Q2 rapid review analysis

1 July to 30 September 2025

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

Key stats

75* rapid reviews submitted

55% were serious harm

43% were deaths

* For incidents between 1 July 2025 to 30 September 2025

Key insights

- Serious harm was the most common incident type
- Deaths increased compared to Q1 2025
- Children aged 11 to 17 were the most affected
- Suicide was a key theme

Type of incidents

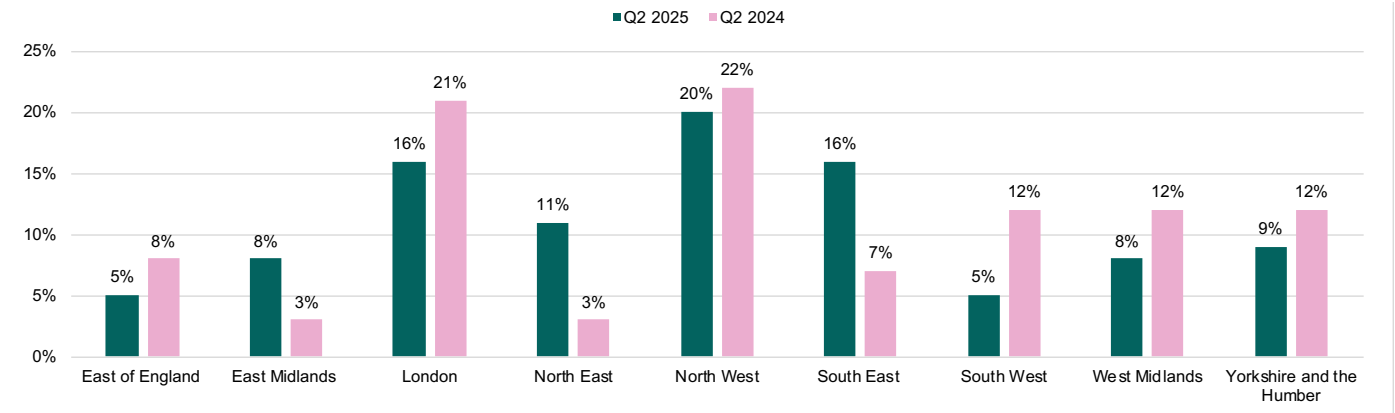
Number of rapid reviews	Q2 2025	Q1 2025	Q2 2024
Death	32 (43%)	19 (25%)	39 (53%)
Serious harm	41 (55%)	55 (72%)	32 (44%)
Other*	2 (3%)	2 (3%)	2 (3%)
Total	75 (100%)	76 (100%)	73 (100%)

Serious harm decreased from 72% in Q1 2025 to 55%.

Deaths increased from 25% in Q1 2025 to 43%.

* 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

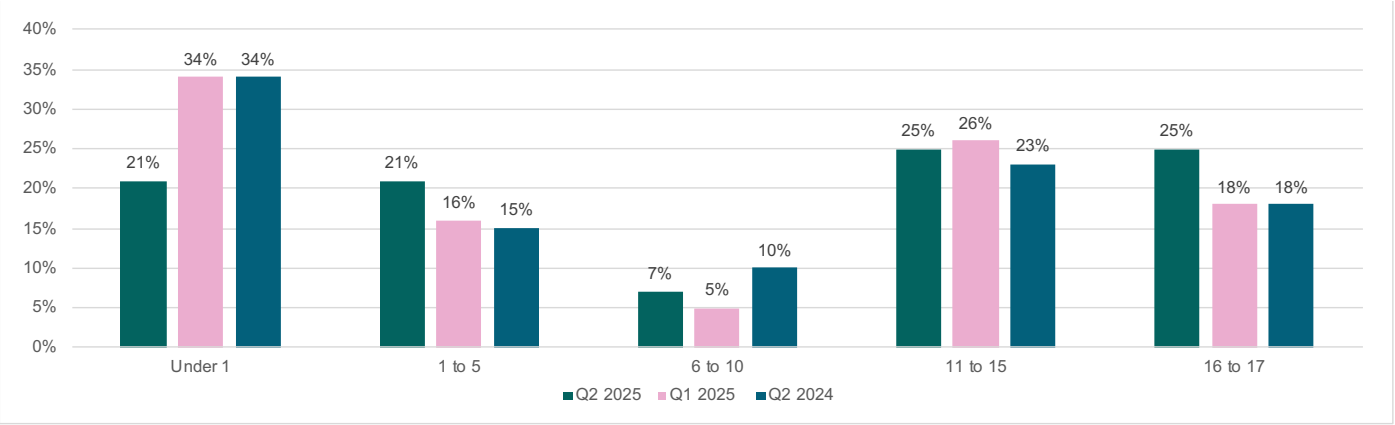


- The North West reported the highest number of incidents
- Compared to Q2 2024, incidents increased in the North East, South East and East Midlands
- Compared to Q2 2024, incidents decreased in London and the South West

THE CHILD **SAFEGUARDING** PRACTICE REVIEW PANEL

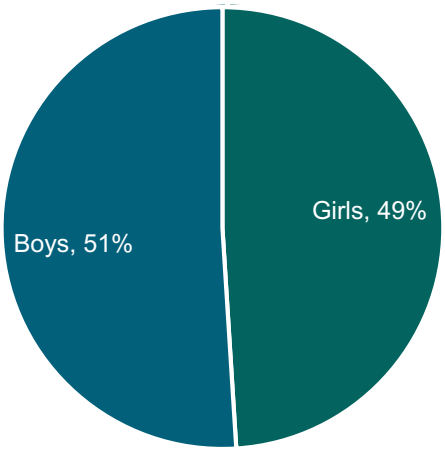
Children at the heart of the reviews

Age



- Half of incidents involved children aged 11 to 17
- Incidents involving children aged under 1 decreased compared to Q1 2025 and Q2 2024
- Incidents involving children aged 16 to 17 increased compared to Q1 2025 and Q2 2024

Sex



There was a relatively even split between boys and girls.

This is consistent with previous periods, including Q1 2025 (51% boys, 49% girls) and Q2 2024 (52% boys, 48% girls).

Ethnicity

Ethnicity Group	Q2 25	Q1 25	Q2 24
White	74%	60%	65%
Mixed/ Multiple Ethnic Group	18%	21%	15%
Asian/Asian British	4%	9%	6%
Black/African/ Caribbean/Black British	3%	9%	13%
Other Ethnic Group	1%	0%	1%

Disability

- 23% of children were recorded as having a disability, an increase compared to Q1 2025
- A further 16% had a possible but unconfirmed disability

- 74% of reviews where the child's ethnicity was reported involved children from white backgrounds
- Compared to Q1 2025, reviews involving children from Black backgrounds decreased while those involving children from mixed or multiple ethnic backgrounds remained high

Understanding the incidents

Causes of incidents

Most common causes of death

- Suicide (31%)
- Unexplained SUDI/SUDC (19%)
- Extreme neglect (16%)

Most common causes of serious harm

- Non-fatal neglect (24%)
- Intrafamilial non-fatal assault (15%)
- Intrafamilial child sexual abuse (15%)
- Extrafamilial child sexual abuse (12%)

Emerging themes

Children hidden in plain sight

There was a pattern of vulnerable children and families known to multiple services. Thirteen reviews involving significant agency involvement were analysed.

Characteristics

- Most reviews involved girls (11 of 13)
- Included older children aged 14 to 17 (10 of 13)
- Included children with mental health conditions (12 of 13)

Risk factors

- Neglect and domestic abuse were common
- Physical, emotional and sexual abuse featured frequently

Analysis

- Despite service involvement, there was little evidence of meaningful change
- Family non-engagement with, or non-consent to, services was recorded in many reviews
- Weaknesses in risk assessment and decision-making were frequently identified

Children who died by suicide

Ten children died by suicide in Q2 2025, a notable increase.

Characteristics

- Equal split between boys and girls
- All children were aged 11 to 16
- Half were known to mental health services (CAMHS)

Risk factors

- Previous self-harm, suicidal ideation or suicide attempts were common
- Half the cases involved online harms

Common features

- Exposure to harmful online content
- Cyberbullying
- Exclusion from education
- Low school attendance

How to use this data

It can be used to:

- review how your local data and recent cases compare with national patterns
- consider whether services and referral pathways reflect local need
- reflect on how learning from reviews is embedded across partnerships
- explore how long-standing safeguarding concerns are identified and addressed in practice

Reflective questions

- How effectively are long-standing safeguarding concerns recognised and reassessed?
- How are agencies responding when families disengage from services?
- Are patterns of self-harm and suicidal ideation identified early enough?
- How are online harms considered within safeguarding assessments?

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%