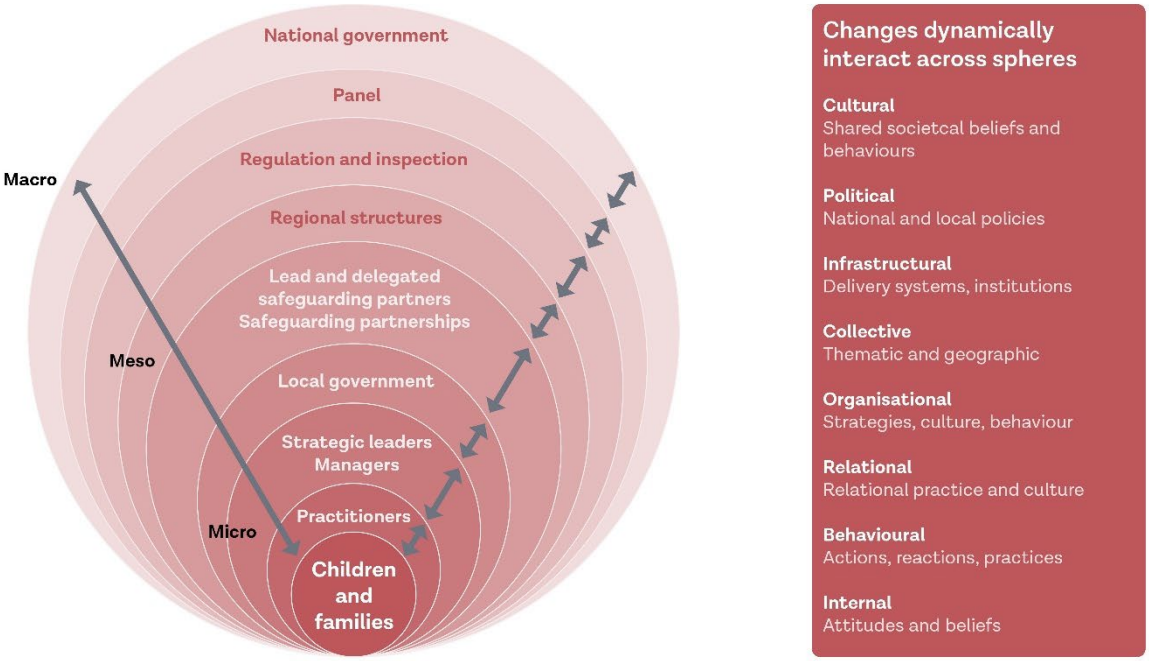
3.116. SPs told us how they recognise the interdependencies between changes they can influence at a local level, and change required at other systems levels. But there is some frustration about a lack of feedback and adaption at regional and national levels. To shift this, more nuanced systems thinking is needed[38]. A simple

[37] Public-service-for-the-real-world

[38] Definitions of systems thinking emphasise the 'interconnections, the understanding of dynamic behaviour, systems structure as cause of that behaviour and the idea of seeing systems as a whole rather than parts' (Arnold and Wade 2015, P.674).

ecological systems framework, like the one in Figure 5 could be used to identify what systems learning is needed at all the necessary levels[39].

Figure 5: An 'ecological model' of the safeguarding 'system'



An 'ecological model' of the safeguarding 'system' (a set of causal relationships between factors). It shows the main stakeholders and levels in the system with children and families at the centre.

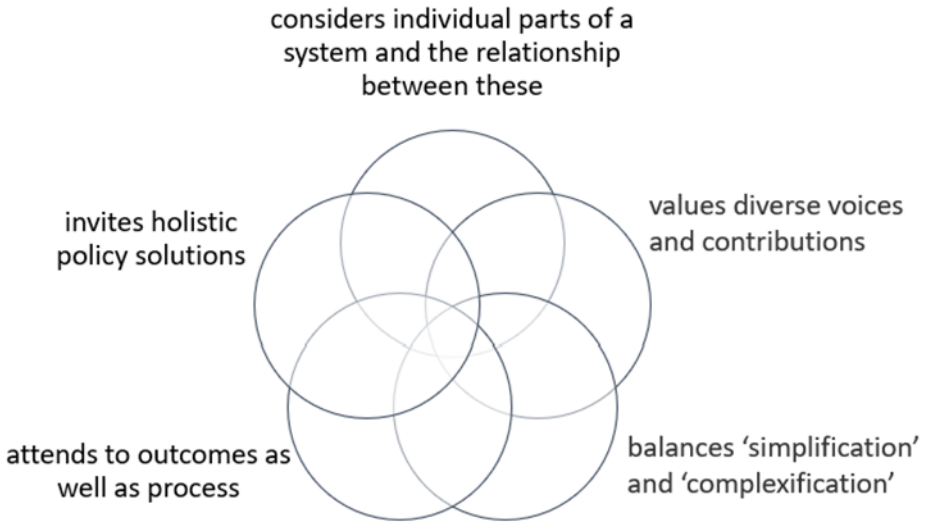
- each of these levels play a role in effecting outcomes.
- different interconnected component parts are linked together by dynamic changes. Behaviours, actions and practices in one level, in turn influence or affect other elements or systems (shown by the arrows and listed in the box on the right-hand side).
- learning in a complex system requires paying attention to these parallel relationships between different parts of the system and depends on valuing these diverse perspectives.

3.117. Public sector innovation research suggests that processes involved in systems thinking and systems change are not only technical and operational but are also relational (Cocker and others, 2024). In their recent work on Transitional

[39] Rather than ask: Is systems learning needed?

Safeguarding and systems change, Cocker and others describe how systems thinking involves a range of overlapping characteristics, as illustrated below:

Figure 6: Characteristics of systems thinking (Cocker and others, 2024)



These characteristics are technical and relational and relevant to delivering reviews and methods for learning. For example, ensuring that children, families and practitioners contribute to review processes, and play a role in understanding and driving better outcomes.

3.118. There is scope to facilitate greater connectivity and dialogues between SPs and regional and national actors. For example, to build on national thematic reviews and Annual Reports from the Panel which are valued by safeguarding partnerships; partnerships indicate that information about themes and trends help them to make decisions about where 'further learning' is needed, and that increased availability of data and insight, e.g. on SIN rates or rapid review themes, would be helpful.

3.119. Sharing learning regionally and nationally was identified as important by SPs, drawing on existing activity deemed to be helpful. One area has developed a regional network with the aim to share learning. Ideas for greater regional collaboration included a regional mechanism for supporting peer learning, regional roundtables, and regional business manager and scrutineer meetings.

3.120. It was suggested that the challenge around repetition of themes and recommendations – expressed keenly by professionals from policing and the health service who often sit across multiple local authority boundaries – could be mitigated by providing a clearer overview of patterns and issues across boundaries and localities, at both regional and national levels. The role of regional Panel representatives was mentioned as an opportunity to strengthen connectivity

between SPs and one way to engage more proactively with the community of independent reviewers.

3.121. Partnerships indicated that a central hub or repository would help professionals to make informed decisions about where learning is needed and strengthen consistency and quality of approach. Rather than duplicate the NSPCC repository, the value of a central place (either regionally or nationally) for tools and templates was viewed as having potential for reducing duplication and enabling consistency and efficiencies.

3.122. Greater attention to professional networks and relationships would support the sharing of skills and knowledge. There is potential to develop more consistent and effective approaches, maximise resources and ensure preparedness amongst multi-agency professionals for the process. Throughout this project, safeguarding partners, business managers, reviewers and scrutineers expressed a high appetite for connection to learn from each other and develop better ways of working. Participants suggested that the relational and emotional elements of the work shouldn't be underestimated and need to be addressed through forms of mutual support.

4. Conclusion

4.1. At the current moment, a continued emphasis on learning for practitioners, might be limiting learning to compliance oriented and corrective actions. Participants expressed a desire to go beyond common types of learning activity, and have more opportunities for deeper, reflexive learning. There is some ambivalence about including national recommendations with implications for systems leaders and how systems learning is articulated and responded to. There has been a partial shift to a systems approach, but a lack of analysis of why things happen, and defensive reasoning persists. Arguably, if learning is limited in this way, the 'predictability' of reviews will continue, leading to further 'learning fatigue' amongst the professionals relied upon to generate learning opportunities.

4.2. Factoring in knowledge about the system's complexity would better reflect the operational experiences of multi-agency safeguarding partners. This would also involve a shift away from the current improvement paradigm which assumes that learning is a phase i.e. identify a SMART solution, action and embed it, monitor it and move on. In this, learning has been largely conceived as linear, as an output of the process, rather than the process itself. In fact, partnerships identified the 'constantly changing' and emergent dynamics of change. The way in which the Panel conceptualise and describe learning would benefit from being more attuned to the messy, reality of how change occurs in complex systems.

4.3. More nuanced systems thinking is necessary. On a practical level, this means creating stronger feedback loops across the system levels, encouraging mutual insight into what is needed, and building momentum for change. It means disrupting

the primary ways in which learning is received or imposed, such as via training or mandates. It also means acknowledging how limited capacity can inhibit opportunities for the types of deeper learning needed, by a wider range of stakeholders (practitioners, managers, system leaders) and at every level (local, regional, national). Change is accepted when people are involved in the decisions and activities that affect them. More creative methods for gathering data and information and the creation of 'learning cycles' for continuous testing and building might help produce better outcomes.

5. Implications and priority areas for change

5.1 The policy direction in recent years has intended to create a 'learning system' and systems approach, but there is a disconnect between the world imagined in the policy framework, and the world in which local partnerships and multi-agency arrangements operate.

5.2 There is continuity from the previous system of Serious Case Reviews, not least the continued influence of a limited pool of independent reviewers. Addressing the need for greater professionalisation, quality assurance and a coherent theoretical basis for 'a systems approach' to learning from reviews is now overdue.

5.3 There are significant challenges around how reviews can perpetuate and reinforce inequalities, with gaps in confidence and capabilities regarding EEDI evident across the review process. The implication is that the lived experience of children and practitioners is not seen or heard in reviews, seriously limiting learning and potential for transformative change. Leadership is required at every level in promoting cultural humility and open learning cultures.

5.4 Involvement and engagement of families and practitioners can be strengthened within safeguarding partnerships so that diverse perspectives inform findings and recommendations. For learning to be generated *with* as well as for children, families and practitioners, greater attention must be given to engaging them early in safeguarding processes in an ongoing dialogue and creating clear feedback loops.

5.5 There is an opportunity to realise 'shared and equal responsibility' amongst statutory partners and move towards a multi-agency ownership of safeguarding children.

5.6 In the short-term this means explicitly recognising the structural and cultural differences between agencies; ensuring that Panel guidance and Working Together (DfE, 2023) is more finely attuned to how different parts of the system operate. Capacity building needs to account for varied learning and operational cultures, and 'starting points' to deliver what is needed, so that all partners can fulfil their safeguarding duties.

5.7 It will also mean addressing inequitable distribution of resources and examining how to strengthen shared ownership of children's safeguarding responsibilities at every level of government and the system.

5.8 Moving beyond single agency mechanisms for learning, and towards shared multi-agency learning and goals, presents unique challenges for government and Panel. Unlike the creation of a safety system in a single agency, here capacity building is required across organisational boundaries and different geographic footprints. It is therefore essential that executive leaders understand core safeguarding partnership functions, including the purpose of reviews, and become more alert to the potential efficiencies that multi-agency and regional infrastructure could offer.

Annexes

Annex A: Glossary of terms and abbreviations

SPs	**Safeguarding partners:** Local safeguarding arrangements are led by three statutory safeguarding partners: the local authority, the police and the integrated care board. **Safeguarding partnership:** There is no legal entity of a safeguarding partnership in WT2018 or the primary legislation. Therefore, the term safeguarding partnership should be avoided in favour of "safeguarding partners". The exception is a proper noun (e.g. The Lambeth Safeguarding Partnership) or collective reference to individuals as a partnership.
The Panel	The Child Safeguarding Practice Review Panel
Review group	SPs commonly have sub-groups for the purposes of delivering reviews. The review group are usually involved in setting terms of reference, commissioning an independent reviewer, overseeing findings and developing recommendations and action plans.
SIN	Serious Incident Notification
RR	Rapid review
LCSPR	Local Child Safeguarding Practice Review
Minoritise	To make (a person or group) subordinate in status to a more dominant group, its members or another person
Intersectionality	The concept of intersectionality describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination "intersect" to create unique dynamics and effects.

Annex B: Policy context

Since recommendations were first made by Professor Eileen Munro (2010) for a 'systems approach', there has been a long-standing aim to move away from culture of blame to a culture of learning and development. The Munro Review of Child Protection (2010) criticised Serious Case Reviews (SCRs)[1] for lack of engagement with practitioners, absence of a transparent methodology, concerns regarding shallowness and sustainability of learning. There was concern that reviews were preoccupied with getting the review process right with insufficient attention to improving outcomes for children.

In 2016 the Wood Report (Wood, 2016) echoed many similar points to Munro and made a case for 'fundamental reform'. He referenced parallel developments in safety science and NHS Patient Safety framework, and the opportunity to follow their 'move to a safety culture that focuses on learning, even when things have gone very wrong'. It brought in a

new era, recommending the end to Serious Case Reviews, (criticised for being too prescriptive)[40], and establishment of a new independent body at national level to oversee a new learning framework for inquiries into child deaths and cases where children have experienced serious harm.

The Children and Social Work Act 2017 introduced a duty for the Safeguarding Partners (Local Authorities, Police and CCGs) to make arrangements to work together to protect and safeguard children[41]. It placed further emphasis on shared multi-agency responsibilities for safeguarding children and the creation of Multi-Agency Safeguarding Arrangements (MASAs).

For the first time, local partners could look to a national body for guidance on best practice for undertaking new local child safeguarding reviews (LCSPRs), and advice on how learning should be shared and reported. There was a new system for national reviews which would share learning widely. Wood proposed that the body should be tasked with setting up a new national learning framework, but this development was never explicitly implemented when the National Child Safeguarding Practice Review Panel was set up in 2017.

Working Together (DfE, 2023) includes several key changes related to the Child Safeguarding Practice Review Panel and further strengthened expectations for multi-agency collaboration and for family involvement. Key duties, including the requirement to notify the Panel of serious incidents remains largely the responsibility of local authorities.

Changes to roles and responsibilities and mechanisms for independent scrutiny, governance and oversight have evolved. Most recently, Working Together (DfE, 2023) introduced a distinction between Leaders of Safeguarding Children Partnerships (Chief Officer of Police, Local Authority Chief Executive and Chief Executive of Integrated Care Boards) and Delegated Safeguarding Partners (DSPs) taking decisions on their behalf. It requires SPs to bring representatives of Education into strategic planning. It also updated instructions of Independent Scrutiny functions.

A need for accreditation, sharing of knowledge and expertise, and development of independent reviewers was discussed at length by Munro (2010). Wood referenced findings from the Learning into Practice Project (LiPP) which examined what was needed in order to improve the quality of SCRs, recommending a common framework for commissioning and conducting reviews and adequately skilled workforce of reviewers.

There has been growing attention to how reviews explore systemic inequalities and discrimination or focus on issues of EEDI in the system of reviewing and reviews. [42]Well known methodologies and approaches are also not explicit about EEDI.

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[40] Munro, E. 'Munro review of child protection: final report - a child-centred system - GOV.UK'. See page 60: 'Serious Case Reviews were generally successful at identifying what had happened to the children concerned, but were less effective at addressing why', Department for Education, 2011.
[41] Section 16E Children Act 2004 (as amended by Section 16 Children Act 2017) Children Act 2004
[42] The Panel recently undertook a thematic analysis into 'Race, racism and safeguarding children' . See also, The Child Safeguarding Practice Review Panel - Annual Report 2023 to 2024; Dickens and others (2022) Annual review of local child safeguarding practice reviews

Annex C: Methodology

Safeguarding partner interviews (with and without reviewers)

Recruitment process: SIN data was provided by the panel Secretariat of safeguarding partnerships with a current or recent LCSPR within a 12-month period. It was agreed with the Panel that 9 recent LCSPRs would be selected and 3 current reviews. The sampling and selection process was as follows:

- For recent LCSPRs the main categories for selection were region and Ofsted rating. Selecting 9 recent reviews ensures that one is selected from each region, leaving 3 current reviews.
- It was reasonable to select 3 current reviews based on soft intelligence from the project team, and from VKPP where information about criminal investigations could be obtained.
- A randomly generated sample was produced using a formula (see page 66). Once the sample was generated, consideration was paid to the following to produce a final sample.
- Category of serious harm (death, serious incident, other).
- Child / parent characteristics (type of abuse etc.) where data is available.
- Protected characteristic (disability, gender, ethnicity) where data is available.

Back-up selection and further sampling

- If any of the safeguarding partnerships selected are not able or willing to participate in the project further to being contacted, then options will be selected from our back up list.
- For recent reviews, this will involve selecting from the randomly generated sample.

A total of ten safeguarding partnerships participated in group interviews. Each safeguarding partnership was interviewed twice in relation to an index case, a child who had been the subject of an LCSPR in the last 12 months. The first group interview was without the reviewer. The semi-structured interview covered the different stages of the LCSPR *process* and also had a focus on EEDI. Interviews were undertaken by one academic researcher and one research associate. The research associates comprised senior professionals, including an independent scrutineer, experienced reviewers and a senior police officer. They were able to use their expert knowledge of the process to probe and explore points of interest during the interview.

After the first interview a summary was written up and discussed within the research team. The summary was provided to the safeguarding partnership in advance of the second group interview where they were joined by the reviewer. In one instance the reviewer was not present during the second interview and was not interviewed individually. In another instance there was no independent reviewer as the rapid review did not proceed to a child safeguarding practice review. The second interview was used both to sense check the summary from the first interview, and to explore the topic of *learning* from reviews in more depth.

Interviews took place via Teams. Written consent was obtained prior to the first interview. Debriefs were sent to participants after the interviews.

Reviewer interviews

Eight reviewers who had produced a report under discussion during safeguarding partnership interviews participated in a one-to-one interview with the academic researcher. Following the interview, they participated in the second group interview with the safeguarding partners. Written consent was obtained prior to the interview or verbally at the start of the interview. The interview was semi-structured and covered their experience and expertise as well as all stages of undertaking reviews and working with safeguarding partnerships and the national panel.

Interviews were via Teams and a debrief was emailed to the reviewer after the interview.

Table 1. Reviewers, experience and training

Background	Years as a reviewer	Methodology & training[43]
Social worker	14	SILP & SCIE
Social worker	8	SCIE
Social worker	8	SCIE
Social worker	17	SCIE
Social worker	18	SCIE
Social worker	6	SILP / DHR / OWHR
Social worker	15	SILP
Social worker	10	SCIE

[43] See: Safeguarding reviews - SCIE and SILP Reviews – Review Consulting and Domestic homicide review - GOV.UK and Offensive weapons homicide reviews: statutory guidance (accessible version) - GOV.UK

Family and friends' interviews

Families and friends were recruited via gatekeepers. Gatekeepers included the safeguarding partnerships involved in the interview aspect of the study, partnerships on a list from the National Panel and partnerships who attended the workshops.

Family was considered using a broad definition as those close to the child or parents and the final sample included a grandmother, a child, a father, and a mother. No friends were interviewed. Only family members who had been involved in a child safeguarding practice review completed within the previous 12 months took part.

Teams calls with business managers / staff were arranged to explain the inclusion / exclusion criteria and the process. The business manager from the partnership would approach the participant initially to explain the study and ask about their interest in participating. The potential participant would either make contact directly with the lead researcher or ask the business manager to pass their details to the researcher who would make contact. The study was explained, inclusion criteria confirmed, and a suitable date arranged. A semi-structured interview took place via WhatsApp video, telephone, or Teams. Informed consent was given verbally during the interviews. Four family members were interviewed, including a mother, a father, a grandmother and a young person who was the subject of a review. After the interview a debrief was emailed with a gift voucher and a follow up telephone call offered and arranged.

Practitioner interviews

Table 2. Practitioners by agency/role

A total of 15 interviews. Agency/role.
Health - GP (2)
Health - nurse (1)
Local authority / social worker (3)
Local authority / youth worker (1)
Police (3)
Education - pastoral care (2)
Education - early years / nursery manager (1)
Education – family liaison officer, primary school (1)
Housing officer – (1)

Practitioners were recruited through safeguarding partnerships not engaged with the main interview study. This was to ensure that they felt able to speak anonymously about their experiences of the LCSPR process. Safeguarding partnerships on the list from the National Panel and those attending the workshop (but not in the interview study) were approached to support the recruitment. Practitioners were usually approached by the business managers via email to groups who had attended a practitioner event as part of a recent LCSPR. Practitioners got in touch directly with the academic researcher. The process was explained, and a suitable time arranged. Written consent was sent to the researcher in advance by some participants, but others gave verbal consent at the start of the interview.

The interview was semi-structured and covered their experience and involvement in the practitioner event, learning from the LCSPR process, support, and impact of the process. After the interview a debrief was emailed to the participant.

Focus groups

The focus groups for health professionals and police colleagues followed a consistent semi-structured format to explore key themes while accommodating the distinct roles and contexts of participants.

For police colleagues, two focus groups were conducted with participants from five selected police forces. Seventeen officers and staff participated, split into one group of practitioners and another of strategic leaders. Two tailored question sets were used to explore shared themes, with a focus on operational experiences for practitioners and strategic leadership perspectives for senior participants. The sessions, facilitated by a National Child Reform Facilitator for Policing and a research assistant, ran for two hours on Microsoft Teams. Recordings were transcribed with consent, and participant identities were anonymised for analysis.

For health professionals, two focus groups were conducted with 38 participants recruited through the National Network of Designated Healthcare Professionals and the National Network of Named GPs. A single question set ensured consistency in exploring key themes across the groups. Sessions were co-facilitated by the National Child Reform Facilitator for Policing and the Development and Innovation Programme Lead from NCB. The two-hour discussions were recorded with participant consent, supported by high-level notes. Recordings were anonymised, and the data was systematically charted and thematically analysed to identify recurring patterns and key insights.

Table 3. Focus group participants by agency / role

Health Focus Group Participants	Police Focus Group Participants
Named Practitioners - 10	Practitioners - 8
Designated Professionals - 28	Strategic Leaders - 9

Both focus groups shared a common methodological foundation—including duration, virtual delivery via Microsoft Teams, and thematic analysis—the police focus groups distinguished between practitioner and strategic leader perspectives, while the health focus groups maintained a unified approach across designated and named roles.

Workshops

A series of five workshops was undertaken. The first four of these used a combination of presentation of preliminary findings with further breakout groups and discussion. These allowed participants from the interview study to come together with representatives from a wider range of Safeguarding partnerships. Consent was gained before and at the beginning of the workshop, with ongoing participation taken as reflecting ongoing consent.

Recruitment was by invitation to all participating SPs in the fieldwork and a further 9 SPs who had been in contact with the project showing an interest in taking part. The workshops were also posted on the Research in Practice website on the CSPRP pages – open registration was possible via the website.

The workshops were themed as follows:

- Strengthening multi-agency safeguarding partners to deliver high quality LCSPRs
- Decision-making and ownership in the LCSPR process
- Equity, Equality, Diversity and Inclusion in Safeguarding and Review Processes
- Generating learning from LCSPRs to better support children and young people
- The fifth workshop was used to discuss recommendations for the National Panel and Department for Education.

Table 4. Workshop participants diversity survey results

Category	Diversity Details	Count	Percentage %
Gender	Women (cisgender)	68	86%
	Men (cisgender)	11	14%
	Total	**79**	
Ethnicity	White	70	89%
	Asian or Asian British	3	4%
	Black, African, Caribbean, or Black British	2	3%
	Mixed/multiple ethnic groups	1	1%
	Other ethnic groups	3	4%
	Total	**79**	
Disability Status	No disability	67	85%
	With a disability/health condition	11	15%

	Prefer not to say	1	1%
	Total	**79**	
Sexual Orientation	Heterosexual	63	80%
	Lesbian	6	8%
	Bisexual	6	8%
	Gay	2	3%
	Prefer not to say	2	3%
	Total	**79**	

In all there were 110 professionals who engaged in an interview/workshop or both from a total of 35 Safeguarding Partnerships. 79 returned a diversity survey. They comprised 68 women and 11 men, all cisgender. 70 participants said they were White with 3 Asian or Asian British, 2 Black, African, Caribbean or Black British, 1 of mixed or multiple ethic groups and 3 other ethnic groups. 67 said they had no disability with 11 stating they had a disability or health condition and 1 preferring not to say. 63 identified as heterosexual with 6 lesbian, 6 bisexual, 2 gay and 2 preferring not to say. Of the 79 participants who returned the demographic survey participants were predominantly White (89%) female (86%), heterosexual (80%), cisgender (100%) and without a disability or chronic illness (85%), with age range skewed towards the over 40s.

Table 5. Workshop participants by age

Age	Count	%
25-29	1	1
30-34	1	1
35-39	12	15
40-44	9	11
45-49	21	27
50-54	10	13
55-59	12	15
60-64	9	11
65+	4	5
Total	79	99% (due to rounding)

Data handling and analysis

All interviews were recorded and transcribed using Microsoft Teams. Transcripts were checked against recordings to ensure accuracy of quotes selected.

Data from safeguarding partner interviews and reviewer interviews were analysed thematically (Braun and others, 2021) with the aid of NVivo 14. Group interviews were undertaken by an academic paired with an expert associate (experienced reviewer, senior police officer, independent scrutineer) After each interview a summary was written and shared with the participants. Summaries were discussed at a weekly fieldwork meeting of the research team (RiP, UEA, VKPP, expert associates) over the course of data collection to discuss potential themes. Practitioner and family interview data were summarised and a thematic analysis undertaken. Case summaries were written for each interview as part of this analysis and then reviewed for cross-cutting themes which were discussed amongst the UEA team.

In the workshops notes were taken from the breakout groups as well as the Teams chat and used to sense check findings from the interview study and explore themes in more detail.

Quotes are identified by source of data (safeguarding partnership interview, reviewer interview, workshop, focus group) and by agency where relevant. To preserve anonymity participants are identified broadly by sector, Health, Police, Social Care, Education, although it is recognised that these are each complex organisations with many different professional roles.

Further information

Generating a random sample for recent LCSPRs

- A representative spread of nine Ofsted ratings was determined: 2 x outstanding, 2 x good, 2 x requires improvement, 2 x inadequate and 1 x rating at random.
- To obtain the one random rating, each type of Ofsted rating was listed in a column alongside randomly generated numbers. The two columns were grouped in a table and the numbers sorted in ascending order. The rating randomly assigned the highest value was chosen: Requires improvement.
- The nine ratings and nine regions were listed into columns, each assigned randomly generated numbers, and grouped into two adjacent tables. By sorting the two tables into ascending order, the regions were randomly assigned a rating.
- Once data entries matching criteria were highlighted, manual sampling was used to select entries that were representative of population demographics and other characteristics.

Annex D: Roles and structures in health and policing

For health and police there are centralised strategic teams, post holders and mechanisms along with local teams and functions, both engaged with review processes.

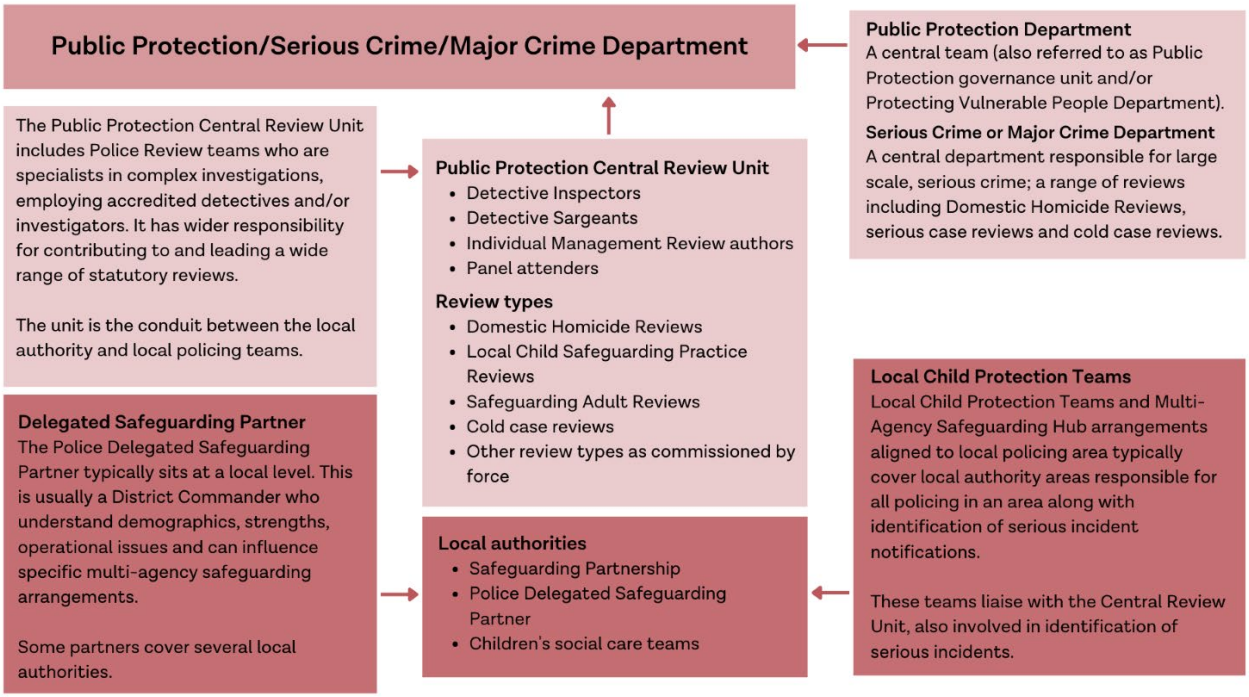
The ICB has ultimate responsibility for the coordination of safeguarding arrangements for health. Delegated professionals, e.g. Director of Nursing sit at ICB level. The central governance model was described as having a level of expertise and consistency within safeguarding practices and oversight within the review process; however, examples were also given, where safeguarding representatives, were disconnected and didn't always understand the operational context, for example at a local hospital within a busy and complex area within London. This was partly due to the scale of the area the safeguarding lead covered.

The advantages of having designated roles however, ensured the coordination of health providers, and a strength of this model, was the ability to provide chronologies and analysis, and consistency in attendance at panel meetings, and subgroups. The designates attend local panel meetings and sub-groups, provide chronologies for RR and LCSPRs analysis for rapid reviews; they also share information across different health services and provide oversight of the process.

In policing, there are local policing teams where the DSP – usually a District Commander sits - and a Central Review Unit. Connectivity between the two can be difficult with forces often being criticised for being 'too central' or 'too local'. The connection between local policing and central review teams was viewed as difficult to balance due to differences in structures, geography, funding, and partnership arrangements. It can influence how police engage effectively in review processes in keyways. For example:

- How learning is shared by Central Review Units due to having to influence a larger number of frontline practitioners compared to influencing at a district level.
- Timeliness of notification about the commissioning of single agency reports for RR and LSCPRs. Despite having a centralised serious case review mailbox, local officers, and partners, don't always scan for serious incident notifications and inform the Central Review Unit where Police Review Teams sit.
- Timelines for rapid reviews are made even more challenging partly by delays in notification, and because of the amount of information that the police hold.

Figure 7. Police structures and how they interact with Rapid Reviews and LCSPRs



Annex E: Project definitions of EEDI

Definition of Equity, Equality, Diversity, Inclusion (EEDI)

To provide clarity and ensure consistency of understanding and application, we use one EEDI definition in this project. The definition was shared with stakeholders as part of fieldwork to support their understanding and framing of our research.

In line with the Equality Act 2010 and Working Together to Safeguard Children (DfE, 2023), EEDI as a general frame of reference refers to 'how the diversity of children, families and professionals are accounted for and responded to across systems' (Laurelle Brown Training Consultancy, 2024).

In this project EEDI is defined as:

EEDI	Definition	Example
Equality	Ensuring that people have the same opportunities, are treated fairly, and are not treated any less favourably than others due to their protected, or wider, characteristics.	All practitioners have access to the same training grant to support Continuous Professional Development.

Equity	Assessing and putting in place measures to address barriers faced by different groups.	Practitioners without access to the training systems are identified before the financial year starts and supported to set up an account, to ensure they can access their grant.
Diversity	Acknowledging, taking account of and valuing different backgrounds, circumstances and strengths of individuals and groups.	The backgrounds of practitioners are recorded and analysed to inform the planning and delivery of training activities.
Inclusion	Taking steps to ensure different individuals are respected, feel valued and can express their full identity, should they wish to. (Recognising that diversity and equity do not automatically result in individuals being welcomed, respected and valued like others, such as those from dominant groups).	Feedback from practitioners is obtained every year, and results in changes. This has included more women-only training sessions being commissioned, and Kosher food options being catered for during learning events.

Annex F: Equity, equality, diversity and inclusion (EEDI) framework

1. The most important part of this framework

While this Framework provides key information and guidance to support the best possible approach to EEDI within this project, we must remember that EEDI is the responsibility of every person and organisation involved in this project. Without our collective commitment, proactive approach, and accountability for implementation, this document risks being little more than a tick-box exercise. **Achieving 'EEDI' in this work relies on each of us.**

2. Purpose

The EEDI Framework serves two key purposes within this project:

1. **Assure:** Provide a clear stance on the project's EEDI approach to instil confidence and good practice.
2. **Embed:** Support the mainstreaming of EEDI across all project levels to enhance outputs' quality, depth, and relevance.

It is intended to serve as a high-level guide to enable a consistent and proportionate approach. More detailed, activity-specific, guidance and information can be found in the full Framework, with iterative developments to be added as the project progresses.

EEDI Framework Domains

01: Partnership. Organisations: Research in Practice, Vulnerability Knowledge and Practice Programme and University of East Anglia.

02: Team. Individuals: Those engaged in fieldwork.

03: Activities: Research activities and outputs.

This framework is underpinned by the reflective process of Cultural Humility.

Cultural humility entails openness, awareness and supportive interactions across various characteristics including race, ethnicity, sexual orientation and social status (Foranda and others, 2016). It acknowledges power imbalances and aims for mutual empowerment, respect, and optimal care. It's viewed as a lifelong process that support inclusive environments and mutual benefit through ongoing learning and reflection.

Although our EEDI Framework is grounded in evidence, it's important to note the predominance of US-based research in EEDI literature (Chambers and others, 2017), with a heavy focus on gender and race / ethnicity, and little on sexuality and disability. These characteristics are prominent themes in recent rapid reviews and CSPRs across England (CSPR Panel, 2024).

3. Components

Cultural Humility is the primary theory informing **all aspects of the project** as indicated in Image 1 (below).

Why Cultural Humility?

We are keen to understand how cultural identities are acknowledged and examined within safeguarding reviews and learning processes, recognising that without this, issues underpinning Critical Race, Queer and Disability theories may not be adequately identified or addressed.

EEDI Key Lines of Enquiry

Pursued through delivery of the project.

- **Intersectionality (multiple identities)**. Interplay of protected and wider characteristics. See to uncover intersectional impacts. Race, gender, sexuality and disability of particular interest.

- **Critical Race Theory (race and ethnicity).** Racial hierarchy and racism embedded across systems. Interplay of race, ethnicity and racialisation. Critical examination of manifestation. Centering and amplifying racially minoritised.

- **Queer Theory (sexuality and gender).** CIS heterosexuality dominance and underpinnings of normative assumptions. Conflation of sexuality and gender, critical examination of manifestation. Centering and amplifying LGBTQ+

- **Disability Theory (disability and health).** Medical, Social and Social Relational Models of Disability. Structural ableism and disablism embedded across systems. Interplay and spectrum disability and impairment. Seek to understand approaches and impact.

Applying Cultural Humility enables a deeper understanding of how personal biases and privileges influence decision-making (Yeager & Bauer-Wu, 2013), and the ability to critically consider how and if input from those with diverse lived experiences is sought**.**

Our goal is to explore and gain insights into the nuanced cultural dynamics at play in safeguarding review, and learning processes, while also supporting the team, and other stakeholders involved in the project, to continually examine and reflect on their own cultural identities.

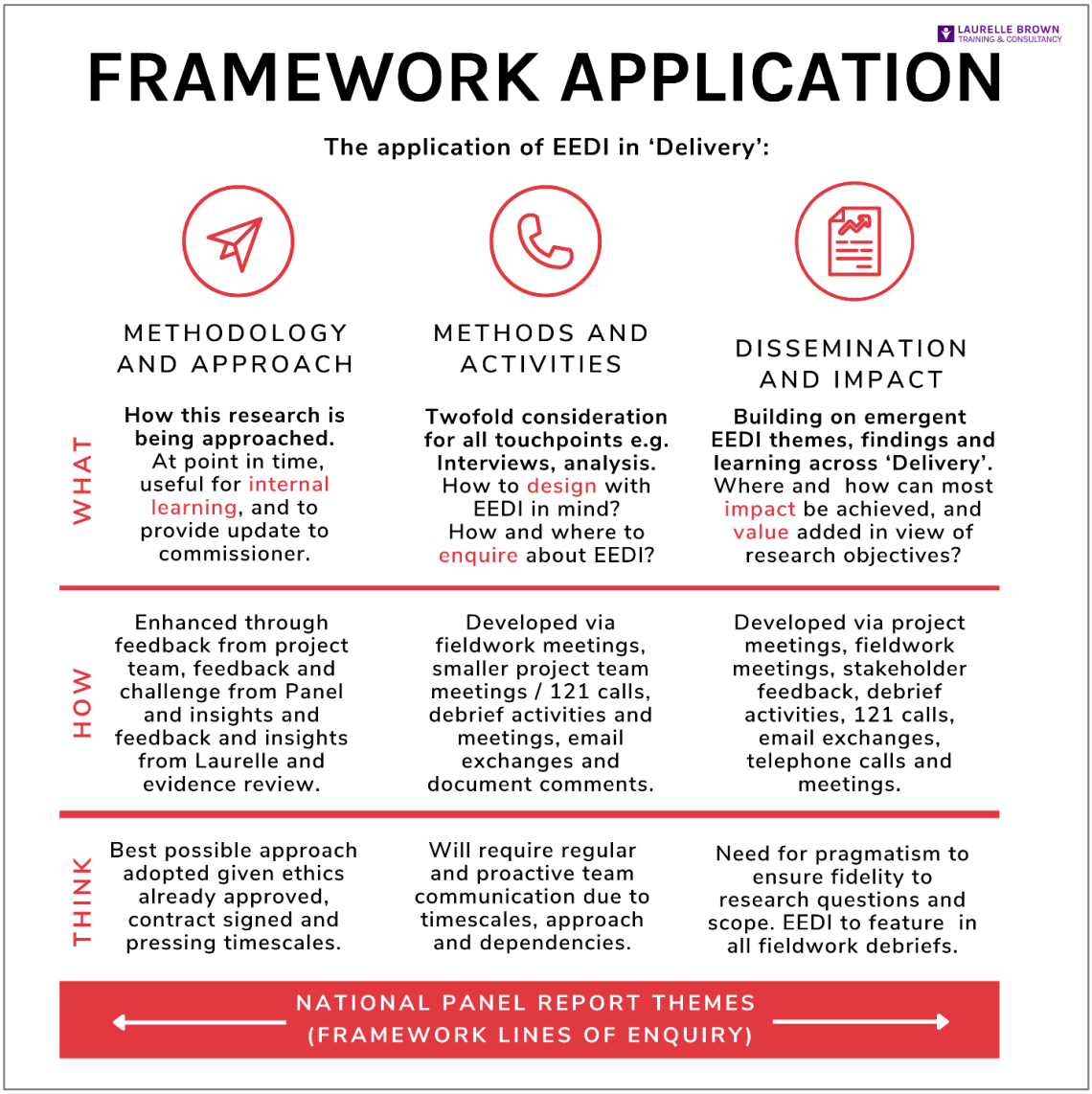
Punch (1994) highlights that researcher positionality, geographic proximity, and institutional background shape the ‘politics of research’, impacting avenues for inquiry. Our challenge is to remain alive to this and apply accordingly.

Key lines of enquiry

Across the delivery’ domain, all project activities and fieldwork should apply Intersectionality, Critical Race Theory, Queer Theory, and Disability Theory in our approach, as outlined under ‘ley lines of enquiry’. This is based on insights from CSPRs nationally.

Image 1: EEDI Framework Application

Recognising the project's scope, timescales, and pressures, key aspects of these theories are highlighted for quick and easy reference and use.



4. EEDI in this project

This Framework version outlines how we conceptualise and implement EEDI across the 'Methods and Activities' and 'Dissemination and Impact' delivery phases, as outlined in Image 3.

This version has been developed based on team feedback and the iterative project approach. Support is available at all stages, with specifics determined by factors such as availability, existing team member knowledge, and the particular activity.

The EEDI Framework approach will continue to be reviewed and developed iteratively as the project progresses. **Consistent definitions of EEDI will be applied (see Annex E).**

While we aim to understand EEDI across partnerships and reviews in broad terms, we will focus on specific areas highlighted in the National Panel's most recent annual report (CSPR, 2024). These areas involve the processes, experiences, and outcomes for children and families minoritised based on the following protected characteristics: Disability; Race; Sexual orientation and Gender reassignment.

Minoritisation may involve one, or the intersection of several characteristics, such as a Black gay child or a disabled trans child.

Clarification points

The following topics of clarification are outlined following project team feedback:

Topic	Clarification
Gender	▪ Gender is generally conceptualised through a binary girl / boy lens by services and professionals. ▪ As a project, our conceptualisation of gender is based on a wider focus, recognising that gender is on a 'spectrum'[44]. ▪ When referring to gender, we should pay attention to the language we use, ensuring that assumptions are not made about a person's gender. ▪ In this research, we want to understand how gender is conceptualised, recognised and responded to across Partnerships, informed by our application of Queer Theory.
Wider characteristics	▪ Several characteristics and backgrounds are neither protected characteristics nor captured within the key lines of enquiry in this framework, such as families with low incomes or experiencing poverty and the in / exclusion of fathers. Where there are insights or findings relating to these demographics, they should be noted and explored within the broader aims of this Framework (refer to EEDI definition).
Bias, discrimination, prejudice	▪ Across the project, bias, discrimination and prejudice will feature at various levels. ▪ Bias is often framed as unconscious attitudes and behaviours that feature in interpersonal interactions, however, it is important to note that many individual biases are conscious, and they can operate at multiple levels, such as institutional. They can be positive or negative.

[44] Available resource – Living Gender in Diverse Times: Young People's Understanding and Experiences of Gender Diversity in the UK

	▪ Throughout delivery, we want to actively recognise and acknowledge the presence of biases, discrimination, and prejudice within the processes and interactions of the project, and in fieldwork.

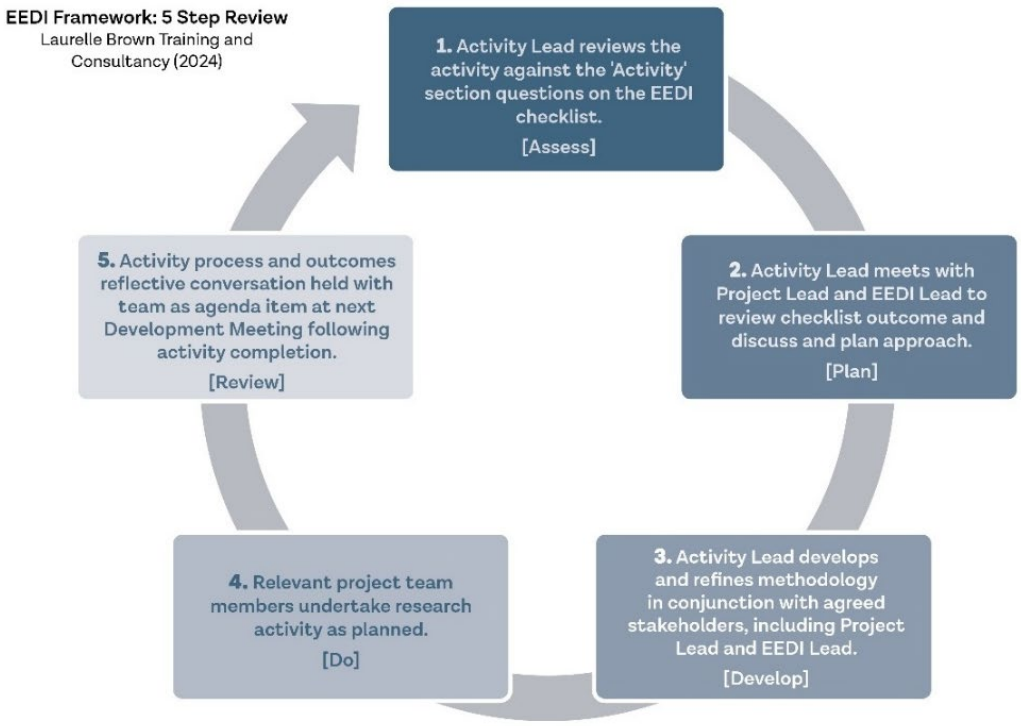
5. Methods and activities

Applying this EEDI framework consistently is the primary task for the project team. All team members must **proactively take collective responsibility** for their roles to make a meaningful difference in project delivery and generate valuable learning and insights, both personally and in the research. This entails closely following the '5 Step Review' process (Image 2) by initiating calls, communication and feedback.

Given the tight project timelines, fluid delivery, and busy schedules, it is acknowledged that it may not always be possible to strictly adhere to this process for every research method and activity. However, strategically using email and collaborative tools e.g. Teams can support strong communication and collaboration.

Recognising that extensive input from the EEDI Lead may not be feasible for every method and activity, the tailored checklist below should be referred to by team members when planning and delivering activities. This ensures that project delivery remains inclusive, impactful, and responsive to the needs of diverse children, families and systems.

Image 2: EEDI Framework: 5 Step Review



Historical context and structural inequalities

- Have past EEDI challenges in similar research and projects been considered, assessed and, if required, sufficiently mitigated in this work?
- Has previous research excluded certain groups / demographics?
- How might historical and structural issues affect marginalised and minoritised group participation?
- What strategies will be used to navigate these issues effectively?

Research questions

- Do research questions address the needs and experiences of minoritised groups, especially concerning the EEDI key lines of enquiry?
- Do the research questions include an exploration of any impact of EEDI change, leadership and culture across systems?
- Have the project's core EEDI frameworks - Anti-racism, Queer Theory, intersectionality, and cultural humility - been incorporated into the research questions?

Selection of sites, and samples

- Is the sample generalisable?
- How were sites / samples selected, and were geographical and population factors considered through the lens of EEDI?
- Are there any exclusions being made, and if so, are they justified?
- How is demographic and other data relevant to EEDI collected, and have unintended impacts been considered?

Participants (e.g. children and families, members of the public)

- How are EEDI issues addressed in any participant recruitment strategies?
- Are there groups that require or would benefit from targeted recruitment efforts?
- How are diverse participants supported and empowered?
- Have data ownership, control and possession for the participants been discussed and agreed upon?

- Will recruited participants be needed for any further activity? If yes, what are the EEDI considerations e.g. compensation?

Data collection

- Have accessibility needs been considered for participants involved in the research?
- Is the data collection strategy equitable?
- Do the methods address participants' characteristics and needs?
- What steps are taken to include 'seldom heard' or minoritised groups?
- Are diverse and representative perspectives, experiences and epistemologies reflected in data sources and data disaggregation?
- Has the impact of interviewer identity been considered and acknowledged by interviewers?
- What tools and strategies might be needed to ensure interviews explore EEDI effectively?
- Do researchers recognise and understand how their behaviour and actions can undermine EEDI efforts, marginalise other team members and research participants and protect positions of privilege when collecting data (and wider activities)?

Data analysis and presentation

- Are results interpreted with diverse and representative perspectives, knowledge, and skills?
- How will EEDI demographic data be analysed and reported, race, ethnicity, gender, sexual orientation, and disability in particular?
- Are participants' EEDI demographics and system contexts described accurately?
- What are the implications and benefits for different groups?
- Where possible, have issues of EEDI been considered from a holistic, systemic and / or longitudinal perspective?
- Have EEDI issues been framed in such a way as to highlight their systemic roots or manifestation?

- Whose voices and narratives are highlighted, whilst maintaining anonymity?
- What political projects or narratives are promoted in how findings are presented?
- Has the presence and impact of systemic inequalities been presented, with consideration of any cumulative impact?
- Is there clarity and agreement on how to analyse and present data about identities (e.g. race), structural forces (e.g. racism) and frameworks in use (e.g. intersectionality)?

Dissemination, implementation, and impact

- Are findings disseminated via inclusive formats and channels? If so, how?
- Does the research benefit minoritised and / or children overrepresented in negative outcomes?
- Is there a focus on impacting those most in need?
- How are key findings mobilised to support specific groups' goals?
- Are effective knowledge mobilisation strategies used, considering language diversity?

6. In practice

Researchers likely encounter challenges, resistance, or defence from participants when making enquiries about EEDI. The following tips may help avoid such circumstances, or support a more positive way forward should they arise:

- **Build trust and rapport:** Begin by creating a safe and respectful environment. Clearly explain the purpose of the research and how it will benefit all stakeholders. Share your positionality and commitment to EEDI principles, demonstrating openness and honesty. Explain the terminology that will be in use.
- **Use inclusive and respectful language:** Be mindful of language that might imply assumptions about participants' experiences or identities. Use terms that are inclusive and neutral, avoiding jargon or terminology that might be unfamiliar or offensive.
- **Provide context and relevance:** Clearly articulate why EEDI enquiries are essential for this research and how they can contribute to better outcomes – for everyone.
- **Empower participants:** Let participants know that their input is valuable and that they have control over their participation – we are not trying to trick them or reflect

them badly. Provide options for how they can respond to enquiries if required e.g. follow up email.

- **Address concerns directly:** Acknowledge and address any discomfort or resistance directly and respectfully. Use follow-up questions to reflect, surface the potential issue and further explore meaning and gaps, e.g. “You mention that EEDI was not important in this review, can you explain how the panel / reviewer / executive determines what is important?”

- **Follow up:** Before closing. follow up with participants to see how they are feeling about the process and address any lingering concerns.

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Annex G: Rapid Evidence Review

Introduction

Working Together (DfE, 2023) makes the purpose of a child safeguarding practice review clear:

The purpose of serious child safeguarding case reviews, at local and national level, is to identify improvements that can be made to safeguard and promote the welfare of children. Learning is relevant locally but has a wider importance for all practitioners working with children and families and for the government and policymakers. P131

Local safeguarding partnerships are responsible for local learning and the panel has overall responsibility for national learning[45]. Although the guidance emphasises improvements to practice it has been argued that LCSPRs have other overt and covert purposes (Dickens and others, 2023). Overt functions include accountability, reassurance and commemoration. More covert purposes are suggested, including dissipating public outrage and deflecting attention from underlying causes. LCSPRs thus have a public and community function.

This evidence review considers what is known about learning and improvement through the LCSPR process drawing upon analysis of LCSPRs, the previous Serious Case Review (SCR) system and other types of review. First issues of quality are traced through the biennial and triennial reviews of SCRs, drawing attention to the interface with policy development. Issues of quality are then laid out exploring themes linked with process and outputs. The final section focuses on generating learning from review processes and measuring and monitoring impact. A consideration of where and how learning takes place is necessary to understand the value of the review process. Dickens and others (2022): 60) suggested that more learning goes on than is captured in the final LCSPR report. If the process of learning is viewed in its widest sense, then it is important to capture some of this additional learning rather than focusing only on the final report as an output and disseminating the learning from that. In earlier reviews of SCRs not all reports identified the learning that came from the wider review process (Sidebotham and others, 2016). The move to LCSPRs introduced a staged process where initial learning is captured through a rapid review, and then a LCSPR is initiated where the potential for further learning is identified.

Policy & Guidance

The Munro review of child protection (2010) criticised SCRs for lack of engagement with frontline staff, absence of transparent methodology, concerns regarding shallowness and sustainability of learning and inconsistency in the presentation of findings. There was

[45] S16F (2) Children Act 2004 and Section 16B (2) Children Act 2004

concern that reviews were preoccupied with getting the review process right with insufficient attention to improving outcomes for children. Recommendations focused on developing new procedures and compliance with procedures, with less emphasis on management, supervision, resources and knowledge and skills (Munro, 2010: page15).

In 2014, the national panel of independent experts identified some key problems regarding the quality of SCRs. These included too much detail, listing what happened but not asking why, lack of attention to human motivation, failure to focus on the child, and unclear recommendations (DfE, 2014). A second report found there were still reports '*burdened with detail*' (DfE, 2015: page 7) of what went wrong but less about *why* and *how* and what needed to change. This concern with critical analysis, or lack of it, has been the most common recurring theme across the analyses of reviews, and has also been found in relation to a broader range of reviews, including Domestic Homicide Reviews, Independent Investigation Reports, Serious Case Reviews / LCSPRs and Safeguarding Adult Reviews (SCIE, 2020; VKPP, 2020).

To respond to the criticisms of SCRs the Learning into Practice Project (LiPP) was funded by the Department for Education with the objective of improving the quality and use of SCRs and understanding what 'good' looks like (NSPCC/SCIE, 2016). At the same time a triennial review of SCRs was commissioned with part of the remit to look at different report styles used in SCRs and recommendations made.

In their triennial review, Sidebotham and others (2016): page 212), considered quality of SCR reports. They found that reports were becoming shorter (mean of 48 pages, with longer reports reflecting the complexity of the case). There were at least nine different review types, not including hybrid and blended approaches. Key findings included the need for proportionate reports fit for publication, including critical analysis and generating clear learning points.

The LiPP project explored process as well as outputs, so broadening the quality issue and moving away from focusing only on the final SCR reports (NSPCC/SCIE, 2016). It suggested quality markers for each stage of the process, to improve reviews. An evaluation of the project suggested an outcome of the LiPP was the principle that improving the quality and use of SCRs should not be imposed upon the sector – but needed to be a collaborative process involving families, practitioners, Local Safeguarding Children's Boards (LSCBs), different agencies and national level bodies (Thomson and others, 2017).

However, the Wood report (Wood, 2016) suggested that lessons were not being adequately learned from the SCR process and that the findings tended to be 'predictable, banal and repetitive' (Wood, 2016: page 8). The new LCSPR system aimed to produce reviews that were more focused, analytical and effective (CSPRP, 2024b). The National Child Safeguarding Practice Review Panel was established in 2018 and a new system introduced of LCSPRs with a timescale of completion of six months, the same as for SCRs. When an incident is notified, a rapid review should be completed and submitted

within 15 working days of notification by the local authority. Rapid reviews are not published, although analysed by the National Panel and cross-cutting learning is presented in the Annual Report. At the point of rapid review, a decision is made about whether an LCSPR should be undertaken. A criterion for that decision is that there is '*scope for additional learning'* (CSPRP, 2024a: page 52). Involvement of frontline practitioners and family members is expected if an LCSPR is undertaken.

Indicators of high-quality reviews

Published guidance for safeguarding partnerships for undertaking LCSPRs includes framework questions used by the Panel to consider whether an LCSPR report is of good quality (CSPRP, 2022b: page 24).

1. Is there a clear rationale for the scope of the LCSPR based on the analysis from the rapid review? Is the review focused? What are the key lines of enquiry that the review is seeking to address?

2. Has the chosen methodology helped with exploring the identified themes?

3. Where relevant to the focus of the review, does it give a sense of the daily life of the child / children?

4. Where relevant to the focus of the review, does the report consider the race / ethnicity and any disability of the child / children? Does it interrogate potential direct or indirect experiences of discrimination?

5. Where relevant to the focus of the review, does the report explore intersectional identities of the child / children?

6. Where relevant to the focus of the review, does the report show an understanding of the distinct context for the child / children (background, culture and history)?

7. What is the quality of analysis and interpretation of findings? Does the review go beyond simply identifying 'what went wrong' to consider the impact of organisational context and leadership, and any system issues underlying practice?

8. What is the quality of identified learning points, recommendations, and any linked action plans?

9. Is the report timely and with a quality structure (including independence of author, accessibility, usefulness, length etc)?

10. Are there implications for local / national practice and / or policy?

Interestingly, there is no mention of family and practitioner involvement in the list of framework questions despite the expectation that the *perspective* of the child / family, as well as *the views of practitioners*, should be included in an LCSPR (CSPR Panel, 2022:

19). In an early annual review of LCSPRs Dickens and others also mention the utilisation of existing research evidence and learning from other local and national cases in a list of what would be considered in a high-quality review.

Below, we discuss in more depth some of the themes in the evidence relating to quality of reviews.

Equity, Equality, Diversity and Inclusion (EEDI)

See project definition above (in Annex E) and (EEDI framework Brown, 2024, Annex F)

Factors relating to EEDI are primarily considered in the literature on reviews in relation to protected characteristics of children and families, rather than a wider consideration of practitioners, teams, organisations, leadership or structural and systemic discrimination. Furthermore, there is a focus on race / ethnicity, and less attention to sexuality and disability (CSPR Panel, 2024). Three central themes were highlighted in the literature. Firstly, the commissioning of reviews, secondly inadequate recording regarding protected characteristics and thirdly the extent to which aspects of intersectional identities of children and families are adequately explored in reviews.

Commissioning of reviews may involve decision making processes that result in inadequate consideration of cases. An analysis of statutory reviews of homicides and violent incidents carried out by the SCIE for the Mayor of London's Violence Reduction Unit (2020) noted that four Serious Case Reviews of youth homicides had been published in London between 2016 and 2020 in the context of 120 deaths of children and young people aged 16-24 over this period. Although they acknowledge that SCRs are undertaken only for children under 18, they suggest that part of the decision making about whether cases meet the criteria depends on whether peer violence is acknowledged as a form of abuse. If reviews are not commissioned this may hide inequalities and limit learning. (SCIE, 2020). Even where reviews are commissioned Firmin, in an analysis of SCRs found that they provide a limited account of the contextual dynamics of extra familial harm (Firmin and others, 2023).

Recording of information may be inconsistent or unclear. In previous SCR reviews it has been noted that ethnicity is not always recorded although this had improved by the latest annual report of the national panel. The latest annual report of the CSPRP (CSPRP, 2024b) also comments on the recording of disability and sexuality. It points out that 7% of the children in rapid reviews had a physical disability, though it was often not clear what this was. In relation to sexual orientation (it's not clear whether this includes gender identity though they use acronym LGBT) 3% of children under ten in the rapid reviews were recorded as LGBTQ+, increasing to 6% of children 10 years and older.

A further difficulty highlighted is the need to develop more consistent recording practices, since the absence of an attribute being recorded does not mean it is not present in the case (CPRP 2024). This makes it harder to understand and analyse the risks to a person or a particular group. (HMIC, 2024). Issues of recording may affect different marginalised

groups in different ways. Whilst guidance for rapid reviews suggests that demographic factors such as gender, sex, ethnicity and disability should be recorded, sexual orientation is not mentioned. This may result in LGBTQ+ young people being hidden in review processes, although elsewhere the guidance does suggest considering sexual orientation as part of a discussion of intersectionality.

A third theme is the exploration of protected characteristics as part of the review. Across the reviews of SCRs and LCSPRs there is some discussion of ethnicity. Brandon and others (2020) explored learning from reviews about children from ethnic minority groups. Two issues emerged from one locality: *'fear factor' from white workers of being seen as racist, and black workers not feeling sufficiently empowered to challenge* (p210). The latest Annual Report (CSPR Panel, 2024) found that in 95% of the rapid reviews (2022-2023) ethnicity was reported although *this did not always translate into the review considering its impact on a child's life and on practice* (p10). Some LCSPRs raised concerns about assumptions made by individual practitioners about a lowering of expectations and lack of understanding about ethnic groups and different cultural beliefs (CSPR Panel, 2024). This echoes previous research on SCRs which found that SCRs do not examine how professional assumptions can be challenged in a context of institutional and societal racism (Bernard and Harris, 2019).

Other reviews have called for attention to be paid to how ethnicity interacts with aspects of identity, how it affects people's day to day lives, and how it may impact their interaction with services (SCIE, 2020). Dickens and others (2022) argued that reviews sometimes did not mention or discuss race, ethnicity and culture, even when they could have been relevant factors. This is taken as an example of 'invisibilisation', a concept also relevant to other minoritised groups including LGBTQ+ children experiencing serious youth violence who may avoid disclosing their need for support to professionals (Open Innovation Team, 2023). Disabled children are at a disproportionately higher risk of experiencing significant harm, particularly during adolescence (Franklin and others, 2022; Brandon and others, 2020). However, '*Attitudes, which could be defined as disablist and discriminate against disabled children, can render disabled children invisible, and / or seen as better protected than their non-disabled peers which can lead to greater risk*.' (Franklin and others, 2022: page 3)

The lack of information about protected characteristics does not allow a full understanding of children and families' lived experiences and welfare inequalities (CWIP/Nuffield Foundation, 2020; SCIE, 2020). This is sometimes argued to be necessary to protect children's anonymity (Dickens and others 2022; SCIE, 2020) but does not appear to be consistently applied. Allnock (2020) suggests that lack of information can obscure learning for all agencies about communities that may face disproportionate levels of harm and therefore lead to knowledge gaps about practice and engagement with marginalised groups and communities. Clearly, not understanding or paying attention to diversity and interplay of gender, race, ethnicity, disability, class, and other characteristics, reduces the ability to learn from reviews or implement systems learning. If both practitioners and reviews ignore those intersections, then progress will not be made in safeguarding minoritised and marginalised groups of children. For

example, if the issue of adultification[1] is not attended to, ethnically minoritised children will continue to experience a criminal justice response rather than a child protection response. Awareness of adultification will help ensure that ethnically minoritised young people are responded to as vulnerable children (Marsh and Davis 2020; Dickens and others 2022).

Timeliness

Timeliness has been a longstanding concern, since if reports are published after a change in practice has taken place, then it will not always add value for practitioners, who may not engage with it, or feel it is less relevant. An analysis of SCRs (Sidebotham and others, 2016) found many reasons for delay including delays in initiating a review, ongoing parallel reviews, debates about appropriate methodology, ongoing disciplinary or court proceedings, changes of reviewer, concerns about quality arising in the review process and delays in release for publication. The current system of rapid reviews and child safeguarding practice reviews attempts to address the problem of timeliness. The rapid review aims to identify immediate learning from the case which can be implemented without delay, even if an LCSPR is planned.

There have been a number of reviews of rapid reviews since the new system was introduced (Dickens and others, 2021; Dickens and others, 2022; CSPRP, 2024a). In the first review rapid reviews were found to be of variable quality, fewer than half containing detailed analysis (Dickens and others, 2021). This first annual review (Dickens and others, 2022) recommended thinking about what is reasonable to expect from a rapid review and suggested a national template. Since then, there have been further suggestions about maximising learning from rapid reviews including publishing a learning summary and action plan (Dickens and others, 2022).

The quality of rapid reviews has improved over time, although the most recent Panel report identified a need to focus on 'why' and suggested there was not enough information on context, the history of the case and the lived experience of the child. (CSPRP, 2024a). Whilst the quality of rapid reviews has been assessed to have improved and most are completed within timescale, there remains a question about what it is realistic to expect from a rapid review, with consequences for assessing whether further learning could be gained from an LCSPR.

In the first annual review of LCSPRs Dickens and others (2022) found that the median length of time to complete a review was 58 weeks, compared with the statutory requirement of 26 weeks. There has also been an issue of timeliness in the publication of the analyses of reviews. The latest Annual Report (CSPR Panel, 2024) acknowledges that the analysis provided within the report relates to LCSPRs already published and therefore cannot always reflect current practice. It is nonetheless an improvement if analysis is annual rather than biennial or triennial in terms of relevance to practice. Publication of past reviews of SCRs has sometimes been delayed. For example, an analysis of SCRs completed between 2001-2003 was not published until 2008 (Rose and

Barnes, 2008) and the triennial review of SCRs completed between 2014-2017 was published in 2020 (Brandon and others, 2020). Delays in publication may impact on relevance of findings to practice, as risks and the context of children's lives, are constantly changing both inside and outside the home.

Cost

Commissioning a safeguarding practice review (or a serious case review in the past) is costly, including both the cost of undertaking the review, and of implementing recommendations (Rose and Barnes, 2008). Using an independent reviewer adds to the cost. The second report from the independent panel of experts (DfE, 2015) included a discussion of costs, acknowledging the financial expense and additional workload incurred, but arguing that cost should not be a consideration in commissioning a review or the type of review.

In a rare comparative review of safeguarding methodologies, Kingston and others (2018) found that the Welsh Practice methodology was preferable to a Traditional methodology in terms of quality of analysis, accessibility and economic cost. Average cost for the Traditional methodology of review was £55,866.12 with the Welsh methodology averaging £16,531.90, a significant saving by using the latter (Kingston and others, 2018: page 27; Brandon and others, 2020 survey of local authorities in England, found concerns about the cost of SCRs and the growth of the 'SCR industry' P218. Unfortunately, studies comparing review methodologies for their usefulness and cost are lacking.

Methodologies and critical analysis

The Munro review (Munro, 2010: page 18) advocated for a systems methodology with a focus on practice in context. This approach offers an opportunity to reflect on what works well as well as what needs to change. Guidance on statutory reviews (CSPRP, 2022b), and well-known review methodologies (Fish, Munro and Bairstow, 2008; Laird, 2017; Review Consulting, 2024), do not appear to have been developed with systematic or explicit focus or incorporation of structural inequalities and their impact on safeguarding systems and practice.

There is little comparative research on the usefulness of different review methodologies. The methodology used can depend on cost, availability, and area of expertise of potential independent authors / reviewers. Sometimes reviewers have their own agenda or preferred methodology (Rose and Barnes, 2008; Brandon and others 2020). Analysis of SCRs and LCSPRs suggest that methodology is not always clearly stated and that there is some confusion between methodology and methods. One study of LCSPRs found only 27% of reviews stated a specific methodology (Dickens and others 2022), compared with an earlier study of SCRs which found that 75% stated the methodology employed (Brandon and others 2020).

It has been difficult to link the quality of critical analysis to a specific methodology (Sidebotham and others, 2016, Dickens and others 2022). An analysis of Safeguarding

Adult Reviews found little research regarding review methodologies and recommended commissioning of comparative research on the effectiveness of review methodologies (Preston-Shoot and others, 2020).

Many analyses highlight the importance of the reviewer in choosing the methodology and producing a high-quality report (Brandon and others 2020; Dickens and others 2022). However, studies suggest a shortage of reviewers, variations in skillset, problems with commissioning and the need for training for reviewers. (Brandon and others 2020, Dickens and others 2022). Independence of the reviewer from the commissioning agency may be viewed as important as it demonstrates accountability and transparency (Sidebotham and others, 2016). Earlier versions of Working Together emphasise the importance of the reviewer being independent of the LSCB and agencies, more latterly this position has shifted to a more flexible notion of independence from the case. Arguably the reviewer is never fully independent, since the LSCB / SP has a role in quality assurance, agreeing recommendations and a responsibility to acting on learning (Sidebotham and others, 2016). From the point of view of accountability and transparency independence might be more desirable; from the point of view of maximising the learning, a collaborative approach might be preferable.

Family involvement / perspectives

Laird's (2017) study of family representation in 41 Serious Case Reviews undertaken in England, found that engagement with families was by a single interview, and their views were reported but not integrated into the analysis with *family members are often treated primarily as sources of historical details or missing information* (Laird, 2017: page 426).

More recently, Dickens and others (2022) explored a subsample of 20 LCSPRs and found that in 18 reviews there had been an attempt to involve the family with more creative ways of capturing the voice of children and families, such as using emails, letters and texts, although some families had declined to take part. The authors found that in eight cases there was useful incorporation of the information from family members including direct quotes. However, in some reports family accounts were described, but not included in critical analysis. Morris and others (2015: page 205) suggest that what is included within the report after engaging with family members *implies a set of messages for families about the relative worth and weight of their information.*

Quality marker 12 in the SCR quality markers (NSPCC/SCIE, 2016: page 35) relates to family involvement and includes attention to equality and diversity to facilitate engagement with the review process, although this is limited to suggestions about methods for engagement rather than consideration of systemic barriers to participation such as prior experience of discrimination, and of state intervention (NSPCC/SCIE, 2016: page 36).

Practitioner involvement

Working Together (DfE, 2023) explains that a review of satisfactory quality should involve the perspectives and views of professionals. Regarding professionals, they must be *fully involved and invited to contribute their perspectives without fear of being blamed for actions they took in good faith* (HM Government, 2023: 140). Involvement of practitioners in reviews might potentially help practitioners deal with the emotional impact of the work as they recognise that they are part of a system without sole responsibility although they have a part to play in making that system function (Brandon and others, 2020).

In an early study of SCRs Brandon and others (2009) interviewed frontline practitioners and found limited involvement in the review process. Involvement at the stage of fact finding (often an interview with the practitioner) but then having no further involvement in the process until the outcome was known, was not seen as conducive to learning. An opportunity to have greater involvement throughout *would help the learning process rather than giving the information so many months later* (Brandon and others, 2009: page 92). At the time of those interviews (incidents notified between 2005-2007), it was also hard for practitioners to access the final report or even an executive summary.

In a systems approach involvement of practitioners is critical in understanding how their practice was influenced (context of their work / practice) and why they may have acted as they did. However, in seeking to understand this context there has been little consideration in reviews or analyses of reviews of the impact of discrimination and oppression on practitioners involved in reviews, although there is a more general literature on the impact of discrimination on practitioners (Brown and others, 2021; Guaru and Bacchoo 2022; Casey 2023; NHS, 2024b).

Recommendations

The distinction between learning throughout the review *process* and learning from the LCSPR as an *output* is important. There is more focus in the literature on findings and implementation of recommendations from reports, rather than learning throughout the process. Where messages have been repeated this has been taken to be an indication of a failure of the review process, for example the Wood report's indictment of SCRs as resulting in findings that were '*predictable, banal and repetitive*' (Wood, 2016: page 8). However, it has been suggested that themes that recur cannot be ignored but should be explored in more depth and across systems (Sidebotham, 2012). New understandings and approaches can be applied to 'old' problems (e.g. trauma informed practice, strengths-based practice) (Dickens and others, 2022). More pragmatically turnover of staff and resulting '*depleted organisational memory'* (Brandon and others, 2020: page 22) means that the same learning must be repeated (Sidebotham, 2012, Brandon and others, 2020). This latter point draws attention to the fact that learning should be approached systemically, thinking about who is learning, where, and how the learning is sustained within and across organisations, and what barriers there may be (for example lack of resource, difficulties with staff retention).

In an earlier review Sidebotham and others (2016:234) include a discussion of whether there is even a place for recommendations in a systems approach to reviews. They give

the SCIE Learning Together methodology as an example. Systems issues are presented as findings, rather than recommendations, with questions posed to the LSCB and the onus on them to generate an action plan which is context specific. This allows a distinction between lessons to be learnt and actionable recommendations. Presenting findings rather than recommendations in the report should not be viewed as less likely to generate impact. In fact, the authors stress the importance of the action plan that is generated from the report. The onus was on the LSCB to own the action plan rather than being presented with a list of recommendations in a mechanistic way. However, whilst local ownership and generation of the action plan could be seen as beneficial, it could lead to implicit assumptions not being questioned regarding inequity, bias and discrimination if there were not sufficient expertise within the locality.

The number of recommendations has reduced over time from an average of 47 per SCR in the 2009-2010 study (Brandon and others, 2012) to seven in the periods 2011-2014 and 2014-2017 (Brandon and others, 2020). In the latest Annual Report from the Panel, the quality of recommendations within LCSPRs is addressed (CSPR Panel, 2024). Recommendations should be clear and 'translate into specific actions with accountable owners, and which are designed to impact clearly on practice'. (CSPR Panel, 2024: 53).

In a biennial review Sidebotham and others (2016) found that most recommendations were targeted at the LSCB. Single agency recommendations most often involved health, then social care, education and the police. More recently, Allnock and others (2020) explored learning for police in 126 reviews of death and serious harm, and found that recommendations were often multi-agency, highlighting missed opportunities for learning for specific agencies within the review narrative. The authors suggest that the predominance of recommendations in reviews relating to health and social care may reflect in some part the professional backgrounds of reviewers, few of whom come from a police background.

Some research on the usefulness of recommendations has been via staff surveys – therefore based on staff perception rather than outcomes for children. For example, single agency recommendations (Brandon and others, 2020) found that professionals regarded single agency recommendations as likely to make the most difference to practice, followed by multi-agency recommendations, and then recommendations for LSCBs.

A more recent study of staff perceptions found that recommendations were viewed to be useful if they could be translated into a SMART action plan. Where recommendations were viewed as less helpful this was because they had either already been implemented at the time the review was completed, or they were general and could not be actioned (Dickens and others, 2022). However, arguably this is a reductive view. Some of the learning had already taken place at the time the report was completed but could still usefully be documented. Some of the learning might not easily be actionable at a local level, but could still be useful, for example drawing attention to national issues. Wider

systemic and structural issues are beyond the scope and influence of local actors but still important.

Debates about the usefulness of SMART actions also include concerns that they could lead to a proliferation of prescriptive tasks and a compliance culture that might compromise professional judgement (Brandon and others, 2011, Sidebotham and others, 2016), and that recommendations and action plans may be '*too mechanistic, linear and top-down*', paying insufficient attention to enablers and barriers to change (Preston-Shoot 2017:17). Munro (2019) has argued for a set of risk 'principles' drawing on work from the College of Policing (ACPO, 2011) to promote a positive learning culture rather than a culture of blame. These include taking into account the context in which individual decisions are made, and judging decisions not based on their outcomes, but by the quality of decision-making, particularly important where capacity is limited.

The focus on training individual professionals as a way of effecting change has been queried. Jackson and others (2015) argue that CPD programmes in nursing presume the efficacy of training individual practitioners during time out from their everyday practice, which they then return to the workplace to implement. By contrast they argue for the development of the workplace as the main place of learning, development and innovation, with attention paid to bottom-up learning based on the insights of patients and frontline professionals rather than top-down approaches to learning (Jackson and Manley, 2021).

Implementation and Impact

Currently, there is little knowledge about any actions taken as a response to recommendations or their impact on outcomes for children, other than information provided in individual partnership yearly reports (see Briggs and others, 2021 for an overview).

If the purpose of reviews is to result in improvements in practice the system can only deliver if there is an emphasis on acting on learning. Devaney and others (2010: page 256) stressed the importance of auditing the implementation of recommendations to avoid 'drift and fatigue' in child death reviews. Across all types of review, tracing implementation of action plans resulting from findings and recommendations is difficult (Dawson, 2021 re DVDRs; Sanders and others, 2020 re CDRs; University of South Wales, n.d. re DHR). Two themes arise that are generally applicable, the first is the ownership of recommendations and implementation, the second is oversight (Preston-Shoot and others, 2020).

An article exploring learning in the healthcare system, discusses the problem of monitoring of recommendations when inquiry teams are dissolved once a report has been completed and therefore, they are not able to independently review any progress against the recommendations (Macrae and Vincent, 2014). This again raises the issue of implementation and monitoring of recommendations from all reviews where an independent reviewer / team is employed. The Patient Safety Incident Response

Framework (PSIRF), developed for the purpose of learning and improving patient safety in the NHS, may address this (NHS, 2024a).

Whilst the LCSPR process facilitates local ownership of action plans there is perhaps more to be done in relation to the second theme of oversight of implementation. It is possible that SPs' yearly reports for the national panel could be better utilised to support this oversight. However, it is of concern that in the latest annual report fewer reports were received by the panel containing less information regarding actions following LCSPRs (Annual report 2024). There may be a tension between ownership (perhaps better developed at local level) and oversight (allowing scrutiny but also facilitating wider learning). These themes of ownership and oversight might also be relevant when considering learning throughout the whole process of undertaking an LCSPR.

Conclusion

The decision of undertaking a review, writing a report outlining findings and recommendations, developing an action plan and implementing it may suggest a linear process of learning resulting in actions, which when they lead to improved outcomes for children. However, it is apparent that learning takes place throughout the review process and there are many different contextual factors external to the review system influencing acting on learning and outcomes for children. Preston-Shoot argues that systemic reviews 'may themselves be insufficiently systemic' if they do not pay attention to the social, legal and political contexts in which they take place (Preston-Shoot 2018: page 14).

A 2014 report into barriers to learning from SCRs identified issues that may only have been partly addressed by the change to the LCSPR system (Rawling and others, 2014). These include a culture of blame and defensiveness and a lack of recognition of the role of emotion, decision-making and judgement in safeguarding. They also identified problems with accessibility of findings for different agencies and practitioners, lack of attention to national themes, and lack of training - with frontline staff insufficiently involved in training to ensure its relevance. Contextual factors included too much policy and procedural change with insufficient time to embed, and workload across agencies. Conversely the report also argues for enablers for learning: including more involvement of frontline practitioners in the review process, supporting interagency relationship building to address the emotional aspects of decision making, more regular and focused training involving case study approaches, and a national repository with learning targeted at different professionals and agencies. This report was written before the change from SCRs to the LCSPR system and it is timely to explore whether some of the barriers to learning persist or new ones have arisen and whether the enablers for learning are still relevant.

Methodology for rapid evidence review

1. Identify and review all published SCR/LCSPR annual/biennial/triennial reviews (1998-2022) with focus on (Quality, Methodology, Value, Process)

2. Search Scopus for known authors: Brandon, Sidebotham, Dickens, Taylor, Garstang, Preston-Shoot (Author name, Social science, Article; review, United Kingdom, English)

3. Search databases 1998-2024 (Search terms – to be decided)

4. Search for other reviews (Child death reviews, Domestic homicide reviews, Safeguarding adult reviews)

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