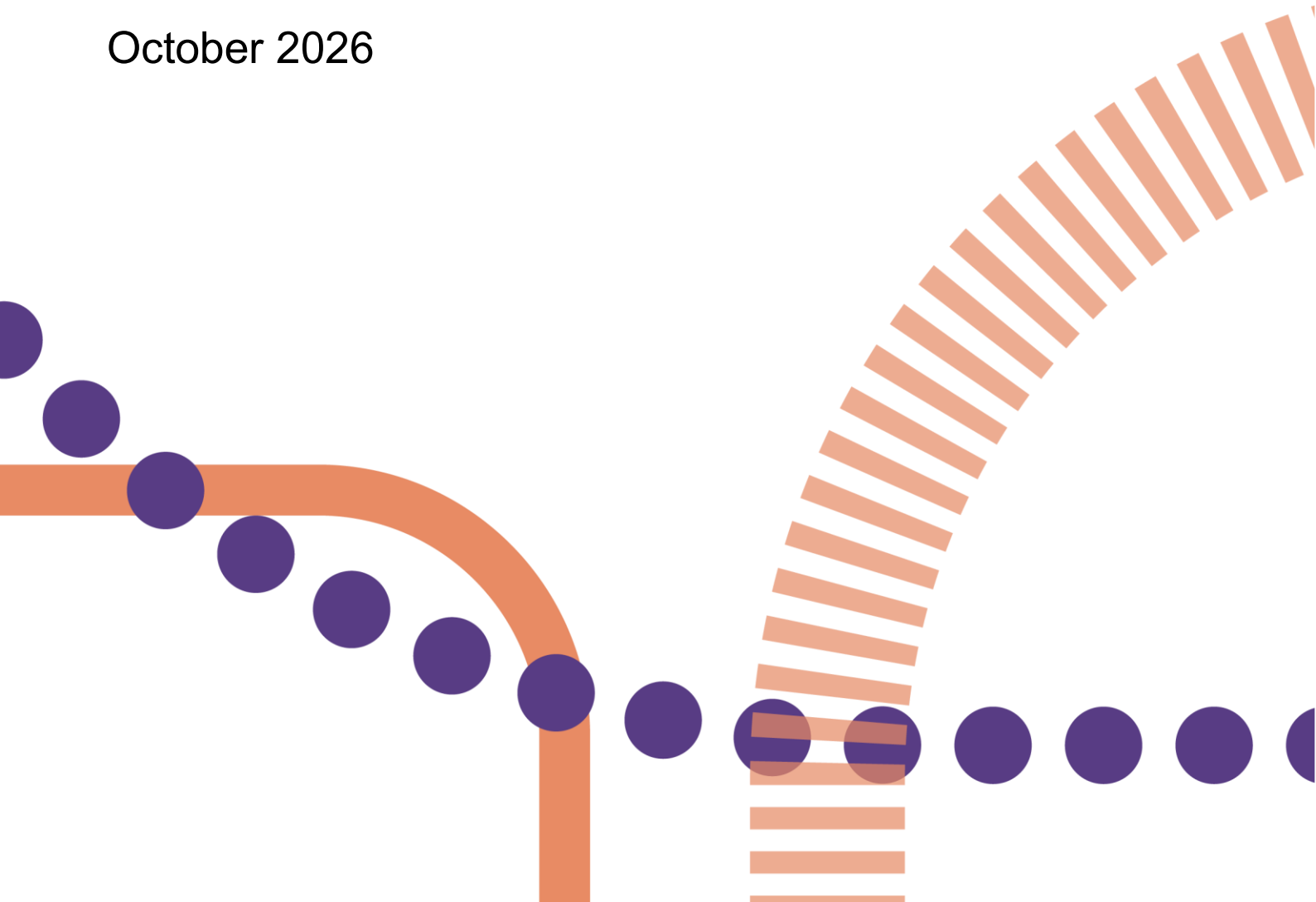


Persistent themes in child safeguarding reviews

Strategic leadership and partnership
reflection

October 2026



Introduction

The Child Safeguarding Practice Review Panel's persistent themes bring together national learning from child safeguarding reviews where children have died or suffered serious harm from abuse or neglect. They focus on recurring challenges that continue to feature across safeguarding practice and the wider safeguarding system.

These themes are not new, but their continued appearance in safeguarding reviews makes them impossible to ignore. Tackling them is a shared responsibility for practitioners, managers, leaders, safeguarding partnerships and the wider safeguarding system. The Panel has a role too, bringing together the national picture and sharing this learning with local leaders, policymakers and national partners to highlight where wider action is needed.

The themes reflect the complexity of family life, safeguarding practice and the organisational and multi-agency systems in which it takes place. Reviews consistently show how these wider conditions can influence practice and outcomes for children, particularly during periods of significant reform and change. The Panel has therefore drawn together the recurring messages from this evidence to support partnerships to reflect on their own safeguarding arrangements, practice conditions and opportunities for improvement.

The Panel encourages leaders and safeguarding partnerships to consider these themes not only as practice learning, but also as an important opportunity for organisational and partnership reflection. Alongside the practice messages within each theme, leaders may wish to reflect on what local reviews, quality assurance activity and practitioners' experiences tell them about the local conditions in which safeguarding practice is taking place, and whether there are opportunities to strengthen the support available to those working directly with children and families. While many of these issues reflect wider system pressures, reviews also demonstrate clearly that safeguarding partnerships can and do take practical steps to strengthen practice conditions, support effective decision-making and improve outcomes for children. These materials are designed to help you reflect on the progress you are making and to identify where there may be more to do.

Who is this document for?

Safeguarding children partnerships and strategic leaders across agencies, including education, health services, police, local authorities, youth justice and the third sector.

How to use this resource

These themes are designed to support discussion, reflection and learning across safeguarding partnerships. The individual practice themes may be used within team meetings, supervision, safeguarding forums, learning events and practitioner development activity. They can, of course, be used in partnership discussions too alongside this briefing which has been prepared with leaders and strategic partnerships in mind. We hope that these themes provide an opportunity for agencies to learn together, develop a shared understanding of the challenges identified and consider collectively how they can inform improvements in practice, policy and service delivery.

What are the persistent themes?

Designed for practitioners, managers, leaders and safeguarding partnerships, the themes encourage reflection, critical thinking and discussion at every level of the safeguarding system. They provide an opportunity to consider why these challenges persist, what can be done differently locally and what needs to be addressed across the wider system.

There are 10 persistent themes and the suggested reading order is below. It follows a safeguarding journey, starting with understanding the child's lived experience and family context, before exploring harm, risk and information-sharing, and then moving into engagement, decision-making and the organisational conditions that support effective safeguarding practice.

1. [The Child's Lived Experience](#)
2. [Understanding the Whole Family – Think Family](#)
3. [Naming and Understanding Harm](#)
4. [Understanding and Responding to Risk](#)
5. [Information Sharing and Triangulation](#)
6. [Positive and Skilled Engagement with Families](#)
7. [Consent and Responding When It Is Absent](#)
8. [When Cases Become Stuck](#)
9. [Stepping Back Safely](#)
10. [Culture, Leadership and Practice Conditions](#)

Visit the persistent themes homepage: [Persistent themes in safeguarding reviews | Child Safeguarding Practice Review Panel](#)

What is the evidence base?

Across child safeguarding reviews, the Panel frequently sees the influence of:

- Strategic leadership and governance
- Organisational and partnership culture
- Workforce capacity, confidence and stability
- Learning, supervision and opportunities for reflection
- Professional challenge and information sharing
- Multi-agency relationships and shared responsibility

These factors are usually presented as contextual reasons that help us to understand why serious incidents could not be prevented and/or as responses to serious incidents to

explain why those incidents will be less likely to happen again (because those factors have now been addressed).

None of these practice issues will surprise safeguarding leaders or partnerships. They are, of course, the practice issues that you have identified and told the Panel about through the safeguarding reviews that you have conducted.

This paper does not seek to provide general guidance on leadership or to duplicate the leadership materials already available to the sector. The leadership, contextual and systemic issues we have highlighted bring together the evidence and learning from safeguarding reviews and are reflected in the wide variety of action planning that follows at local level.

The themes encourage reflection on both safeguarding practice and the organisational conditions that support practitioners, managers and agencies to safeguard children effectively. Partnerships may wish to consider how this national learning compares with their local priorities, review findings, audit activity, quality assurance information and workforce feedback. They may wish to consider whether there is evidence that the learning identified through local reviews and safeguarding partnership activity is being implemented effectively, embedded in practice and contributing to lasting and positive practice change and sustained improvements for children and families.

Culture, professional judgement and challenge

The Panel continues to see the significant influence of organisational culture on safeguarding practice.

Reviews highlight the importance of positive cultures where practitioners and managers feel confident to exercise professional judgement, raise concerns, seek support when cases become stuck and challenge decision-making where uncertainty remains. They also demonstrate the importance of inclusive and anti-discriminatory leadership, where practitioners feel able to identify and challenge discrimination, bias and disproportionality where they affect children and families.

When critical safeguarding decisions are about to be made it is important to recognise them clearly, including decisions about escalation, service withdrawal and case closure, and ensuring that professional judgement and challenge remain central when those decisions are made.

Where organisations encourage learning, reflection, critical thinking and honest dialogue, practitioners are better supported to make informed decisions at critical points and in a context of complexity, uncertainty and risk.

Workforce capacity, support and practice conditions

The Panel continues to see the impact that workload pressures, workforce instability and limited opportunities for reflection can have on safeguarding practice. While recognising the significant pressures facing many services, reviews continue to demonstrate the importance of creating and protecting the conditions needed for reflective, relationship-based and confident practice.

Effective safeguarding depends on practitioners having sufficient capacity, effective supervision and organisational support to engage in meaningful reflection and critical thinking. Practitioners also need the time and opportunity to undertake purposeful direct work with children and families, understand children's lived experiences and make well-informed decisions.

Learning, development and expertise

Across reviews, the Panel continues to highlight the importance of workforce development, quality supervision and access to specialist expertise. Practitioners need consistent support to recognise, explore, understand and respond to issues such as complex family circumstances, cumulative harm and trauma, and children's lived experiences.

Reviews demonstrate how learning, reflective supervision, specialist advice and training can strengthen analysis, professional judgement and safeguarding decision-making.

Multi-agency working and shared responsibility

Reviews repeatedly show that effective safeguarding depends on strong partnership working. The Panel continues to see the importance of shared analysis, constructive challenge and collective ownership of safeguarding concerns. Reviews highlight clearly how fragmented working, differing professional perspectives and assumptions about the responsibilities of other agencies can negatively affect safeguarding decisions.

Effective safeguarding relies on agencies developing a shared understanding of need, risk and harm and working together effectively to protect children and support families. Reviews also continue to highlight the importance of effective collaboration between children's and adult services, including whole-family approaches that bring together safeguarding, adult services and relevant multi-agency arrangements where appropriate.

Systems, pathways and organisational barriers

The Panel continues to identify organisational and system factors that influence safeguarding practice. Reviews highlight how differences in the interpretation and application of thresholds, alongside information-sharing processes, service pathways, siloed working and governance arrangements, can all contribute to delay, drift or fragmented responses. Challenges are also seen where adult and children's services do not work effectively together to understand and respond to family circumstances, vulnerability and risk.

Reviews also highlight the importance of taking a Think Family approach that considers adults both in relation to their own needs and as parents or carers, alongside clear links between child protection arrangements, adult services and wider multi-agency processes, including MARAC and MAPPA where relevant.

Leadership accountability, assurance and continuous improvement

Reviews, quality assurance activity, data and practitioner feedback all provide valuable opportunities to understand how local safeguarding systems are functioning. Effective safeguarding partnerships require leaders to maintain a clear line of sight on frontline practice and children's lived experiences. Assurance is not simply about whether actions have been completed, but whether they have led to improved practice and better outcomes for children.

The Panel continues to identify recurring themes including drift, normalisation of harm and situations where extensive professional involvement has not resulted in sustained improvement in children's circumstances or reduced the risk of harm. Partnerships can use this learning to identify strengths, address systemic barriers and strengthen safeguarding arrangements over time.

Reflective questions for safeguarding partnerships

- What do local reviews and quality assurance activity tell us about the local conditions in which safeguarding practice is taking place and what is the evidence that this learning is improving practice and outcomes for children?
- How do leaders maintain line of sight on frontline safeguarding practice and children's lived experiences?
- How effectively do local agencies, including children's and adult services, share information and develop a shared understanding of family needs, risks and lived experience whilst maintaining collective responsibility for safeguarding children?
- Are there any local organisational, cultural or systemic barriers, including between children's and adult services, that may be contributing to drift, delay or fragmented responses?
- What evidence do we have that local systems recognise and respond appropriately to discrimination, disproportionality and inequality and the impact these may have on children's experiences and outcomes?
- If a serious incident occurred in the next 6 months, what aspects of our local safeguarding system that we know about today would most concern us and why? What can we do about those issues today?
- How confident are we that learning identified through safeguarding reviews is being implemented effectively, and what evidence do we have that it has resulted in meaningful improvements to practice and outcomes for children?

Where can I find out more?

Find more information on the Panel's new learning hub:

<https://childsafeguarding.independent-panel.uk/persistent-themes>