TITLE: **BRIEFING: CSPR Panel Annual Report 2020**
DATE: 22nd June 2021
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A summary of key messages from the Child Safeguarding Practice Review Panel's annual report looking at rapid reviews, local child safeguarding practice reviews and serious case reviews in England during 2020.

Background to the report

The Child Safeguarding Practice Review Panel are responsible for identifying and overseeing the review of serious child safeguarding cases that raise issues of complex or national importance in England.

Following a serious safeguarding incident, local safeguarding partners are required to submit a rapid review to the Panel within 15 working days. This should set out, in detail, the circumstances of the event.

Local child safeguarding practice reviews (LCSPRs) are commissioned by safeguarding partners in response to a serious safeguarding incident. They provide learning in order to avoid similar incidents occurring in the future. The system of rapid reviews and LCSPRs replaced serious case reviews following a transition period, which ended in September 2019.

This is the Panel's second annual report (Child Safeguarding Practice Review Panel, 2021). It highlights the key messages from a range of sources including:

- Serious Incident Notifications
- Rapid Reviews (for each notification)
- Local Child Safeguarding Practice Reviews
- Serious Case Reviews

National reviews, thematic analysis and commissioned reports also formed the evidence base for this annual report.

Serious incident notifications

The Panel received **482** serious incident notifications between 1 January and 31 December 2020, relating to 514 children.

Age, gender and ethnicity of children

Of the **514** children and young people involved in serious incidents reported to the Panel:

- 53% of children were male, 46% were female and two were transgender
- the majority of children were either under one (35%) or aged 15-17 (30%)
- 69% of children involved in incidents were White British.
  - When compared to census data from 2011, Black teenagers and mixed ethnicity children of all ages were over-represented in serious incidents. Children and young people from Asian ethnic groups were under-represented.

Child deaths

206 fatal incidents were reported to the Panel, of which:

- 31% • were sudden unexpected deaths in infancy, making this the most common cause of death
- 20% • were suicide
- 17% • were caused by maltreatment within the family
- 10% • were related to, but not directly caused by maltreatment
- 8% • were extra-familial assaults or homicide
- 14% • were either not related to maltreatment or the cause of death was not clear.

Non-fatal incidents

276 non-fatal incidents were reported to the Panel, of which:

- 38% •related to physical abuse, making this the most common form of non-fatal serious harm
- 12% •related to neglect as the primary form of serious harm
- 10% •related to intra-familial sexual abuse, 7% to extra-familial sexual abuse, and 2% to child sexual exploitation
- 2% •related to emotional abuse
- 1% •related to criminal exploitation
- 18% •related young people involved in risk-taking or violent behaviour, of which 75% had evidence of criminal exploitation, gang violence or county lines as background factors
- 3% •related to the young person as the perpetrator of harm
- 7% •related to other non-fatal incidents.

Case characteristics

Information on the context in which incidents occurred was also recorded for all 482 serious incident notifications. Common characteristics included:

Domestic abuse	Mental ill-heath	Drug and alcohol misues	Neglect	Child Protection
•featured in 42% of all serious incidents	•maternal mental ill-heath featured in 24% of all serious incidents •paternal mental ill-health featured in 7%. •In 16% of incidents, the child had experienced mental ill-health	•18% of incidents featured parental alcohol misuse •24% featured parental drug misuse	•identified as the primary form of serious harm •34% of non-fatal incidents and 35% of fatal incidents mentioned neglect as an underlying feature	•in more than 60% of incidents reported to the Panel, the child protection system had previously identified the children as vulnerable.

Coronavirus pandemic

The report also looks at the impact of the coronavirus pandemic on child safeguarding in 2020. Serious incident notifications to the Panel in the period April to September 2020 were 27% higher than the same period in 2019.

Practitioner working

- There were good examples of safeguarding partnerships using the learning from rapid reviews to make immediate changes in COVID-19 protocols for practitioners.
- Local authorities worked with safeguarding partners to establish clear frameworks for risk assessment and identifying and sharing information about vulnerable children.

Parental and family stressors

- Increasing domestic abuse and mental health concerns were key features in rapid reviews involving COVID-19.
- Lack of contact with extended family, changing family dynamics, disrupted routines and overcrowding were also highlighted as issues in rapid reviews.

Harm to babies under 12-months-old

- Babies under 12-months-old continue to be the most prevalent group in serious incident notifications to the Panel and there were a high proportion of cases involving non-accidental injury and sudden unexpected infant death.
- Parental and family stressors were the most significant factor in escalating risk in these cases.

Young people's mental health

- Being away from the support of friends, trusted adults and school was evident in all cases of suicide that featured COVID-19.
- Rapid reviews highlighted incidents of self-harm, exposure to sexual abuse and bullying.

School closures

- Having children at home full time added pressure for parents and carers, particularly those with disabled children.
- School not being available as a source of support or a trusted environment for children to disclose concerns meant that some vulnerable children remained 'below the radar'.
- There were also good example of schools maintaining contact with children and families and adapting their approach following national guidance.

Adaptations for COVID-safe practice

- Adapting practice was an important factor across the full range of cases featuring COVID-19.
- Where adaptations worked well, practitioners were able to observe children, assess the home environment and use focused questions to address changing risk and need.
- Safeguarding partnerships identified opportunities to take forward adaptations to develop a blended practice, using a combination of visits and remote support.

Key practice themes and learning

The Panel has identified *six key practice themes* to make a difference in reducing serious harm and preventing child deaths caused by abuse or neglect.

1. Understanding the child's daily life

- It is important for practitioners to build a trustful and respectful relationship with the child and critically reflect on what the child is trying to communicate through their behaviour, interaction with others and physical presentation.
- Practitioners should be aware that challenging or help-seeking behaviour may reflect harm and distress.
- They should also challenge circumstances where children try to minimise the potential risks of harm and are reluctant to accept support.

2. Working with families where engagement is reluctant and sporadic

- Reviews often refer to a 'lack of engagement' by vulnerable families, including missed appointments, cancelled home visits and refusals of offers of support.
- It is important to understand the underlying issues, such as unresolved adverse childhood experiences, socio-economic pressures or difficulties engaging with large numbers of professionals, that give rise to reluctant or sporadic engagement from families.
- Relationship-based practice and motivational interviewing can help practitioners develop connections with families and maintain a balance between being directive, supportive and non-judgmental.

3. Critical thinking and challenge

- Reviews frequently highlight 'over optimism' and a lack of 'professional curiosity'.
- Practitioners should be confident in using the authority of their role to promote 'support and challenge' relationships between themselves and children and young people.
- Critical thinking can provide a framework for practitioners to analyse and reassess their work with children and families.

4. Responding to changing risk and need

- Weaknesses in risk assessment feature in the majority of case reviews.
- Evidence-based risk tools can support assessment but they require critical reflection about the evidence to inform next steps.
- Concerns about domestic abuse, parental mental health and substance misuse are not sufficiently taken into account when assessing risks to children.
- Similarly, the role of fathers or other adult males is not sufficiently understood or considered when assessing risk.

5. Sharing information in a timely and appropriate way

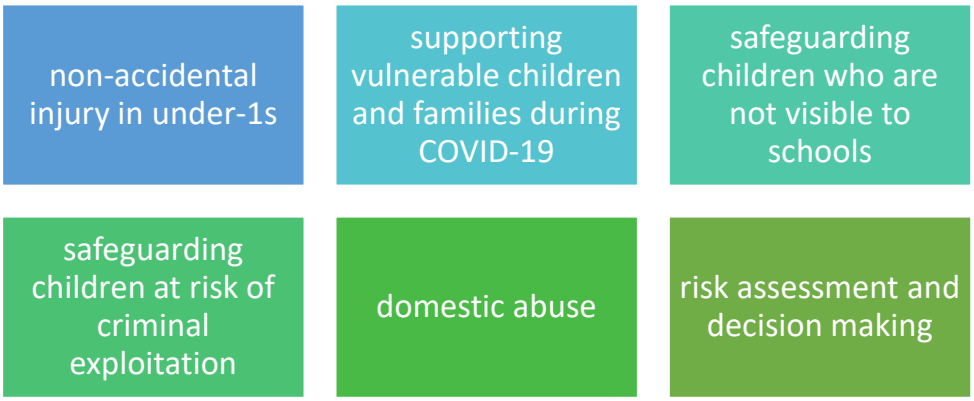
- Constraints in systems and processes for accessing and sharing information between agencies are noted in both national and local reviews.
- Poor quality recording and inaccurate or out-of-date information can result in partial understandings of the needs of a child.
- The development of IT systems could allow for better information sharing between agencies.

6. Organisational leadership and culture for good outcomes

- Case reviews are key opportunities to identify and act on improvements required such as improving practitioner and service capacity, consistent use of methodologies and developing holistic approaches to assessment.
- Drift and delay in completing assessments and decisions are common features in case reviews and reviews also highlight the importance of management oversight to promote practice standards.

Work programme for 2021

The Panel has agreed priorities which will inform and shape its work over the next one to two years. The Panel has plans to deliver a range of national reviews, thematic and practice analysis and research in 2021-22 on a range of topics, including:



Looking forward – System leadership, learning and improvement

The Panel will develop further its system leadership role through its communication and stakeholder engagement programme. To date it has done this through a quarterly newsletter, creating a Twitter account, and running a series of webinars. In the next year, they will build on that work by providing more opportunities for engagement through quarterly practice briefings and Panel-run virtual events, as well as stakeholder channels.

Reflective questions for local leaders

1. How do safeguarding partners model personal leadership of, and accountability for, the dissemination and embedding of learning in their local area?
2. How do you know that the new system of learning is making an impact? What are the key barriers? How can the Panel work with you to address them?
3. How can we make better use of national reviews to support learning and improvement in your area?
4. How can we work together to give practitioners a sense of confidence, support and progress in addressing the stubborn challenges in child safeguarding?

For further information:

- Child Safeguarding Practice Review Panel: 2020 annual report
- Child Safeguarding Practice Review Panel: 2020 executive summary