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| **TITLE:** | **BRIEFING:**  **CSPR panel’s commissioned review of LCSPRs and rapid reviews** |
| **DATE:** | 22nd June 2021 |

**An overview of key themes from the University of East Anglia and the University of Birmingham’s annual review of rapid reviews and Local Child Safeguarding Practice Reviews (LCSPRs).**

# Background to the report

Following a serious safeguarding incident, local safeguarding partners are required to submit a rapid review to the Child Safeguarding Practice Review Panel, the body responsible for identifying and overseeing the review of serious child safeguarding cases in England. This review, which should be produced within 15 days of the notification of a serious incident, sets out the circumstances of the event. If a case raises issues that are complex or of national importance, the decision may be made to commission an in-depth Local Child Safeguarding Practice Review, which should be published within six months of the notification of a serious incident.

This report, by the University of East Anglia and the University of Birmingham, looks at all 33 completed LCSPRs received between 1 October 2019 and 31 December 2020 and a sample of around a quarter (135) of the rapid reviews completed in January – December 2020.

# The child’s pathway

The authors start by taking a ‘pathways’ approach to their analysis of rapid reviews and LCSPRs, by looking at key moments when things went ‘wrong’ for a child or where chances to improve outcomes were missed.

## Identification and referral

Nearly half of reviews identified issues with either the early identification of risks and/or agencies not responding adequately to referrals. The importance of quality and timeliness of referrals and assessments and the use of clear and accurate language was emphasised in a number of reviews.

## Case management

Reviews regularly highlighted issues around case management, including: failure to act on information about risk factors, not looking at the lived experiences of children, and difficulties in accessing services. The importance of recording, sharing and acting on multi-agency meeting decisions was also emphasised.

## Engagement with families and case closure

Difficulties engaging with children and families, including barriers to accessing services and a lack of engagement with fathers, were a common theme. In some cases, lack of engagement with services led to the closure of a case, rather than the escalation of concerns or increased efforts to reach a family.

# Recurring themes

Qualitative analysis of rapid reviews and LCSPRs identified a number of key concerns, many of which have been identified and discussed in previous reviews.

## Opportunities to be curious

Practitioners were not always suitably curious or challenging. In cases where practitioners worked with families over a long period of time, or where families were hostile to intervention, a need was identified for safe spaces in which practitioners could discuss cases and explore concerns. Cases where a lack of professional curiosity was highlighted included those involving:

* adolescents – leading to a focus on ‘troubling’ behaviour, rather than the causes of the behaviour
* babies – leading to acceptance of explanations for injuries which were incompatible with babies’ stage of development
* fathers and men in families –leading to a lack of consideration of men’s capacity to provide care or support to their families, as well as any risks they might pose
* minority ethnic groups –leading to a lack of consideration of how ethnicity or cultural background might impact on parenting style, beliefs and interaction with the wider community.

## Resources

Financial pressures affected services’ ability to respond to children at risk. Work pressures and heavy caseloads were a recurring issue, as were gaps and delays in service provision.

## Inter-agency communication and sharing

Barriers to sharing information between safeguarding partners were highlighted in almost half of all reviews. Issues included: relying on other agencies to make referrals, not valuing information from third sector organisations, different IT systems and difficulties around what to share, when and how.

## Policies, protocols and training

Almost a quarter of reviews mentioned the need to review policies, protocols or processes, and almost a third of all reviews mentioned a need for more training.

# New and emerging themes

Analysis also identified new and emerging themes which would benefit from further development and learning.

## Working with families during the coronavirus pandemic

36 reviews highlighted the impact of Covid-19 on services and/or families. Not being able to meet face to face presented issues for the provision of and engagement with services and the efficacy of risk assessments. Changes to services also presented some positive opportunities, including: telephone calls providing a less intimidating alternative to face-to-face appointments; non-attendance at school providing opportunities for agencies to visit vulnerable young people at home; and the scaling back of social care home visits leading to improved interagency working as social workers relied on other agencies to be their ‘eyes’ on children.

The pandemic also had a significant impact on the lives of families and children, including: feelings of isolation during lockdown and agitation once restrictions were lifted, challenges balancing childcare and work, lack of support and monitoring by social networks, delays in seeking support because of fear of infection, and financial issues.

## Peer-on-peer abuse

13 reviews discussed peer-on-peer abuse related to adolescent harm and death. The reviews involved bullying, sexual abuse, knife and gun violence and exploitation. Learning and recommendations focused on the impact of school exclusions, the need for preventative work, the impact of early adverse experiences, thresholds for intervention, the promotion of social networks for children in care, placements out of borough and parental support when harm is outside the home.

## Young people’s gender and sexual identity

Awareness of how support can be coordinated and mental health services accessed for young people who are transitioning was identified as learning in one rapid review. Although not a new issue, working with transgender young people and how young people wish to identify is new to some professionals.

## Trafficking of children

In one case, there was a delay in recognising that a child had been trafficked into the UK, partly because the young person initially presented as an adult. Recommendations included the need for professional curiosity about the age and developmental stage of a presenting person and the use of dispute resolution processes.

# Quality and value of rapid reviews and LCSPRs

## Rapid reviews

The length of rapid reviews varied significantly. Many were missing important details about the child, their family or who participated in the review; whilst others were long and unstructured. A minimum amount of information was required to provide the detail and context needed to understand the learning from the review, and the best reviews followed a clear template which prompted the inclusion of this information.

## LCSPRs

Local partnerships are still coming to terms with the new requirements and there is little guidance about what an LSCPR report should contain. This means the reports vary widely, making comparison challenging.

LCSPRs are required to include the views of children and families where possible, however this was missing from over a third of LCSPRs. Many did not explain why it was not possible to include their views.

Many LCSPRs set out key learning and linked this to recommendations for change. However, it was less common for reports to set out how these changes might come about or how to measure their effectiveness.

# Conclusions and recommendations

It is too early to say whether the new system will overcome some of the issues identified with the old serious case review system. Many of the same messages have come out of the new LCSPRs, however this is to be expected as the challenges of safeguarding work remain the same.

**Areas for potential improvement or future action include:**

**For further information:**

* [Commissioned review of LCSPRs and rapid reviews](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984770/Annual_review_of_LCSPRs_and_rapid_reviews.pdf)