



Child Safeguarding Practice Reviews (CSPR) National Panel Annual Report Headlines 2020

Visit the Swindon Safeguarding Partnership [website](#)

Visit the Child Safeguarding Practice Review Panel [website](#)

Thanks to Sandwell Children's Safeguarding Partnership for their 7 minute brief

1. Who are the Child Safeguarding Practice Review Panel? The panel is the independent commissioner of reviews into serious child safeguarding cases with a view to improving learning, professional practice and outcomes for children. Statutory guidance in 'Working Together' sets out how the panel operates however the panel is independent of the government. The panel supervises the production and quality of reviews. The panel is chaired by Annie Hudson.

2. Annual Report 2020 Headlines. The report comprises information from all serious safeguarding incidents submitted to the National Panel in England throughout 2020. It acknowledged the unprecedented challenges of the COVID-19 pandemic and that agencies had to adapt rapidly to provide services. Risk escalated where there were parental/family stressors, particularly for under 1s. Disrupted routines, overcrowding and increased pressures in households saw increased incidences of domestic abuse and poor mental health. Schools play a crucial role in safeguarding and in lockdown some vulnerable children remained 'below the radar.' Absence from school had a particular impact on young people's mental health and was evident in all cases where children took their own life.

3. Key Statistics 1.

- 482 serious incidents regarding 514 children (206 deaths, 267 serious harm and 9 Other e.g. child was perpetrator of harm).
- 53% of those referred were male and 46% female. 2 were transgender.
- 69% White British however when compared with census data there is a higher proportion of ethnic minority children referred.

4. Key Statistics 2.

- Predominance of infants under 1 (35%) followed by young people aged 15-17 (30%).
- Of the 206 deaths 17% were due to family maltreatment and 31% were Sudden Unexpected Deaths (SUDIC).
- Domestic abuse featured in 41% and neglect in 35% of cases where children died. Fathers were DA perpetrators towards mothers in 74% of cases.
- Poor parental mental health was evident in 146 serious incidents and mainly affected mothers (78%).
- Neglect was an underlying feature in 35% of fatal incidents and 34% of non fatal incidents. Recognising cumulative neglect remains an ongoing challenge.
- 16% of reported incidents included children with mental ill health.
- 51 incidents involved children engaged in risky/violent behaviour. 75% of these incidents were linked to gangs/county lines activities.



7. Safeguarding in Swindon.

The SSP is underpinned by guidance in Working Together 2018 and the Children and Social Work Act 2017. We plan and deliver a catalogue of [safeguarding training](#) to colleagues across Swindon in line with local need. We identify and oversee all learning reviews and CSPRs. We play a key role in developing local practice in line with our strategic priorities: Neglect, Exploitation and Early Help. We quality assure multi agency systems and practice to ensure the needs of children living in Swindon are met. Visit our [website](#). Follow us on Twitter [@SwindonSafegua1](#) or [LinkedIn](#). See our other [7 minute and practice briefs](#) which provide information of several of the themes identified in this brief including professional curiosity, safeguarding adolescents, capturing the voice of the child in records, effective information sharing and consent.

6. Other National Publications.

[‘It was hard to escape’](#) – Safeguarding children at risk from criminal exploitation (published March 2020)

[‘Out of routine’](#) – a review of Sudden Unexpected Deaths in Infancy/Childhood (SUDIC) where children are at risk of harm (published July 2020)

Future publications:

Non accidental injuries to babies under the age of 1 – autumn 2021

Suicides; the secure estate and serious violence and Looked After Children (LAC)

<https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel>

5. Key Themes from 2020 Report

- 1) Continuous understanding of what the child’s daily life is like and how that feels for them. Be mindful of all children (e.g. those who are non verbal) and that children may deliberately minimise difficulties.
- 2) Getting to the root cause of why families may be reluctant to engage.
- 3) Critical thinking and challenge in supervision, plans and assessments.
- 4) Responding to changing risks and needs – assessments should be reviewed when there is a significant change and should review known fragilities e.g. mental ill health.
- 5) Information sharing and that GDPR should not be a barrier. Some agencies remain unsure of what they can or can’t share.
- 6) Organisations should create and sustain a culture of honesty, effective supervision and learning/development.

