THE CHILD
SAFEGUARDING
PRACTICE REVIEW PANEL

Annual review of local child safeguarding practice reviews

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Disclaimer

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

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Executive summary

This report is based on a study of Local Child Safeguarding Practice Reviews (LCSPRs) completed and submitted to the national Child Safeguarding Practice Review Panel in 2021. The report highlights learning for safeguarding practice and policy, especially for addressing issues of race and racism. It also identifies learning about the process of reviews, especially the quality of the reports and the implementation of the recommendations; this learning draws also on a questionnaire and focus group discussion with representatives from 22 local child safeguarding partnerships. This executive summary gives the key messages from each chapter.

Chapter 1: Overview of LCSPRs received in 2021

- There were 84 LCSPRs in total, relating to 33 deaths (39%) and 51 cases of serious harm (61%).
- The largest age groups are infants aged under 1, making up 30% of the cases, and 16-17 year-olds, who make up 28%.
- The median length of time to complete an LCSPR after the rapid review was 58 weeks, compared to the statutory requirement of 26 weeks. The longest case took over 2.5 years.

Chapter 2: Messages for practice

- All safeguarding agencies need to promote cultures that give their staff the confidence to ask questions. Staff need to be able to both give and receive challenge and work together to resolve professional differences.
- Practitioners need and deserve proper support and resources for their work with some very demanding cases. Specialist services to support children and families are often in scarce supply, and hard to access.
- The term ‘reluctant and sporadic engagement’ rather sanitises and disguises the realities of working with some extremely hostile and intimidating families and young people, some highly demanding families, and some that are deliberately deceptive.
- The detail and realities of day-to-day frontline practice are not usually visible in the reports. Although it is important to avoid long chronologies, demonstrating the realities of practice is necessary to understand the strengths and shortcomings of practice, and what support practitioners need.

Chapter 3: Race, ethnicity and culture in LCSPRs

- Racial, ethnic, and cultural identities are often central factors in the daily lives of minoritised people, and should be given proper weight when exploring such children's lives, in practice and in reviews.
- Working effectively with Black children may require regular training for professionals, highlighting the implications for practice of the children being *invisibilised*, *responsibilised* and *adultified* (see Appendix 2 for explanations). Black children must be seen and treated as *children*.
- Cumulative social hazards, including poverty, intra-familial difficulties, learning needs and negative peer relationships, amongst others, are harmful to children. For some children, the impact of racism magnifies these adversities. All practitioners need to be aware of these interactions and apply the understanding in their work with children and families.
- Poor parental engagement by minoritised parents has been linked with fear, including fear of the power professionals wield. Professionals need to recognise, explore and seek to allay such fear while working with the parents.

Chapter 4: Quality and methods of LCSPRs

- In high quality reviews, the contributions of the family and young person, and of practitioners, are clearly visible and analysed, not just taken at face value.
- LCSPRs should use a systems methodology, but understandings of this were uncertain. A range of named and alluded methodologies were offered, but most used the same methods to undertake the review. There was no apparent correlation between specified methodologies and the quality of the review.
- There is wide variation in style of writing, length of reports, grounding in evidence, analytic detail and clarity of learning. The main factor for the quality of the review is what the individual author brings, their skills and approach.
- Clear 'key lines of enquiry' from the rapid review that provide the opportunity for new learning are most helpful.

Chapter 5: The impact of LCSPRs on practice

- Partnerships identified a direct link between the quality of the LCSPR and the potential for impact. Crucially, LCSPRs needed to contain recommendations easily converted by the partnership into SMART action plans.

- Recommendations which focused on 'macro level' issues beyond the control of the partnership were less likely to lead to impact.

- Partnerships favoured 'bite-sized' approaches to disseminating learning from LCSPRs including 'seven-minute briefings', 'lessons learned' briefings and short YouTube videos.

- Partnerships favoured the use of multi-agency and themed audits to measure practice change. However, they identified difficulties evidencing impact in relation to long-term cultural change and changes to face-to-face practice with families.

Chapter 6: Conclusions

Learning for the Child Safeguarding Practice Review Panel

- There are always likely to be tensions between a national panel and local agencies. The Panel is frustrated about the timeliness and quality of some reviews, but some local partnerships express frustration about what they experience as a 'top down' mentality. The Panel needs to build on its efforts to engage with partnerships.

- The LCSPRs show that many of the issues that undermine the effectiveness of safeguarding practice are to do with serious resource shortages. The Panel has a unique role and opportunity to influence national policy as well as practice at a local level. The Panel will need to consider how they can best help secure the necessary resources and reforms to help practitioners help children and families.

- 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. We recommend that the Panel secure the funds to commission such a project.

Learning for local child safeguarding partnerships

- We think there would be benefits in having fewer LCSPRs, making the process a clear 'step higher' and the lessons more distinctive. Greater use of thematic reviews could help with this. Partnerships should focus as far as possible on completing their learning in the rapid reviews. Publishing a learning summary and action plan from the rapid reviews would demonstrate to agencies, families and the public that they have learned the lessons and are working to implement them.

- When it is considered necessary to commission an LCSPR, it is crucial for the rapid review to produce clear and focused key lines of enquiry (KLoE). If reviewers do not wish to follow them, this needs to be discussed and agreed.

- There should be SMART action plans for the partnership and local agencies arising from the recommendations of the review (or a clear statement of why the partnership does not accept them). These should be published alongside the LCSPR, for accountability and as a sign of the partnership's commitment to learning and improvement.

- Partnerships should take steps to build a wide range of contacts with skilled independent reviewers, and to build up their own pool, with mentoring and sufficient time in workloads. It may be helpful to develop reciprocal relationships with other partnerships.

Learning for reviewers

- It is important for reviewers to specify the racial and cultural background of the children and their families, and other characteristics such as age, gender, disability and sexuality, unless there are overwhelming reasons not to do so. If so, these should be explained. More than that though, reviewers should discuss explicitly how these characteristics shaped the families' and children's lives, experiences and views, and how practitioners and services responded to them.

- Reviewers should be clear about the objective of a systems methodology, whatever the details of the methods they use. They should be looking to understand the dynamic between individual actions and decisions, and the social, organisational and professional systems within which the individual operates.

- Reviewers should look to discover, analyse and report more about the details of direct practice. The challenge is to do this without going back to lengthy chronologies or enquiries that seem accusatory and blaming. But individual practice matters, and the children and families deserve good practice.

- The best reviews have few and focused recommendations that take understandings further than the rapid reviews, and can readily be translated into SMART action plans.

Chapter 1: Introduction and overview of LCSPRs received in 2021

Introduction

The brief provided for the study by the Child Safeguarding Practice Review Panel had five elements:

- A review of all 84 LCSPRs completed and submitted to the Panel in the calendar year 2021, with in-depth qualitative analysis of a smaller sub-set. The brief specified the purpose of the analysis as being ‘to gain an increased understanding of the root causes of systemic strengths and vulnerabilities within local practice, in particular where there are emerging or entrenched problems …’. We were also asked to consider learning in relation to the six key practice themes identified in the Panel’s 2020 Annual Report (CSPR Panel 2021);

- An assessment of the quality of LCSPRs, in particular considering how the LCSPR responds to and builds on the rapid review;

- An evaluation of the implementation and impact of the reviews – for this we used a questionnaire for local partnerships on a sub-set of reviews, and a focus group discussion with representatives of those partnerships;

- A review of the methodologies used in LCSPRs, to identify those best suited to deliver high-quality reviews;

- To look at how LCSPRs address and analyse the impact of race, racism and culture on practice, and where there is good or emerging practice in this area in terms of review quality as well as practice quality.

The research methods are described in more detail in Appendix 1.

This chapter presents the statistical overview of the whole sample. Where possible we have compared the profile of 2021 LCSPRs with the patterns in previous periodic reviews of Serious Case Reviews (SCRs). Intriguing differences emerge. There are now more cases of serious harm than death, and the proportion of 16-17 year-olds has risen markedly.

The chapter also describes the profile of the sub-samples in the study. There were in effect three. The main sub-sample comprised 20 cases, purposively selected to help us address the questions specified by the Panel about practice, quality and methodology, but broadly representative of the whole sample.

We also used these 20 cases for the analysis of implementation and impact, but added four extra cases that had been completed in 2020. This was to ensure that the sample had some cases with a longer period of implementation.

To examine the impact of race, racism and culture, we selected a different sub-sample, all the cases involving Black or other minority ethnic children. This gave a total of 30 cases, although some were in both sub-samples.

Statistical analysis of the 2021 LCSPRs

LCSPRs should be completed within 26 weeks of initiation. Almost two-thirds of the reports completed in 2021, 64%, relate to incidents which were notified in the previous year, 2020. However, there were outliers which show a significant period between the incident being notified and the report being completed (see Table 1 below). The 2017 incident is unusual, because it became a rapid review in May 2019, when further information came to light about a closed case. The three 'missing' cases in the table below include two thematic reviews with multiple incident dates, and one smaller thematic review with no accompanying rapid review or SIN (Serious Incident Notification) data.

Table 1: LCSPRs received in 2021, by year of incident

Year of incident	Frequency of LCSPRs received in 2021.
2017	1
2018	2
2019	25
2020	52
2021	1
Total	81/84

We understand that at the end of 2021, a total of 372 LCSPRs had been initiated since the system was established in 2018. We received 33 completed LCSPRs for the 2020 review and 84 in 2021, meaning that a total of 117 had been completed and submitted to the Panel by the end of 2021 (just 31%, although we could not

expect any that were initiated in the second half of 2021, because they have six months to be completed).

It is not straightforward to contextualise the 84 LCSPRs in relation to the number of SINs and rapid reviews, given the varying timespans between incident, rapid review and LCSPR. There also was the transitional period between July 2018 and September 2019 when SCRs could still be initiated as well. Taking only 2020 and 2021, therefore, we can see that just over 40% of the rapid reviews received in 2020 led to LCSPRs, and just over 30% in 2021 (Table 2).

Table 2: Proportion of rapid reviews leading to LCSPRs, 2020-2021

Year	No. of rapid reviews received this year	No. of LCSPRs commissioned (% that proceeded to LCSPR)
2020	456	185 (41%)
2021	433	134 (31%)

The 84 LCSPRs relate to 141 children/young people. There are seven thematic reviews (unrelated cases of 2 or more children), 13 cases that include more than one child from the same family, two cases of unrelated children killed or harmed in the same incident and 59 individual cases.

Duration: from incident date to rapid review, and from rapid review to LCSPR completion

Table 3 shows the time in weeks between the incident date and the rapid review date, and then from the rapid review to the completion of the LCSPR. The rapid review is expected to be completed within 15 working days, although this is not a statutory timeframe (it comes from the Panel's guidance). The period from the rapid review to the LCSPR is expected to be within 26 weeks, as specified in the statutory guidance, *Working Together 2018* (HM Government 2018, updated in 2019 and 2020).

The proportion of cases completing the rapid review within the 15 working day timescale is 55% (42 of the 76 cases).

Table 3: Time taken to complete reports in the 2021 sample

	No. of weeks from incident date to rapid review	No. of weeks from rapid review to LCSPR
N (not all had sufficient information)	76	75
Median	3.00	58.00
Range	57	140
Minimum duration	Under 1 week	5
Maximum duration	57 (this excludes the unusual 2017 case)	145

The median for the period from rapid review to LCSPR stands at 58 weeks, over twice the expected 26 weeks. The longest case took 140 weeks, more than 2.5 years. The proportion of cases in our sample that completed the LCSPR within 26 weeks is very low, just 7% (5 of the 75).

The records supplied to us by the Panel showed that 79% of the LCSPRs completed in 2021 had been published, and 21% had still not been, sometimes with various reasons given, typically that there are ongoing court processes. We return to the issues of duration, completion and publication rates in the discussion in the concluding chapter.

Characteristics of the children at the centre of reviews

For 82 LCSPRs the child who was the main focus of the review was selected as the 'index child'. In two of the larger thematic reviews of unrelated children (for which we do not have all SIN or rapid review data) an index child was not chosen.

Ages of children

The age characteristics of the children at the centre of these reviews show broadly similar trends to previous biennial and triennial reviews of SCRs (see Table 4 below). The under-1s are still the largest group, but as a proportion they have fallen over time, and now make up just 30% of the cohort. The second largest age category is now young people aged 16-17, with a notably higher proportion in this sample than previously (28%).

Table 4: Ages of index children in SCRs and the 2021 LCSPRs

Age	**SCRs 2005-07**	**SCRs 2007-09**	**SCRs 2009-11**	**SCRs 2011-14**	**SCRs 2014-17**	**SCRs 2017-19***	**LCSPR 2021**
N	189	280	178	293	368	235	82
Under 1 year	86 (46%)	123 (44%)	64 (36%)	120 (41%)	154 (42%)	86 (37%)	25 (30%)
1-5 years	44 (23%)	60 (22%)	51 (29%)	64 (22%)	79 (21%)	46 (19%)	11 (13%)
6-10 years	18 (10%)	26 (9%)	21 (12%)	28 (10%)	20 (5%)	20 (9%)	6 (7%)
11-15 years	20 (11%)	40 (14%)	27 (15%)	41 (14%)	63 (17%)	38 (16%)	17 (21%)
16+	21 (11%)	31 (11%)	15 (8%)	40 (14%)	52 (14%)	45 (19%)	23 (28%)

*N.B: The 2017-19 review is in progress and covers 2.5 years; Dickens et al 2022.

Ethnicity

When we look at ethnicity in relation to type of incident, the overall proportions are again similar to those found in the periodic overviews of SCRs. White British remains the ethnic group with the highest number of cases (67%). There are proportionately fewer children from Black/Black British ethnic groups than in previous rounds – this has been between 6-9%, but in this sample is just 4%. The ethnicity of the child at the centre of the LCSPR could not be found for 3/82 cases, but it is important to state that we often had to go back to the SIN to determine it. The family and child's ethnicity was very often not given or considered in the LCSPRs, an issue to which we return in Chapter 3.

Nature of the incident: death or serious harm

In comparison to previous overviews of SCRs, where samples consistently include more cases of death than serious harm, in this sample of LCSPRs we have more cases of serious harm than death, shown in Table 5.

Table 5: Death and serious harm cases in SCRs and the 2021 LCSPRs

Death/ Serious harm	**SCRs 2005-07**	**SCRs 2007-09**	**SCRs 2009-11**	**SCRs 2011-14**	**SCRs 2014-17**	**SCRs 2017-19***	**LCSPR. 2021**
Total	189	280	178	293	373	235	84
Death	65%	56%	66%	67%	57%	56%	39%
Serious Harm	35%	44%	34%	33%	43%	44%	61%

*N.B. The 2017-19 review is in progress, and covers 2.5 years; Dickens et al 2022.

The changing pattern is also apparent in the data on SINs and rapid reviews for 2021, analysed by Alma Economics. This suggests that it is not simply a change in the decision-making about which cases go to LCSPRs (although that may be part of it), but reflects changes earlier in the process, about the cases that are notified and which go on to rapid reviews. It may also be linked with the changing age profile and forms of harm, but this shift is a topic that merits further investigation.

Deaths

Of the 33 deaths, the largest classification is 'Death related to malreatment' (58%) followed by 'fatal physical abuse' (15%). 'Death related to maltreatment' was categorised according to the defintion used in the previous overviews of SCRs (see Brandon et al 2020, Appendix B[1]).

Of the 19 deaths related to maltreatment, the largest group, just under half, were sudden unexpected deaths of infants (SUDI: 8), with suicides accounting for just

[1] Includes sudden unexpected deaths in infancy (SUDI) with clear concerns around parental care but where the death remains unexplained or is attributed to a natural cause. Includes fatal accidents where there may be issues of parental supervision and care. Includes those children dying of natural causes whose parents may not have sought medical intervention early enough. Includes deaths of older children with previous maltreatment, but where the maltreatment did not directly lead to the death, for example, death from an overwhelming chest infection in a child severely disabled by a non-accidental head injury, suicide or risk-taking behaviours, including substance abuse in young people with a past history of abuse.

over a quarter (5). As might be expected, the eight SUDI cases were infants under 1 year of age, and the five cases of suicide were teenaged children.

Serious Harm

Of the 51 LCSPRs that relate to an incident of serious harm, the largest subcategory was physical abuse: 17/51, which constituted one third of these incidents (33%), fairly equally across gender. The next largest category was sexual abuse, 14/51 cases (27%) split equally across intra- and extra-familial sexual abuse. These related to 11 girls and three boys. There were a further three girls in the category relating to CSE (criminal sexual exploitation). Taking the sexual abuse and exploitation categories together gave 17 cases, equal to the number of physical abuse cases. There were nine cases of neglect (18%).

The purposive sub-sample

We purposively selected a sub-sample of 20 LCSPRs to support further exploration and qualitative enquiry. This sub-sample was not intended to be statistically representative, but to allow us to focus on the practice issues identified by the Panel, and to give us a good range of examples to show key issues in the reviews themselves – that is, both good analysis and where issues have remained unaddressed or less well integrated. The sub-sample includes a variety of cases in terms of thematic reviews, family and/or single child cases.

Whilst not aiming to be representative, the sub-sample is split 60%/40% in relation to serious harm/deaths, the same as the wider sample. The eight deaths comprise four cases of death related to maltreatment (three suicides and one where a young woman in care and at risk of sexual exploitation died from a pre-existing health condition), one relating to fatal physical abuse, one case of extreme neglect and two where the cause of death was not clear. The 12 cases of serious harm are six cases of physical abuse, two of intra-familial CSA, two of neglect, one of risk taking/violent behaviour and one ‘other’.

Within the sub-sample the child characteristics are as follows: 11/20 relate to males, 8/20 to females and one (a thematic review) to children of different genders. In terms of the child’s age at incident, the sub-sample has seven children under 10 years old and 12 children over the age of 10, and the thematic case concerns teenagers.

Overall, we focused our analysis on the cases in the sub-sample of 20, but we drew on cases in the wider sample as appropriate. One of the themes we were asked to explore in greater depth was race, racism, ethnicity and culture. For that analysis, we looked at all the cases involving Black or other minority ethnic children. This gave a

different sub-sample, of 30 cases, although some were in both. Our findings on this theme are given in Chapter 3.

To explore the implementation and impact of LCSPRs, we added an extra four cases to our sub-sample of 20, where the reviews had been completed in 2020, as this gave more time for learning to have been disseminated and embedded within the partnerships. We discuss impact in Chapter 5.

Chapter 1 summary points

- This report is based on a study of the 84 LCSPRs completed and submitted to the national Child Safeguarding Practice Review Panel in the calendar year 2021.
- The reports relate to 33 deaths (39%) and 51 cases of serious harm (61%). The two largest age groups are infants aged under 1, making up 30% of the cases, and 16-17 year-olds, who make up 28%.
- The median length of time to complete an LCSPR after the rapid review was 58 weeks, compared to the statutory requirement of 26 weeks. The longest case took over 2.5 years.
- The statistical overview relates to all 84 cases. For more in-depth analysis, the researchers selected a purposive sample of 20 cases. For the study of implementation and impact, they added four cases that had completed in 2020, to give a longer timeframe (see more in Chapter 5).
- For the study of the impact of race, racism, ethnicity and culture, the researchers looked at all the cases involving Black or other minority ethnic children. This gave a different sub-sample, of 30 cases, although some were in both (see more in Chapter 3).

Chapter 2: Messages for practice

This chapter highlights key messages for practice from the 2021 reviews, using the six key themes identified in the Panel's 2020 annual report. These are: 'Understanding what the child's daily life is like', 'Working with families where their engagement is reluctant and sporadic', 'Critical thinking and challenge', 'Responding to changing risk and need', 'Sharing information in a timely and appropriate way' and 'Organisational leadership and culture for good outcomes'.

We were asked to focus on critical thinking and challenge, and responding to changing risk and need, and so most of this chapter is under those two headings, but of course all the themes interweave – 'critical thinking and challenge' is fostered by good organisational leadership and culture, 'responding to changing risk and need' requires timely information sharing, 'understanding what the child's daily life is like' is complicated when families or young people are reluctant to engage, and so on.

'Critical thinking and challenge'

Critical thinking to respond effectively to complex and changing situations has to take place at different levels: in direct front-line practice with families, often 'in the moment'; in case meetings, often inter-agency; in supervision; and at a management level, in the making of plans and policies to respond to new circumstances. LCSPRs themselves are required to demonstrate critical thinking.

The terms 'professional curiosity', 'respectful uncertainty', 'healthy scepticism' and 'thinking the unthinkable' are phrases used in LCSPRs (and previously, in SCRs), often with a tone of frustration, to try to emphasise the importance of critical thinking. As we observed in our 2020 review of LCSPRs and rapid reviews, these phrases have become rather clichéd and do not usually help to shed light on *why* there was insufficient probing and analysis, and if necessary, challenge (Dickens et al 2021).

Furthermore, 'challenge' is a complex notion, and has three aspects: 'challenge' in direct practice with families and young people, challenge to practitioners in supervision, and in inter-professional practice. The LCSPRs are often critical of practitioners (from all agencies) for not being suitably challenging with families, but accepting answers at face value; and of not pursuing questions with other agencies on actions or decisions they are doubtful about. However, co-operation is usually regarded as a more effective way of 'working together', both with families and other professionals; within that there may be a place for challenge, but this requires clear thinking, insight and usually subtlety rather than confrontation. One of the LCSPRs in our sample used the term 'authoritative enquiry', and this may be a preferable way of thinking about it. Challenge also needs to be accompanied by support for families and workers, and it is worth saying that it sometimes requires courage too – for fear

of angry reactions from parents or young people, or of resistance and counter-criticism from other professionals.

Challenge in inter-agency practice

In terms of inter-agency practice, one review described a case where there was confusion about the outcome of a strategy meeting, and then disagreements about whether or not to call another. The review asserts that:

> '*Future safeguarding practice will be strengthened by practitioners and organisations recognising that differing professional views are an asset to multi-agency working particularly given what is known from research about errors in human reasoning. Valuing differing professional views will promote and strengthen the culture of partnership working.*'

It is unlikely that anyone would argue with this, but reviews often show the challenges of consistently achieving this sort of effective professional exchange. In this case, the review notes that the need for clearer guidance on strategy meetings had been highlighted in an earlier SCR, but not addressed. It also reports that there had been an internal audit of strategy discussions shortly before the incident in question, which had identified similar issues: so the problem was known, and via other routes, but effective action had not been taken. There is no explanation of why action had not been taken earlier, but there is now a clear and informative video about strategy meetings on the safeguarding partnership website.

In another case, a very thorough rapid review highlighted what it described as a 'laissez faire' culture in the local authority, taking the path of least resistance and avoiding conflict. It said that previous efforts to address this had not been successful. This was in fact a criticism that had been made of the local authority in an Ofsted inspection shortly before the incident in question. (The department had been rated inadequate.)

The rapid review asked the LCSPR to investigate this, but it does not really get to grips with it, despite holding a total of nine practitioner events. The review says that practitioners '*reflected that culture and practice impacted on professional engagement in and challenge to the MASH decision making*', and also that '*Professionals acknowledged that the injury to [the child] did not lead them to reconsider their assessment and direction'*. But the analysis of these reflections is limited. The LCSPR says that there is research to show that when people are deeply involved in a cohesive group, their striving for unanimity can override their motivation to realistically weigh up alternative courses of action. That may be so, but the review does not say whether that was a factor in this case, or how this sort of 'group think'

may have operated, or how it could be averted. It does not lead to any clear recommendations for change.

The 2014-17 periodic review of serious case reviews described how changing the term to 'resolving professional differences' had empowered staff to raise issues with other professionals and pursue them if necessary (Brandon et al, 2020: 201). The terminology seems to have spread, but one of the LCSPRs found that although there appeared to be a robust 'Issue Resolution Procedure', even so '*on the evidence from this case, professionals may be reticent to push the challenge beyond the initial stages*'. The LCSPR also refers to the partnership's 'Resolving Professional Disagreements' procedure, commenting that it '*appears less robust and may need to be strengthened and given greater publicity*'. A change of terminology can be helpful then, but it needs more than that – the underlying approach needs wider backing and promotion, and professionals have to be willing to accept challenge as well as give it.

Challenge in work with families and young people

A frequent finding in the LCSPRs is of practitioners not questioning and challenging parents about their care of the children, but accepting circumstances or explanations too readily. This is shown especially clearly in the cases where there were high levels of violence and criminality in the families. In one case, a 15-year-old young man was becoming involved in increasingly serious violent offending. There had been safeguarding concerns for many years because of violence, drug misuse and drug dealing in his family, his own violent behaviour, criminal exploitation and possible sexual exploitation. He had been on a child protection plan, but the review concluded there had been 'little impact' from all the work. It comments:

> *It remains uncertain why some responses seem to be less than rigorous. The possibilities that emerge and might usefully be debated range from a belief that the much 'disadvantaged' young person should be afforded more chances, a hope that he would not re-offend through to his family representing sufficient threat i.e. that minimal responses might be for the 'greater good' or safeguard 'community harmony'. It might also be that the dramatic nature of his conduct distracted professional attention from his very substantial emotional needs.*

The LCSPR suggests additional possibilities including 'a good deal' of disguised non-compliance from the parents, 'the extraordinary turnover of allocated social workers' and 'an apparently widespread reluctance to challenge the young person's family'. It also mentions poor record-keeping and a weak management structure, and that the review 'had not been provided with any detail of how individual practitioners were supported or challenged by their managers'.

It might have been useful if the review had pursued these possibilities further itself. It says that there had been four ‘panel meetings’ with representatives of children’s social care, health, education, the youth offending service and the police, but it is not clear whether these were practitioners or managers, or how well they knew the case.

Case study: the need for ‘critical thinking’ and the subtleties of effective ‘challenge’

A case which illustrates shortcomings in critical thinking and the sensitivity and skills needed for effective challenge concerns a child who was at risk because of his mother’s drug and alcohol misuse and a violent partner. At one point the boy was taken into care because he was found ‘home alone’ when the police were investigating a report of his mother driving a car under the influence of alcohol. There was a rehabilitation plan, but the rapid review found that this was *‘premature’*. There did not appear to have been multi-agency planning or meetings at that stage. The rapid review commented that the focus of the plans was around the mother’s ability to make effective changes to her lifestyle, but the criteria to assess this was only for her to submit negative drug tests. Furthermore, the rapid review found *‘There is limited information that evidences the actual work and intervention with mother … There is no indication that mother’s use of alcohol was addressed as part of the work undertaken …’*. The LCSPR does not say any more about this.

During the period of the rehabilitation plan there were suspicions that the mother and her child were having more contact with her partner than she was admitting, and the mother crashed her car whilst intoxicated. Nevertheless the plan went ahead. The rapid review concluded that the decision to continue with the rehabilitation plan was made *‘without a clear rationale as to why’*. Setbacks are not necessarily a reason to change a plan, but the decision was not discussed more fully in the LCSPR, so the reasoning behind it is still unclear.

On the question of ‘challenge’, there are thought-provoking comments from the mother, who was interviewed by the author of the LCSPR. She said that *‘accepting that you were wrong is the most difficult thing’* and that professionals should have been ‘softer’ but also ‘more persistent’ with her. She said *‘it is all about relationships’*, and that

> *… persistence might have been the only thing that could have encouraged her to behave and think differently at the time but she isn’t really sure whether this would have prevented what happened …. She thinks that she should have been “forced” to engage with the domestic abuse service but she also recognises that people can’t be “forced” to do these things*.

The mother's remarks show that confrontational 'challenge' is unlikely to have been successful, and a more skilful approach would have been necessary.

As for inter-professional challenge, the LCSPR asserts that

When challenging it is important to be clear as to what the precise nature of the challenge is and what the expected outcome is … It would also benefit from the inclusion of a timescale … In many cases these challenges can have an early resolution … There is a need for all agencies … to be responsive to appropriate professional challenge. When there is poor or no response this should be logged … When the case appears to be stuck then professional curiosity and a wider multi-agency approach must be utilised.

Critical thinking' in the reviews themselves is an issue we consider further in Chapter 4, on the methodology and quality of reviews.

Learning points: critical thinking and challenge

- If lack of critical thinking and challenge is an issue (with families or other professionals), it is important to be clear about why it did not happen.
- Effective challenge is subtle and skilled work. Practitioners and managers need training, supervision and time to do it well.
- Skilful challenge to families takes place in the context of effective relationship-based practice.
- Less confrontational language, such as 'resolving professional differences', can give a more constructive framework for questioning and pursuing matters.

'Responding to changing risk and need'

There are two dimensions to responding thoughtfully to changing risk and need – for practitioners, to respond to changes in a family or young person's circumstances, and for managers, to ensure their agency is responding effectively to new or widespread challenges.

Casework

The reviews show how difficult it can be for practitioners to keep up with all the changes in a family or young person's circumstances, their needs and demands and related tasks; understanding the bigger picture behind them requires time to think, and good guidance and supervision.

About 10% of the families lived with very high levels of violence and criminality, often associated with drug dealing. This could at times be overwhelming for practitioners (as also found by Brandon et al 2020). One review dealing with this sort of case was mentioned above; another, describing the case of a young man who was being drawn ever deeper into extreme criminality, found that

> *'… professionals by this time were at a loss as to how to work with [the young man] and keep him safe … the review team was unable to determine exactly what pro-active interventions, if any, were in place to work with him … It would have been difficult to embark on any work without [his] cooperation and motivation, but even so plans did not change to reassess risks, which were in fact steadily growing. … records refer to [him] being dismissive of anything social workers could offer and he frequently expressed the view that he knew what he was doing and didn't require any help.'*

There are a number of learning points from this case. First, the last sentence gives a hint of the neediness that underlies the young man's bravado. He was being criminally exploited, and was caught up in 'turf wars', between organised criminal gangs. He was eventually seriously injured in a shooting. Secondly, the LCSPR is critical that it was '*unable to determine exactly what pro-active interventions, if any, were in place to work with [the young man or his mother] at this time*'. Practitioners may need supervision and support to see beneath the presenting behaviour; if they do not receive this, it is possible that they will retreat, consider the young person (or parents) as 'impossible' and stop trying to engage. And thirdly, the LCSPR also describes how the local authority had made an application to court for a Secure Accommodation Order, but '*whilst the threshold for this was met, the order could not be granted because a secure placement was not available anywhere in the UK at the time*.' The local authority continued to search for a secure placement up until, and after, the serious assault on the young man.

The lack of suitable placements for the most needy children has become a national problem, commented on forcefully by senior judges in several high profile cases: the LCSPR refers to one. It also refers to a 2020 report from the Children's Commissioner for England*, The Children who No-one Knows what to do with*. It is important to understand shortcomings in local-level practice in this wider context of severe resource shortages (it also applies to CAMHS, discussed below).

Learning points: responding to non-engagement and hostility

- It is important to look beneath the presentation and behaviour – what is the underlying need and vulnerability?
- The psychological and emotional impact on practitioners must be recognised, and support provided – they need help to think clearly and see the patterns behind the behaviour, and support in their continued efforts.
- Suitable services must be available to help; it is unfair to expect frontline practitioners to manage these challenging cases without specialist resources.

Despite the challenges, there are examples of persistent and proactive help, of workers continuing to try to find out what was going on and ensure that action was taken. Determined work like this may not always be from 'mainstream' child safeguarding staff. One review describes proactive and determined work by a worker in the housing department, concerned about the welfare of children who were supposed to be receiving home education; but when she referred the case to the 'elective home education' team, the father's answers were taken at face value and it was not pursued, leaving the children in a harmful environment.

In keeping with the motto that 'safeguarding is everyone's business', there are other examples of proactive, determined help from workers outside children's social care – as examples, in one case a probation officer and in another a youth worker. In that case, the LCSPR reports that the youth worker made the point '*that one reason this relationship may have flourished was that, in the mind of the young person, he was not "tarred" as a social worker or police officer, and so could relate differently.*' So there is value in different approaches, but at the same time core safeguarding principles and responsibilities must be known and followed.

Responding to wider change

Responding to changing risk and need may not be just a case-related matter, but a wider issue for the local area and even the country. Covid-19 is of course an example of that. The Panel has published a report on the responses to the pandemic (CSPR Panel, 2020), which acknowledged the hard work and flexibility of safeguarding partners, but recognised the increased risks for children and young people that the lockdowns brought. There are now some LCSPRs coming through that comment on events during the first months of the crisis.

Suicides

As an example, a review into the suicides of two unrelated young men in autumn 2020, states that '*the pandemic and lockdown did not materially undermine or decrease the safeguarding support [the boys] received'*. The reviewer found *'strong commitment to the boys throughout and creative and innovative modifications to practice'.* However, the reviewer also comments on the lack of face-to-face contact with the young people in the period up to their deaths, and asks for reassurance from the partnership that *'children at risk or of concern should be regularly seen in person and that alternative contacts (social media messages, email, telephone calls) should not replace … face to face meetings.*'

Teenage suicides have featured in a significant minority of serious case reviews since the turn of the century (Brandon et al 2008), and the topic was discussed in depth in the 2011-14 periodic review (Sidebotham et al 2016). The LCSPR from which the example above comes was initiated by a partnership that had called for a national review of young people's suicides, and did its own thematic review when this was not agreed. There are many suicides of young people who do not have a background of abuse or neglect, but there is learning about suicide in LCSPRs that could be disseminated more widely, perhaps as part of a national campaign to raise awareness for practitioners and improve prevention across society as a whole. (The National Child Mortality Database, 2021, estimates about two suicides per week of young people aged under-18, based on the year 2019-20. There is now evidence that children and young people's mental health worsened during the pandemic: House of Commons Health and Social Care Committee, 2021.) The LCSPR on the two young men shows the need for wider awareness, reporting that when the police were searching for one of them, very concerned for his welfare, they found a security guard who reported seeing a young person with a rope around his neck, an hour and a half previously. If the guard had simply made a telephone call, that young man's life might have been saved.

Learning point: There is a need to raise professional understanding and public awareness of the risks of suicide in young people. This could be part of a wider national campaign, drawing on learning from all suicides of young people (not only where abuse or neglect may have been a factor).

Organisational risks and needs

Changing risks and needs may apply to the agencies themselves. Many of the reviews comment on the impact of staff shortages and turnover, high volumes of work and resource shortages, including long delays for CAMHS and unavailability of suitable placements. One case reports a two-year wait for a service from CAMHS. These difficulties are long-standing and well-known from other reports (see House of

Commons Health and Social Care Committee, 2021, and House of Commons Library report, 2021). There is a case for the national Panel to add its voice to the calls for improvements in this service.

Other reports, such as Ofsted inspections, can provide insight into the wider challenges facing local authorities and other agencies, beyond those of individual cases. There is an example of this in one LCSPR, where an Ofsted inspection the year before the incident had resulted in an inadequate rating for the local authority. The report was highly critical, referring to 'longstanding and widespread failures in the quality of social work practice' and that 'children live in situations of chronic neglect for too long before action is taken to improve their circumstances'. The LCSPR refers to that report, but in most cases LCSPRs do not draw on Ofsted findings (at least, not explicitly). It is also worth noting that cases of serious harm and death are not confined to poorly-rated authorities; within our sample there are cases from authorities with 'good' and 'outstanding' evaluations.

Point for reflection: the impact of other reports and inspections

There are many other reports, from inspections and research, that identify shortcomings and strengths in practice and organisational systems. This gives rise to a number of questions for reviewers, local partnerships and the national Panel, regarding the relationships between LCSPRs and other evaluations. All inquiries and evaluations absorb a large amount of resource – people's energy as well as funds – and 'doing things once' would be the most effective and efficient outcome. Which are more effective, how can unnecessary overlaps be avoided and productive overlaps used to the full? Our current study does not give us the data to explore those questions, but it would be a useful topic for further research.

'Sharing information in a timely and appropriate way' and 'Organisational leadership and culture for good outcomes'

Shortcomings in information sharing were a feature in almost all the cases in the cohort. It is a well-known and long-standing issue in serious case reviews. It was especially challenging in cases where families were highly mobile, moving across local authority and health service boundaries, but was not confined to that. It could happen between and within any of the partner agencies – for example, one review comments on how information got lost and forgotten in a young woman's many changes of placement.

The reviews show a number of dimensions, including technical difficulties, such as unreliable IT systems, and issues of organisational history and culture, such as

experiences of not feeling 'heard' by another agency, and so a belief spreads that there is no point referring matters. Other issues are frustrations about agency thresholds for responding to cases; poor assessments, meaning that inadequate or misleading information is transferred; and mistaken decisions about not to pass on certain information. In a number of cases there are comments that the police did not pass on information about home visits, which could be down to individual officers not being aware of the requirements and processes. This was noted in several cases when the police had been involved following an incident of domestic abuse. In the case highlighted as the case study about 'challenge', the ambulance service held important information, but did not realise its significance, and the child's 'core group' had no way of knowing that the ambulance service had this information.

LCSPRs can also be useful for raising issues about the role of MAPPAs (multi-agency public protection arrangements), which focus on managing the risks posed by sexual and violent offenders, and MARACs (multi-agency risk assessment conferences), which focus on protecting people at high risk of domestic abuse. Effective coordination between these processes and child safeguarding services emerges as an issue in a number of reviews. There are calls for increased training and publicity about these processes, so that all professionals and agencies are aware of how they can contribute to the meetings and how information can be shared back to the child's core group.

Misunderstandings about GDPR requirements and principles of confidentiality are highlighted in some reviews. In some cases, staff were not aware of established procedures and policy for information sharing.

As for organisational leadership and culture, this is not usually addressed explicitly in the reports, in contrast to Ofsted reports which do address these matters directly. However, the influence is everywhere – as shown in the earlier discussions about one organisation's 'laissez faire' culture, or another's approach to professional differences and challenge.

'Understanding what the child's daily life is like' and 'Working with families where their engagement is reluctant and sporadic'

There are two core aspects to reviewing the learning about these issues: what was known and understood about the child's life or family engagement *at the time*, and what is discovered *now*, in the review.

A clear picture of the child's daily life is often missing from the LCSPRs, which may be because the information was not available in the files. One of the LCSPRs reports

a criticism that '*home visits amounted to a "tick in the box" rather than a meaningful event*', although it does not expand on it. If information is missing, it raises a question about the focus of the review: whether the priority to discover more about what the child's life was like at the time, and report on that, or to raise questions for how the agencies could do it better, in future.

It is a tricky balance to get right: LCSPRs need to have enough information to give a sense of the child's life, to underpin the lessons and ground the recommendations, but 'too much information' can be a substitute for analysis and hide the key messages. It may also cause harm to children and families by putting too much information in the public domain, which is an issue that safeguarding partnerships were acutely conscious about in our survey and focus group.

Seeing the child's home is important to get a sense of the child's daily life, but it is not simply a matter of seeing it; practitioners need to assess and when necessary act on what they are seeing. As a 'practitioner briefing' from one review said:

> *Seeing where children live provides a window on their lived experiences. In this case the home was found to be cluttered and dirty, with evidence that [the youngest child] routinely slept in her pram and was locked in her room to protect her from her siblings. Accessing family homes usually requires consent, which may not always be forthcoming. In such situations practitioners should question what the lack of consent is telling them and raise their concerns with others.*

When children and young people go missing from home (their family home or a care placement), especially if this happens frequently, it can be an indicator of their unhappiness, possibly from being ill-treated in the home and/or exploited outside it. Two checks should take place when children are found or return. There should be a police 'safe and well check' (also known as a welfare check or prevention interview), and the local authority should offer a 'return home interview' within 72 hours (DfE 2014). If done well these can be important ways to gain an understanding of the child's views and experiences, and then share safeguarding information with other agencies if appropriate. A number of reviews commented on shortcomings in the practice, or simply that they did not happen.

One review observed that it was impossible to keep up with the number of missing episodes that a young person was having, but if that happens the point is that another type of response is urgently required. In another case, '*The review author has seen very little evidence that these return home interviews took place on a regular basis and even if they did take place, what positive action took place following them?'*. Research undertaken for the Children's Society (Pona et al 2019)

found wide differences between areas in undertaking and acting on these interviews, and that the main challenge for agencies was capacity to do so.

'Reluctant and sporadic engagement' is a feature in many of the cases, and applies to some of the young people, not only the parents. The reviews give a powerful picture of the challenges of working with some extremely hostile and intimidating families and young people, some highly demanding families, and some that are deliberately deceptive. The term 'reluctant and sporadic' rather sanitises and disguises those realities.

It is also important to appreciate that it can be difficult to work with families who require, and sometimes demand, a high level of services and support – that is to say, apparently the opposite of reluctant to engage, but very insistent, perhaps with high-level needs and changing demands. An example is a case involving parents from an Irish Catholic background, both with learning disabilities, who had four previous children in care. They fled from their local authority while the mother was pregnant, but remained in touch via telephone calls and texts, without saying where they were. The review found that the parents were '*unrestrained in contacting staff frequently if they wanted something, sometimes creating a hectic environment. This could be viewed as them setting their own terms of engagement and intervention. It is important for professionals to be aware of this and communicate with families accordingly*'. The LCSPR observes that health staff and social workers had '*tried every way possible to engage with the family, and there is evidence that this was taken advantage of by the parents*.'

The demands from the parents had become overwhelming for the workers. Their engagement appears to be both reluctant (in the sense that they ran away) *and* excessively demanding. But, as with hostility, it is worth considering the background to it. The parents had learning disabilities and had already had four children removed. They must have been frightened and unable to think clearly. The review calls on professionals '*to use their expertise to assess needs wherever possible with the cooperation and understanding of the family, ensuring they receive the appropriate help without dictation or pronouncements*' – a call that highlights the skills required in this difficult work, and as noted earlier in the chapter, the need for good supervision and support for workers to help them deliver it.

The absence of practice in the practice reviews

To conclude this chapter on messages for practice, we found that it was often hard to see exactly what workers, from all professional backgrounds, were actually *doing* in their direct work with children and families – for example, how often they met them, how long they spent with them, what they observed, what they talked about,

what explanations the families gave and why the workers responded as they did. This close-up picture of practice is regularly missing from the reports.

It may be that this aspect is covered in the ‘practitioner events’ that take place as part of the LCSPR process, but the outcomes of these conversations are often not clearly described in the final report (discussed further in Chapters 4 and 5).

This is not to call for a return to the long chronologies that became such a feature of SCRs, because despite their length they often failed to give a clear picture of practice themselves. But SCRs and now LCSPRs tend to focus on organisational issues and inter-agency communication, rather than analysing direct work with children and families (see Ferguson, 2010, 2021). Focusing on a selection of ‘critical incidents’ or ‘key episodes’ could be a way of looking at practice in-depth without creating unhelpful detail. Direct practice is shaped by context and systems (workloads, availability of other services, training, supervision and team culture being prime factors), so the need is to understand face-to-face practice in context – that is the point of a systems methodology, a topic we return to later in the report.

Chapter 2 summary points

- All safeguarding agencies need to promote cultures that give their staff the confidence to ask questions. Staff need to be able to both give and receive challenge and work together to resolve professional differences.
- Many of the families have very great needs, sometimes with high levels of violence and criminality associated with drug dealing. This created great challenges for intervention and could at times be overwhelming for practitioners.
- Practitioners need and deserve proper support and resources for their work with such demanding cases. Specialist services to support children and families are often in scarce supply, and hard to access. Notable examples are secure placements and CAMHS.
- The findings of LCSPRs need to be contextualised with other reports, inspections and audits, to get a broader understanding of practice and organisational challenges.
- The term ‘reluctant and sporadic engagement’ rather sanitises and disguises the realities of working with some extremely hostile and intimidating families and young people, some highly demanding families, and some that are deliberately deceptive.

- The detail and realities of day-to-day frontline practice are not usually visible in the reports. Without going back to long chronologies, this is important to understand the strengths and shortcomings of practice, and what support practitioners need.

Chapter 3: Race, ethnicity and culture in LCSPRs

Of the 84 LCSPRs in our full sample, 27 featured children or young people who were of Black and other minoritised backgrounds (nearly a third). There was one 'white British' family where culture in the form of religion was an issue, and two 'white Other' families where English was the parents' second language. In total, 30 LCSPRs were reviewed for this chapter.

The reviews were assessed for key issues and patterns regarding race, ethnicity, and culture in two respects:

- Practice issues, regarding what practitioners did or did not do;
- Reviewers' interpretation – whether the reviewers show that they have addressed the implications of race and culture in the case. If not, this raises questions whether the professionals also addressed them in practice.

Certain words like *minoritise* and *racialise* have been used interchangeably in this chapter; these words, and others such as *invisibilisation*, *responsibilisation* and *adultification* are used in race studies to conceptualise people's experiences of racial injustice. There is an extensive body of literature about these concepts, and language and understandings are always evolving. The overarching point is that the lives of some groups of people are adversely affected by the attitudes and actions of more powerful people. Appendix 2 gives brief explanations of how we are using the terms in this chapter.

'Invisibilised' identities

The LCSPRs did not always mention or discuss race, ethnicity and culture, even when, on the face of, they were or could have been relevant factors. It was often necessary to look back to the SINs to find out the family's race and ethnicity because they were not stated in the practice reviews. This can be understood as an example of 'invisibilisation' – that is, a lack of positive attention to the identity characteristics of racialised and minoritised groups by those in authority (Hope et al 2021).

A notable example involved a severely disabled boy from an Asian family. The 'key lines of enquiry' from the rapid review specifically asked the practice review to investigate 'how well was the culture of the family understood and taken into account in assessment and planning?' However, there are just three short paragraphs on this. His mother did not speak English well, and it is not clear whether she was ever spoken to alone by any of the professionals involved. The reviewer notes that she is only mentioned once in all the records they saw, and concludes that 'a little more professional curiosity' was needed to explore her experiences; but there is no discussion or analysis of the actions or attitudes of the professionals, the suitability of

local services or the availability of interpreters. So the mother was effectively ignored (or 'invisibilised') twice – once in practice, and the second time in the review.

In an LCSPR where the father had abused his four children after his former wife's death, the children were of mixed white and Asian heritage. Whilst other relevant themes were discussed in the review, there was no attention given to their race and culture, or that their father, who was white British, had converted to Islam and had multiple wives in other locations. There is mention that the eldest boy was not a practising Muslim, but how else the dynamics of race and culture might have played out in the abuse suffered by the children was not explored.

A different case where the LCSPR addressed almost all the relevant themes but not whether race might have been a factor, was one where the child was of mixed Black Caribbean and white heritage and was allegedly killed by his mother's white partner. The practitioners were not aware that the mother was in a new relationship with a white man, but the review did not consider that race could have been relevant in the killing of a child from mixed heritage background by his mother's white partner.

An LCSPR of a Black teenage boy who died following a stabbing suggested that undiagnosed learning difficulties were part of the boy's challenges at school. Combined with poor family conditions, these contributed to his dropping out of school and getting involved in youth criminality. The boy's race was not mentioned or discussed in the report, and there was a missed opportunity to explore the interaction between professionals' attitudes, his learning difficulties and his race and ethnicity. There are complex interactions between biological, social and professional factors in the diagnosis of learning difficulties for Black children (Shifrer 2018). There is a risk of bias and misidentification, but professionals working with Black children and their families have to be aware of all possibilities if they are to ensure the right support for the children.

Learning point: When working with Black children who are struggling with learning at school, it is important to consider how the possibility of learning disability, racism and other social inequalities impact on the child's life and the support they need.

There was another review that compared the responses to two children and families with similar experiences (child sexual exploitation), but one family was white British and the other British Asian. It found that the families were treated very differently; the one with white British and articulate parents received significantly more support. The reviewer considered this was not intentional, but highlighted the importance of practitioners and managers asking themselves whether a white British person in comparable circumstances would receive similar treatment. This one of several helpful messages for good practice in the reviews, which we summarise at the end of the chapter.

Anonymity

The need to protect the children's anonymity is sometimes given explicitly by reviewers as a reason for not stating or discussing the children's racial background. In one case, two girls had been subject to a long history of physical, emotional, and sexual abuse, the impact of domestic violence, and being kept out of school. The girls are described as being of dual heritage and 'non-white', but the reviewer limits it to that because of her concern to prevent identification.

The reviewer also writes that:

> *There was little information about father or mother's cultural context beyond descriptions of their ethnicity. There was an absence of information regarding what was important to father and his mother from a cultural perspective and no information regarding whether they were asked about their experiences of racism in the community or when in contact with services.*

In other words, the reviewer gives two explanations for the lack of detailed discussion about race and ethnicity in the review; one is the wish to preserve anonymity, the other is the lack of information about it in the professional records. It is not clear whether this was discussed with practitioners and managers during the review process.

One of the recommendations of that review is that the local child safeguarding partnership '*develop a multi-agency position statement about expectations for culturally competent practice and provide support to improve agencies' practice*'. There is no explanation of what that means, what should have happened in practice, or how to apply culturally competent practice in the future.

The report was published anonymously on the NSPCC website (that is without giving the name of the safeguarding partnership), so anonymity was preserved that way. It is feasible therefore that there could have been a more in-depth discussion of the girls' ethnicity and the attitudes and actions of the professionals involved, and why the girls were left in those circumstances for so long, despite a long history of concerns and referrals.

It is important to note that not all reviewers or partnerships share this approach to anonymity and ethnicity. There was one review, for example, that said the child came from a Tamil family. This report is published on the partnership's website. It is easy to find the identity of the child from the information given; but knowing the background is important for understanding how health services had failed to meet the mother's needs. We discuss the issues of contextualisation, anonymity and learning further in Chapters 4, 5 and 6.

The Children Act 1989 states that a child's race, religion, culture and language must be taken into consideration during assessments and interventions. Despite this it seems that many LCSPRs and professionals still find it hard to fully interrogate race, ethnicity and culture. The possible impact of race and racism on the parents, the families, the children, in the communities and on the professionals is not usually explored in the LCSPRs.

Learning points

- If reviewers struggle to see the children's unique identities, then it is appropriate to wonder whether the professionals working with the families did, with potentially negative implications for the children.

- Identity characteristics of racialised and minoritised groups have been largely *invisibilised* in the reviews. In some instances, such absence is ostensibly intended to protect the individuals, whilst in others, there seems to be an inability to acknowledge that race, identity and culture could be relevant factors in the harm experienced by the children; neither of these reasons is good enough.

- Reviewers should not be striving to make the LCSPR cases completely unidentifiable; rather, the aim should be to ensure that the learning is contextualised and understandable without causing harm to the families.

Black children and schools

School can be a safe place for children, and much more so for minoritised children, who are more likely to be exposed to extrafamilial harm without the structure of schooling (see Graham et al 2019; Graham et al 2015; Warin 2009, 2010). School is directly referred to as 'place of safety' in two of the reviews in our sample involving minoritised children, one for a mixed heritage 17-year-old boy and the other a 9-year-old boy from a 'white other' background. The 'safety' relates to children having a structured life, with proper supervision and help working towards positive goals.

On the other hand, for some children schools are places where they are victimised and bullied, and children from minoritised backgrounds may face additional hazards of racist stereotyping from teachers and other professionals. (The issue came to national prominence in March 2022, as we were writing the final draft of this report, when the LCSPR on a girl known as 'Child Q' was published by City and Hackney Local Child Safeguarding Partnership.)

A thematic LCSPR on child sexual exploitation of two teenage girls of mixed heritage background, where inter-professional working was poor, states that:

> *When the children were excluded from school, this increased the burden on the parents with little consideration as to whether the parents were better placed to manage the subjects' challenging behaviours*.

There can however be an over-reliance on school as a safeguard, as seen in the same thematic review, where the schools involved were unable to cope with the very great needs of the children. One of the schools was a special school. It repeatedly asked for assistance but the requests were '*often met with a response that they were a specialist school and it was for the school to address'*.

School can become a harmful environment for Black children when the teachers and management apply racist treatment towards the children, as highlighted in a thematic LCSPR into criminal exploitation of eight boys, of whom seven are described as being from Black and mixed heritage backgrounds:

> *An education representative felt that systemic discrimination was evident in schools where children from different backgrounds were treated differently in the same circumstances, with Black children disproportionately impacted by this.*

The sentiment was echoed by a young person interviewed for the review:

> *I used to do silly stuff but it wasn't malicious. I would do stuff loud like a teenager. I'd bust jokes. I feel me and my friends were targeted. By Year 9, 15 of my friends had been kicked out and other people were doing way worse. Being black… There isn't the equality in school. Behind the skin we are the same human. There isn't the equality. The shade of my skin shouldn't determine how you deal with me.*

In a review about two Black young men who had been drawn into criminal gangs, the author observes that '*Educational exclusion may well only have served to increase their exposure to a criminal gang*'. The review asks whether alternatives to exclusion were considered. The review does not answer that question, but concludes that '*any efforts to prevent exclusion where possible would be a good preventative move*.' When children do have to be excluded, alternative suitable provision and support should be put into place immediately.

Inter-professional efforts should be made to ensure that children remain in school and are enjoying school. There is strong evidence that excluding minoritised children from school increases their exposure to harm, particularly criminal and sexual exploitation (see HM Government 2017).

Learning points

- Schools can play a positive role in safeguarding children from minoritised backgrounds but there are dangers of racist stereotyping. Teachers and other professionals need to be acutely aware of this.
- Excluding minoritised children from school can increase their exposure to harm, particularly criminal and sexual exploitation. Every effort should be made to ensure that children remain in school and are enjoying school.

Troubling silences and problematic expressions

Use of language can reveal underlying biases of professionals. There was sometimes vague, broad language, as well as poor choice of words, in describing minoritised children and families. An example concerns a girl from a mixed heritage background who had been the victim of child sexual exploitation. She was described as '*flirtatious*' and '*choosing not to communicate with others*'. These phrases reveal a mind-set of responsibilising the child. This is another form of adultification of Black and ethnic minoritised children, where they are not afforded the vulnerability assigned to their white peers (see Cooke and Halberstadt 2021; Davis and Marsh 2020, 2022; Davis 2022). Two thematic LCSPRs, including one on peer-on-peer violence, address these issues of adultification appropriately.

Another LCSPR illustrates how the implications of a family's ethnicity and culture, and the mother's difficulties in communicating in English, were not given due consideration in practice. The mother was the main carer for her teenage daughter and had English as a second language. There were indications that she did not always understand English terminologies, and had an inconsistent understanding of how services worked, including education and health. Professionals seemed reluctant both to support and challenge the mother regarding her child's care. They did not seem able to explain to her what was going on and none of those involved, including the GP, teachers, the social worker and EHE officer (elective home education) had a fair understanding of the situation or probed to find out, until the child died of anorexia.

An LCSPR where a 17-year-old-boy took his life in a public place should have addressed the child's cultural needs as a 'white other' immigrant to the UK. It was not clear in the review whether the professionals always understood the father well enough, or he understood what they were saying to him. The boy and his father seemed isolated in England, with little community support. It also appeared that the boy did not feel included in his school setting. There were several missed

opportunities for the professionals to respond to the boy's feelings of isolation. The school and social workers could have had more positive input in his life, but this was not properly analysed in the report.

In the white British families in our sample, professionals tended to communicate only or mostly with the mothers, but for some families of Global South heritage the reverse was the case. In three cases, the fathers were the main contact for professionals and the mothers' views were not heard. There was one case which ended with the mother killing one of her children and nearly taking her own life. The review found that her physical and mental health needs were not taken seriously enough. The health professionals did not fully understand her use of language, and when she was seen at the emergency department of the hospital there was no interpreter present. There was therefore '*limited opportunity for this woman to fully articulate how terrified she was*'. The review states: *'It essential that all staff recognise and respond to the need for interpreters when working with people who find it difficult to speak English. This has been identified in previous case reviews.'*

One mother of a 14-year-old Asian boy wanted to talk to health and care professionals, but they did not take steps to hear from her or communicate with her as someone for whom English was not their first language. The mother told the review that the health visitor '*didn't make attempts to speak to me*'. She said she would have loved to see a psychologist to talk about how she was feeling but was never offered one.

Research shows that people from Global South are usually more likely to be medicated for mental health issues, with fewer being offered talking therapies than their Global North counterparts (Omonira 2014). There is also a recurring narrative about racialised people, especially women, being expected to bear higher levels of pain stoically (Ghoshal et al. 2020). Practitioners should make concerted efforts to speak to mothers, preferably alone. If the mother is not confident in English, agencies must engage an adult, non-relative interpreter.

Intersection of social hazards

Many of the LCSPRs included families on low income, and research shows that where poverty and race converge, children's outcomes are worse (see Feely and Bosk 2021; Dettlaff et al. 2011; Karlsen and Nazroo 2002). When parental hostility, reluctant engagement or non-engagement is added to poverty and race, professionals can feel truly helpless, overwhelmed by the difficulties. Good managerial support and professional courage is required in these instances, to ensure more deliberate, determined, reasoned casework. As the reviewer observes

in an LCSPR about a mixed heritage child where there were multiple complexities including parental non-engagement, learning difficulties, substance misuse, and anti-social behaviour, '*non-engagement cannot be a reason to stop statutory work to safeguard a child. There needs to be a united front by professionals with an agreed plan, single lead practitioner, shared purpose and agreed outcomes for change*'.

One review offers a helpful insight into the fears that may underpin parental hostility. This was a case where a Black teenage boy had got drawn into criminal activity. Practitioners experienced his mother as very hostile and difficult to work with, but the reviewer observes that she was an asylum seeker, without recourse to public funds, and that she may well have had a suspicious view of people in authority due to experiences in her country of origin (see Okpokiri, 2021). The reviewer suggested that her hostility may be due to fear, and asked whether workers could have used someone from her own cultural group to help them get a better understanding of her experiences and those of her children. This could have helped them engage with her. Community groups or organisations that support minoritised people can indeed be useful for working with such families, but it is also important to be conscious of a suitable ethnic and cultural 'match', and that the family's privacy is maintained.

There are challenging points about racist stereotyping by police and schools in the thematic review of the criminal exploitation of eight boys. The historical backgrounds of the children were not properly taken into account by professionals working with them. Four of the eight boys had been in care, five had suffered domestic violence and physical abuse, and six had some form of mild to moderate learning disabilities and had Special Educational Needs (SEN). All were from socio-economically deprived backgrounds and expressed despair at the lack of opportunities in their lives. In essence, in cases where multiple needs converged, minoritised children were exposed to even higher levels of vulnerability and less support.

An undervaluing of Black children's needs increased the risks of late recognition of their vulnerabilities, and heavy-handedness in dealing with them and their families (e.g. school exclusion, as discussed earlier) (Davis, 2022). The adultification of Black children features from their early years, but is exacerbated during adolescence. For practitioners, the combination of difficulties engaging with the parents (perhaps because of racist stereotyping), plus Black children developing into adolescence and asserting their independence, can lead to them feeling disempowered and unable to see the children as vulnerable persons in need of safeguarding (Davis, 2022). At least a third of the cases involving Black and minority ethnic children included such complexities, termed by a couple of reviewers as '*stuckness*'. These feelings clouded the needs of the children from professional view. Framing of minoritised victims as acting in ways that put themselves at risk – 'responsibilising' and 'adultifying' them – hinders professionals from offering timely, targeted and appropriate support.

In addition to training and appropriate caseloads, it is important that managers have the confidence to support social workers and other practitioners to be thoughtful, courageous and persistent in cases involving ‘stuckness’.

Four messages from the LCSPRs for good practice

- When working with families whose race, ethnicity, and culture may impact on the quality of care, it is important for practitioners to always consider whether the parents and the young people truly understand the concerns and how services work. Use of interpreters and cultural advisers should always be considered, and provided as a priority when needed.

- To help ensure that children and families from minoritised groups do not receive unequal treatment, a key question to ask is: ‘how likely is it that a white British child or adult in comparable circumstances would receive similar treatment?’ If the answer is less likely, action must be taken to correct this.

- Practitioners themselves have a responsibility to increase their own understanding of how race, ethnicity and culture may impact on the quality of care in the families. Agencies have a responsibility to actively support and challenge staff in this regard.

- Another suggestion was that when circumstances around minoritised children’s needs seem unclear, practitioners should consider and document their hypotheses of the situation, albeit with an acknowledgement that they may ultimately be incorrect. This is a way of helping to clarify their own understanding or lack of understanding, and any learning required.

Chapter 3 summary points

- Racial, ethnic, and cultural identities are often central factors in the daily lives of minoritised people, and should be given proper weight when exploring such children’s lives, in practice and in reviews.

- Working effectively with Black children may require regular training for professionals, highlighting the implications for practice of the children being *invisibilised*, *responsibilised* and *adultified*. Black children must be seen and treated as *children*.

- Cumulative social hazards, including poverty, intra-familial difficulties, learning needs and negative peer relationships, amongst others, are harmful to children.

For some children, the impact of racism magnifies these adversities. All practitioners need to be aware of these interactions and apply the understanding in their work with children and families.

- Poor parental engagement by minoritised parents has been linked with fear, including fear of the power professionals wield. Professionals need to recognise, explore and seek to allay such fear while working with the parents.

- Many practitioners, and reviewers, still seem unprepared to address the racial and cultural needs of minoritised children. Lead professionals and managers have a responsibility to support and challenge staff on this.

Chapter 4: Quality and methods of LCSPRs

This chapter addresses the quality of the LCSPRs and the methodologies and methods they used. It is based on our reading of the documents on the cases in our sub-sample of 20, and is complemented by the views of the partnerships, which are reported in Chapter 5.

The chapter focuses in turn on the voice of the family; the input from practitioners; the clarity of methodologies and methods; the contextual information about the child and family; the different styles of the LCSPRs; and the relationship between rapid reviews and LCSPRs. At the end we offer suggestions from our analysis about what comprises a good LCSPR.

The voice of the family

We assessed the ways that families or young people were involved in the LCSPR, and how their contributions are presented and analysed. In good quality reviews family and young person contributions are clearly visible and analysed, and not just taken at face value.

There was an account of efforts to involve the family in 18 of the 20 LCSPRs in the subsample, although in six of these cases, the families did not respond to the invitation or declined to participate. In four cases, it was stated the family had seen a copy of the report and commented on it or had a conversation with the author, and their views had been included in the body of the report. However, it was not possible in these four cases to determine how the family views had been included or contributed to the learning.

There were often meetings with the parents or other family members, although reviews often commented that online meetings had made the whole process much more difficult. For many stated reasons (non-response, fear of re-traumatisation, wanting to move on from the abuse, would put the child in danger), meetings with children and young people were less frequent. Some reviewers still found very helpful ways to reflect the children and young people's views. Most tried to involve the family, including siblings and grandparents, if not children.

The best examples included young people's views of how they thought they could have been better protected. An excellent example is a review about a case where three girls had suffered a long history of sexual abuse, physical abuse and neglect. They did not want to be involved in the LCSPR, but their voice came over very clearly through victim impact statements and information from relatives. Similarly, a review into the death by suicide of a teenage girl captured her personality through

the letters, emails and texts she had sent, and her friends' accounts. No-one, however, had managed to capture the lived experience of the girl. She had been in care for several years, but there were many missing chunks of information regarding where she was, who she was with, and what might have happened to her. The LCSPR is very good at capturing this loss of understanding of her daily lived experience. It concludes that '*knowledge was often 'lost' as key responsibility for the girl moved within and between agencies, and once she entered care, as she moved physically away from her home area'.*

There were eight cases with good inclusion of information from families or young people; this involved not only asking for comments but presenting these contributions in detail so making clear what families have said. One of these is the case study given in Chapter 2, about the mother who reflected that '*professionals should have been "softer" but also "more persistent" … She thinks that persistence might have been the only thing that could have encouraged her to behave and think differently at the time but she isn't really sure whether this would have prevented what happened'*.

Involving families or young people may be more difficult in thematic reviews, though it is still possible to do this well. A thematic review of criminal exploitation managed to include views both from family members and other young people from the wider peer group. The views of one of the young people has already been quoted in Chapter 3. Here, we show the views of a parent:

> *We had no plan of what this worker was going to do with him, we had no targets as to how we were going to get [him] back into school … we tended to do the same things over and over again because that's all we had. It seemed to be more service-led than being led [by his] needs.*

Young people who had been harmed were often keen to be heard, to help prevent others suffering as they had:

> *[The girl] stated that she had been disappointed that professionals had not identified her distress at an earlier point. She had become uncharacteristically difficult at school, but no one seemed to question why this was the case.*

In this LCSPR the child had suffered sexual abuse at home from a sibling. She did not want her parents interviewed and this was respected, but it could have been very helpful to have their views. This was possibly a lost opportunity.

The quotations illustrate the additional learning that becomes available when families and young people are enabled to contribute to the review process. However, not all information concerning family contributions was helpful; some LCSPRs contained great detail on the process of communication with families which was irrelevant, and

others presented family views uncritically. For example, in an LCSPR of a home educated child who died from suicide, the mother's contribution consisted predominantly of criticisms of the hospital staff who had treated the child on intensive care, but barely touched on more relevant issues such as social isolation in home education.

Practitioner input

We also analysed the ways that practitioners contributed to LSCPRs. This is important as practitioners may have key insights into what went wrong or went well for individual cases, which is vital for making improvements to services. All but one LSCPR referred to practitioner events, but it was not apparent in the vast majority of them (15 of the 19) what had been learned from these events, and how they had contributed to the final report.

A typical description of this is that '*A practitioner learning event was arranged to inform this review, which was attended by the following agencies*….' This sort of description gives no information on the grade of practitioner attending, whether they had direct involvement in the case as workers or supervisors, or if the events were limited to management staff only. It is thus possible that the event may have had participants who were speaking without direct knowledge of the case, particularly if there had been only one practitioner event.

Most LCSPRs also gave minimal information on the findings from practitioner events. Nine LCSPRs in the sub-sample had no practitioner findings visible at all and there were only one or two sentences relating to practitioner findings in four other LCSPRs. However, five LCSPRs clearly illustrated the additional insights available from practitioner events and how this translated into learning. Both quotations below show the additional insights available from practitioners:

> *The Community Midwife told this review that in the last four weeks of Mother's pregnancy Maternal Grandmother attended antenatal appointments with mother. Due to the way Maternal Grandmother had behaved at these, the Midwife had some concerns about the relationship dynamics …[but] did not feel that Maternal Grandmother posed a threat…. however there is no evidence of consideration of … how her attitude to services might influence Mother's response to professional advice.*

> *Professionals responding to the practitioner survey reported varied experiences of using the Resolving Professional Difference protocol. Positively, most professionals knew about the protocol; however, those who had used the process, had mixed experiences of its effectiveness. Some of the feedback includes a perception that its use could create a barrier to*

positive working relationships, and it is a time consuming/ bureaucratic process. This feedback is again relevant to the culture of partnership working.

Learning points

- Family contributions are pivotal in informing learning.
- It is important to know which practitioners have been consulted and how involved with the case they were.

Clarity of methodologies and methods

Reviews are often confused in the way that they speak about 'methodologies' and 'methods'. A methodology is an overriding conceptual approach to the issue under investigation (what do we want to find out about and understand better?), whereas the methods are the 'tools' that one uses to answer the questions – so, chronologies, meetings with the family, practitioner events and so on.

All LCSPRs should use a 'systems methodology' because the goal is 'an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report' (specified in *Working Together 2018*: 92). It is for authors and partnerships to determine which methods should be used within this broad methodological approach. Of the 84 LCSPRs examined, 31 declared a specific methodology or working methods, meaning 53 of the reviews may have given some account or indication of what they did, but not referred to a specific methodological approach. Of the 31 that did, eight suggested it was a 'systems' approach; five said they used the Welsh child practice review model; four suggested they had used a hybrid approach (or we assessed it as such); four said they had used a significant incident learning process, SILP. The remaining ten said they used a range of other methods, such as root case analysis, appreciative enquiry and the SCIE model. It should be noted though that *all* of these are systems methodologies.

Despite the diversity of claimed *methodologies*, the actual *methods* used tended to be very similar: the independent reviewer answered to a 'steering group' or similar convened by the partnership with areas to address usually, but not always, specified in the rapid review; information and views were gathered from the different agencies, in writing; one or more practitioner events, usually online over the last 18 months (but details of which practitioners/agencies not often given). Some described what was done very clearly, others gave little indication of what had been done.

LCSPR methods: an example from one of the LCSPRs of key steps in a review

1. Oversight by LCSPR Panel chaired by Independent Chair of the Safeguarding Partnership and led by an Independent Reviewer.
2. A chronology provided by each agency.
3. Single agency analytical report evaluating their involvement with the family and other agencies, using agency standards.
4. Engagement with family members.
5. Agencies should involve relevant practitioners about the work, decisions and actions, followed by a Practitioner Learning Event to seek the views of practitioners about the work and context.
6. Panel may speak to individual practitioners.
7. The Reviewer may request specific case documents and any relevant policies or procedures.
8. The review should refer to relevant law, guidance and research.
9. The Panel may seek legal advice if required.

We tried to determine whether those that used a specified methodology were able to extract more learning and show deeper analysis than those that did not. From those we examined in our sub-sample, there was no apparent correlation between the different methodologies and the quality of the review, with both good and poor examples being found across the different approaches. In the sub-sample there were three very good examples of LCSPRs. One used the Welsh model, another said it was using a systems-based approach, and the other was a thematic report that did not claim to use a particular methodology.

Learning points

- The terminology around 'systems methodology' is ambiguous, with variation in named approaches yet all with similar working methods.
- Further research could investigate how partnerships and reviewers understand and apply the different methodologies they say they use, especially in their analysis of what happened.

Is there enough family context to support learning?

There is variation in how much history and background the reviews give, and how well this is used to understand the incident or harm in question, and to identify lessons for improving practice. Furthermore, there are different views in local partnerships about how much detail should be included, discussed in Chapter 5.

A good LCSPR should have enough background and family context to illustrate the child's daily life and give the 'voice of the child', but should not have a lengthy, detailed chronology. The point is that the context should be enough to help the learning, but no more. Context-free learning can be bland and difficult to rationalise, whilst too much detail can become confusing and overwhelming.

The majority of LCSPRs in the in-depth sample did include enough context to support the learning; including too much background was more of a problem than not enough. There was adequate detail to understand the events leading to the incident in nine of the 18 LCSPRs relating to individual cases, although few gave any sense of the voice of the child. The length of the background context ranged from 0.5 to 4 pages, although the longer ones often included details of professional interactions whereas the shorter ones focused more on the children and families' experiences.

Most LCSPRs made no mention of ethnicity or cultural issues, so it could be said that the family context was inadequate in most (see Chapter 3).

The different styles of LCSPRs

The LCSPRs varied considerably in how they were written, and how long they were. Most authors were independent reviewers, although some were internal to the partnership and one in our sub-sample did not say. Most were individually authored, but in one a team authorship approach was used. The great variation between the LCSPRs is partly down to the tasks, but the different approaches of the authors seems to be the main factor – a point which was confirmed in the survey and focus group with partnerships, discussed in Chapter 5. There are benefits in having differing perspectives and approaches, but the variability does raise questions for the Panel about the best ways of ensuring high quality reviews

The use of research varied considerably. Some LCSPRs relied on a few short (and expected) references to government reports, NSPCC material, *Working Together*, and sometimes previous Triennial Reviews. Sometimes the research literature used was rather out-of-date, and sometimes mis-cited. However, there were some very good examples of relevant and up to date research.

The reports also ranged in their depth of analysis with poorer examples being superficial and at times not appearing to exercise 'professional curiosity' in the same

way that the practitioners in the case may not have done. We questioned some that seemed to focus on particular issues at the expense of other parts of the picture (as an example, focusing on mothers when males were the perpetrators). The difficulty is that it was not made clear why the focus had been put on these aspects. We also questioned reviews that did not consider ethnicity, disability, cultural or sexual identity issues as being perhaps important to the case.

Some relied heavily on the testimonies of one or two people in the case, without corroborating or challenging them with other evidence. It might be helpful if reviewers could do more to document their own judgement of what they think the real issue is, as that would help them to address the question ‘why’, and then ‘how’ to deal with the problem. We also saw a ready resort to jargon, for example ‘lack of professional curiosity’, without really probing into the underlying system issues.

Good examples however were reflective and analytical. For example, some were excellent in picking up on the ‘unrecognised disclosures’ of sexual abuse that had been missed. Another demonstrates that children who view domestic violence can experience trauma to the extent that it can impact on their behaviour: it shows that when managing children who are presenting with behaviour concerns, schools need to engage with the child to find out the reasons for a change in behaviour. Those that got to the heart of the ‘why’ were more useful than those that looked only at the how or what, better at providing ideas of how practice or systems could be improved.

The better reviews were those that provided meaningful learning for practitioners, were grounded in the findings of the case, showed awareness of current work and were linked to current evidence. Reviews that showed clear themes, or analytically pointed out where errors had been made and how to correct them, were the most useful. For example, one explored the issue of elective home education in depth, how this had contributed to the abuse, and how it might have been handled differently. Another LCSPR we found helpful explored other cases in the locality with similar issues, so it was interested in learning from practice patterns. Under each theme the reviewer asked these helpful questions: How was this issue relevant to this case? Does this happen in other cases? Why does it matter? It also highlighted good practice by the professionals.

Recommendations usually (though not always) followed logically from the analysis, but in some cases appeared to be a list of desires rather than realistic objectives, and many were rather broad. This is another issue that came up in our survey and focus group, discussed in Chapter 5. For example, many recommendations took the form of ‘the partnership should seek assurance’, or just reiterated standard practice:

This review has shown it is essential that professionals utilise the resources available to them to identify, assess and support evidence gathering of childhood neglect.

…the need for comprehensive information sharing within and between agencies.

It is difficult to see what would change in practice from such recommendations. Others were unclear. For example, one LCSPR made a recommendation 'to improve the evidence base', but did not say at whom this was aimed – was the partnership expected to undertake research? Another was very specific, but perhaps not practical, when wanting the partnership to consider an app linking to local services in the area and beyond, staffed 24/7, which should be given alongside a phone, to those at risk or potential risk of suicide.

Recommendations that were specific to the case were useful as these could be followed up. For example, one LCSPR suggested the use of a particular risk assessment tool; another suggests a pathway for GPs to share information about fathers/partners when children are on a Child Protection Plan; or notifying schools when children are linked to MARACs so that the school can contribute to the discussion.

Learning point: There is a wide variation in style and substance of LCSPRs, but reflection and deep critical analysis are key.

The relationship between rapid reviews and LCSPRs

The rapid review and the LCSPR for each case were considered together to identify how much additional learning arises from the LCSPR. This included looking at whether the 'key lines of enquiry' (KLoE) had been met, or if the reviewer had identified other areas of learning. We also considered whether the LCSPRs identified any new learning that had not been recognised previously.

Approximately half of the LCSPRs in the in-depth sample identified additional learning when compared to the rapid reviews, although some of the rapid reviews were very brief as it appeared that their only conclusion was that an LCSPR was required. Few LCSPRs identified issues about the case that were previously unknown. If only half of LCSPRs identify additional learning, then it would seem that safeguarding partnerships could commission significantly fewer LCSPRs without losing the possible benefits.

Not all rapid reviews set out a clear remit or KLoE for the LCSPR. When they did, some LCSPRs followed them to the letter, but in other cases they were not followed. One review gave a very specific remit for conducting the LCSPR, including using the

Welsh practice review model, specifying that the reviewer needed expertise in working with autism, learning disabilities and gender identity, and suggesting which agencies should be involved. At the end however, the LCSPR offered fairly minimal additional insights to that from the rapid review, with the exception of some additional information from the young person.

The quality of the LCSPR did not necessarily relate to whether detailed KLoE had been followed. As an example, a rapid review on a case involving a stabbing and gang involvement ran to 66 pages, but it set out a very vague remit for the LCSPR. However, the LCSPR extracted some very clear KLoE from it, and addressed these systematically and thoroughly.

On the other hand, some departures from the KLoE did impact on review quality. One review concerned two (unrelated) cases of non-accidental injury. The rapid review set out very clear KLoE that asked the LCSPR to focus particularly on two questions: Who were the males involved in the lives of the children? And how was the decision made to proceed to ICPC (Initial Child Protection Conference)?

The LCSPR instead focused on the mothers of the two children, when in both cases the father was the perpetrator. Only half a page of the report refers to the hidden men issue, and the LCSPR does not add any more to the ICPC issue than was already in the rapid review. In another example, a suicide in a Jehovah's Witness family, the LCSPR becomes dominated by the mother's account but does not address the question from the rapid review about how services were kept out of the family. In another example the rapid review had given a remit to address the sharing of health information and the input of health services. The LCSPR instead focused mainly on schools, and largely repeated the findings from the rapid review.

Some LCSPRs had hugely wide KLoE that were in effect asking the review to consider every aspect of multi and single agency working, almost inevitably leading to a superficial analysis only. For example, in the case of a young man involved in criminal activity, the KLoE included:

> *His background/experience, acknowledgement of good practice, responses to missing episodes, responses to offending behaviours, supervision and oversight, safeguarding practice, overall effectiveness and criminal exploitation.*

This LCSPR was a total of 18 pages long, so in that space there was little scope to go beyond reporting what actually happened, to try to understand why. Analysis of one or two of these topics in greater detail may have provided more useful insights.

In some cases, it was apparent that there was a key practice episode when, if an alternative decision had been taken, the outcome of the case could have been

different. Although recognising these key practice episodes is an exercise in hindsight, reviewing them in detail as a main focus of reviews could generate significant learning. An example is the case of a young person at risk of criminal exploitation who had made good progress in residential care so was returned to his family, despite no changes in the home circumstances. He was subsequently exploited and suffered life-changing injuries. Understanding why he was returned to his family, given the unchanged risks, would have been impactful. Similarly, in the case where a girl had been sexually assaulted by her brother, there was an incident where blood was found in her brother's bed and her underwear. Although this was investigated by social care, there was no further action and the young person continued to be sexually abused at home. Understanding why practitioners did not recognise the likelihood of abuse in this scenario could have offered significant new learning.

Learning point: There was not always clarity or consistency between rapid reviews and the key lines of enquiry for the LCSPR, but this does not automatically lead to better or poorer LCSPRs.

What makes a good review?

From our analysis of the LCSPRs we have drawn together the features of reviews we found most helpful. We emphasise that this should not become a checklist, because not every point will apply to every LCSPR (in particular, they may not all apply to thematic reviews, many of which were extremely helpful).

First, there needs to be careful consideration of whether an LCSPR is required to bring any necessary additional learning; our analysis would suggest that currently only around half of LCSPRs achieve this.

Reviews should contain enough detail on the context of events so the reader can understand what happened and why, without so much detail that readers become lost in the narrative. Contexts can only be understood when issues around race, culture and other key identity characteristics are included and analysed.

Thematic reviews provide a helpful way of enabling themes and learning across cases but have the same requirement as single case LCSPRs for a sharp focus, succinct description of context and clear analysis.

Features of the most helpful reviews

- Where LCSPRs deviate from the key lines of enquiry outlined in the rapid review they explain why and set out new ones.
- Where rapid reviews have been unclear in setting out the remit for the LCSPR, the LCSPR still agrees key lines of enquiry at the start.
- Every effort is made to include family and young people's views in LCSPRs, unless there are compelling reasons not to do so. Family contributions are readily visible and used to inform learning.
- Details of how practitioners' events took place is provided and findings from these events are clearly visible, along with the grade and role of practitioners as insights from frontline staff and management may differ.
- Methods are described in sufficient detail to know what was done and how.
- Whatever methods are used, every effort is taken to ensure the review gets to the 'why', not just the how and the what.
- There is sufficient context provided to understand the family and child circumstances without providing so much detail the clarity is lost.
- Deep consideration is given where there are potential issues around race and culture, and other characteristics such as gender, disability and sexuality.
- They are succinct and factual, backed up by rigorous reflection and analysis.
- They refer to published research relating to themes and learning identified, which may be particularly relevant for thematic LCSPRs. It is also important that research cited reflects the current evidence-base rather than selective citations.
- There is consideration of other recent cases in the locality and nationally as comparisons.
- Recommendations are few, clear and focused, and can lead to action plans that are SMART: specific, measurable, achievable, realistic and time-bound.
- They provide meaningful learning for practitioners.

The main aim of LCSPRs is to promote learning, as a basis for better practice and any necessary changes. If the learning is not visible in the LCSPR then the process has not been effective, and children will be no safer.

Chapter 4 summary points

- In high quality reviews, the contributions of the family and young person, and of practitioners, are clearly visible and analysed, not just taken at face value.

- LCSPRs should use a systems methodology, but understandings of this were uncertain. A range of named and alluded methodologies were offered, but most used the same *methods* to undertake the review. There was no apparent correlation between specified methodologies and the quality of the review.

- There is wide variation in style of writing, length of reports, grounding in evidence, analytic detail and clarity of learning. The main factor for the quality of the review is what the individual author brings, their skills and approach.

- Clear key lines of enquiry from the rapid review that provide the opportunity for new learning are most helpful.

Chapter 5: The impact of LCSPRs on practice

This chapter examines the impact of LCSPRs on practice. It identifies how local safeguarding partnerships are disseminating, implementing and monitoring practice changes made in response to LCSPRs. In doing so, it explores partnerships' perspectives on whether the LCSPR system is achieving its stated aims. This chapter draws on findings from an online survey completed by 22 safeguarding partnerships, a focus group and a review of partnership websites. These examined how partnerships translate recommendations for LCSPRs into actions to improve local practice. This chapter is structured around three key themes in relation to impact:

- The relationship between LCSPR quality and impact
- Methods for implementing learning from LCSPRs
- Monitoring and measuring impact

Methods

The sample consisted of 20 LCSPRs from the 2021 sub-sample, plus four reviews that had been completed prior to 2021, so had benefited from additional time to achieve impact. First, a review of the partnership websites (n=24) was undertaken focusing on evidence of impact. There was great variation between partnerships' use of websites to publish impact plans. This was explored more deeply in the focus group. Secondly, an online survey was sent to the safeguarding leads/managers of the 24 partnerships. Twenty-two partnerships (92%) agreed to participate and two did not respond. The questionnaire provided a picture of how learning from the LCSPRs was implemented at a local level. A thematic analysis was undertaken, identifying areas of inquiry for the focus group. Thirdly, an online focus group was conducted with 22 participants who were either leads or nominated deputies from the partnerships. This explored factors that aided or hindered impact from LCSPRs. The focus group data was transcribed and analysed thematically.

The relationship between LCSPR quality and impact

Chapter 4 of this report examined the quality of LCSPR reports identifying a wide range of different methodologies and approaches. A number of these points were echoed by the safeguarding partnerships. They identified a direct link between the quality of the LCSPR and its usefulness in terms of achieving meaningful impact on practice. In their responses in the online survey and focus group, partnerships identified the following three aspects of quality as crucial to generating impact:

- Style of the report
- The skills, availability, independence and role of reviewers
- The quality of recommendations

Style of the report

A recurrent theme from partnerships was that the style of the report affected the extent to which the LCSPR could lead to learning and meaningful practice change. Partnerships generally welcomed the switch from SCRs to the new-style LCSPR process. Chapter 4 identified that a good LSCPR has enough background and family context to illustrate the child's daily life and show the 'voice of the child' but does not need a lengthy chronology. This view was shared by partnerships, who saw the move from SCRs to LCSPRs as a shift from case description to learning. This in turn could make LCSPRs more accessible as tools for practice:

> *… The new framework gives us much more flexibility and reviews can be very different... this allows us to take more a pragmatic approach… cutting out unnecessary narrative is hugely helpful because what we're trying to do is make them really accessible as tools of learning... (Focus Group)*

Partnerships identified that avoiding excessive narrative and description could prompt greater analysis and more helpful recommendations:

> *… You're not putting in 'they went to this appointment and that appointment'... you don't need 30 appointments listed, which I think a lot of reviewers used to do previously. I think it's really important that the LCSPRs give us that chance to move away from the family to the system... (Focus Group)*

There was also a strong feeling among many partnerships that the reduced chronology of the LCSPRs remedied some of the ethical issues with the old-style SCRs, the latter of which could slip into reviewing families' lives rather than safeguarding practice:

> *This is a safeguarding review...this is not a review of somebody's life and the mistakes that they have made through their journey… (Focus Group)*

There were concerns that lengthy chronologies of families' histories could be inadvertently identifying, damaging and even re-traumatising to the family:

> *They (LCSPRs) are a lot less traumatic on the family because it's awful having those exposing details out in the public eye, even if it's anonymised... it felt like old SCRs were re-traumatizing families. I'm happy that we're finally stepping away from that... (Focus Group)*

While the pared-back approach of the LCSPRs was generally welcomed, there was some debate about whether this could be taken too far and could de-contextualise learning – a concern also identified in Chapter 4. De-contextualising learning could limit impact. For instance, LCSPRs were often used as a teaching tool in professional training for health and social care staff. It was thought that LCSPRs with short or absent chronologies could be more challenging to use like this, as it was difficult for practitioners to make links to their own practice. The emotional impact of hearing the family's story was also an important catalyst for reflection which was lost in shorter reports. One participant described the challenges in using very short LSCPRs when creating a new professional development module:

> *… where I got completely stuck was with those short reviews - 6 to 10 pages long - because you cannot tell the story of the child - that emotional connection… The more you get into the lives of these children you know what the gaps were in terms of practice and systems. (Focus Group)*

The different views show the subtlety of the issues. For many partnerships, there was an ongoing process of experimentation as they moved from SCRs to LCSPRs. Ensuring that reviews were useful in terms of impact meant balancing sufficient chronological detail to allow the findings to be useful without losing the emphasis on learning.

The skills, availability, independence and role of reviewers

Chapter 4 identified variation between review authors. Similarly, safeguarding partnerships identified that in terms of generating impact, the methodology stated for the review was less important than the approach and skills of the reviewer. There were difficulties and tensions in recruiting reviewers with the availability, suitable skills and independence to draw out relevant learning which could be readily translated into a local action plan.

The difficulty of finding sufficiently skilled and experienced reviewers was a widespread issue. Partnerships described a range of strategies for recruiting reviewers which ranged from personal recommendation, re-appointment of previous reviewers and light-touch screening processes. The timescales for LCSPRs meant that this had to be accomplished rapidly. Partnerships identified an urgent need to develop a pool of suitable reviewers and some described using existing reviewers as mentors for other reviewers, to ensure that good practice could be continued. A need to develop training for reviewers was identified by several:

> *We need some training to build a larger cohort of skilled independent authors, I have been looking for training and cannot find any! (Focus Group)*

Despite these challenges, many partnerships were positive about their experiences with reviewers (see next section).

Learning point: Safeguarding partnerships highlighted an urgent need to increase the pool of suitably skilled reviewers.

Chapter 4 identified that while some reviewers were internal to the partnership, most authors were independent reviewers. Partnerships acknowledged that independence was important but there was some debate about what constituted a sufficiently independent reviewer. Whilst some partnerships considered reviewers to be independent if they had no contact with the case, others did not feel this was sufficiently independent. Others felt that the push from the national Panel was to use internal reviewers. Partnerships reported that in many cases, the decision to use a reviewer from within the partnership was a pragmatic one, influenced by availability and capacity issues.

The quality of recommendations

Partnerships had a clear sense of the types of recommendations which were useful for achieving change, which mirror the findings of Chapter 4. In the online survey, 68% of participants rated the recommendations from the selected LCSPR as 'useful' or 'very useful' - the others said they were neutral or of some use. Where partnerships found recommendations useful, it was generally because they could readily be translated by the partnership into a SMART action plan. The concept of SMART action plans was repeatedly emphasised by partnerships as key to achieving meaningful change. Particularly useful recommendations were developed in a cross-border review which allowed learning from neighbouring partnerships:

> *By undertaking a cross-border review, we were able to look at it the holistic context... It was recognised that these complex issues are not constrained by local authority borders and require a different approach to other safeguarding issues. This review allowed us to learn what is working in neighbouring partnerships and which approaches we are able to grow. (Survey)*

Of the 32% of survey respondents who identified the recommendations in the selected LCSPR as being only of neutral or some use, this was usually either because the recommendations had already been implemented by the time the review was completed, or because they were 'not easily converted into SMART actions' (Survey). As Chapter 4 highlighted, where recommendations were more general this made generating an action plan more difficult.

Recommendations were also less useful where the reviewer targeted areas of practice or agencies that were outside the partnership's immediate control:

> *One review recommended that NHS England need to change their policy position…You end up in this impossible position where you have to evidence you are trying to work towards the recommendation... (Focus Group)*

This was echoed in several responses in the online survey. Partnerships struggled to generate impact from recommendations which focused on what one partnership manager described as the 'macro challenges'. Macro level issues included the following topics: national suicide rates among young people, young people's mental health, young people who receive lengthy custodial sentences and adolescent exploitation. These were identified by partnerships as requiring a national, rather than solely local, response:

> *Issues picked up locally that require national response... some key themes repeat locally because it's not addressed at the national level... there is a piece of research to be done in terms what have the local partnerships reported as national issues and what proportion of that is being ignored. We need clarity around that. (Focus Group)*

Some partnerships felt that they would like a clearer sense of decision-making and how issues they reported were being addressed at a national level:

> *The flow between local and national at the moment - it feels very top down... (Focus Group)*

A related, further difficulty with recommendations and their usefulness reported by the partnerships was that they appeared to be cyclical. It was suggested there was too much emphasis on the wording and style of recommendations when the systemic /structural conditions in which they had to implement the recommendations were the major barriers to change:

> *...It's less of a problem with the recommendations or the formats of the reviews, and more of a problem with making real change... Instead of focusing on tweaking the reviews or the detailed recommendations or who does the review in the first place, it's more about how do we get… to resourcing our social workforce and frontline nursing teams and allowing them some… space to develop practice and take a breath.... (Focus Group)*

Implementing recommendations from LCSPRs

This section examines how partnerships are implementing learning from LCSPRs in practice, focusing on two key areas:

- The relationship between rapid reviews and LCSPRs in relation to impact
- Methods used by partnerships to implement learning from LCSPRs

The relationship between rapid reviews and LCSPRs in relation to impact

In terms of additional understanding of the issues, 21 of the partnerships responding to the survey said that the LCSPR offered additional findings to that of the rapid review. Partnerships also valued the way that the LCSPR process provided opportunities to work with young people and families to understand their experiences. Partnerships said that compared to the rapid review, the practice review process allowed greater insight into the *why* questions behind the initial findings. The partnerships' perspective does differ from our analysis of the rapid reviews and subsequent LCSPRs, reported in Chapter 4. Our analysis found that only around half of the in-depth sample of LCSPRs identified additional learning compared to the rapid review. This difference suggests that possibly more learning goes on than is captured in the final report, and is one of the reasons why a deeper study of the process of undertaking a review is likely to be useful.

In terms of impact however (rather than understanding), many partnerships found that the LCSPR offered little in addition to the rapid review. Nineteen survey respondents (86%) indicated that learning from the rapid review had already been implemented prior to the later LCSPR. There were therefore some concerns among partnerships about duplication between the rapid reviews and LCSPRs. Several partnerships identified a need for greater clarification around when an LCSPR was required:

> *The guidance needs to be updated to clarify… the criteria for… whether to undertake a LCSPR… as it is not consistent, or understandable in some cases. (Focus Group)*

However, other partnerships acknowledged that while duplication between rapid reviews and LCSPRs could be an issue, this was in part related to the transition from SCRs to the new system and that the distinction between rapid reviews and LCSPRs was becoming more clear. Several partnerships identified that thematic LCSPRs in particular offered additional value to rapid reviews: for instance, one partnership described using an LCSPR to synthesise learning from seven rapid reviews.

Learning point: Safeguarding partnerships found that when conducted well, rapid reviews could lead to useful recommendations and impact, without the need for an LCSPR.

Methods used by partnerships to implement learning

The first stage of implementing learning was to convert recommendations into SMART action plans. Involving local agencies was generally seen as key to this:

> *There is a full action plan developed from the recommendations/challenges... a reference panel with representatives from the statutory partners... is ensuring that these are actions are SMART and addressed. (Survey)*

Implementing learning often began with a broad multi-agency learning event which served a dual purpose – to identify SMART goals and to disseminate learning. These learning events typically included breakout groups so that each agency could consider the most effective strategies for embedding the learning from the LCSPR into their practice. In addition to these initial learning events, partnerships described a wide range of methods for disseminating and implementing learning.

Generating impact from LCSPRs

Safeguarding partnerships used a range of strategies to disseminate and implement learning from LCSPRs. These included:

- Training modules for Newly Qualified Social Workers
- Refresher training
- Additions to yearly Training Needs Analysis procedures
- 'Bite-sized' approaches, including 'seven-minute briefings', 'lessons learned' briefings and short YouTube videos
- Use of partnership websites to publish bite-sized approaches
- Creation of dedicated posts to disseminate learning or to address gaps identified in the LCSPR
- Dedicated learning events based on a single LCSPR
- Themed learning events based on several LCSPRs and messages from the national Panel
- Taking learning to busy teams e.g. trainer attending a team meeting
- Using professionals' existing dedicated learning time to present key learning (e.g. GPs' designated CPD days)

Multi-agency and themed audits

There was discussion among partnerships about how learning could be effectively embedded into everyday practice. Approaches that made use of existing CPD time were key as they did not place additional burdens on professionals' limited time. 'Bite-sized' messaging was recognised as a useful strategy for embedding learning;

practitioners were provided with short briefings detailing the key changes necessary and were then signposted to additional resources:

> *We make the use of 'lessons learned' briefings, which we use to provide a synopsis of the back story... and we then present that with the key learning points that are identified from within the context of that story… and then signpost individuals to resources… to better improve and further their understanding of those specific areas... (Focus Group)*

In some cases, partnerships used their website to make learning briefings available. These briefings took various forms, from narrated presentations to one-page summaries distilling key points from the LCSPR. However, there was great variation between partnerships in terms of their approach to publishing learning. Of the sub-sample of 24 cases analysed for impact, only 11 had an online learning briefing that was clearly linked to the LCSPR. Other references to learning could be found in published annual reports.

Within the 84 LCSPRs reviewed in this study overall, it was generally rare to find more specific and targeted actions or action plans. This was explored in the focus group, which uncovered different viewpoints. There was a view that that while general learning or recommendations could be published, action plans were not always suitable for publication. One explanation offered was that the action plan was a 'working document' rather than a static list of items to be achieved. One participant referred to the sensitivity of action plans, particularly when specific improvements to multi-agency practice were identified, many of which may not be resolved at the first attempt. However, other partnerships expressed different views, arguing that action plans made on the basis of the LCSPR should be available on the partnership website as a matter of course:

> *I think it really should be included in the national Panel practice guidance that you include your action plan. (Focus Group)*.

Monitoring and measuring impact

This section focuses on how partnerships measured and reviewed the impact of LCSPRs on practice and the challenges involved in this process.

All of the survey respondents indicated that there were plans in place to regularly monitor the implementation and impact of LCSPR recommendations. However, the strategies used to monitor progress varied between partnerships, and the different methods included:

- Practitioner surveys (including adding additional questions to existing practitioner surveys)

- Multi-agency and themed audits
- Use of the LOGIC model from What Works for Children's Social Care to evaluate outcomes
- Site visits for a 'deep dive' into practice
- An iterative process of dissemination and review
- Agency self-assessment audits
- RAG (Red Amber Green) rating in relation to evidencing recommendations

Within these varied approaches, multi-agency and themed audits were frequently mentioned:

> *Partnerships used multi-agency audits to explore and measure implementation of specific areas of learning - for instance, a 'voice of the child' audit. (Survey)*

Recognising the limitations of 'one shot' learning, partnerships typically engaged in an ongoing process of dissemination and review. First, learning was implemented via the methods described earlier for generating impact. Secondly, the impact was measured using the monitoring approaches identified above. This allowed partnerships to identify areas where more work was needed to ensure the new learning was fully embedded. This would trigger a new round of implementation and improvement:

> *First, we share the story and the learning through multi-agency and single agency forums e.g. multi-agency lunchtime forums, schools safeguarding forums and GP forums. Secondly, we circulate Quick Reference Learning Sheets for each case and agencies are required to disseminate these with discussion within their own organisations. Thirdly, after 2-3 months, we ask for evidence on how the agencies have disseminated this information. Fourthly, we carry out a survey and focus groups with a wide range of staff across the partnership to find out if they recall the learning and seek evidence of how they have applied this to their practice. A report is then produced for the Quality Assurance Subgroup outlining examples of good practice and areas for development within agencies. (Survey)*

Development of staged, cyclical models for generating, measuring and reviewing impact were developed at an individual partnership level. In the focus group there was a great appetite among partnerships to share these models of reviewing and measuring impact. There were requests to share specific quality improvement methodologies. One partnership told how they had developed a model for implementation and monitoring which in turn was used to inform the commissioning of local services. This was planned as a long-term, five-year cyclical model:

We are sending out the self-assessment framework out to our providers next week, so this is our first go at this. It includes… learning from the statutory reviews as well as various other quality markers. It's around the impact of what that learning has achieved... We're then going out to do a quality visit to really dig deep... so we'll be talking to people on the wards, people in the community, patients and service users... The learning that comes out of that will then inform our quality schedules for contracting for the following year, so that we have a cyclical event of learning. This is so we can be reassured that learning has been embedded and there are changes in practice. Then, if there aren't, it will go into the quality schedules for the following year... we have a five-year plan of development. It doesn't have a name because we've made it up ourselves. (Focus Group)

There was a sense that partnerships were engaged in active experimentation and 'doing their own thing' in relation to longer-term, cyclical models of generating and measuring impact. It may be that a series of knowledge-exchange events between partnerships would be useful to share learning.

Challenges in measuring the impact of LCSPRs

While the auditing and cyclical process of monitoring were identified as being helpful, partnerships experienced two common issues in measuring impact from LCSPRs. The first was measuring long-term, sustained change:

[We need to] show where the changes have occurred and how it's being sustained or embedded over a longer period of time... Partnerships are great at acting on the learning initially and putting actions into place and saying that they've been completed, but they need to continue at a later period of time. So, it's how we capture that. (Focus Group)

The second issue was the difficulty of measuring cultural change, particularly in relation to frontline practice. LCSPRs generated important learning for direct practice with service users. Partnerships used surveys and site visits, talking to practitioners to capture and assess the changes to their direct work. However, partnerships also recognised that the nature of changes to face-to-face work with families could not always be captured through audits or practitioners' accounts of their practice:

… in reality, understanding the quality of practice in human relational services requires a lot of observation and time spent alongside someone in those one-to-one transactions. I think it's quite a foggy area to do quality assurance in. (Focus Group)

Learning points: Measuring impact and practice change from LCSPRs

- Partnerships used a range of methods to measure impact and practice change from LCSPRs. Multi-agency and themed audits were popular alongside cyclical, iterative cycles of dissemination and evaluation.
- Partnerships encountered challenges in measuring long-term cultural change as well as changes to frontline work with families.
- There is an appetite among partnerships to share and develop impact strategies.

Chapter 5 summary points

- Partnerships identified a direct link between the quality of the LCSPR and the potential for impact. Crucially, LCSPRs needed to contain recommendations easily converted by the partnership into SMART action plans.
- The more concise approach of LCSPRs (compared to SCRs) was identified as more useful for achieving impact. However, some concerns were raised about the transferability of 'decontextualised learning' from shorter chronologies and loss of the child's story.
- Recommendations which focused on 'macro level' issues beyond the control of the partnership were less likely to lead to impact. Partnerships would welcome additional opportunities to raise these with the national Panel.
- Partnerships identified an urgent need to develop a wider pool of suitably-skilled reviewers at a local and national level.
- Partnerships favoured 'bite-sized' approaches to disseminating learning from LCSPRs, but recognising the limitations of 'one shot' learning, partnerships said that they typically engaged in an ongoing process of dissemination and review.
- Additional opportunities for knowledge-exchange between partnerships would be useful, particularly in relation to models for generating and evidencing impact.
- Partnerships favoured the use of multi-agency and themed audits to measure practice change. However, they identified difficulties evidencing impact in relation to long-term cultural change and changes to face-to-face practice with families.

Chapter 6: Conclusions

This chapter brings together the learning from the various components of our study, focusing on core questions about the publication, commissioning and quality of LCSPRs. Following that, we summarise the key learning points for the national Panel, safeguarding partnerships, and individual reviewers.

The publication of LCSPRs

Our study of LCSPRs has raised two sets of questions about publication: first, about the numbers that have been published so far and the length of time it is taking to reach publication, and secondly about the balances between confidentiality, transparency and potential learning.

As noted in Chapter 1, we understand that at the end of 2021, a total of 372 LCSPRs had been initiated since they started in 2018. Of them, 117 had been completed and submitted to the Panel by the end of 2021. We were told that 75 had been published and three were not going to be published, so there were 39 still awaiting publication or a decision on that. Of the other 255 reviews, we could not expect any from the second half of 2021 (because they have six months to be completed), and it is possible some had been completed but were awaiting publication and had not been sent to the Panel (under *Working Together 2018*, partnerships are not *required* to inform the national Panel or the DfE when they have completed their LCSPRs, only to send a copy of the full report to them no later than seven working days before the date of publication). In summary, there were 294 out of 372 LCSPRs 'in progress', in the sense that they had not been published or had a decision not to publish.

There were delays due to the pandemic and the Panel did allow some leeway for that. However, the Panel's view is that the delays usually seem to be due to other factors and can be lengths that they consider unacceptable.

The importance is, of course, that delays in publication mean delays in disseminating the learning and making any necessary changes. Having said that, we are aware, from comments in some of the LCSPRs and in our survey and focus group, that it is likely some changes will have already been initiated, in the light of the rapid review. Partnerships and reviewers should be clear to specify this in any LCSPR or action plan. But more than that, it may not be necessary to call an LCSPR if the rapid review has already identified relevant learning and the partnership is following through on it, with dissemination of the messages and a clear action plan as necessary to achieve the changes.

As regards the questions about confidentiality and sufficient material for accountability and learning, we are aware from reading the reports, our survey and

the focus group, that partnerships and reviewers take these issues extremely seriously. They want to be transparent about what has happened, but are concerned to safeguard the privacy of the family and individual practitioners. Even though reviews can be taken down from partnership websites after a year, they remain in the NSPCC repository, and most were still on the partnership's website.

The Panel emphasises the importance of LCSPRs being written for publication. They say they very rarely agree with a partnership wanting not to publish or to publish anonymously, but the decision ultimately rests with the partnership. The Panel is aware that 12 LCSPRs have been published anonymously and a further three with only an executive summary. If a partnership intends not to publish, the Panel tells us that its usual response is to suggest that the report be revised in order that it can be published without harming the child or other people.

The Panel's position is that the key consideration should not be 'could this child or family be identified?' but 'is there any potential for harm to the child/ family/ anyone else in what is being published?'. If there have been criminal proceedings then it is likely a lot of material is already in the public domain. Of course we would expect child welfare professionals to have a rather different set of principles about publication to journalists reporting criminal cases, but there is a delicate balance between children's privacy (now and throughout their lives) and public accountability. A greater use of thematic reviews rather than individual case-based reviews might be one way to reduce the risks of identification, as well as generating learning that is more readily transferable to other cases.

The points raised in the chapter on race and ethnicity are also pertinent here. We appreciate it raises challenging issues for partnerships and reviewers, about confidentiality and fears of 'getting it wrong' and causing offence, but if we are to learn how to better safeguard minority ethnic children and support their families then it has to be addressed explicitly. Indeed, the point also applies to disability, gender, sexuality, identity. Furthermore, it is not simply a matter of stating the ethnic background (or disability, sexuality etc), but of applying it to the analysis of the child's life and experiences – what did it mean for their day-to-day life, and for the relevance and helpfulness (or not) of the services they received?

The Panel's view is that the task is to keep the emphasis on learning for practice, including only the relevant contextual/factual information to enable readers to make sense of the learning. At times there may be different views about what is 'relevant', but then the task is to discuss them in the spirit of 'resolving professional differences' (see Chapter 2). If that is achieved, the question about potential harm could be adequately addressed.

Deciding whether to commission LCSPRs

The Panel's view is that there are too many LCSPRs and too many that are of poor quality, and they would rather see a smaller number, more focused and of higher quality. We agree with this. The key requirements to achieve this are to have an effective rapid review and strong decision-making about the potential gains from commissioning an LCSPR; clarity from the rapid review about the key lines of enquiry; the appointment of a skilled and knowledgeable reviewer; and a cross-agency commitment to timely publication.

As regards the rapid review, we are aware that it can be hard for partnerships to complete as full a review as they would like within the three-week timescale. This time limit is not a statutory requirement, and it has been suggested that slightly longer is allowed for rapid reviews, so that they can address more of the immediate issues, and thus reduce the number of cases that go to LCSPRs. The Panel has resisted this, as discussed in the 2019 practice guidance (p. 15). Their view is that the quality of rapid reviews does not seem to be related to the time taken, and typically the better ones are completed on time. They say they are prepared to be flexible and give partnerships longer if it is clear they can achieve the learning with a bit more time, or if, by doing a slightly more thorough rapid review they could avoid the need to progress to a full LCSPR; however, the Panel wants to keep the emphasis on timeliness and learning.

In terms of the decision-making about whether to call an LCSPR, partnerships are not obliged to call one if the criteria are met, but the criteria do make it rather hard to say no. The overall purpose of a review is to identify improvements to practice (*Working Together 2018*), and the criteria include that the case 'may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified'. It must be very hard, professionally and emotionally, to say or imply that there is no learning to be had from the death or serious harm of child or young person, and even more so if it does not have to be new learning, but could have been previously identified.

Calling an LCSPR also brings the opportunity of hearing from the family and practitioners, and a published report. Those are advantages over a rapid review, but it still has to be proportionate to the potential for learning. A clear summary of the learning from the rapid review and the actions to be taken from it could be published, which would meet the need for learning and accountability in most cases.

The Panel's position is that on the whole they see it as the partnership's decision to call or not to call an LCSPR, unless there is a strong reason to counter it, since the partnership will have a more thorough understanding of the context and circumstances and it is they who will need to follow through on it.

The key areas where the Panel will question a decision to call an LCSPR are (a) where the case does not meet the criteria for notification (this may only be apparent after completing the rapid review) – i.e. the child has not died or been seriously harmed, or there is nothing to suggest maltreatment may have contributed to the death/serious harm; (b) where the rapid review has already identified relevant learning and the partnership is acting on it; (c) where there does not appear to be any potential for further learning, particularly where the partnership themselves have already done one or more LCSPRs on similar cases, or where there has been a national review.

The Panel tells us that the proportion with which they disagree has dropped substantially since the first two years. They see this as a reflection of growing confidence and clarity among the partnerships in their decision making; the improved quality of the rapid reviews; and a clearer understanding now that any further review of the case beyond a rapid review should be considered an LCSPR, and not an 'alternative learning review' or any other terminology. The Panel emphasises the benefits of treating it as an LCSPR in a number of respects: ensuring transparency, that it will be undertaken with a view to publication, and that it will engage with the family and practitioners. If the relevant learning has already been identified and there is no need for a further review, the dissemination of the learning should be referred to as that, 'dissemination of learning', not an LCSPR.

The Panel also tells us that when a partnership has decided to commission an LCSPR they will usually ask them to consider how they can keep it focused, and will often challenge them to reduce or clarify their terms of reference/key lines of enquiry.

The quality of LCSPRs

In our 2020 annual review of rapid reviews and LCSPRs, one of our conclusions was that '*The experience of conducting and writing them is still very limited … Our sample is a snapshot of a new system bedding in, and it ought not to be too surprising to see old approaches still in place, and signs of uncertainty about the new requirements ... experience and understandings of the new system are still evolving, and of course there has been a global pandemic to contend with*' (Dickens et al 2021: 49).

Having reviewed the LCSPRs from 2021, and having had our focus group discussion with representatives from 22 partnerships, we consider there is still truth in that observation. It is still relatively early days, but there is evidence that the new ways of thinking about reviews and learning from them are taking hold. That is also the view of the Panel. They consider that there is still too much of the old-style SCR approach, and change is taking time, but generally there appears to be a better understanding of the new system.

The Panel works to help raise the quality of reviews though regional seminars, in individual feedback to and discussions with partnerships, webinars and their newsletters.

There are a number of dimensions to ‘quality’, as we discussed in Chapters 4 and 5: for example, the links with the rapid review, the amount of detail and background, and the use of research. We raise four key points here: the importance of the individual reviewer, his/her knowledge and skills; the clarity of the methodological analysis; the importance of a clear action plan; and the need to focus on practice.

In terms of the individual reviewer, the partnerships and the Panel have told us about the difficulties of appointing suitably experienced and skilled reviewers. It is not a requirement for the reviewer to be external to the partnership agencies, but to be independent of the management of that particular case. This means that partnerships can take a proactive, developmental role in recruiting in-house reviewers and helping them to develop the necessary skills – ‘growing their own’. Having said that, some participants in our focus group expressed doubts about the ‘independence’ of someone who works within the partner organisations. One possibility could be reciprocal arrangements with other partnerships.

The government’s response to the criticisms of SCRs in the Wood report (2016) included a commitment to ‘improve the speed and quality of reviews, at local and national levels, including through accrediting authors’ (DfE 2016: 7). An accreditation system is not a goal for the Panel at the present time given the recruitment difficulties, and they are focusing on training and reflection with local partnerships on what makes for a high-quality review.

At the heart of a high-quality review is the methodological analysis. Researchers often distinguish between methodology and methods. As we discussed in Chapter 4, a methodology is a conceptual understanding of the problem being investigated, the questions one is interested in, the sorts of information one is looking for and how the data will be analysed. The methods are the specific steps that follow from that, the tools to get the answers.

For LCSPRs, the goal is to identify and analyse ‘any systemic or underlying reasons why actions were taken or not’ (*Working Together 2018*, page 92). The central issue is to understand the actions and decisions of individuals in context (which includes understanding the actions and decisions of the parents and young people, as well as frontline practitioners and managers). It is to get a better understanding of the dynamic relationships between individuals and the wider social, organisational and professional systems in which they live or work – how does the context shape the individual, and how therefore could the context be changed to help individuals to act and decide differently.

The various methods used in the LCSPRs – written summaries, interviews with parents and young people, practitioner events, meetings with an advisory group and so on (discussed in Chapter 4) – are steps for gaining that understanding, but they are not the ends in themselves. The important point is the analysis.

On this, our key observation, shared by participants in the focus group, is that the individual reviewer matters most for quality. The focus group discussion showed there are differences in the roles they take on, and ways they undertake them. We suggest that this could be the topic for further research that would be extremely useful, not only for understanding LCSPRs but for a range of other reviewing-type roles in public services.

The LCSPR should produce a limited number of focused, realistic recommendations, which can then be translated into specific and achievable action plans ('SMART' plans). Partnerships emphasise the importance of the action plan, but our reading of the reports and search of the websites showed that it is unusual to find an action plan attached to an LCSPR. We think it would be helpful to publish the action plans alongside the review, as a clear demonstration of the partnership's commitment to put the lessons into practice, and as a form of accountability. Also, it is a way of enhancing the 'quality' of the review – even if the report is weak in some respects, it will still bring benefits if the partnership can draw relevant learning and plans from it.

Finally, as noted in Chapter 2, we found that day-to-day practice is often under- or even un-explored in the reports, which are more likely to focus on organisational issues. In our 2020 review we suggested that one factor behind it could be the reluctance to blame individuals: '*we have found that reviews are careful not to identify individuals as culpable; that is welcome, although arguably a consequence of this caution has been the notable shortcomings of reviews not pursuing the really hard questions about 'why?"* (Dickens et al 2021: 47). The relative absence of practice in practice reviews is a key issue to address, in conversations with partnerships and reviewers, to raise the quality and usefulness of LCSPRs.

Learning for the Child Safeguarding Practice Review Panel

- There are always likely to be tensions between a national panel and local agencies. The Panel is frustrated about the timeliness and quality of some reviews, but some local partnerships express frustration about what they experience as a 'top down' mentality. The Panel needs to build on its efforts to engage with partnerships.

- Revised Panel guidance was published in September 2022 providing advice on conducting reviews. [Child Safeguarding Practice Review Panel - GOV.UK (www.gov.uk)](https://www.gov.uk)

- The LCSPRs show that many of the issues that undermine the effectiveness of safeguarding practice are to do with serious resource shortages. The Panel has a unique role and opportunity to influence national policy as well as practice at a local level. The Panel will need to consider how they can best help secure the necessary resources and reforms to help practitioners help children and families.

- 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. We recommend that the Panel secure the funds to commission such a project.

Learning for local child safeguarding partnerships

- We think there would be benefits in having fewer LCSPRs, making the process a clear 'step higher' and the lessons more distinctive. Greater use of thematic reviews could help with this. Partnerships should focus as far as possible on completing their learning in the rapid reviews. Publishing a learning summary and action plan from the rapid reviews would demonstrate to agencies, families and the public that they have learned the lessons and are working to implement them.

- When it is considered necessary to commission an LCSPR, it is crucial for the rapid review to produce clear and focused key lines of enquiry. If reviewers do not wish to follow them, this needs to be discussed and agreed.

- There should be SMART action plans for the partnership and local agencies arising from the recommendations of the review (or a clear statement of why the partnership does not accept them). These should be published alongside the LCSPR, for accountability and as a sign of the partnership's commitment to learning and improvement.

- Partnerships should take steps to build a wide range of contacts with skilled independent reviewers, and to build up their own pool, with mentoring and sufficient time in workloads. It may be helpful to develop reciprocal relationships with other partnerships.

Learning for reviewers

- It is important for reviewers to specify the racial and cultural background of the children and their families, and other characteristics such as age, gender, disability and sexuality, unless there are overwhelming reasons not to do so. If so, these should be explained. More than that though, reviewers should discuss explicitly how these characteristics shaped the families' and children's lives, experiences and views, and how practitioners and services responded to them.

- Reviewers should be clear about the objective of a systems methodology, whatever the details of the methods they use. They should be looking to understand the dynamic between individual actions and decisions, and the social, organisational and professional systems within which the individual operates.

- Reviewers should look to discover, analyse and report more about the details of direct practice. The challenge is to do this without going back to lengthy chronologies or enquiries that seem accusatory and blaming. But individual practice matters, and the children and families deserve good practice.

- The best reviews have few and focused recommendations that take understandings further than the rapid reviews, and can readily be translated into SMART action plans.

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Appendix 1: Methods

The aims of the study were specified in the 'invitation to tender' issued by the national Panel in August 2021:

- A review of all LCSPRs completed in the year, to identify common themes and trends.
- An in-depth qualitative analysis of a smaller sub-set, in order 'to gain an increased understanding of the root causes of systemic strengths and vulnerabilities within local practice, in particular where there are emerging or entrenched problems …'. The analysis should also consider learning in relation to the six key practice themes identified in the Panel's 2020 Annual Report.
- An assessment of the quality of LCSPRs, in particular to evaluate the 'added value' of the LCSPR compared to the learning in the rapid review, and whether the questions and suggested learning areas had been addressed in the subsequent LCSPR.
- An evaluation of the implementation and impact of the reviews, based on a representative sub-set of LCSPRs, 'to demonstrate how the learning from LCSPRs has been implemented and evaluated in local areas and how systems issues have been addressed'.
- A review of the methodologies used in LCSPRs, to identify those best suited to deliver high-quality reviews.
- To look at how LCSPRs address and analyse the impact of race, racism and culture on practice, and where there is good or emerging practice in this area in terms of review quality as well as practice quality.

We were supplied with the 84 LCSPRs completed in 2021, along with the relevant rapid review and significant incident notification form (SIN), where these were available. We were also given access to the quality assessment forms completed for each LCSPR by members of the national Panel (this process was introduced in spring 2021, so only applied to reports submitted after that). We were given access to the documents via the DfE secure SharePoint site. We were also able to track down published LCSPRs on the partnership websites and/or the NSPCC repository.

Members of the research team read all of the LCSPRs, completing a schedule to capture key information. For 82 of the 84 LCSPRs an 'index child' was chosen. This was the child who was the primary focus of the review. In two of the larger thematic

reviews of unrelated children (for which we do not have all SIN or rapid review data) an index child was not chosen.

The data collected included factors such as the child's age and ethnicity, other family members, the category of death or serious harm, the dates of the incident, the rapid review and the LCSPR, and the recommendations made. We also assessed the reports for whether and how they addressed each of the Panel's six practice themes, and issues of race and racism.

On the basis of these findings, we identified a sub-sample of 20 cases. These were purposively selected to help us address the questions specified by the Panel but were broadly representative of the whole sample, as described in Chapter 1. It included a variety of reviews in terms of thematic, family or single child cases.

To examine the impact of race, racism and culture, we selected a different sub-sample, all the cases involving Black or other minority ethnic children. There were 27 LCSPRs on children or young people who were of Black and other minoritised backgrounds. There was one 'White British' family where culture in the form of religion was an issue, and two 'White Other' families where English was a Second Language for the parents. This gave a total of 30 cases, although some were in both sub-samples. This aspect of the study is described in Chapter 3.

We used the 20 cases in the first sub-sample for the analysis of implementation and impact, but added four extra cases that had been completed in 2020.This was to ensure that the sample had some cases with a longer period of implementation. This aspect of the study is described in Chapter 5. There was a review of partnership websites, a survey and an online focus group.

All 24 partnership websites were reviewed, looking for evidence of impact planning or achievement. Next, an online survey was sent to the safeguarding leads/ managers of the 24 partnerships. Twenty-two partnerships agreed to participate and two did not respond, an extremely good response rate (92%). The survey focused on the particular LCSPR in the study, and asked what the 'added value' of the LCSPR had been compared to the rapid review, how the learning from the review was being implemented, and what steps there were to ensure this and monitor it. The responses were used to identify areas to discuss further in the focus group.

Thirdly, an online focus group was conducted in March 2022 with 22 participants who were either leads or nominated deputies from the partnerships. The focus group explored questions about the quality of the review, how recommendations are translated into action plans, the 'visibility' of action plans, the methods of disseminating the learning, and what might facilitate or hinder the impact of the learning. The focus group data was transcribed and analysed thematically.

We benefited from productive links with the national Panel. We had an initial meeting with them to clarify the terms of the brief and our plans. We submitted an interim report in January 2021 and attended a meeting of the Panel to discuss it. We subsequently received helpful written comments. We submitted a second interim report, in the form of an update on progress and a series of questions to help us in our analysis, as we moved from findings to conclusions. We had a helpful conversation about that with Peter Sidebotham of the Panel, and very useful written comments. We also had the benefit of a meeting with Jahnine Davis of the Panel, to discuss the chapter about race, ethnicity and culture. We had two useful meetings with the team from Alma Economics, who were undertaking the 2021 review of rapid reviews. We are grateful to John Leppard for arranging all these meetings.

Having said all that, it is important to be clear that we are responsible for findings and the analysis in this report, and for any errors of fact or interpretation. The views expressed are ours, not necessarily those of the national Panel or any of the safeguarding partnerships.

Appendix 2: Explanation of key terms used in Chapter 3

- **Adultify, adultification** – Overlooking the innate vulnerability of children. Black children are more likely to experience this form of bias by treating them as though they were older, less innocent, more culpable and more mature than their age, and so holding them responsible for their behaviour in ways that would not apply to white children of similar age and background.

- **Invisibilise, invisibilisation** – not acknowledging the distinctive needs, qualities, characteristics and/or achievements of certain groups, particularly Black people.

- **Marginalise, marginalisation** – excluding a person or group from the main systems and benefits of society on the basis of their social characteristics, such as race, age, gender or sexuality. Chapter 3 focuses on race.

- **Minoritise, minoritisation** – treating persons or groups who are fewer in number in society as having limited strengths and qualities in contrast to the majority; particularly, as being peculiar and potentially a problem.

- **Racialise, racialisation** – the process by which a person or organisation in a position of power projects negative narratives or characteristics onto other persons or groups based on the latter's race or ethnicity.

- **Responsibilise, responsibilisation** – holding a person responsible for their actions, especially someone who is vulnerable or with limited capability, usually in a way that underestimates their needs and tries to justify offering them reduced or limited support.