Q1 rapid review analysis

1 April to 30 June 2025

An overview of rapid reviews submitted to the Panel, highlighting key risks and emerging themes

Key stats

76* rapid reviews submitted

72% were serious harm

25% were deaths

* For incidents between 1 April 2025 to 30 June 2025

Key insights

- Serious harm was the most common incident type
- Deaths decreased compared to Q1 2024
- Babies under 1 were the most affected
- Mental health was a key theme

Type of incidents

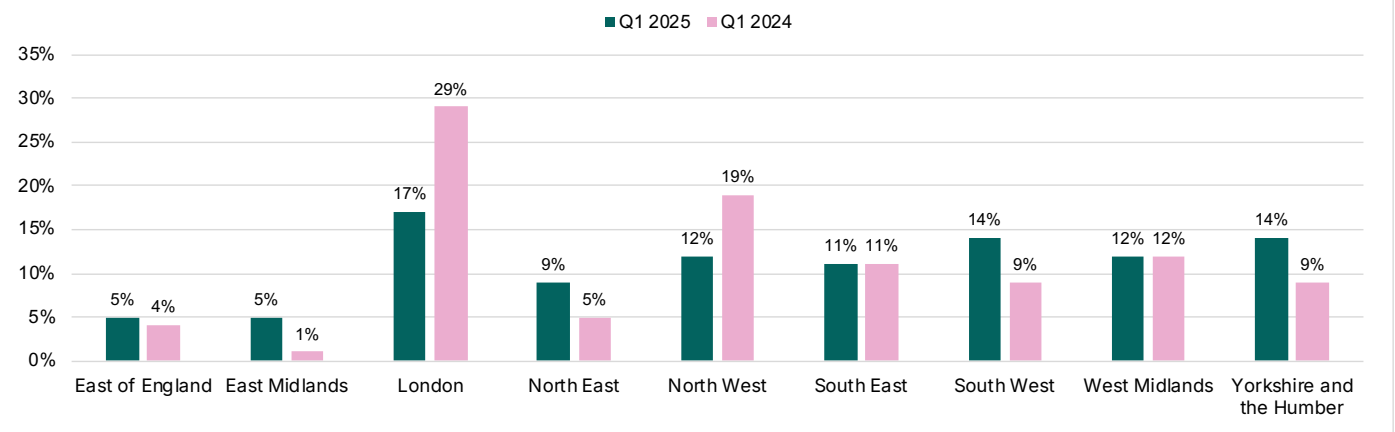
Number of rapid reviews	Q1 2025	Q1 2024	24/25
Death	19 (25%)	29 (39%)	128 (47%)
Serious harm	55 (72%)	45 (60%)	138 (50%)
Other*	2 (3%)	1 (1%)	8 (3%)
Total	76 (100%)	75 (100%)	274 (100%)

Deaths decreased from 39% in Q1 2024 to 25%.

Serious harm increased from 60% in Q1 2024 to 72%.

* Some notifications were classed as 'other' issues, for example where harm was caused by a child or a child was exposed to a serious incident or trauma.

Regional breakdown

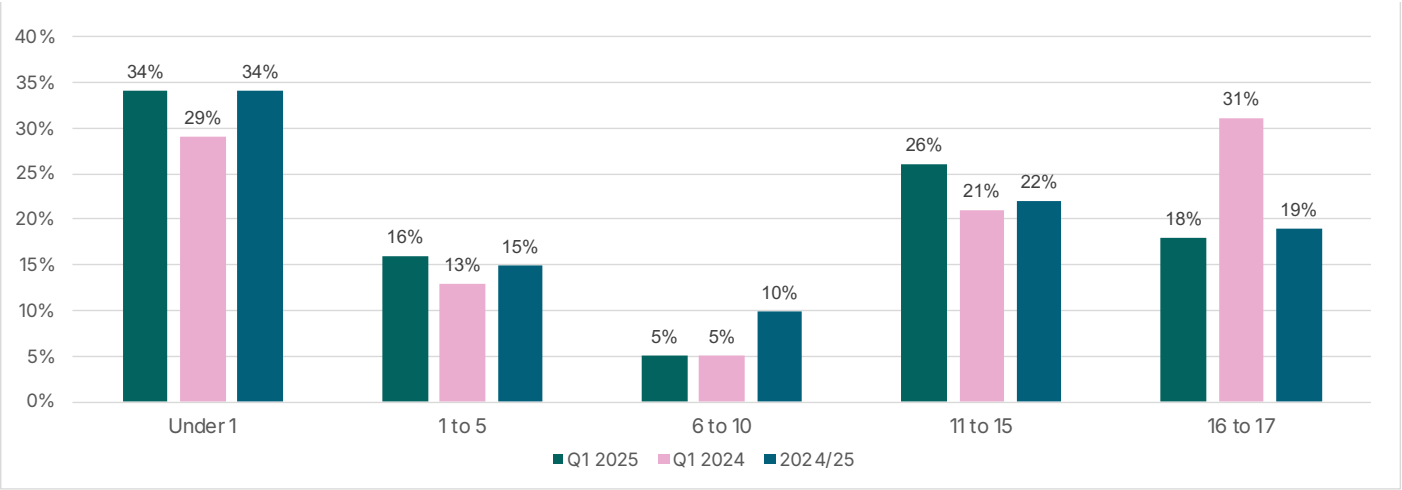


- London reported the highest number of incidents
- Compared to Q1 2024, incidents increased in the North East, Yorkshire and the Humber, and the South West
- Compared to Q1 2024, incidents decreased in London and the North West

THE CHILD **SAFEGUARDING** PRACTICE REVIEW PANEL

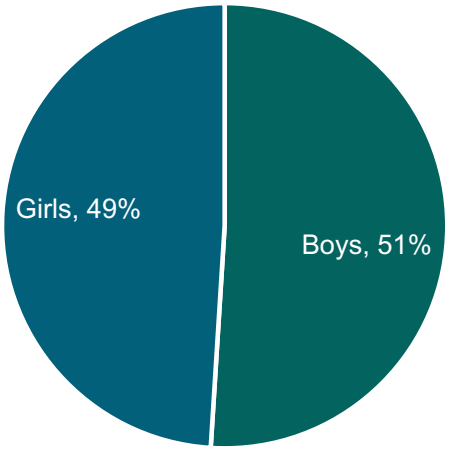
Children at the heart of the reviews

Age



- Over a third (34%) of incidents involved babies under 1 year old
- Incidents involving children aged 16 to 17 decreased compared to Q1 2024

Sex



There was a relatively even split between girls and boys.

This is consistent with Q1 2024 (52% girls, 48% boys) and the 2024 to 2025 total (50% girls, 50% boys).

Ethnicity

Ethnicity Group	Q1 25	Q1 24	24/25
White	60%	62%	70%
Mixed/ Multiple Ethnic Group	21%	9%	11%
Asian/Asian British	9%	9%	6%
Black/African/ Caribbean/Black British	9%	19%	12%
Other ethnic group	0%	0%	1%

Disability

- 16% of children were recorded as having a disability
- A further 12% had a possible but unconfirmed disability

- 60% of reviews where the child's ethnicity was reported involved children from white backgrounds, a decrease from 2024 to 2025 overall
- Compared with Q1 2024, harm to children from Black backgrounds decreased

Understanding the incidents

Causes of incidents

Most common causes of death

- Unexplained SUDI/SUDC (42%)
- Suicide (21%)
- Extreme neglect (11%)
- Risk-taking behaviour (11%)

Most common causes of serious harm

- Intrafamilial non-fatal assault (31%)
- Non-fatal neglect (13%)
- Extrafamilial non-fatal assault (13%)
- Extrafamilial child sexual abuse (13%)

Emerging themes

Mental health

A range of mental health concerns were identified, including suicidal ideation, self-harm, anxiety, depression, complex trauma and challenges with emotional regulation.

- Of the 34% of reviews where the child was recorded as having a diagnosed/ undiagnosed mental health condition:
  - 46% were receiving support at the time of the incident
  - 31% had previously received support
- Of the 61% of reviews where the child's parent/relevant adult was recorded as having a diagnosed/ undiagnosed mental health condition:
  - 15% identified service responses to parental mental health needs as a concern
  - Only 1% identified examples of good practice

Online harm

16% of reviews involved an online context, most commonly linked to social media use.

Co-occurring risk factors included:

- child sexual abuse or exploitation
- harmful sexual behaviour
- emotional abuse
- poor school attendance

Kinship care

Kinship care is where a child lives with a friend or family member rather than a parent.

- 4% of children were living in kinship care
- 9% had previously lived in kinship care

How to use this data

It can be used to:

- review how local data and learning compare with national trends
- consider workforce development, training and support needs
- assess whether local services and referral pathways reflect need
- reflect on how learning from reviews is embedded across partnerships
- explore how emerging themes are identified and addressed in rapid reviews

Reflective questions

- Do these themes align with issues you are seeing locally?
- Are there specific risks or groups of children requiring further attention?
- How effectively is learning from reviews being applied in practice?
- What opportunities exist to strengthen multi-agency responses?

Further resources and feedback

You can access related learning resources, newsletters and reports on our website.

We welcome feedback on this report, including:

- examples of local practice or learning
- resources you would like to share
- topics you would like to see explored further

Contact us at **Communications.NATIONALREVIEWPANEL@education.gov.uk**

Caveats to this data

- Rapid reviews should be submitted within 15 working days of notification, but submission times can vary. Therefore, the totals presented may not include all incidents notified within the quarter and may be subject to change
- Emerging themes reflect both rapid review data and Panel analysis within case discussions
- The themes presented are only a sample and not an exhaustive picture of all emerging themes within the data
- Percentages are based on reported incidents. Some incidents involved more than one child, and figures are rounded. As a result, percentages may not always sum to 100%