THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Child Safeguarding Practice Review Panel

Plymouth SP Annual Conference

Sally Shearer 20 November 2025

Agenda

Introduction to the Panel and our future plans

Our Panel Guidance

Annual Report 23/24 Key Themes

‘I wanted them all to notice’

‘It’s Silent’ Race, racism and safeguarding children

Questions

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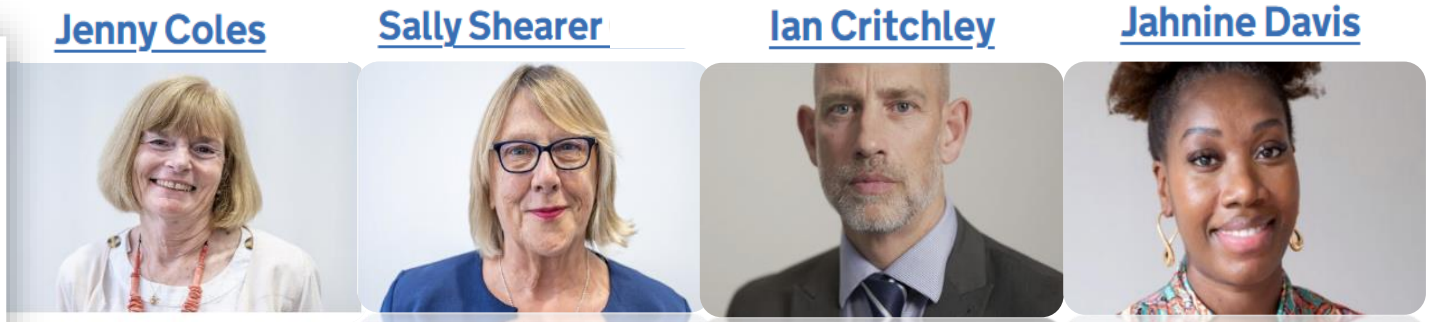
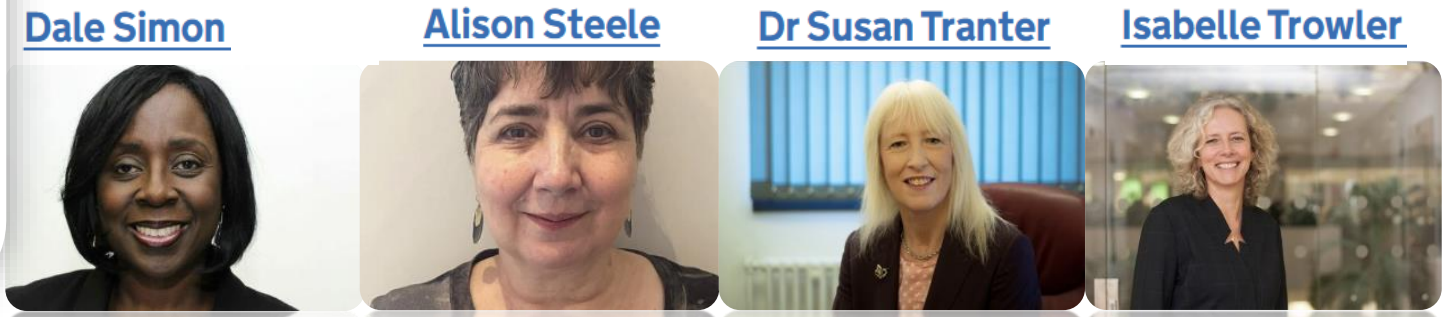
About the Panel





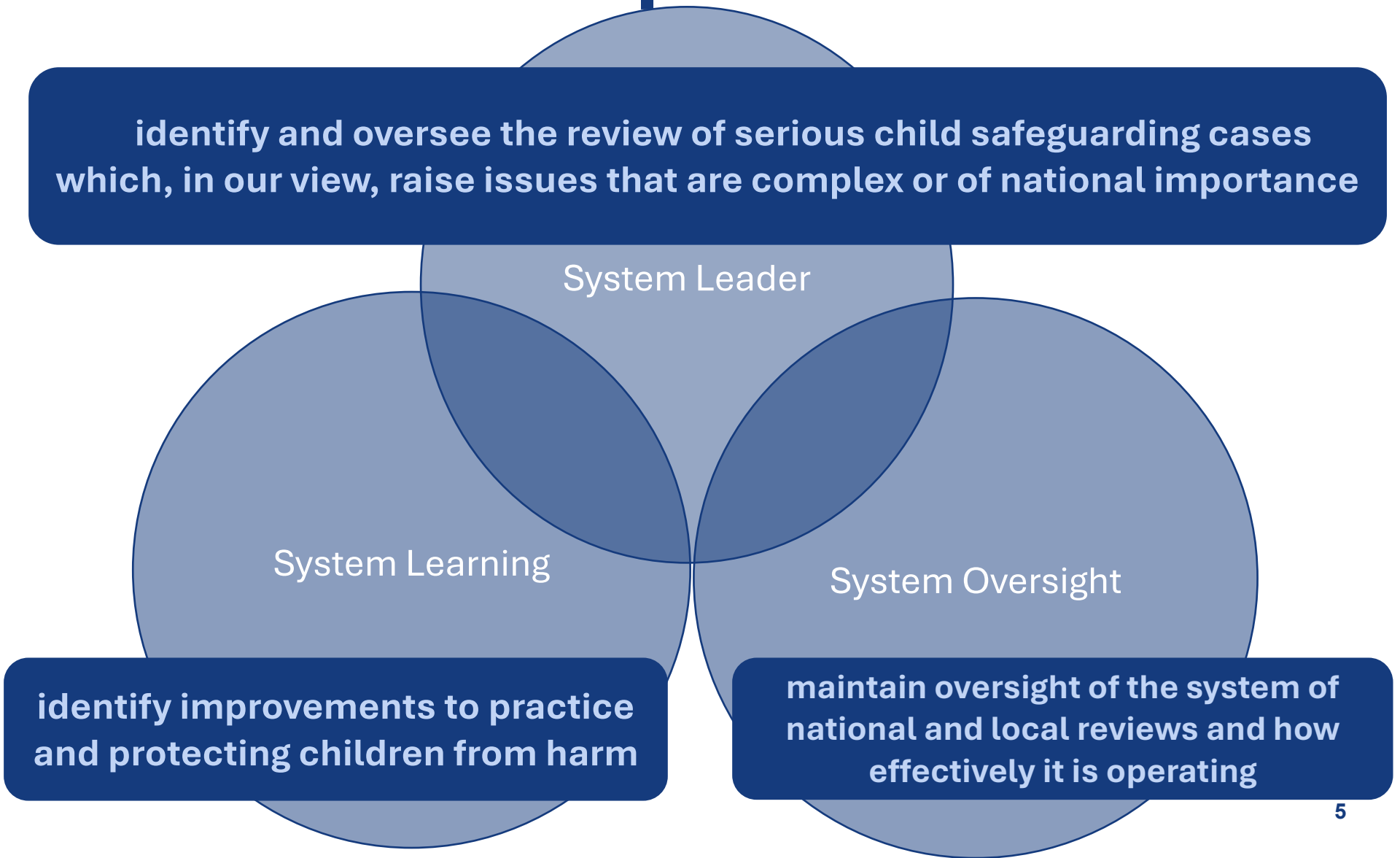
The Child Safeguarding Practice Review Panel

The national Child Safeguarding Practice Review Panel is an independent body that was set up to identify, commission and oversee reviews of serious child safeguarding incidents.

It brings together experts from social care, policing, health, education and the third sector to provide a multi-agency view on incidents which they believe raise issues that are complex, or of national importance.

Statutory and independent what is an "expert committee"?

identify and oversee the review of serious child safeguarding cases which, in our view, raise issues that are complex or of national importance



identify improvements to practice and protecting children from harm

maintain oversight of the system of national and local reviews and how effectively it is operating

Serious Incident Notifications

16C (1) of the Children Act 2004, amended by the Children and Social Work Act 2017 states:

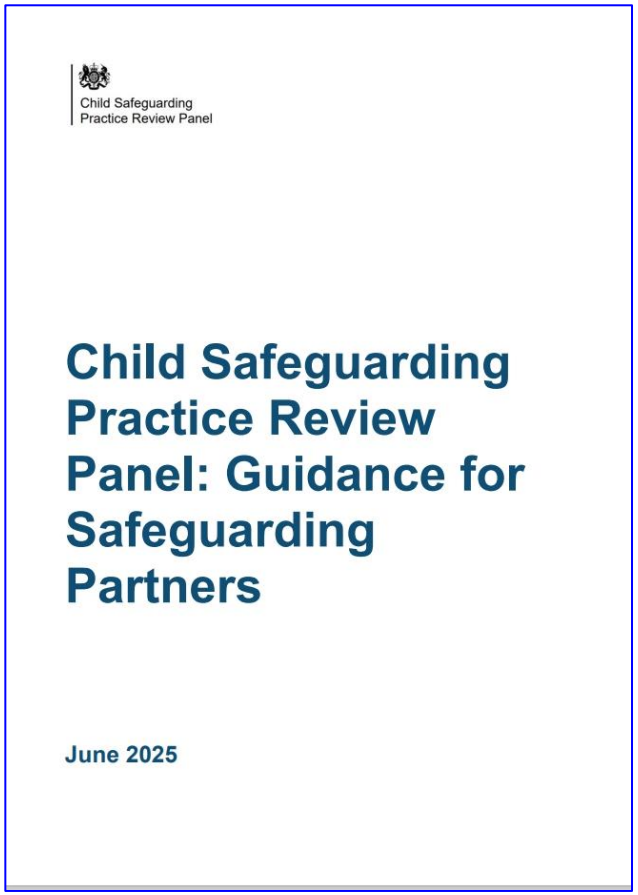
Where a local authority in England knows or suspects that a child has been abused or neglected, the local authority must notify the Child Safeguarding Practice Review Panel if:

(a) The child dies or is seriously harmed in the local authority's area

(b) While normally resident in the local authority's area, the child dies or is seriously harmed outside England

- Notify the incident to the Panel within 5 working days
- Rapid review reports should be submitted to the Panel within 15 working days

WEBINAR: What's good practice for notifying and reviewing serious Child Safeguarding Incidents?



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Current Work

Current review

- **The Baby Victoria national review** examines the issues raised by the tragic death of Baby Victoria. Although the review centres on an individual child, the findings will be informed by learning from other serious incidents with a focus on the wider safeguarding system.

- It will cover various issues and themes, including:
  - Concealed pregnancies
  - Working with parents and carers who are unable or unwilling to engage with agencies
  - Working together across different areas and jurisdictions
  - Management of serious offenders

Coming soon .....

We have received investment to:

- Strengthen the Panel's digital and data analysis capability
- Develop an online learning hub
- Offer monthly webinars

10/12/25 Emerging themes and reflections on the year
11/2/26 Private law proceedings

Planning stage
February Baby Victoria review
March The new learning hub
April A good rapid review
May Neglect

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Annual Report 2023/24

A window on the system

330 serious incidents submitted between April 2023 to March 2024 – 18% decrease from previous years

46% of the incidents were related to the death of a child

47% were related to serious harm

7% were classed as 'other', e.g. when the child perpetrated a crime

36% of children under 1

Black/ Black British children over-represented: 10% reviews vs 6% population

Asian/Asian British children under-represented: 5% in reviews vs 12% population

Intrafamilial Non-Fatal Assault: The leading cause of serious harm at 30%

Suicide: Making up 16% of deaths. Girls had higher suicide rates than boys

Neglect present in 49% cases

A window on the system

- 10% of children reported to be home educated
- 15% children not enrolled in school
- 5% children not receiving any form of education
- 9 /10 incidents family known to CSC
- 41% were, or had, “child in need” status
- 27% of children were, or had been, on a child protection plan

Statistics

Elective Home Education (August 2020 –October 2021)

27 serious safeguarding incidents involving 41 school age children who were being electively home educated

6 children died and 35 seriously harmed as a result of abuse & neglect

10 children suffered physical abuse

8 children had their access to food restricted, were malnourished & under weight

10 children suffered sexual abuse

20 children experienced physical neglect

Spotlight Themes

Annual Report 2023/2024 identified three spotlight themes:

1. **Safeguarding children with mental health needs**
2. **Safeguarding pre-school children with parents with mental health needs**
3. **Extrafamilial Harm**

Key Statistics

Here are some of the statistics noted in the report on **safeguarding children with mental health needs**

- **22% of children had a diagnosed or undiagnosed mental health condition**
- **92% of the children who died by suicide were recorded as having a mental health condition**
- **96% of children identified with at least one mental health condition were between the ages of 11 and 17**
- **Among children with a mental health condition who experienced serious harm, child sexual abuse or exploitation was the most prevalent cause**

Key Statistics

Here are some of the statistics noted in the report on **safeguarding pre-school children with parents with mental-health needs**

- **Over half of the incidents involving pre-school children involved a parent with mental health conditions**
- **In 25% of incidents, at least one parent or relevant adult had a physical, mental health-related, learning, or developmental disability (all ages)**
- **15 of the children with a parent with a mental health condition died and 12 experienced serious harm**
- **41% of reviews reported a parent with an addiction to or misuse of alcohol and/or substances**

Key Statistics

Here are some key statistics on **extrafamilial harm** from the Child Safeguarding Review Panel's annual report for 2023 to 2024:

- **78 incidents were reported, with 56% involving youth or gang-related violence, 55% involving child criminal exploitation, and 40% involving child sexual abuse or exploitation**
- **97% of children who experienced extrafamilial harm were aged 11 to 17 years old**
- **Black children were over-represented, making up 24% of the extrafamilial harm cases**
- **26% of children experiencing extrafamilial harm were not enrolled at school or receiving an education, and 59% had poor school attendance**

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“I wanted them all to notice”

Protecting children and responding to child sexual abuse within the family environment

Statistics

The review is based on an analysis of
136 rapid reviews involving **193 children**

Demographics

- 75% of the children were under the age of 12
- 24% involved children with learning disabilities, autism, or ADHD
- 27% of children were from Black or other minoritised communities
- 10 children became pregnant, and 7 children died by suicide

Cross-cutting themes

- 47% of reviews involved neglect
- 29% of reviews involved domestic abuse experienced by the child
- Over a third of reviews featured a family member with a known history of sexual offending or who was known to present some risk of sexual harm

Findings from fieldwork

This national review highlights a **systemic failure** across all services to recognise and respond when children are at risk of, or are already, being sexually abused by someone in their family environment.

Practice issues we have identified include:

- Not hearing children's voices and understanding their needs
- Not understanding parents' and carers' contexts, vulnerabilities and needs
- Challenges in identifying signs, understanding risk and raising concerns
- Issues in responding to concerns of intrafamilial child sexual abuse

Key Learning for Practitioners

Systematic challenges

- Children are often ignored or disbelieved, and risks posed by family members are frequently overlooked or minimized
- Practitioners lack the support, guidance, and direction needed to intervene effectively

Challenges in Practice

- Practitioners rely too heavily on children to verbally report abuse and lack proactive engagement to identify it
- Fear of interfering with investigations stops practitioners from talking directly to children about possible abuse

Professional Development

- Critical need for enhanced training and resources for professionals
- Practitioners need to be equipped to recognise and respond to sign of child sexual abuse confidently

Key Learning for Practitioners

Impact of Domestic Abuse

- Domestic abuse and coercive control significantly impact parents' ability to protect their children
- Practitioners often fail to recognize and address the influence of domestic abuse on safeguarding

Race & Ethnicity

- Practitioners do not sufficiently consider children's race, ethnicity, and culture in their responses
- There is a lack of understanding of the specific needs and contexts of children from Black and other minoritised communities

Support for Disabled Children

- Disabled children are at increased risk of sexual abuse
- Practitioners often misinterpret signs of abuse as related to the child's disability, highlighting the need for better understanding of disabled children's needs

Key learning for safeguarding partners

Strategic Planning

- Develop local action plans to respond to the report's recommendations, ensuring a coordinated approach to safeguarding

Professional Development

- Conduct multi-agency training needs assessments to ensure practitioners have the necessary skills and knowledge to identify and respond to child sexual abuse

Quality of Enquiries & Investigations

- Audit local multi-agency decision-making to ensure safeguarding decisions consider all indicators of sexual abuse, not just verbal disclosures

Key learning for safeguarding partners

Risk Assessment & Management

- Review and manage individuals posing sexual harm risks, ensuring robust information-sharing and collaboration

Communication with Children

- Ensure practitioners are confident in talking directly to children about concerns of sexual abuse, keeping children and families informed throughout investigations

Health Pathways

- Ensure local pathways for referring children for appropriate forensic medical and other health assessments are in place, involving health representatives in strategy discussions

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Race, racism and safeguarding children

Race, Racism & Safeguarding Children

Black/ Black British children over-represented: 10% reviews vs 6% population

Mixed/ multiple ethnic children over-represented: 17% reviews vs 7% population

Asian/Asian British children under-represented: 5% in reviews vs 12% population

Our sample was 40 rapid reviews and 14 LCSPRs with incidents that took place between January 2022 and March 2024
(one rapid review and LCSPR explored the same incident)

28 reviews related to the death of a child

The most common causes of death were suicide, sudden unexplained death in infancy, and fatal assault perpetrated by an individual unrelated to the child.

26 reviews related to serious harm

The most common causes of harm were non-fatal assaults both perpetrated by a family member and perpetrated by an individual unrelated to the child.

Race, Racism & Safeguarding Children

Key findings:

- **Limited Attention to Race and Ethnicity:** The analysis reveals a concerning lack of focus on race, ethnicity, and culture in both safeguarding practice and reviews. This oversight has resulted in insufficient critical analysis and reflection on how racial bias impacts decision-making and service offers to children.

- **Silence on Racism:** The report identifies a pervasive silence and hesitancy to address racism and its manifestations. This silence renders the safeguarding needs of Black, Asian, and Mixed Heritage children invisible, both in practice and in the system for learning from reviews.

- **Missed Opportunities:** In failing to acknowledge race, racial bias and racism, the current system misses many opportunities to learn from incidents where Black, Asian, and Mixed Heritage children have been seriously harmed or died. This failure to see the totality of children's lives or to scrutinise how racial bias may have affected decision-making leaves children vulnerable and at risk of harm.

Report published March 2025

Race, Racism & Safeguarding Children

Key recommendations:

- **Acknowledging and Challenging Racism:** Local leaders should ensure that appropriate internal structures are in place to support practitioners to recognise, discuss and challenge internal and institutional racism.

- **Empowering Practitioners:** Creating conditions that empower practitioners to have conversations with children and families about race and identity. This includes building skills and confidence and ensuring there are safe opportunities for self-reflection within teams and in supervision to acknowledge their own biases.

- **Reviewing Local Strategies:** Child Safeguarding Partnerships should review their local strategies and approaches to addressing race, racism, and racial bias in their work with Black, Asian, and Mixed Heritage children.

Report published March 2025

Discussion

What are the challenging safeguarding themes that your agency teams and multi agency partnerships are addressing ? Have these been reflected in the presentation or are different themes emerging ?

Communications:

You can sign up to the mailing list online to receive Panel newsletters: http://eepurl.com/g6z_Tf

Follow us on: LinkedIn

Email: Mailbox.NationalReviewPanel@education.gov.uk