Summary of the Child Safeguarding Practice Review Panel's annual report 2023/24

A summary of patterns in practice and key messages from serious incidents, rapid reviews and local child safeguarding practice reviews in England.

January 2025

Background to the report

The Child Safeguarding Practice Review Panel (the Panel) is responsible for commissioning and overseeing national and local reviews of serious child safeguarding cases to improve learning, professional practice and outcomes for children in England.

This fifth annual report covers the Panel's work from April 2023 to March 2024. It uses evidence and learning from: **Serious Incident Notifications (SINs)** where abuse or neglect was known or suspected; data from **rapid reviews**; data from a sample of **Local Child Safeguarding Practice Reviews (LCSPRs)**; and letters from the Panel

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.

to safeguarding partnerships. It also draws on evidence from a **thematic analysis** on **Safeguarding children in elective home education** published by the Panel in May 2024.

Find out more about the case review process in each UK nation

Context, conditions and safeguarding practice

The report identifies **strains and stressors in children's lives**, such as poverty, housing and other social forms of deprivation and inequality. More children than the previous year are living in poverty and living in insecure and inadequate housing (Department for Levelling up, Housing and Communities, 2024). The report also highlights practice challenges in differentiating between poverty and neglect.

Pressures in practice include high staff turnover rates and challenges in recruitment. These can negatively impact relationships with families, assessment quality, information sharing and decision-making. There is a need for high-quality supervision, good multi-agency training and professional development.

Action is needed from **national government** around: securing a skilled and well-led workforce; investment in new multi-agency approaches at national and local levels towards family help and child protection; and making better use of data and other forms of evidence to know what is happening in practice.

A window on the system

330 rapid reviews were submitted to the Panel between April 2023 and March 2024. 22% of the 330 reported incidences involved more than one child and overall 485 children were reported as likely having experienced harm. Of the 330 reviews, 49% were deaths, 48% were serious harm incidents and 3% were 'other'.

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.

- A range of risk factors were present in the lives of children, including neglect, domestic abuse and physical abuse. 20% of children had previously experienced emotional abuse and 18% sexual abuse.
- A high proportion of families involved in incidents were known to children's social care (CSC); either as an open case (49%) or previously known (38%).
- Sudden unexpected death in infants (SUDI) and suicide were the most common likely cause of deaths. Nonfatal intrafamilial assaults were the most common likely cause of harm.
- The age distribution within the rapid reviews showed that under 1s were the largest age group represented (36%), followed by 16-to-17-year-olds (22%).
- Black/African/Caribbean/Black British children and children with a mixed/multiple ethnic background were overrepresented within the rapid reviews. Asian/Asian British children were underrepresented.
- Boys experienced more extrafamilial harm and girls experienced more incidences of sexual abuse or exploitation.
- 53% of parents had mental health conditions, 43% had substance use problems, and 25% had a reported disability.

Spotlight themes

The Panel identified three spotlight themes. For each theme, the report includes a quantitative and qualitative analysis of the rapid reviews.

Theme 1: Safeguarding children with mental health needs

Children with mental health needs consistently featured in the reviews received by the Panel. In just over a fifth of the 330 rapid reviews, the child in focus was recorded as having at least one mental health condition. In these cases, the majority of children were aged 11 to 17. It's important to highlight that mental health conditions in younger children may be under-reported (Royal College of Psychiatrists, 2023).

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.

Some reviews reported **good practice** around effective multi-agency working, planning and information sharing. Others highlighted how children's voices, wishes and feelings were often acknowledged and recorded. The **key findings** from the qualitative analysis are summarised below.

- **Assessing and responding to the mental health needs of children**
  - Recognising and responding to mental health needs was sometimes secondary to the identification of and response to abuse or neglect.
  - Practitioners sometimes focused only on managing the behaviours of children with complex needs, rather than exploring the underlying causes or considering any harm the child may have experienced.
  - Assessments of need and other opportunities for agencies to recognise a deterioration or escalation in the child's mental health or behaviour were often missed.
- **Think Family:** Practitioners often overestimated how well parents and carers understood their child's needs, and the capacity of parents to look after a child with mental health needs.
- **Race, ethnicity and culture**
  - Children's race, ethnicity and culture were rarely addressed or explored in review reports concerning children's mental health.
  - Children from minoritised ethnic backgrounds experienced adultification bias, both from practitioners and within their home environments.
- **Legislative frameworks and interventions:** Professionals were sometimes unsure of how to apply legislative frameworks concerning mental capacity, especially in assessing a child's capacity to be able to make decisions.
- **Engaging with children and their families:** Turnover within CSC and other services could result in inconsistent quality in the monitoring and delivery of safety plans for children and undermine the ability for professionals to develop effective and good relationships with children.

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.

- **Referrals:** Referrals to appropriate mental health or emotional wellbeing services were delayed or did not accurately reflect the full range of concerns regarding the child, often resulting in rejections.
- **Adult-child services interface:** There were significant gaps in information sharing, shared decision-making and effective risk assessment for children approaching adulthood.
- **System issues:** There were numerous system issues affecting children with complex needs. These included the impact of long waiting times, challenges in identifying appropriate local care and health placements, and a lack of specialist provision.

The **key learning** for this spotlight theme is summarised below.

- **Learning for direct practice** includes:
  - Considering the interrelationship between neglect, abuse and mental health and avoid making assumptions about a child's diagnosis.
  - Working closely with multi-agency colleagues, including those with specialist mental health knowledge, and adopt a 'Think Family' approach.
  - Keeping the voice of the child central in plans and interventions.
- **Learning for strategic leaders and senior and middle managers** includes:
  - Appointing a lead practitioner or key worker to help continuity and quality of care and address delays.
  - Considering alternative sources of support where there are gaps in early intervention and emotional wellbeing support at local level.

Theme 2: Safeguarding pre-school children with parents with mental health needs

Mental health needs can impact the capacity of parents to care for their children safely (Child Safeguarding Practice Review Panel, 2024b). There is a gap in the specific

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.

consideration of pre-school children who have parents with mental health needs. 27 of the 330 rapid reviews analysed involved pre-school children aged 1 to 5 years old with a parent or relevant adult with either a diagnosed or undiagnosed mental health condition.

Good practice included medical professionals effectively identifying and managing risk around the mental health of parents and challenging other services to take action. The **key findings** from the qualitative analysis are summarised below.

- **Identifying, assessing and responding**
  - Assessments and interventions often focused only on the issues that prompted the initial engagement, rather than on other issues that came to light, such as parental mental health needs.
  - In many cases, agencies did not explore, or take into consideration, how issues such as parental mental health needs might impact on the parent's capacity to safely care for the child.
  - Practitioners did not always fully consider how parental mental health difficulties affected the daily life of the pre-school child being cared for.
- **Engaging with parents and carers**
  - Services often faced difficulties in securing consent for mental health assessments and successfully engaging parents in other health care or support services, including those for their children.
  - There was a lack of professional curiosity about the men involved in the child's life and the identification of any mental health needs they might have been experiencing.
- **Information sharing:** How information was shared within agencies and between agencies was recognised as a common issue, affecting the ability of services to assess and respond to any possible risk of harm associated with parental mental health.
- **Adult and child service interface**

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.

    - There were issues in communication and co-ordination between adult services (such as social and mental health) and with nurseries and children's services.
    - Concerns about parents' ability to care for their children were not always escalated within agencies.
- **Engagement between statutory and non-statutory partners:** There is a need for better links between adult mental health practitioners and specialist teams so that parents with mental health concerns and children can be supported.
- **Race, ethnicity and culture:** There was a lack of reporting on and understanding around race, ethnicity and culture and how these interacted with and influenced parents' mental health and support needs.

The **key learning** for this spotlight theme is summarised below.

- **Learning for direct practice** includes:
    - Understanding the impact on the pre-school child of the mental health of the adults around them.
    - Using processes such as contingency planning to help provide support when a parent's mental health deteriorates.
    - Supporting multi-agency working and responses by creating a comprehensive family history that includes information about current and historical parental mental health.
- **Learning for strategic leaders and senior and middle managers** includes:
    - Maintaining effective links and communication between statutory and non-statutory services.
    - Building on services' ability to provide preventative support by increasing understanding around how services can effectively engage parents.
    - Enabling opportunities for effective reflective supervision is important in supporting practitioners to engage with families with sensitive needs.

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.

Theme 3: Extrafamilial harm

The Panel defines 'extrafamilial harm' as covering a range of different forms of abuse and neglect, including child criminal exploitation and child sexual abuse and exploitation (CCE and CSA/E), institutional based abuse and online harm. The analysis focuses on extrafamilial harm primarily occurring outside the home and perpetrated by adults and peers who were not members of the child's own family. Extrafamilial harm featured in 78 of the 330 rapid reviews received by the Panel.

Some reviews reported **good practice**, including practitioners being consistent and persistent in their attempts to engage with children and families. Others noted how schools demonstrated good multi-agency working. The **key findings** from the qualitative analysis are summarised below.

- **Extrafamilial harm and contextual safeguarding**
  - Practitioners struggled with understanding, identifying and recognising extrafamilial harm and did not draw on a contextual safeguarding approach when needed, including not taking a child-first approach.
  - Adultification of children occurred where practitioners were working with children who were both vulnerable to risk and posed a risk to others.
  - Practitioners did not always recognise how trauma and adversity may affect children's behaviour and their ability to engage with services.
- **Understanding children's lived experiences**
  - Children's **education, learning and developmental needs**, **neurodiversity** and **mental health**, and how these interacted with their experiences of extrafamilial harms and the support they received, was sometimes not adequately understood, considered or assessed.
  - The impact of **race, ethnicity and culture** on service responses to extrafamilial harm was not always understood or explored by practitioners.

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.

  - Practitioners did not always consider how a child's **gender identity and sexual orientation** may have affected their vulnerability to harm from CSA/E.
- **Working with children and families experiencing extrafamilial harm**
  - Practitioner responses were often reactive rather than proactive. In some cases, practitioners did not do enough to learn more about the risks children were facing and sometimes made assumptions about children's actions.
  - Practitioners sometimes struggled to develop positive relationships and were not able to gather important information from children and families.
  - Service thresholds sometimes acted as a barrier for children **accessing services and support**.
  - **Assessments and interventions** were sometimes ineffective and delayed, with a lack of professional understanding around how to use screening tools, leaving children vulnerable to risks.
  - Agencies, particularly police, sometimes missed opportunities to gather evidence and disrupt extrafamilial harm.

The **key learning** for this spotlight theme is summarised below.

- **Learning for direct practice** includes:
  - Identifying early indicators of extrafamilial harm, particularly missing episodes, to prevent harms escalating into exploitation.
  - Increasing engagement by taking advantage of 'reachable' moments in children's lives, such as transitions and incidents that involve contact with services.
  - Developing positive relationships with families to better understand protective or risk factors in the home environment.
- **Learning for strategic leaders and senior and middle managers** includes:

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.

- Providing support, supervision and training to help practitioners understand how to respond to extrafamilial harm and ensure the best outcomes for children.

The Panel's analysis identified some **cross-cutting themes** across reviews, including:

- a lack of a co-ordinated multi-agency approach and effective information sharing when working with children and families
- children's voices and perspectives going unheard or unexplored
- insufficient links between adult and children's services
- a lack of engagement between practitioners and children and their families.

The Panel at work and forthcoming priorities

The Panel will continue to carry out its core functions in overseeing, analysing, promoting and disseminating learning in the English child protection and safeguarding system. Priorities for the coming year include:

- delivering a project to evaluate the Panel's impact
- developing a series of practice briefings from data, scoping projects and the existing evidence base
- improving the quality of reviews and the impact of their learning, including by refreshing the guidance on rapid reviews
- working to support safeguarding partnerships in improving their practice, including through quarterly meetings and a learning support project to better understand how safeguarding partners deliver LCSPRs.

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.

References

Child Safeguarding Practice Review Panel (2024a) **Annual report 2023/2024: patterns in practice, key messages and 2024/25 work programme**. [London]: Child Safeguarding Practice Review Panel. <https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2023-to-2024>

Child Safeguarding Practice Review Panel (2024b) **Annual report 2022/23: patterns in practice, key messages and 2023/24 work programme (PDF).** [London]: Child Safeguarding Practice Review Panel. <https://assets.publishing.service.gov.uk/media/65ba77e5f51b10000d6a7e7a/Child_Safeguarding_Review_Panel_annual_report_2022_to_2023.pdf>

Department for Levelling Up, Housing and Communities (2024) **Statutory homelessness in England: July to September 2023**. [Accessed 19/12/2024]. <www.gov.uk/government/statistics/statutory-homelessness-in-england-july-to-september-2023>

Royal College of Psychiatrists (2023) **Infant and early childhood mental health: the case for action**. [Accessed 19/12/2024]. <https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2023-college-reports/infant-and-early-childhood-mental-health--the-case-for-action-(cr238)>

+ More ways to help you protect children

Take our online introductory child protection course
nspcc.org.uk/cpintro

Sign up to our weekly current awareness email newsletter
nspcc.org.uk/caspar

Visit **NSPCC Learning** for more information about case reviews
nspcc.org.uk/casereviews

© NSPCC 2025. Registered charity England and Wales 216401. Scotland SC037717. Jersey 384.