THE CHILD **SAFEGUARDING**
PRACTICE REVIEW PANEL

Annual Report

2024 to 2025

April 2026

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The Panel would also like to thank safeguarding partnerships for continuing to submit rapid reviews and Local Child Safeguarding Practice Reviews and engaging so positively with us. These reviews and positive engagement provide important insight into practice and learning. We have used this insight to ensure the annual report is as relevant and useful as possible for those working directly with children, young people and families, as well as leaders and managers.

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Executive summary

The Child Safeguarding Practice Review Panel's sixth annual report covers our work from 1 April 2024 to 31 March 2025. The report shares evidence and learning from our national oversight of rapid reviews and local child safeguarding practice reviews (LSCPRs), as well as the Panel's reviews of national issues.

The evidence base

The findings presented in this report are based on:

- rapid reviews and their associated Serious Incident Notifications (SINs), for incidents that occurred between April 2024 to March 2025
- letters from the Panel to safeguarding partnerships covering incidents within the same period

Wider context

This annual report is being published shortly after the Government's consultation on the scope, functions and powers of the new Child Protection Authority (CPA) closed, and ahead of the publication of the Government's response.

The Government has already announced its intention to establish a CPA. Until then, Panel is strengthening its impact and analytical capacity in ways that align with the developing vision for the CPA.

In April 2026, the Panel launched its new website and online learning hub. The platform brings together resources to support the sharing of learning from serious incidents and forms part of wider work to improve how the Panel communicates with the safeguarding sector.

Reflections from the Panel

The Panel has a unique national view of the most serious child safeguarding incidents. Its core challenge remains communicating insights, themes, and learning from those incidents effectively, so they can drive system-wide improvement.

The continued fall in Serious Incident Notifications and rapid review submissions in 2024–25 is of concern to the Panel. The Panel's insight relies on serious incidents being reported to us whenever required, to ensure learning is not lost locally or nationally.

The Panel's work takes place against a backdrop of evolving child protection policy. There are major reforms underway across children's social care, health, schools and SEND, local government, policing, and youth justice. It is also delivered within a context of systemic pressures, including:

- shortage of placements for children with complex needs, in relation to social care, mental health, and education
- increased need for mental health support

- SEND resourcing pressures on local authority, health and school budgets
- family poverty, housing challenges and other forms of deprivation and inequality

Needs

The 2024–25 data, when viewed alongside previous annual reports, shows persistent and emerging patterns in the needs of children and families involved in serious incidents.

The children and families involved in incidents often have complex and overlapping needs. Incidents reviewed by the Panel frequently see children living in poverty, in poor quality or overcrowded housing, and children who are not in school or who miss significant amounts of education. Many are living in families that have been known to various agencies for years, have received multiple services, and may have moved between areas or be working with agencies across different localities.

The Panel regularly sees children living with domestic abuse, substance use, or mental health difficulties within their families. Many children are neurodiverse, have social and emotional health needs, or have Speech, Language and Communication Needs. Some children are isolated or face pressures both in person and in today's rapidly evolving digital world. Often, children experience a combination of these issues or other compounding factors.

Emerging trends

The Panel is concerned about:

- a rising proportion of young parents involved in incidents
- decreases in SIN and rapid review submissions in 2023-24 and 2024-25
- the increasing prominence of online harms in rapid reviews

Learning and practice themes

The annual data analysed for this report shows both persistent and emerging issues in the incidents considered by the Panel. The Panel will be hosting a webinar exploring the key themes from this annual report shortly – follow our LinkedIn to stay updated. The Panel is also developing new resources for leaders, managers and practitioners which reflect on the key learning and practice themes that the Panel regularly identifies through its national oversight of serious incidents. These new resources will be published on our new website and learning hub soon.

We encourage all Safeguarding Partnerships to consider the content of this annual report and to engage with the Panel's rapidly developing range of learning resources as you drive forward your own work at local level.

A window on the system

Between 1 April 2024 and 31 March 2025, 274 SINs and rapid reviews were submitted for serious incidents where abuse and/or neglect was known or suspected. This was a decrease of 21% from the previous year, reflecting the ongoing reduction in incidents notified to the Panel over the last two years.

The key findings from the analysis of this data are set out below:

- Half of the incidents reported were due to serious harm, 47% were due to the death of a child and the remaining 3% were categorised as 'other'.
- There was an even split between boys (138) and girls (136), which differs from previous years where boys made up slightly larger proportion.
- As in previous years, the largest age group was babies under 1 years-old (34%). This was followed by children aged 11-15 (22%) and 16-17 years-old (19%). Babies under 1 also made up the largest share of deaths (61%).
- Compared to the child population in England, children from Black/African/ Caribbean/Black British ethnicities and those with Mixed/ Multiple ethnicities continue to be overrepresented in reviews. Children from Asian/ Asian British and Other ethnicities remain underrepresented. The proportion of children reported as being Black/African/Caribbean/Black British has increased over the last three years.
- Unexplained Sudden and Unexpected Death in Infancy or Childhood (SUDI/SUDC) was the most common likely cause of death (29%), followed by suicide (16%). The proportion of SUDI/SUDC incidents was higher for boys at 34% compared to 22% for girls, while the proportion of deaths by suicide was higher for girls at 22% compared to 12% for boys.
- Suicide has been the second most common cause of death over the past three reporting years. Children who died by suicide often had one or more mental health conditions (88%) and many had experienced abuse prior to the incident.
- Consistent with previous years, the most common cause of reported serious harm was intrafamilial non-fatal assaults (28%), followed by non-fatal neglect (16%). A higher proportion of girls (30%) experienced intra- and extrafamilial child sexual abuse than boys (11%) whereas a higher proportion of boys (58%) experienced intra- and extrafamilial non-fatal assault than girls (27%).
- Many families were known to children's social care (CSC) (84%), either previously or at the time of the incident. Nearly two-fifths (39%) were or had been on a child in need plan, a slight decrease from the previous year (42%). There was a slight increase in the number of children who were or had been on a child protection plan (14%) compared to the previous year (10%).
- Compared to the previous year, the proportion of school-aged children enrolled in a mainstream school reduced from 67% to 62%. Across all school age children, 45% were recorded as missing some of their schooling or education. Of those children, 36% had a mental health condition(s) (compared with 17% of who were not regularly missing school). A higher proportion also had substance use issues, were receiving SEND support, or had an EHCP in place.
- One in five children (20%) were reported to have one or more mental health conditions, like previous years. This was particularly common among older age groups, with 58% of 16–17-year-olds and 36% of 11–15-year-olds affected. In 23 reviews, the child's mental health was reported to be linked to their death or serious harm.
- Over the last three years, the proportion of parents recorded as using or being addicted to alcohol and/or substances has been gradually increasing from 39% in 2022-23 to 44% in 2024-25. This is higher for incidents involving babies under-1 (50%).

1. Wider context

1.1 The Child Safeguarding Practice Review Panel's sixth annual report (2024 to 2025) is being published shortly after the closing of the Government's consultation on the scope, functions and powers of the new Child Protection Authority (CPA), and ahead of the publication of the Government's response. The Government has announced its intention to establish a CPA, following recommendations from the final report of the Independent Inquiry into Child Sexual Abuse.

The consultation proposed that the CPA would have three core functions:

- provide national oversight and system leadership, using varied data sources to identify emerging risks and advise on policy
- promote and embed good practice, supporting local areas to implement what works and sharing resources through a national digital platform
- drive improvement and accountability, ensuring recommendations lead to measurable change and advising on inspection and regulation activity

The changing role of the Panel

1.2 The Government has already announced that the CPA will build on and evolve from the work of the Panel. It will inevitably take some time to establish the CPA, and this will require primary legislation.

1.3 Until then, analytical capacity and impact are being strengthened in ways which align with the developing vision for the CPA. In April 2026, the Panel launched its new website and online learning hub. This platform brings together resources to support the sharing of learning from serious incidents and forms part of wider work to improve communication with the safeguarding sector. This includes developing improved data insights and a more collaborative and interactive approach to sharing Panel learning including through webinars, short briefings, infographics, animations, videos, case studies, and commissioned work.

What this means for the annual report

1.4 Given the changes in how the Panel shares its learning and communicates with the wider safeguarding system, this year's annual report has been approached differently. As in previous years, it includes a summary of the serious incidents and reviews considered by the Panel during the reporting year, alongside analysis of the data and key learning arising from those reviews. Unlike previous annual reports, this year's report does not include in-depth thematic analysis or extended discussion of the wider policy context. Instead, it provides a shorter overview of the national picture in England for the reporting year. This reflects the development of the Panel's new website and online learning hub which now provide dedicated and more interactive spaces for this content. As a result, this annual report is more tightly focused and shorter than in previous years, supporting accessibility for readers.

1.5 This more focused report is supported by a range of accompanying resources. These include an infographic and an animation which distil its key content, as well as a video reflection released following publication. A webinar exploring the key themes from this report will be scheduled shortly. In addition, new resources for leaders, managers, and practitioners, reflecting on the persistent themes identified in serious incidents and actionable learning from them, are in development and will be published on the Panel's website.

2. Reflections from the Panel

The role of the Child Safeguarding Practice Review Panel

2.1 As an independent body, the Panel plays a key role in child protection in England by:

- maintaining oversight of the system of national and local reviews and how effectively it is operating
- identifying and overseeing the review of serious child safeguarding incidents which, in the Panel's view, raise issues that are complex or of national importance
- identifying improvements to practice and protecting children from harm.

2.2 This report covers rapid reviews with incident dates falling between 1 April 2024 and 31 March 2025, aligning with the financial year to ensure consistency with reporting across the system.

2.3 We encourage service leaders, managers, and frontline practitioners to use this report as a tool and lens through which to examine their own services. By reflecting on the evidence and insights presented here, organisations and practitioners can identify opportunities for improvement and support positive, sustained change.

2.4 To support this process, we have highlighted key messages, learning points and reflective questions throughout the report.

The Panel's unique role

2.5 Learning from serious incidents involves taking a forensic look at how practitioners responded to risks of harm to children to make sense of how effectively we all worked to protect them. Practice will be shaped to varying extents by a range of contextual factors that influence both the daily lives of children and the conditions within which practitioners operate.

2.6 The Panel recognises that every day many tens of thousands of professionals across England are undertaking skilled and complex work to keep hundreds of thousands of children safe. We are always mindful to remember that we see only those tragic incidents where children have died from abuse or neglect, or where children have experienced the most serious harm. That said, the insight that we gain from considering these most serious incidents is both unique and significant.

2.7 The Panel meets on a fortnightly basis throughout the year, and members consider the reviews that follow the most serious incidents. We receive and consider on average 15-20 rapid reviews and LCSPRs at each of our fortnightly meetings. This provides a unique national perspective on the most serious cases, particularly when set against the experience of most safeguarding partnerships, which may only encounter one or two such incidents in any given year.

2.8 The insight gained from considering a high volume of the most serious incidents brings with it a clear responsibility to identify learning that can support improvement across the safeguarding system. The core challenge is to identify what has been done well and what could have been done better, to draw out important policy and practice themes and emerging trends, and to capture and distil the most important learning. This learning must then be communicated effectively across the safeguarding system so that it can be shared, understood, and acted upon to support system-wide improvement.

2.9 It is of concern to Panel that the number of Serious Incident Notifications and subsequent rapid reviews fell again during the 2024-25 year. The Panel's insight depends on serious incidents being reported wherever warranted or rapid reviews will not follow and resulting learning for the safeguarding system both locally and nationally will be lost. Between 1 April 2024 and 31 March 2025, 274 rapid reviews were submitted for serious incidents that occurred, where abuse and/or neglect was known or suspected. This was a decrease of 21% from the previous year. We urge the leaders of Safeguarding Partnerships to assure yourselves that all eligible serious incidents are being notified to Panel. You may find it helpful to refer to *Child Safeguarding Practice Review Panel: Guidance for Safeguarding Partners*. If you are ever in doubt about whether an incident should be notified, please contact us and ask using the Panel's mailbox at *Mailbox.NationalReviewPanel@education.gov.uk*.

The wider context in which the Panel works

2.10 The Panel's work takes place within a context of continually evolving child protection and safeguarding policy and practice, alongside the development of the future Child Protection Authority.

2.11 This report is being published at a time when the Children's Wellbeing and Schools Bill, which legislates for key aspects of the Government's reform programme, is before Parliament. The Bill seeks to strengthen safeguarding practice, through the establishment of multi-agency child protection teams, registers of children in elective home education, and a new single unique identifier initiative. At the same time, there has been significant government investment in the Families First Partnership Programme, which aims to ensure families can access the right help and support when they need it, with a strong emphasis on early intervention to prevent crisis.

2.12 The Panel is also mindful of continuing pressures on public service delivery. As identified in previous annual reports, a decade and more of financial austerity has reduced the availability of preventative support and help, including youth provision and early help (Gomez-Quintero and others 2024). This financial austerity has been compounded by the pandemic and continuing cost of living pressures on families. In the Panel's view, multi-agency early support and family help is an important area for focus and resource. The £2.4 billion investment in the Families First programme over the 2026-27 – 2028-29 spending review period will make a difference.

More widely, the Panel notes the government's reform programme across the public sector. Recent white papers have set out reforms to local government following the Dec 2024 English Devolution White Paper: Power and partnership: Foundations for growth and changes to policing force structures following the

From local to national: a new model for policing White Paper. The Government will also soon set out plans to reform the youth justice system. Structural reforms in health are also underway with changes to Integrated Care Board structures, footprints and budgets. The Panel is concerned about the impact of these various changes on capacity and resources for involvement in safeguarding leadership, oversight and operations at local level.

Systemic pressures influencing safeguarding practice

2.13 The Panel's work is also conducted in the context of significant systemic pressures that are frequently reflected in the incidents that come for review. The following pressures are of particular concern:

- Shortages of placements for children with complex needs, across social care, mental health and education. Delays in securing appropriate placements can result in children being placed inappropriately or remaining in hospital for extended periods.
- increased need for mental health support, with many serious incidents involving children with complex mental health needs who experience long waits to access CAMHS support or ADHD/ASD assessment, diagnosis and intervention.
- From Local to National: A New Model for Policing and the English Devolution White Paper: Power and Partnership – Foundations for Growth provide important context for changes to policing and local government structures. Alongside this, special educational needs and disability (SEND) resourcing pressures continue to affect local authority, health and school budgets. The Panel recognises that SEND reform and additional investment are Government priorities, but pressures on capacity and access to support remain evident in reviews.
- Family poverty, housing challenges and other forms of deprivation and inequality, which are often significant contextual factors in the incidents considered by the Panel (see further detail in the section on Needs below).

Panel reflections on key findings and insights from the analysis of 2024-25 data

2.14 Chapter 3 highlights key findings and insights from the data analysis for the reporting year. Looking at this data through a lens of previous Panel annual reports, it is worth noting and considering the implications of some key consistent patterns and emerging trends.

2.15 We recognise that the language used when referring to children, their families and communities can at times be contested and that preferred terms can develop and change quickly. A full glossary and a note on language can be found in Appendix A.

Types of incidents

2.16 Between 2022-23 and 2024-25:

- SUDI/SUDC and suicide have remained the most common likely causes of death of children in rapid reviews relating to fatal incidents
- non-fatal intrafamilial assaults and non-fatal neglect have been consistently amongst the most common causes of reported serious harm

Who is involved in incidents

2.17 Between 2022-23 and 2024-25, babies under 1 were consistently the largest age group of children in focus for incidents that came to the attention of the Panel. In general, 11–15-year-olds made up the next largest age group; however, 16-17-year-olds were the second largest age group in 2023-24.

2.18 The Panel has consistently emphasised the importance of recording the race and ethnicity of children who are the subject of incident reporting and rapid reviews. Better recording of these characteristics is essential in supporting the safeguarding system to understand how race and culture impact on agency responses to children and the needs of families. Positively, the percentage of rapid reviews where the ethnicity of the child in focus was recorded has improved from 95% in 2022-23 to 99% in 2024-25.

2.19 Between 2022-23 and 2024-25 children from Mixed/Multiple ethnic groups and Black/African/Caribbean/Black British ethnicities were consistently overrepresented within rapid reviews, when compared to the ethnic breakdown of the wider population of 0-17-year-olds within England. Over these three reporting years, the proportion of children in focus with a known ethnicity and reported as being Black/African/Caribbean/Black British has been increasing.

Needs

2.20 The context of family life in England today matters too. The children and families involved in incidents that come to the attention of Panel have a complex range of overlapping needs. Reviews considered by Panel repeatedly show how challenges in many families' lives impact their ability to protect and keep children safe, including parental capacity to respond to interventions.

2.21 Across the reviews considered by the Panel, we frequently see children:

- living in poverty or in poor quality or overcrowded housing
- not in school or missing significant amounts of education
- living in families known to multiple agencies over many years
- moving between areas or working with agencies across different localities
- experiencing domestic abuse, substance use or mental health difficulties within their family

- with neurodivergence, social and emotional needs, or speech, language and communication needs
- experiencing isolation or pressures both offline and online

Children often experience several of these challenges at the same time. The paragraphs below summarise how key indicators of need appeared between 2022–23 and 2024–25.

Families open or previously known to children's social care

2.22 A high proportion of families involved in incidents were known to children's social care, either at the time of the incident or previously.

- 78% in 2022–23
- 87% in 2023–24
- 84% in 2024–25

Mental health needs of both children and their parents/carers

2.23 Between 2022–23 and 2024–25:

- around one fifth of children had one or more mental health conditions, diagnosed or undiagnosed
- the percentage of incidents where at least one parent or relevant adult had a mental health condition increased from 50% to 57%

Housing issues

2.24 The impact of housing needs has remained a persistent issue. Housing issues were present in 33% of incidents in 2023-24 and 35% in 2024-25.

Family Poverty

2.25 Similarly, reviews suggested there was financial hardship within the family environment in 17% of incidents in 2023-24 and 18% in 2024-25.

Alcohol and/or substance use or addiction

2.26 The proportion of parents recorded as using or being addicted to alcohol or substances has increased over the past three years, rising from 39% in 2022–23 to 44% in 2024–25.

Education

2.27 The importance of school as a potential protective factor has been consistently shown between 2022-23 and 2024-25. The Panel's national review '*It was hard to escape'* *(2020a)* highlighted the point of exclusion as significant in escalating the vulnerability of young people to exploitation. The Panel's May 2024 briefing

'*Safeguarding children in Elective Home Education*' (*2024d*) highlighted the importance of local safeguarding partnerships having evidence-based understanding of safeguarding issues relating to EHE and children who are home educated needing to be known to key agencies where there are concerns that they may be at risk of significant harm. The Panel's 2022-23 Annual Report highlighted that rapid reviews continued to show that too many children spend long periods of time outside formal education and persistent school absence remains high. Missing education continues to be an issue; in this reporting year 45% of all school age children in focus were recorded as missing some of their schooling/education due to regular absences or exclusion. This pattern is reflected in the consistently high proportion of 16- and 17-year-olds who were not in education, employment or training:

- 31% in 2022–23
- 33% in 2023–24
- 27% in 2024–25

Domestic abuse

2.28 Previous annual reports have highlighted recurring issues including a lack of understanding of domestic abuse, adult males in families being unknown to or not seen by services, the need to involve perpetrators in assessments, and the need to strengthen the multi-agency response.

In 2024–25, just over half of children in focus (51%) were reported to have experienced domestic abuse.

Emerging trends

2.29 Alongside the persistent issues above, the Panel is concerned about several emerging trends:

- **Young parents**
  In 2024–25, 19% of reviews involved parents aged under 25. This has risen from 13% in 2022–23 and 17% in 2023–24
- **Decreasing notifications and rapid reviews**
  Submissions continued to fall in 2023–24 and 2024–25, potentially limiting national learning if any eligible serious incidents are not being notified
- **Online harms**
  In 2024–25, 9% of rapid reviews reported an online context to the harm, including cyberbullying, harmful social media use and engagement with harmful online content

Learning and practice themes

2.30 Analysis of the annual data shows both persistent and emerging issues in the incidents considered by the Panel.

Persistent issues include insufficient learning from previous reviews being embedded into practice; key information being shared too late or not at all; limited understanding of children's daily lived experiences; and an over-focus on presenting issues rather than wider contextual factors. These issues often contribute to weak risk assessment and inconsistent multi-agency understanding. Emerging issues reflect the trends set out above, including the increasing proportion of young parents involved in serious incidents, decreasing numbers of serious incident notifications, and the growing presence of online contexts to harm.

We must continue to identify and apply learning to improve child safeguarding. The ongoing challenge is moving beyond recognising persistent and emerging issues to achieving real, sustainable change in leadership, management, and practice across the safeguarding sector. The Panel has an important role to play in this. The data and analysis in this annual report are a starting point, but we can strengthen their impact by sharing key information in clearer, more accessible ways. This includes our webinars, content on the new website and learning hub, and the new learning resources we are developing for leaders, managers, and practitioners. These will explore the recurring themes emerging from serious incidents and how they can be addressed at every level of the safeguarding system.

2.31 Safeguarding partnerships are encouraged to consider how these persistent and emerging themes are reflected in their local contexts and to use the findings in this report to inform ongoing reflection, learning and improvement. Alongside this annual report, the Panel continues to share learning through its website and supporting resources for leaders, managers and practitioners, which reflect on the themes identified in serious incidents and how they can be responded to across the safeguarding system.

Panel activity April 2024 – March 2025

2.32 During the period covered by this annual report, and in addition to reviewing individual incidents, the Panel also delivered the following national activity:

Major publications

- May 2024 - Publication of the Panel's practice review paper on Safeguarding children in elective home education

- November 2024 - Publication of the Panel's national review into child sexual abuse within the family environment – "I wanted them all to notice" Protecting children and responding to child sexual abuse within the family environment.

    - As part of the report and publication activity the Panel urged government to develop a national action plan (CSPRP, 2024e)

- March 2025 - Publication of the Panel's report on safeguarding children from Black, Asian and mixed heritage backgrounds – "It's silent": Race racism and safeguarding children

Webinars

During the period covered by this Annual Report the Panel also delivered 5 webinars:

Elective Home Education webinar	October 2024
2 x webinars on Child Sexual Abuse within the Family Environment	January 2025
Annual report: Mental health webinar (A spotlight theme in the annual report)	February 2025
Annual report: Extra familial harm webinar (A spotlight theme in the report)	February 2025

A further webinar on our report "It's Silent": Race, Racism and Safeguarding Children was held just outside the reporting period covered by this review in April 2025.

If you haven't already subscribed, *please sign up to our monthly email newsletter* to receive updates on future webinars and publications.

Activity for 2025-26

2.33 During 2025–26, the Panel has taken forward a programme of work to strengthen national learning and support safeguarding partners. This has included:

- May 2025: Publication of findings from the Learning Support and Capability Project with Research in Practice, exploring how safeguarding partners learn from serious incidents.
- June 2025: Publication of the Panel impact evaluation conducted by IFF Research Ltd, assessing the Panel's impact since 2018.
- June 2025: Publication of updated Panel guidance for safeguarding partners.
- September 2025: Recruitment of four new Panel members.
- October 2025: Launch of a new monthly webinar series on key topics including the changing role of the Panel, good practice in notifying serious incidents, emerging safeguarding trends, private law proceedings and child safeguarding, and safeguarding vulnerable babies.
- November 2025: Establishment of an Expert Reference Group to support the development of the Panel's new website and online resource hub.
- February 2026: Publication of the national review into the broader safeguarding issues raised by the death of baby Victoria Marten.
- April 2026: Launch of the new website and learning hub, including new resources on neglect, child sexual abuse, vulnerable babies and safeguarding Black, Asian and Mixed Heritage children.

3. A window on the system

Key findings

The following key findings summarise the national picture from the 274 rapid reviews submitted for incidents that occurred between 1 April 2024 and 31 March 2025:

- the number of rapid reviews submitted was 274, a 21% decrease on the previous year, reflecting the wider national decrease in SIN submissions
- incidents continued to be split evenly between girls and boys, although girls experienced more suicides and sexual abuse, and boys experienced more non-fatal assaults and deaths perpetrated by non-family members
- babies under 1 remained the largest age group reported, with a third (33%) of incidents relating to sudden unexpected death in infancy (SUDI)
- as with previous years, Black children and children from Mixed/Multiple ethnic backgrounds were over-represented within the reviews, while Asian, Asian/British and Other ethnicities were under-represented
- SUDI and suicide remained the most common likely causes of death, while non-fatal intrafamilial assaults remained the most common likely cause of serious harm
- a high proportion of children who were the focus of these reviews came into contact with, or whose families were known to, children's social care (CSC) before the incident
- A fifth of children were reported as having one or more mental health conditions, particularly among older age groups
- parental alcohol and/or substance use, or addiction continued to be a key risk factor, particularly in cases of SUDI
- over half of the children had experienced domestic abuse and 60% had experienced neglect in their life
- lack of coordination or handover between services, limited professional curiosity and weak risk assessment and decision-making continued to be key practice and learning themes identified within the rapid reviews

3.1 This chapter provides insight into the incidents and challenges faced by safeguarding partners. It draws on the unique information the Panel has access to through its oversight of serious safeguarding incidents and rapid reviews.

3.2 In England, when a child dies or is seriously harmed and abuse and/or neglect is known or suspected the local authority must submit a serious incident notification (SIN). Following this, the safeguarding partnership for the area must carry out a rapid review to establish whether any immediate action is needed to ensure a

child's safety and the potential for practice learning. Only one SIN is submitted per incident, so where an incident involves multiple children, a primary child is identified in the SIN and is the focus of the rapid review. Within this report, the primary child is referred to as the child in focus.

Please see Appendix B for more detail about SIN and rapid review submissions and our data approach.

3.3 The following sections present analysis based on information from the rapid reviews, supported by information from the associated SIN, for those incidents occurring over the 12-month reporting period of 1 April 2024 to 31 March 2025. Comparison is also made with previous reporting years. **Please note, unless otherwise stated analysis is based on the date of the incident, not when the rapid review was submitted**.

3.4 It should be noted that the number of incidents reported for this period may be liable to change in future reports due to the late identification or reporting of incidents.

3.5 The Panel also received 117 Local Child Safeguarding Practice Reviews (LCSPRs) between 1 April 2024 and 31 March 2025. LCSPRs are conducted by safeguarding partners where there is additional learning to that identified within the rapid review. These have not been counted within this analysis as they will all have been the subject of a previous rapid review except for in very rare cases where the safeguarding partners have proceeded directly to an LCSPR.

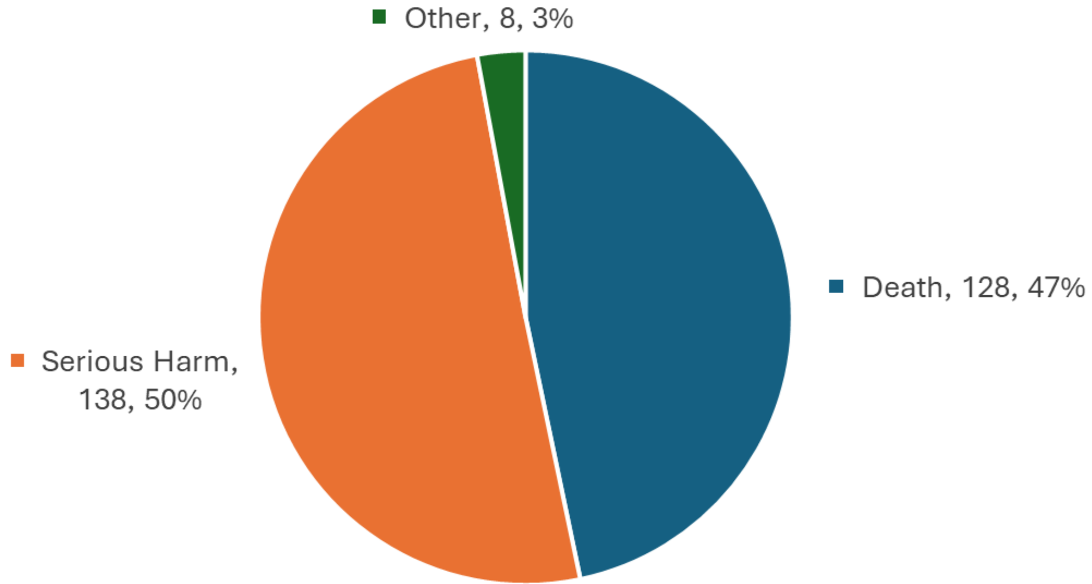
Number of rapid reviews

3.6 The Panel received 274 rapid reviews for incidents occurring between 1 April 2024 and 31 March 2025. Chart 1 shows the breakdown:

- 50% concerned incidents of serious harm
- 47% related to the death of a child
- 3% were classed as 'other', for example where harm was caused by another child

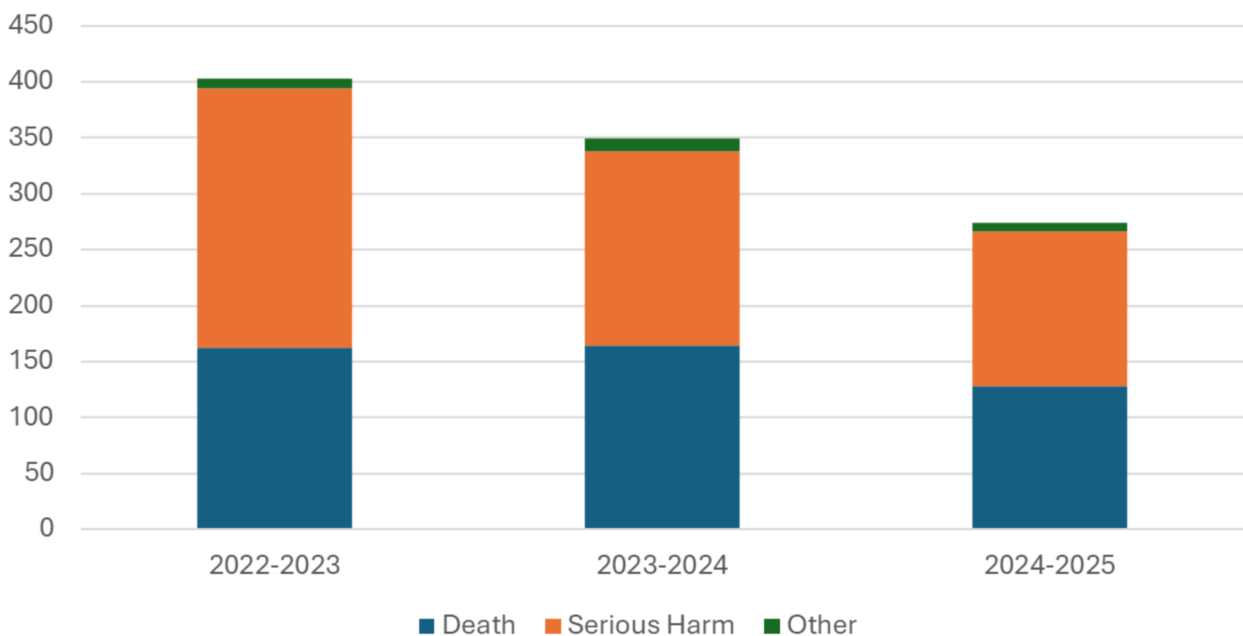
These proportions are unchanged from 2023–24.

Chart 1: Number and proportion of rapid reviews by incident type, 2024-25.



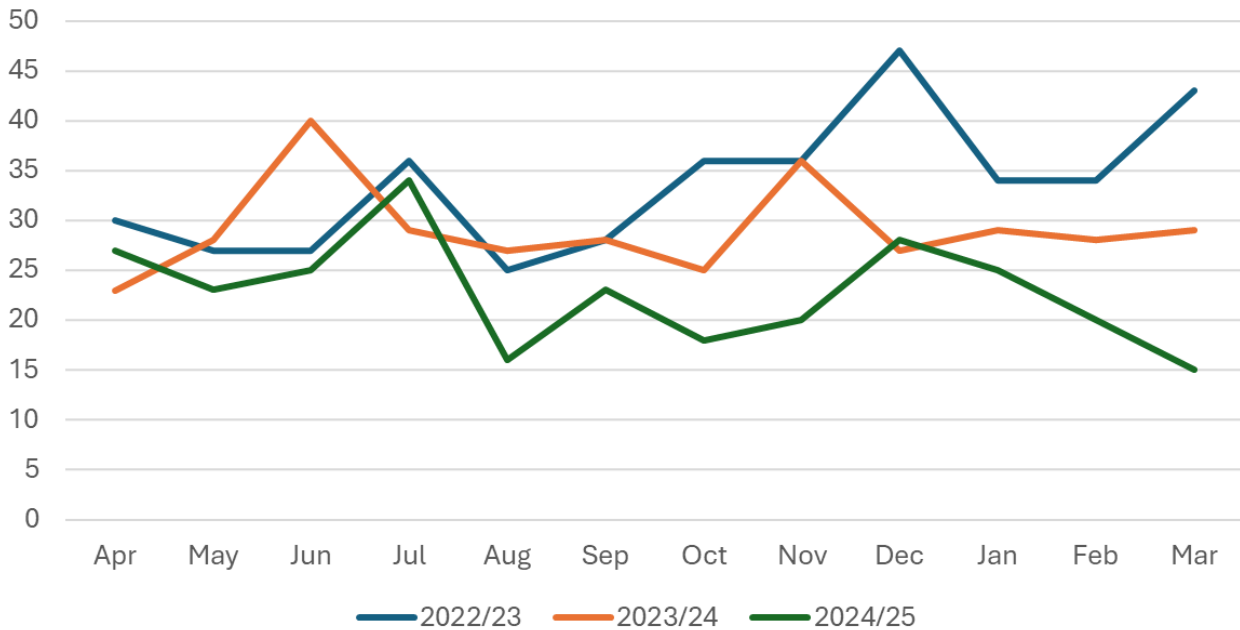
3.7 Overall, the number of rapid reviews has decreased by 21%, from 349 in 2023-24 to 274 in 2024-25, as shown in Chart 2. The average number of incidents per month has decreased from 33.6 in 2022-23 to 29.1 in 2023-24 to 22.8 in 2024-25. This reflects the general downward trend in SIN submissions as reported by the Department for Education in their annual data release (2025c).

Chart 2: Number of rapid reviews by year broken down by incident type for 2022-23, 2023-24 and 2024-25.



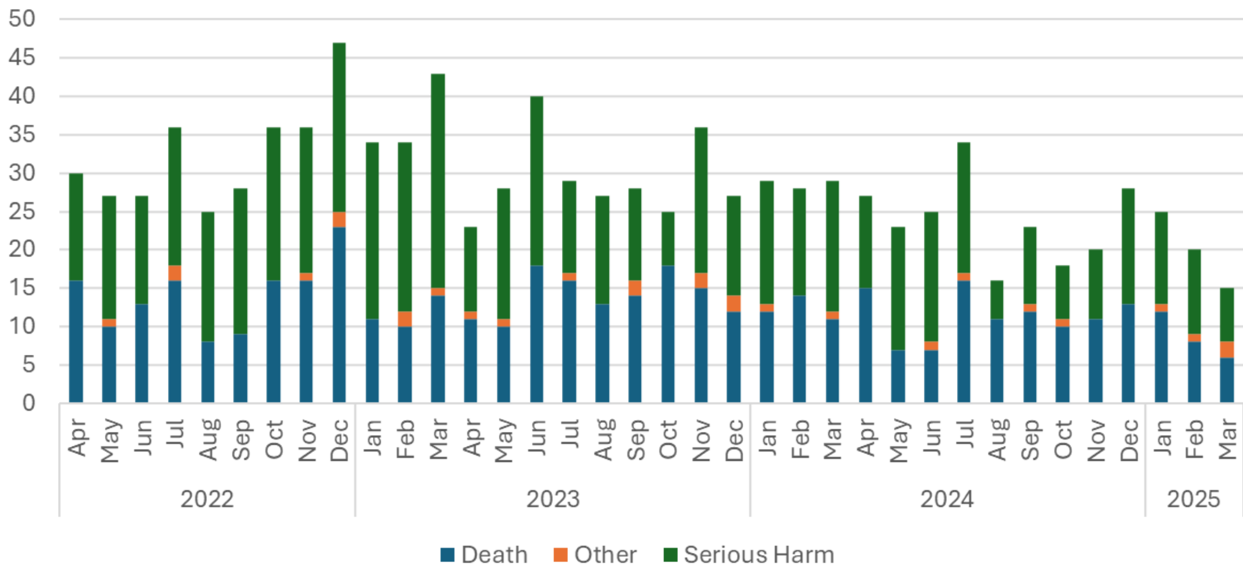
The Department for Education is aware that, in some instances, not all incidents that meet the definition for a serious incident are notified. It is not possible to ascertain whether the fall in 2024–25 reflects a decrease in serious incidents, or whether fewer notifications were reported compared with earlier years. This reduction in SINs is being explored further by the Panel, working with DfE officials, to better understand what factors may lie behind the reduction. In addition, we have updated our guidance to support safeguarding partners in identifying when a serious harm incident or death of a child should be reported. Safeguarding partners are encouraged to review this when making decisions around submissions.

Chart 3: Monthly number of rapid reviews by date of incident, April 2022 to March 2025



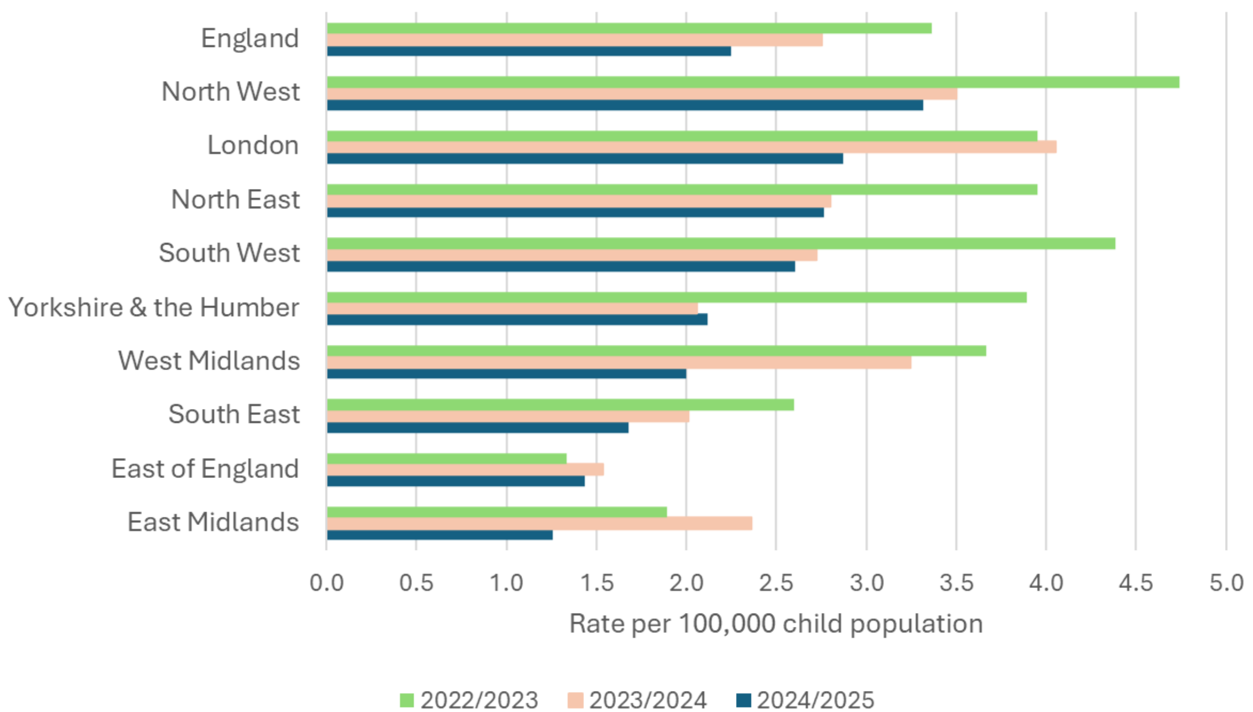
3.8 Chart 3 shows the number of rapid reviews by month and reporting year of the incident. Interestingly, incidents for 2022-23 and 2024-25 follow a similar pattern between April to September and November to January, however incidents for 2023-24 do not fit this pattern. Chart 4 shows the monthly figures by incident type which demonstrates a seasonal pattern, with peaks in the summer and winter months.

Chart 4: Monthly numbers of rapid reviews by incident type, April 2022 to March 2025



3.9 Across England there were 2.3 rapid reviews submitted per 100,000 child population, as shown in Chart 5. This has decreased over the previous two years, reflecting the overall decrease in the number of SINs and rapid reviews submitted.

Chart 5: Rate of rapid review submissions per 100,000 child population by region, for 2022-23, 2023-24 and 2024-25

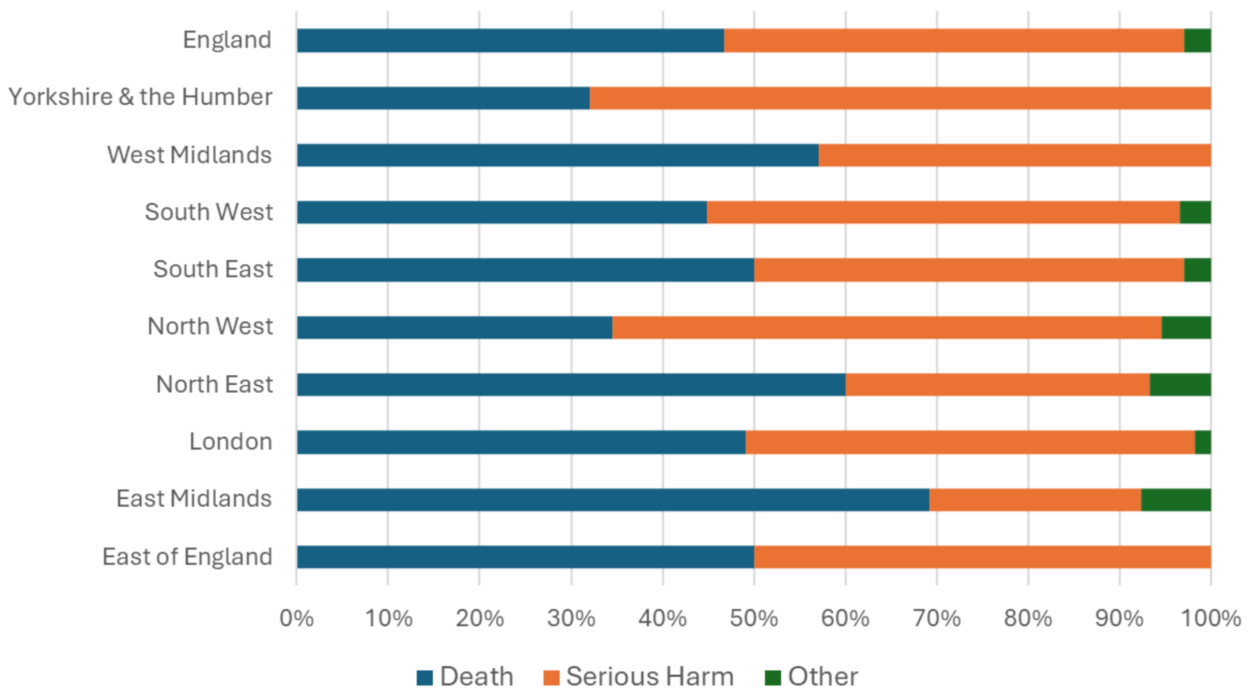


3.10 The regional rate of submission for 2024-25 varied from 1.3 in the East Midlands to 3.3 per 100,000 child population in the North West. All regions apart from

Yorkshire & the Humber have seen a decrease in the rate of rapid reviews per 100,000 population on last year (Chart 5).

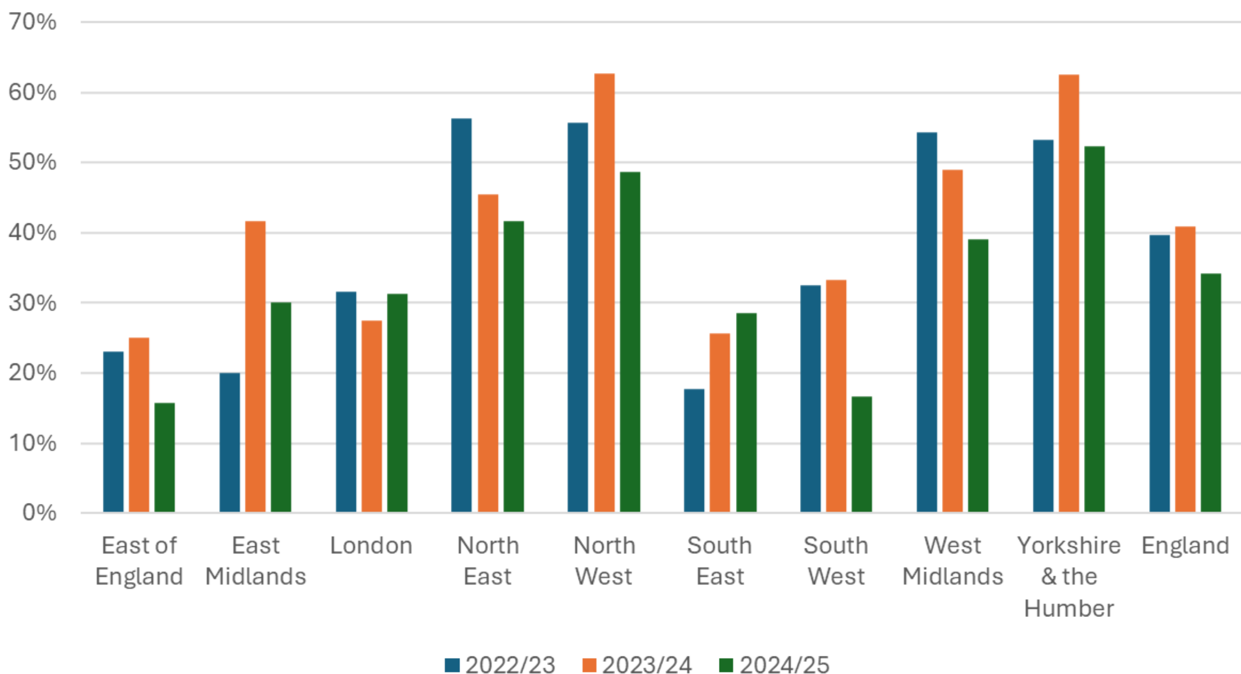
3.11 These numbers are not a comment on the practice of the regions, and it is important to note that differences in notification numbers across regions could be indicative of varying socio-economic contexts as well as child population sizes. An increase or reduction in the number of SINs and subsequent rapid reviews submitted should not be interpreted as equalling greater or less harm, nor can a higher number in one region be seen as that area having higher rates of harm. However, we encourage safeguarding partners to investigate why submission rates have changed across the two years, particularly where large decreases have been seen. We also reiterate the importance of SINs being submitted whenever the SIN notification threshold is met. SINs are essential for us to be able to keep an overview of the most serious safeguarding incidents nationally and to ensure that the safeguarding system is learning all it can from those incidents.

Chart 6: Proportion of rapid reviews by region by incident type, 2024-25



3.12 Chart 6 shows that although the number and proportion of deaths and serious harm incidents reported in the reviews was even for England as a whole, this varied by region. For example, 69% of rapid reviews for the East Midlands were in relation to child deaths whereas this was 32% in Yorkshire & the Humber.

Chart 7: Proportion of rapid reviews by region for incidents occurring in the 20% most deprived areas, 2022-23 to 2024-25



3.13 Chart 7 shows the proportion of incidents reported in rapid reviews that were for children living in the 20% most deprived areas, for each region. Across England, over a third (34%) of incidents involved children living in the 20% most deprived areas. This is less than the previous year when 41% of children in focus lived in the 20% most deprived areas.

Reflective questions for safeguarding partners

The following questions are designed to support local reflection and learning.

Serious Incident Notifications (SINs)

- How does your partnership know that all incidents which meet the SIN criteria are identified and submitted to Panel?
- Who is involved in the decision-making process for SIN submissions and how are professional disagreements resolved?
- Do you contact the Panel if you are unsure if a SIN submission should be made?

Scrutiny and auditing

- What scrutiny and auditing processes do you have in place regarding SIN submissions and how do you consider near-miss incidents?
- How do you ensure that these processes are clearly communicated, understood, and consistently applied across your partnership?

Understanding your local context

- The above statistics showed regional variations in terms of deaths and serious harm reported. Reflecting on your local safeguarding partnership data, how does it compare to the regional data and what might this comparison tell you?
- In the rapid reviews you have submitted in the last year, what proportion of children were living in the most deprived areas? Have you seen an increase or decrease in these numbers, and what might be behind any changes?

Child characteristics

3.14 As mentioned previously, only one notification is submitted per incident, even if more than one child has experienced harm. During 2024-5, over a fifth (21%) of notifications reported more than one child was likely to be involved in the incident, equating to over 360 children affected by the 274 incidents reported[1].This is a reduction from 510 in 2023-24 although a similar proportion (22%).

Please note that the following analysis is based on the child in focus.

3.15 Of the 274 rapid reviews for the children in focus there was an even split between boys and girls, with only two more reviews submitted for boys (138) than girls (136).

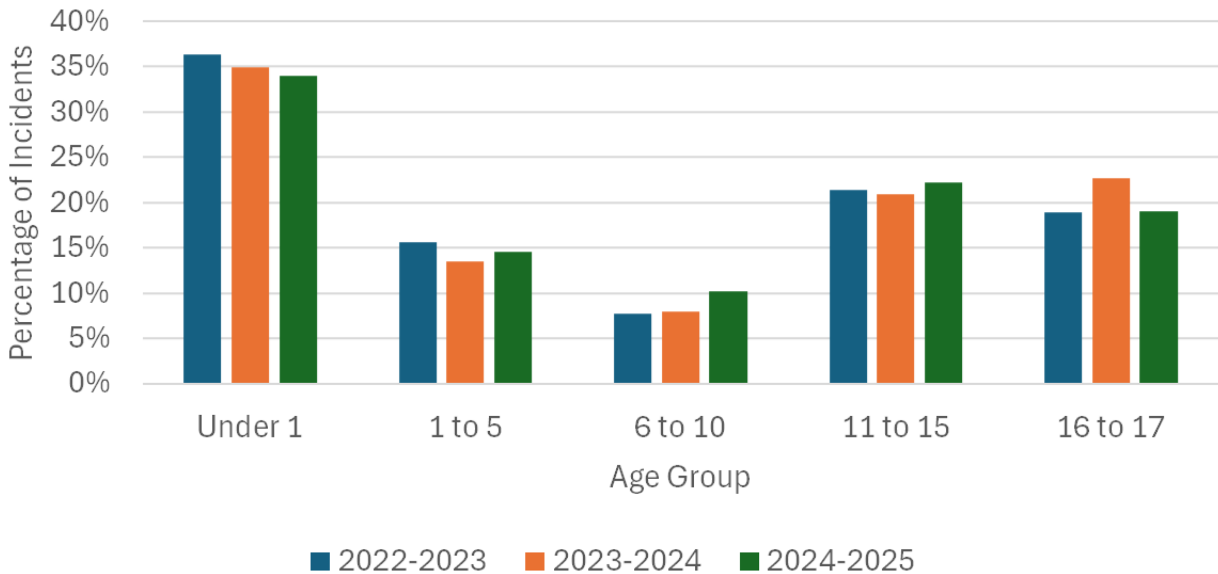
In previous years there have been slightly more rapid reviews for boys (54% in 2022-23 and 55% in 2023-24) than girls.

3.16 In line with previous years:

- 60% of deaths reported relate to boys and 40% to girls
- 60% of incidents of serious harm related to girls and 40% to boys

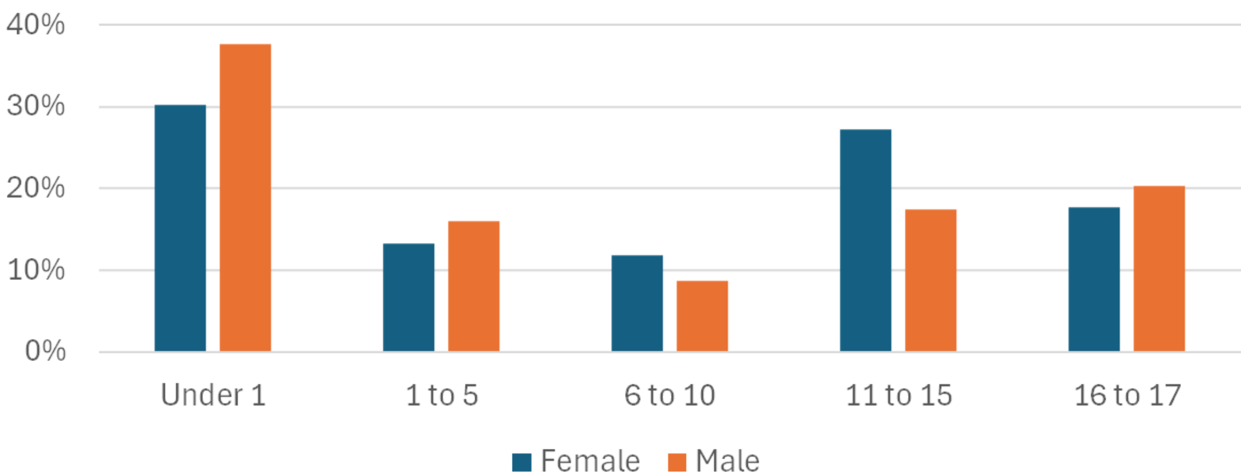
[1] There were two incidents involving multiple children where, due to the complexity of the cases, the true number of children involved was still being identified when the rapid review was conducted.

Chart 8: Proportion of rapid reviews by age group for the reporting years of 2022-23, 2023-24 and 2024-25



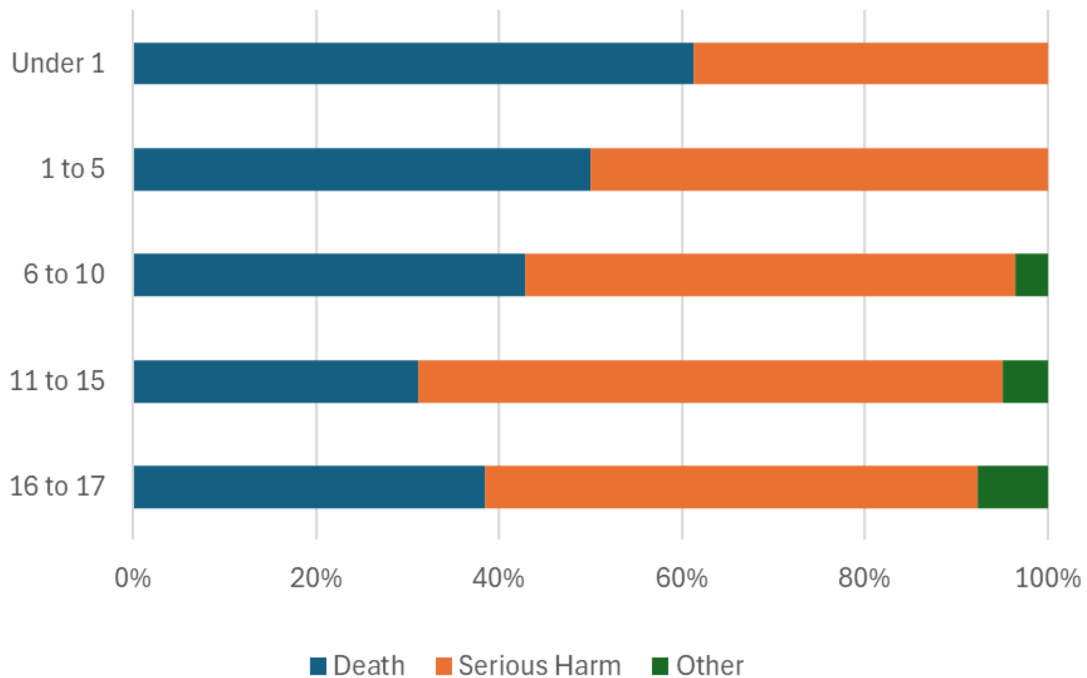
3.17 Chart 8 shows that, as in previous years, babies aged under 1 accounted for the largest age group, with 34% in 2024-25. The second largest age group was 11-15-year-olds accounting for a fifth (22%) of incidents followed by 16–17-year-olds with 19%. There were variations to this at a regional level however, for example 15% of rapid reviews from the East of England were for babies under 1's compared to nearly half (48%) of reviews from the South West. Similarly, the proportion submitted for 11-15-year-olds varied from 12% of rapid reviews from the South East to 36% of reviews from the North West. Further data on this can be found in Appendix E.

Chart 9: Proportion of incidents by age group and sex, 2024-25



3.18 Chart 9 shows the breakdown of incidents by sex and age group. As with the overall figure, babies under 1 was the largest group for both sexes, however it was slightly greater for boys (38%) compared to girls (30%). Conversely, 27% of girls were aged 11-15-years-old compared to 17% of boys. The average age of the child in focus was 7.4 years, like the previous year (7.3).

Chart 10: Proportion of rapid reviews by age group and incident type, 2024-25



3.19 Chart 10 shows the proportional split between the types of harm for each age group. The age group with the largest proportion of fatal incidents was babies under 1 with 61%, followed by children aged 1-5-years-old with 50%. Only a third (31%) of incidents involving children aged 11-15 years-old were for the death of a child and 64% of incidents were for serious harm. Additionally, 16-17-year-olds had the greatest proportion of other incidents (8%), with all 4 of these incidents being where the child had caused harm.

3.20 In terms of the child's gender, 5 children were reported to have a gender identity different from the sex registered at birth or to be non-binary, accounting for 4% of children aged 10 and above. This is slightly less than the previous year (6%). However, it should be noted that, in most reviews where it may be age appropriate to do so, characteristics such as gender or sexual orientation were not recorded.

3.21 In addition, 5 children were recorded as being LGBTQ+, 4% of children aged 10 and above. This is a reduction from 2023/24 where 7% of children aged 10 and above were recorded as LGBTQ+. Overall, there were 2 children who were recorded as both identifying as LGBTQ+ and with a gender identity different to their sex at birth.

3.22 The ethnicity of the child in focus was recorded in 99% of rapid reviews for 2024-25 with it not being reported in only 3 of the 274 rapid reviews. This is a continued improvement from 95% in 2022-23 and 98% in 2023-24.

Table 1. Ethnicity breakdown of children subject to rapid reviews 2024/25 (where ethnicity is known n=271) compared to the 2021 census figures for England[2]

	2024/25		2021 Census (*)
	N.	%	%
White	**191**	**70.5**	**72.5%**
1. White British	162	59.8	66.9%
2. Irish	1	0.4	0.3%
3. Gypsy or Irish Traveller	3	1.1	0.2%
4. Any other White background	25	9.2	5.1%
Mixed/Multiple ethnic groups	**30**	**11.1**	**6.8%**
5. White and Black Caribbean	9	3.3	1.9%
6. White and Black African	10	3.7	1.1%
7. White and Asian	1	0.4	2.1%
8. Any other Mixed/Multiple ethnic background	10	3.7	1.7%
Asian/Asian British	**15**	**5.5**	**12.3%**
9. Indian	3	1.1	3.5%
10. Pakistani	3	1.1	4.5%
11. Bangladeshi	4	1.5	1.8%
12. Chinese	0	0	0.6%
13. Any other Asian background	5	1.8	2.0%
Black/ African/Caribbean/Black British	**33**	**12.2**	**5.7%**
14. African	14	5.2	3.7%
15. Caribbean	11	4.1	0.8%
16. Any other Black/African/ Caribbean background	8	3.0	1.2%
Other ethnic group	**2**	**0.7**	**2.7%**
17. Arab	0	0.0	0.9%
18. Any Other ethnic group	2	0.7	1.8%
Total Known	**271**	**100.0**	100.0%

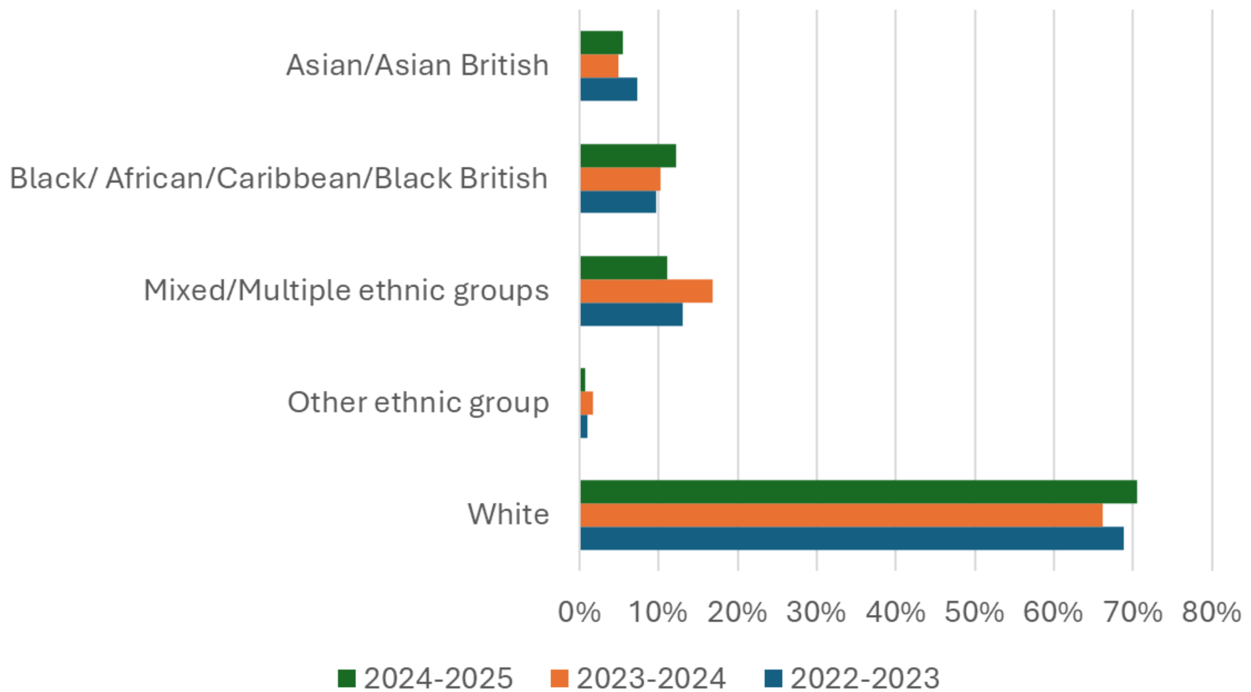
(*) Source: Office for National Statistics, population of children aged 0-17 years old

3.23 Table 1 shows that 71% of children were recorded as white, with the next largest group being Black/African/Caribbean/Black British with 12% followed by Mixed/Multiple ethnic groups with 11%. Overall, 6% of children were recorded as Asian/Asian British and 1% as Other.

3.24 As with previous years, comparison with 2021 census statistics for children shows an over-representation of Black/African/Caribbean/Black British children and those with Mixed/Multiple ethnicities within reviews and an under-representation of children from Asian/Asian British and Other ethnicities.

[2] These are the most up-to-date figures available that include the whole child population by ethnicity. More recent figures for school children are provided in the education statistical release Schools, pupils and their characteristics

Chart 11: Proportion of rapid reviews by ethnic group, 2022-23 to 2024-25



The consistent recording of the child's characteristics such as sex, gender, sexuality, disability and ethnicity is important to better understand children's and families' lives and experiences, and subsequent practice decision-making. The inclusion of this information, whether directly related to the incident or not, can contribute to the knowledge and understanding of broader aspects of practice and whether there are systemic practice issues to be addressed.

3.25 Chart 11 shows the change in proportional breakdown of rapid reviews by ethnic group over the last three years. This shows that the proportion of children reported as being Black/African/Caribbean/Black British has been increasing over this time.

Reflective question for regions

- Do you discuss SIN submissions from safeguarding partners within your region to support consistency of decision-making?

Reflective questions for safeguarding partners:

- Do you compare the characteristics of children who are the focus of rapid reviews with those of the child population in your area? Are any groups of children over- or under-represented in serious incidents and if so, why might this be and what is being done to address it?

- How does demographic information shape commissioning, service provision and your area's ability to engage and support different groups within communities?

Deaths

3.26 The likely cause of death reported within this section is based on the information presented in the rapid review and what was known at that time. In some circumstances, the cause of death may have been suspected but was still waiting to be confirmed and/or changed post-rapid review. Further definitions of the causes of death can be found in Appendix C.

3.27 Of the 128 fatal incidents which were reported for incidents occurring between April 2024 to March 2025, 60% were for boys and 40% for girls.

Table 2. Number and proportion of fatal incidents by likely cause of death and sex of the child, 2024-25

	Female		**Male**		**Total**	
Likely Cause of Death	**N**	**%**	**N**	**%**	**N**	**%**
Unexplained SUDI/SUDC	11	21.6%	26	33.8%	**37**	**28.9%**
Suicide	11	21.6%	9	11.7%	**20**	**15.6%**
Fatal Assaults-Intrafamilial	5	9.8%	7	9.1%	**12**	**9.4%**
Medical	7	13.7%	4	5.2%	**11**	**8.6%**
Unclear	3	5.9%	6	7.8%	**9**	**7.0%**
Death from Extreme Neglect	5	9.8%	3	3.9%	**8**	**6.3%**
Overt Child Homicide by primary caregiver	4	7.8%	4	5.2%	**8**	**6.3%**
Child Homicide – Extrafamilial	0	0.0%	7	9.1%	**7**	**5.5%**
Accident/injury	2	3.9%	4	5.2%	**6**	**4.7%**
Risk taking behaviour	3	5.9%	0	0.0%	**3**	**2.3%**
Fatal Assaults – Extrafamilial	0	0.0%	3	3.9%	**3**	**2.3%**
Child Homicide – Intrafamilial	0	0.0%	2	2.6%	**2**	**1.6%**
Covert Child Homicide by primary caregiver	0	0.0%	2	2.6%	**2**	**1.6%**
Total	**51**	**100.0%**	**77**	**100.0%**	**128**	**100.0%**

3.28 As with previous years, unexplained SUDI/SUDC was the most common likely cause of death in rapid reviews relating to fatal incidents, accounting for 29% of them as shown in Table 2. The proportion of SUDI/SUDC incidents was higher for boys (34%) than girls (22%). The next most common category was suicide with 16%, like previous years. As with previous years, suicides were more commonly reported in deaths of girls, accounting for just over a fifth (22%) compared to 12% of deaths of boys. Conversely, extrafamilial child homicide and extrafamilial fatal assaults (where the death followed a physical assault and there was no clear intent to kill the child) combined were only reported for boys (13% of fatal incidents for boys), with none reported for girls.

Suicides

- A total of 64 suicides were reported, accounting for 14% of the 454 deaths
- 59% were suicides of girls and 41% of boys
- In most of these incidents (69%) the child was 15–17 years old
- In 5% (3) of deaths the child was aged under 12, all of whom were boys
- 60% of suicides of children aged 17 were of boys
- 88% of children dying by suicide were reported to have one or more mental health conditions, both diagnosed and undiagnosed
- 33% of children were recorded as neurodivergent
- 19% of children were recorded as LGBTQ+

Over the three years, 12 of the children who died by suicide were reported as being LGBTQ+. This is nearly half (46%) of all children (26) reported as being LGBTQ+ over the three-year period. This high proportion may, however, be due to how and when LGBTQ+ status is recorded in rapid reviews. Characteristics such as sexuality are more likely to be recorded within the rapid review if it is seen to be a factor in the harm the child experienced. All 12 of these children were noted as having mental health conditions and all were known to CAMHS either at the time of the incident (7), previously (4) or a referral had been made (1). In general, those children dying by suicide (n = 64) were more likely to suffer abuse prior to the incident than those experiencing other causes of harm (n = 962):

- 45% of children dying by suicide had experienced emotional abuse compared to 21% of all other children
- 23% had suffered bullying compared to 5% of other children
- although smaller in difference, 28% of children dying by suicide had experienced CSA/E compared to 20% of other children
- the proportion of children experiencing domestic abuse was similar between those who died by suicide (52%) and overall (50%)

Children who died by suicide were also more often known to CSC:

- 30% of children who died by suicide were a looked-after child at the time of the incident, compared to 14% of children overall
- 48% of children dying by suicide were either a Child in Need at the time of the incident or previously, compared to 36% for all other children

Reflective questions for safeguarding partners:

- What do you know about the characteristics and lived experiences of children in your area who have died by suicide? What can this tell you about the mental and emotional support needs these children may have? Does your partnership contribute to your area's suicide prevention strategy?

- What interim support (local, regional or national) is available to children with mental health needs and their families while they are awaiting assessment or to access services?

Serious harm

3.29 As with fatal incidents, the likely cause of harm for serious harm incidents is based on the information reported in the rapid review and may have changed since the review took place. Further definitions of the causes of harm can be found in Appendix D.

3.30 Of the 138 incidents of serious harm reported in the reviews, 60% were for girls and 40% for boys.

Table 3. Number and proportion of serious harm incidents by likely cause of harm and sex of the child, 2024-25

	Female		Male		Total	
Likely Cause of Harm	**N**	**%**	**N**	**%**	**N**	**%**
Non-fatal Assaults-Intrafamilial	20	24.1%	19	34.5%	**39**	**28.3%**
Non-fatal neglect	14	16.9%	8	14.5%	**22**	**15.9%**
Child sexual abuse – Intrafamilial	13	15.7%	3	5.5%	**16**	**11.6%**
Child sexual abuse – Extrafamilial	12	14.5%	3	5.5%	**15**	**10.9%**
Non-fatal Assaults – Extrafamilial	2	2.4%	13	23.6%	**15**	**10.9%**
Other non-fatal incident	7	8.4%	4	7.3%	**11**	**8.0%**
Attempted suicide	2	2.4%	1	1.8%	**3**	**2.2%**
Accident/injury	3	3.6%	0	0.0%	**3**	**2.2%**
Self-harm	2	2.4%	0	0.0%	**2**	**1.4%**
Risk taking behaviour	2	2.4%	0	0.0%	**2**	**1.4%**
Severe, persistent child cruelty	1	1.2%	1	1.8%	**2**	**1.4%**
Unclear	2	2.4%	0	0.0%	**2**	**1.4%**
Fabricated/induced Illness	0	0.0%	2	3.6%	**2**	**1.4%**
Medical cause	2	2.4%	0	0.0%	**2**	**1.4%**
Child sexual exploitation	1	1.2%	0	0.0%	**1**	**0.7%**
Child criminal exploitation	0	0.0%	1	1.8%	**1**	**0.7%**
Grand Total	**83**	**100.0%**	**55**	**100.0%**	**138**	**100.0%**

3.31 As with previous years, the most common cause of serious harm reported was non-fatal Assaults – intrafamilial (28%), followed by non-fatal neglect (16%) as shown in Table 3.

3.32 Reported serious harm incidents relating to child sexual abuse, both intrafamilial and extrafamilial, were more likely to relate to girls (30%) than boys (11%).

Conversely, non-fatal assault, both intra and extrafamilial were the likely cause of harm for 58% of boys experiencing serious harm compared to 27% of girls.

The recent National Audit on Group‑based Child Sexual Exploitation and Abuse by Baroness Casey (2025) highlighted the need to do more to protect vulnerable children from group‑based child sexual abuse and other forms of sexual abuse and exploitation. The government is currently taking immediate action to take forward all 12 of the recommendations from the report, including setting up a new national inquiry, with full cross‑government cooperation. The Children's Wellbeing and Schools Bill will be a key step towards delivering these recommendations, with new measures to improve information sharing and to enable better join-up between agencies. The Department for Education (DfE) also recently published Children in need: A focus on sexual abuse and exploitation, meeting the Casey Audit recommendation 9. This includes analysis of children who were assessed as being affected by child sexual abuse or exploitation, giving valuable insight into their demographics, outcomes, trends over time. It will help us to better understand practice and recording for these children. Other steps being taken by the DfE include developing guidance and training for practitioners to strengthen the identification of, and response to, child sexual exploitation. The Panel has also recently updated its guidance for safeguarding partners on submitting serious incidents notifications, including incidents involving child sexual exploitation – Child Safeguarding Practice Review Panel: Guidance for Safeguarding Partners (CSPRP, 2025).

Children's social care involvement

3.33 In some incidents, the child in focus and/or their family are known to CSC before the incident occurred. This section looks at the capacity in which the child is known to CSC at the time of the incident, as set out in Table 4.

Table 4: Number and proportion of incidents by type of incident and contact with CSC, 2024-25

	Death		Serious Harm		Total[1]	
	N	%	n	%	**n**	**%**
Family Known to CSC						
Yes – current open case	58	*45.3%*	58	*42.0%*	**122**	***44.5%***
Yes – previous known	48	*37.5%*	58	*42.0%*	**108**	***39.4%***
Total known	106	*82.8%*	116	*84.1%*	**230**	***83.9%***
Child in Need (CIN)						
Yes – at time of the incident	17	*13.3%*	6	*4.3%*	**26**	***9.5%***
Yes – previously	31	*24.2%*	47	*34.1%*	**82**	***29.9%***
Total CIN status	48	*37.5%*	53	*38.4%*	**108**	***39.4%***
Child Protection Plan (CPP)						
Yes – on CPP	14	*10.9%*	21	*15.2%*	**37**	***13.5%***
Yes – previously on CPP	26	*20.3%*	26	*18.8%*	**54**	***19.7%***
Total CPP status	40	*31.3%*	47	*34.1%*	**91**	***33.2%***
Child Looked After						
Yes – child in foster care	5	*3.9%*	3	*2.2%*	**8**	***2.9%***
Yes – child in other residential setting	7	*5.5%*	7	*5.1%*	**14**	***5.1%***
Yes – child in residential home	5	*3.9%*	11	*8.0%*	**17**	***6.2%***
Previously looked after	6	*4.7%*	9	*6.5%*	**16**	***5.8%***
Total Looked After status	23	*18.0%*	30	*21.7%*	**55**	***20.1%***
Child Subject to a Care Order						
Yes – currently subject to care proceedings	2	*1.6%*	3	*2.1%*	**5**	***1.8%***
Yes – interim care order	7	*5.5%*	7	*5.1%*	**14**	***5.1%***
Yes – permanent care order	7	*5.5%*	6	*4.3%*	**14**	***5.1%***
Yes – special guardianship order	4	*3.1%*	1	*0.7%*	**5**	***1.8%***
Yes – other or unknown order	1	*0.8%*	10	*7.1%*	**11**	***4.0%***
Yes – previously subject to care order	4	*3.1%*	4	*2.9%*	**8**	***2.9%***
Total Care Order status	25	*19.5%*	31	*22.5%*	**57**	***20.8%***
Total Incidents	**128**		**138**		**274**	

1 Total includes 8 cases with the incident type of ‘Other’

3.34 In some cases, families can be known to CSC even if the child in focus is not, for example in relation to a sibling or where a parent was known to CSC as a child themselves. In line with previous years, in 84% of reviews the family was known to CSC either previously (39%) or as an open case at the time of the incident (45%).

3.35 Overall, nearly two-fifths (39%) of children were classed as a Child in Need either at the time of the incident (10%) or previously (30%). This is a decrease on the previous year where 42% of children were classed as a Child in Need either at the time of the incident (15%) or previously (27%).

3.36 The proportion of children classed as a Child in Need at the time of the incident was greater for child deaths (13%) than serious harm incidents (4%). In contrast, 34% of children experiencing serious harm were previously a Child in Need, compared to 24% of children who died.

3.37 This year, there was a slight increase in the proportion of children on a child protection plan (CPP) at the time of the incident with 14% compared to 10% for the previous two years. In addition, a fifth (20%) of children were recorded as previously having been on a CPP compared to 18% the previous year.

3.38 The proportion of children who were Looked After remained at a similar level to previous years at 14%. A further 6% of children in focus were recorded as having previously been Looked After, which is an increase on the previous year (3%).

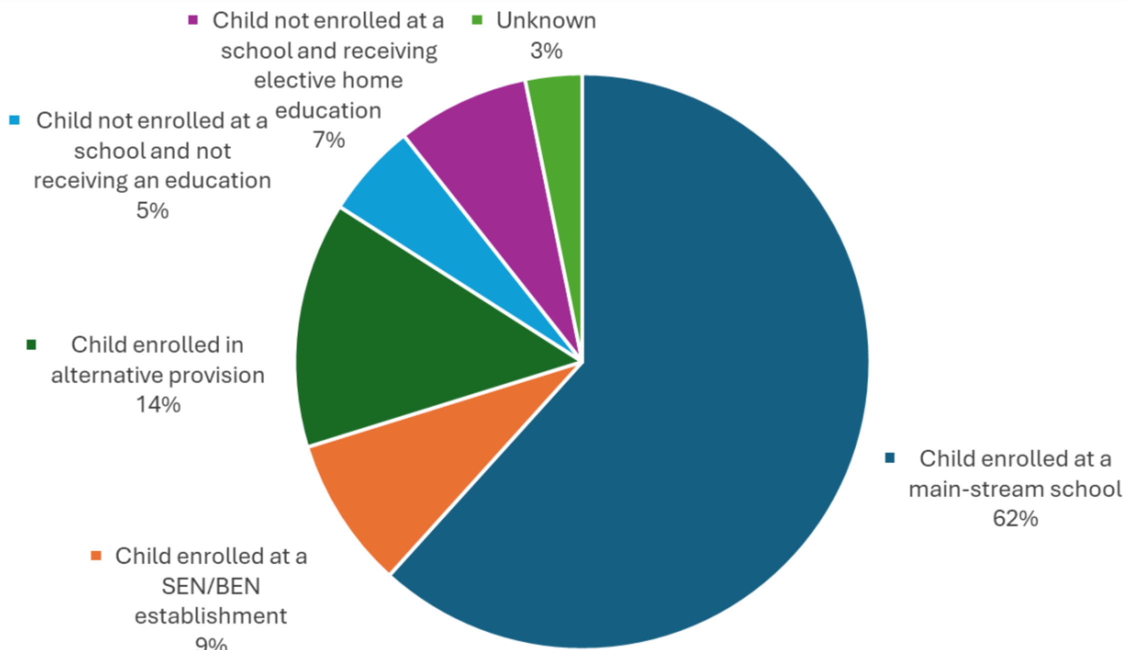
3.39 In 5% (n=14) of reviews the child in focus was reported to be undertaking caring responsibilities, a slight increase on the previous year (4%). Two of the 14 children were officially recognised by the local authority as a young carer, which is a decrease on last year (5).

Needs of the child

3.40 This section relates to the needs of the child in focus in relation to other service provision such as education, health and support services. Further data on this can be found in Appendix E.

Educational needs

Chart 12: Proportion breakdown of educational status of 4- to 15-year-olds at the time of the incident (n=94), 2024-25



3.41 Chart 12 shows that 62% (n=58) of school-aged children were enrolled in main-stream schools. A further 22% (n=21) were enrolled either at a special educational needs establishment or in alternative provision. This is a change on the previous year where 67% (n=73) of children of school age were enrolled in mainstream schools and 16% (n=17) in special educational needs establishments or in alternative provision.

3.42 Twelve of the children (13%) were not enrolled at a school at the time of the incident, with 7 of these children receiving elective home education (EHE). In 2023-24, 15% (n=16) of school age children were not enrolled, with 11 of these children receiving EHE.

3.43 As with previous years, the proportion of girls (69%) enrolled in mainstream school is greater than for boys (51%), with 31% of boys being enrolled either at a special educational needs establishment or in alternative provision, compared to 16% of girls.

3.44 Across all school age children, 45% were recorded as missing some of their schooling/education, for example, through regular absences, exclusion or long-term health conditions.

3.45 Overall, there were 52 children in focus who were aged 16-17-years-old. Of these, 27% (14) were recorded as not being in education, employment or training. Of these, 9 (64%) were boys and 5 (36%) were girls.

In our previous annual report and our briefing paper Safeguarding children in elective home education we identified that school can be a protective factor, particularly as elective home education leads to less visibility to safeguarding agencies. However, it should not be forgotten that children who have regular absences through poor attendance or exclusions may also be less visible, whilst also experiencing vulnerabilities.

- 36% of children of school age who were missing school were recorded as having one or more mental health conditions, compared to 17% of those not regularly missing school
- A third were recorded as having substance use issues compared to 6% of those who were not regularly missing school
- Nearly a quarter (24%) were receiving SEND support compared to 10% of those not regularly missing school
- 17% had an EHCP in place compared to 13% of children not regularly missing school

Additional support needs

3.46 As with the previous year, 9% of the 274 children across all ages were receiving special educational needs and disabilities (SEND) support. Again, as with last year, this was slightly higher among boys (11%) than girls (7%). The proportion of children receiving SEND support increased with age from 5% of 1-5-year-olds to nearly one in five (18%) 11-15-year-olds.

3.47 Children who need more support than is available through SEND services can be assessed for and receive an education, health and care plan (EHCP) which sets out the child's needs. Overall, 8% of children were reported as having an EHCP in place at the time of the incident, which is slightly lower than last year (11%). In addition, 2% of children were being assessed at the time of the incident and 1% of children had previously had an EHC plan in place.

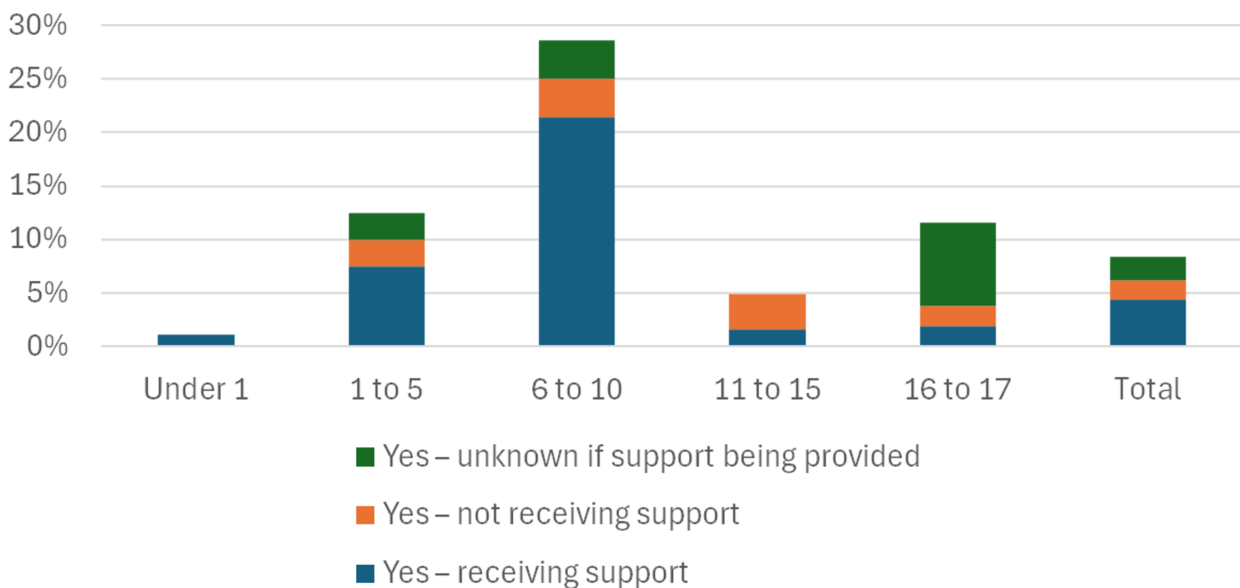
3.48 The proportion of boys on an EHCP was greater than girls (11% compared to 6%), which was similar to the previous year. As with those receiving SEND support, the proportion of children with an EHCP in place, or being assessed for one, was greater for older children (20% of children aged 11-15 and 17% of children aged 16-17).

3.49 Overall, 13% of children were recorded as either receiving SEND support or having an EHCP in place.

3.50 Speech and language challenges were reported as affecting 8% of children, which is a decrease on last year (12%). Of these 23 children, over half (52%) were receiving support, 22% were not receiving support and, in the remaining 26%, it was unclear in the review if they were receiving support.

3.51 Chart 13 shows over a fifth (21%) of 6-10-year-olds within the reviews were receiving support for speech and language challenges.

Chart 13. Proportion of children with speech and language challenges by age group, 2024-25



Mental health needs

3.52 Overall, one in five (20%) of the 274 children in focus were reported to have one or more mental health conditions, either diagnosed or undiagnosed, which is like the last two years (21% in both 2022-23 and 2023-24).

3.53 The proportion of children with mental health conditions was greater for older age groups with 58% of 16-17-year-olds and 36% of 11-15- year-olds reported as having one or more conditions.

3.54 In 23 incidents, it was suggested in the review that the mental health condition of the child was linked to their death/harm. Of these, over half (13) were in relation to suicides, and a further 4 in relation to attempted suicide or self-harm.

3.55 Overall, 13% of children were recorded as being neurodivergent, which is like the previous year (14%). However, this proportion is greater amongst older children, with 31% of 11-15-year-olds and 33% of 16-17-year- olds being recorded as neurodivergent.

Although presented separately in the analysis above, it should be remembered that the children in focus often have a range of additional needs that may be multifaceted and long-term, which can add to their vulnerability. The response by services to support children with additional needs can often be hampered by long waiting times for assessments and diagnoses, which we have seen demonstrated within the rapid reviews. Long waiting lists for mental health support is something that we highlighted in last year's Annual Report (CSPRP, 2024) and is an issue that we continue to see. Reviews emphasise how children struggle to access support without a diagnosed mental health need, including support for neurodiversity. Uncertainty about diagnoses can also mean that practitioners struggle to understand children's behaviours and put appropriate support in place. However, where possible practitioners should put in safeguarding arrangements that support the child holistically.

3.56 Child and adolescent mental health services (CAMHS) support children experiencing mental health difficulties, including those with neurodiversity. For the incidents occurring in 2024-25, over a fifth (20%) of children were known to CAMHS which is slightly lower than the previous year (24%). Of these 56 children, 43% had previously been supported by CAMHS, 36% were an open case, and 21% were either on a waiting list or had a referral made.

Other service needs

3.57 In 12% (32) of incidents the child in focus was known to Youth Justice Services (YJS), this is the same proportion as the last two years. Of the 32 children known to YJS, 47% were known at the time of the incident and 53% were previously known. Two thirds (66%) of these 32 children were aged 16-17-years-old and most children who were known to YJS (72%) were boys.

3.58 It is worth noting that 28% of the 32 children known to YJS, either previously or at the time, were receiving SEND support compared to 9% overall. Additionally, 19% were recorded as being neurodivergent compared to 13% overall and 66% (21) were also known to CAMHS.

Parental needs

3.59 This section explores the needs of the parents, therefore highlighting the potential service needs/support for the wider family unit.

3.60 In nearly a fifth (19%) of reviews, the parents of the child in focus were known to be young parents (i.e. under 25 years old). This proportion has been increasing over the years from 13% in 2022-23 and 17% in 2023-24.

3.61 Overall, in 6% of reviews one or more of the parents were a care leaver, either clear as per the definition or indicated within the review. In addition, in 8% of rapid reviews, at least one of the parents had care experience.

3.62 In a fifth (20%) of reviews, at least one of the parents was recorded as having a disability.

3.63 In over half of the reviews (57%), one of the parents/relevant carer was recorded as having a mental health condition, although it was not always clear in the reviews as to whether these conditions were diagnosed or not. This proportion has been increasing over the last three years and was 50% in 2022-23.

3.64 In line with last year, the proportion of incidents where the parent was reported to have a mental health condition was greater for fatal incidents (65%) than for serious harm incidents (50%).

3.65 Overall, in 58% of these incidents in 2024-25 where there were parental mental health conditions, the child was aged 5 or under. This links to our last annual report, where we discussed issues around parental mental health and caring for young children.

3.66 In 44% of incidents during 2024-25, at least one of the parents was recorded as using or being addicted to alcohol and/or substances. Of these 121 incidents:

- nearly half (47%) were for substances alone
- 30% were for both alcohol and substance use
- 23% were for alcohol use alone

3.67 In over a third (34%, 94) of rapid reviews, both parental substance/alcohol use and parental mental health conditions were recorded.

Parental substance and/or alcohol use or addiction

Over the last three years the proportion of parents recorded as having problematic use of alcohol and/or substances has been gradually increasing from 39% in 2022/23 to 44% in 2024/25. Over this period:

- half of all incidents involving babies under 1 had one or more parents recorded as using or having problematic use of alcohol and/or substances, compared to 31% of parents of children aged 16-17
- the proportion of fatal incidents where there was parental substance and/or alcohol use increased from 44% in 2022/23 to 52% in 2024/25
- among fatal incidents involving parental alcohol and/or substance use, 44% were recorded as sudden unexpected death in infancy (SUDI) as the likely cause of death
- 32% of serious harm incidents where there was parental alcohol and/or substance use were recorded as non-fatal intrafamilial assaults and 17% were recorded as non-fatal neglect

As outlined in Out of routine: A review of sudden unexpected death in infancy (SUDI), a key risk factor for SUDI is parental use of alcohol and drugs during pregnancy and when co-sleeping. Tailored safe sleep advice should be given in hospital prior to discharge, on the midwife's first visit and should include having sight of the infant's sleeping arrangements. The advice should include fathers and be reinforced on an ongoing basis by health visitors, GPs, and social workers.

Case study: Parental substance use

A 20-day-old white British baby girl died while co-sleeping with her mother and two older siblings. The child's mother was reported in the review to have been drinking heavily during the day and woke to find the baby unresponsive the following morning.

A key concern highlighted in the review was that the mother's alcohol use, and the potential impact of this on her children, had not been fully considered. Historical concerns about the mother's alcohol use had not been adequately addressed or followed up at the time.

During her pregnancy with the child in focus, there were several missed or rearranged health appointments. The mother was not referred to social care, and a pre-birth assessment was not completed despite her meeting the criteria. She was referred to Early Help, but the assessment did not address concerns about possible drug and alcohol use.

Following the birth, health visitors discussed safe sleeping but were unaware of safeguarding concerns due to the family moving area. The lack of focus on alcohol use limited the advice and specialist support offered and adversely impacted safeguarding planning.

Overall, there was fragmented information sharing and concerns including frequent housing moves, poor home conditions, neglect and drug use were dealt with individually. The review highlighted the need for improved multi agency working, particularly across boroughs, and that there should be specific discussion on substance or alcohol use and co-sleeping at all first day health visits by midwives.

Risk factors

3.68 This section presents analysis on factors, which if present in a child's life, add to their vulnerability of harm particularly if they intersect with other characteristics of the child and their family. Additional figures are set out in Appendix E.

3.69 During 2024-25, over half (51%) of the children in focus were reported to have experienced domestic abuse in their lives. This is a slight increase on the previous year (48%). In 28% of these reviews there was also a history of inter-generational abuse. The practice theme of hidden males – where males within the family are either not known to or are unseen by services – was identified in nearly a fifth (19%) of reviews where domestic abuse was present.

3.70 Neglect is often a key factor present within these children's lives and was present in 60% of rapid reviews in 2024-25. This is an increase from the previous year (49%).

3.71 In 89% of the 164 reviews where neglect was present in the child's life, the family was known to CSC, either as an open case at the time of the incident (52%) or previously known (37%).

3.72 In relation to the child in focus, in almost half (48%) of these incidents where neglect was present, the child was or had previously been classified as a Child in Need. Additionally, in 45% of incidents where neglect was present, the child

was on a CPP either at the time of the incident or previously. These figures underscore that the children and families that CSC are involved with often have multifaceted, persistent and recurring child welfare concerns.

3.73 Financial hardship can often be a contributing factor in neglect. In 18% of incidents the reviews suggested there was financial hardship within the family environment, although this was slightly greater among deaths (20%) compared to incidents of serious harm (16%). In 83% of incidents where financial hardship was reported, neglect was also a factor.

3.74 Housing issues, such as temporary accommodation, overcrowding, and poor housing conditions, were also an issue in over a third (35%) of incidents overall. Similarly to financial hardship, the majority (77%) of incidents with housing issues also included neglect as a factor.

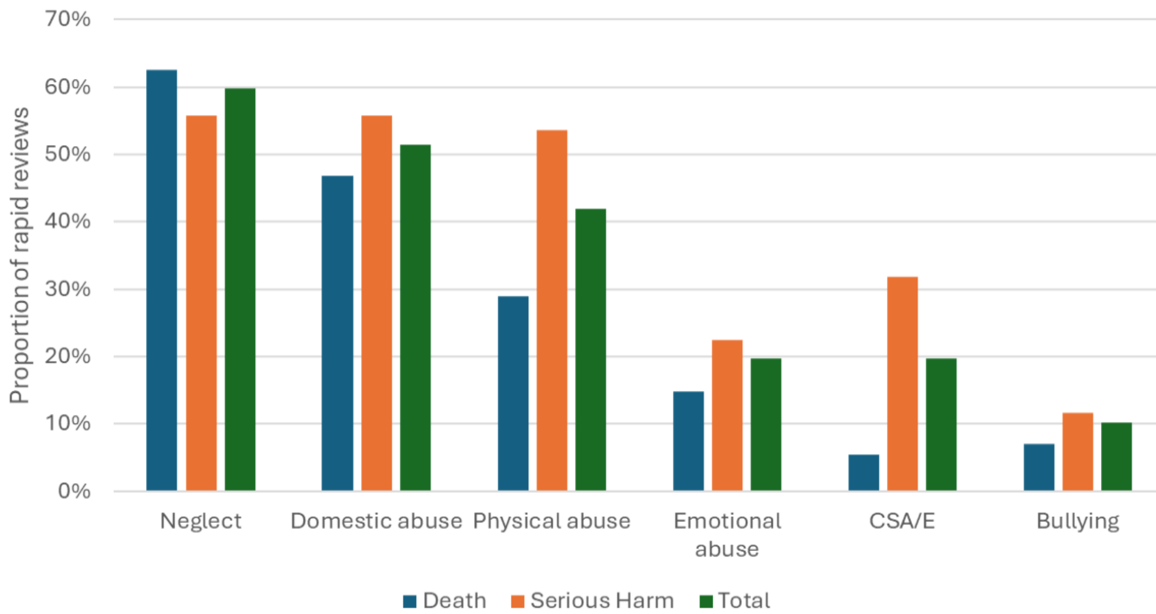
As identified in our previous reports, poverty can often be a factor in neglect. Poverty is estimated to be affecting over 4.5 million children, an issue being addressed by the Government in their strategy Our Children, Our Future: Tackling child poverty.

We found within the rapid reviews that financial hardship within the family environment and housing issues could be interlinked with neglect and a range of other factors that could increase the child's vulnerability. These cases were often complex, with issues that could be long-term or chronic.

- As mentioned above, the child had suffered neglect in over three-quarters (77%) of the 97 rapid reviews where housing issues were identified, and in 83% of the 48 rapid reviews where financial hardship was identified
- In addition, more than six in ten children had experienced domestic abuse in homes affected by financial hardship (63%) and housing issues (62%)
- Parental disability was also more common in these cases, identified in 35% of reviews where financial hardship was identified compared to 16% of all other rapid reviews

These findings suggest that a holistic approach is needed when dealing with ongoing neglect, to look at the needs of the family as a whole to support the child better. Our thematic report on neglect explores how neglect is defined, identified and addressed by safeguarding partnerships in England, and highlights the systemic changes that are needed to respond to this complex and multifaceted issue.

Chart 14: Proportion of deaths and serious harm incidents by abuse type present in the child's life, 2024-25



3.75 Often the children in focus have also experienced other forms of abuse prior to the incident that is reported. Chart 14 shows the proportion of deaths and serious harm incidents where these types of abuse had been present in the child's life. Out of the 274 incidents occurring in 2024-25, the review identified that half (51%) of the children in focus had experienced domestic abuse, 42% physical abuse, one in five (20%) had experienced emotional abuse and 20% had experienced sexual abuse or exploitation within their lives. 10% experienced bullying. These are similar levels to the previous year. As Chart 14 shows, often the proportion of children experiencing abuse in their lives prior to the incident was greater in incidents of serious harm than deaths.

3.76 Child-on-child abuse (of any kind) was reported in 10% of incidents, like the previous year (11%). Of these, over three-quarters (78%) were extrafamilial in nature.

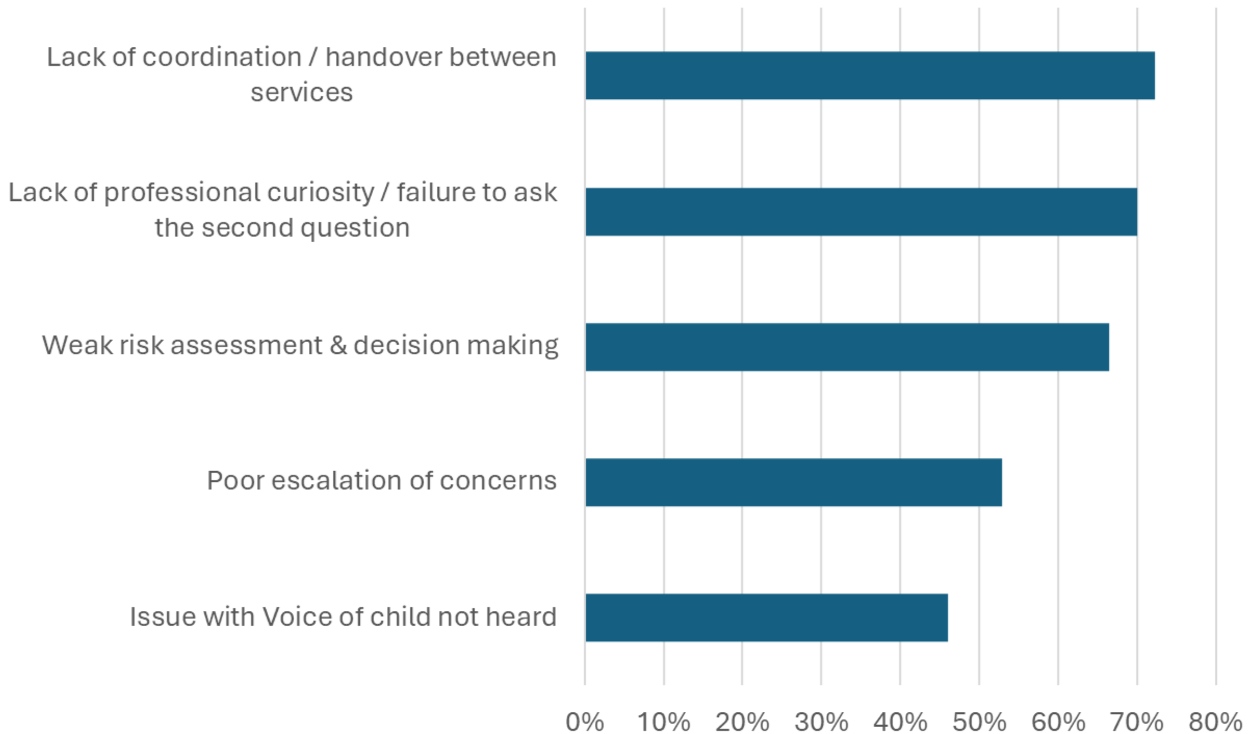
3.77 Overall, 9% (n=26) of incidents involved gang-related and/or youth violence, which is a decrease on last year (13%). In addition, 8% (n=23) of incidents involved child criminal exploitation (CCE). The was some overlap between the two, with both CCE and gang related and/or youth violence being present in 14 of these incidents. In 16% of the reviews there was also a victim/perpetrator overlap, where the child, as well as being the victim, had also previously caused harm.

3.78 Online contexts, both directly related to the incident and within the child's life, are increasingly discussed within reviews, rising from 5% in 2022-23 to 7% in 2023-24 and 9% in 2024-25. Of the 24 reviews in 2024-25 that noted an online context, 58% (n=14) involved incidents of serious harm, particularly extra and intrafamilial child sexual abuse, 29% (n=7) were fatal incidents, with 4 of these identifying suicide as the likely cause of death, and 13% (n=3) were for Other incidents. In 63% of reviews which involved an online context to the harm, the child in focus was a girl.

Learning and practice themes

3.79 Chart 15 shows the most common learning and practice themes identified within the rapid reviews for 2024-25. These themes have consistently been the 5 most common themes identified across the three years. The presence of these themes within rapid reviews can also be in relation to good practice in this area.

Chart 15: Proportion of incidents by learning and practice theme, 2024-25



3.80 Lack of coordination/handover between services featured in 72% (n=198) of rapid reviews with a quarter (25%, n=49) of these also including good practice such as: strong multi-agency communication and information sharing, good attendance at multi-agency meetings and effective joint decision making, and positive working relationships.

3.81 Lack of professional curiosity and failure to ask the second question featured in 70% of rapid reviews with 6% of these demonstrating good practice including proactive information-seeking and cross-checking across agencies, and professional challenge of decision-making.

3.82 Weak risk assessment and decision-making was a feature in two-thirds (66%) of rapid reviews with nearly a fifth of these (19%) including good practice such as having timely, holistic and child-centred risk assessments, and using agile decision-making within safeguarding frameworks.

3.83 Poor escalation of concerns featured in 53% of rapid reviews, with a quarter of these (25%) showing good practice such as early escalation of concerns and use of escalation pathways.

We have used the term 'professional curiosity' in relation to practitioners 'asking the second question' and enquiring beyond what is presented to them. We know, however, the term is often used without considering what it means at a deeper level or why practitioners might struggle to be professionally curious. It is important for safeguarding partners to have a clear sense of what they mean by 'professional curiosity' when using the term to describe practice and that supervision supports and encourages this, as well as seeking to understand barriers to practitioners in demonstrating such skills.

In addition to the practice and learning themes currently captured within the dataset, the Panel also explore other themes seen within rapid reviews such as failure to take a step back and reassess the situation or a failure to reassess the approach when there is lots of action, but no tangible progress made. The Panel are looking at reviewing which practice and learning themes are included in the data collection to ensure relevance and a shared understanding of the issues.

Reflective question for safeguarding partners:

What common practice and learning themes are you seeing coming out in rapid reviews within your partnerships?

3.84 Issues with the voice of the child not being heard were identified in 46% of rapid reviews. In nearly a quarter (24%) of these, there were examples of good practice, including child-centred decision making and children's voices informing assessments and planning, recognising the child's voice through behaviour-as-communication and professionals building trusted relationships with children.

Quality of reviews

3.85 Working Together 2026 (HM Government, 2026) states that the local authority should submit a SIN within five working days of becoming aware of an incident where a child has died or been seriously harmed, and abuse or neglect is known or suspected.

This year, just 45% of the 274 SINs met the five-day threshold, which is lower than the previous year (50%). There was an average of 15 days between the incident date and the notification date, which is slightly less than the previous year's average of 16 days.

Overall, 86% of notifications occurred within four weeks (28 working days) of the incident date. However, it should be noted that, in some incidents, SINs were submitted retrospectively, for example where there were delays in the identification of the incident or technical difficulties with the reporting system.

3.86 Rapid reviews are expected to be completed and submitted by safeguarding partners within 15 working days of the SIN. One of the key purposes of a rapid review is to identify if there is any immediate action required to ensure children's safety, therefore meetings need to be held promptly.

Excluding rapid reviews where the SIN was submitted later, 48% of reviews were submitted within this timeframe, which is slightly lower than last year (51%). The average time between SIN and rapid review submission was 20 working days.

3.87 The Panel's guidance on rapid reviews states that they should provide: a concise summary of facts, including information on the child and family members and any immediate safeguarding arrangements; an analysis of practice, including an integrated chronology; and the learning and recommendations identified, including an action plan with clear agency and partnership actions. The average length of rapid reviews for incidents occurring in 2024-25 was 14 pages.

3.88 Following consideration of the rapid review by the Panel, the safeguarding partners are sent a response letter confirming whether we agree with their decision to progress to an LCSPR. Of the 274 rapid reviews for 2024-25, 33% concluded that an LCSPR was required. Overall, the Panel agreed with the majority (82%) of the safeguarding partners' decisions on whether an LCSPR was needed or not.

3.89 Of the 25 rapid reviews where we did not agree with the decision:

- in over half (56%) of the reviews the safeguarding partners had decided an LCSPR was not needed, but we felt there was still additional learning to be gained
- in the reviews where safeguarding partners felt an LCSPR was needed but we disagreed, this was primarily due to questioning whether any additional learning would be identified through the process, or whether an action plan based on rapid review analysis might be more beneficial

3.90 We also use the response letter as an opportunity to provide feedback on the quality of reviews. Most reviews submitted have been of good quality and have identified relevant learning in a clear and comprehensive way. Table 5 shows six key areas identified from our letters to safeguarding partners that impact on the quality of rapid reviews.

Table 5: Common quality themes identified from the Panel response letters, 2024-25

Child's voice and lived experience	Race, ethnicity and culture (REC)	Analytical depth
• Variety in how well the voice of the child and their daily life experience was incorporated into reviews. • The relevance of child-centred learning was strengthened where this was present and well executed.	• Consideration of REC was not consistently present in reviews. • There were missed opportunities for learning where REC was not explored within the review. • Where this was done well, REC was linked to family experience, service responses and access to support.	• Variation in the extent to which reviews moved beyond descriptive summaries to reflective analysis. • Reviews that lacked exploration into decision-making made it harder to identify learning. • Where this was done well, the analysis explained why decisions were made and how agencies worked together.
Integrated Chronology	**Multi-agency learning**	**Governance and sign off**
• Chronologies are an important part of a review for showing escalation, timeliness and multi-agency coordination. • When chronologies were detailed and linked to the analysis, the Panel were able to understand decision making and assess key points of learning. • Well-structured and integrated chronologies significantly enhanced clarity and accountability.	• Reviews that looked at how agencies worked together offered stronger strategic learning, including learning on leadership, information sharing and oversight. • Reviews that focused mainly on one agency reduced the amount of partnership learning.	• The provision of an action plan can be a supportive tool in demonstrating the ownership and implementation of learning being taken forward. • Rapid reviews should be signed off by the three statutory delegated safeguarding leads. This is important in providing assurance that the learning and resulting actions have clear local oversight and ownership. However, we are still seeing reviews with only single agency sign off.

Summary

3.91 There were 274 rapid reviews submitted for incidents that occurred between 1 April 2024 and 31 March 2025, which is a decrease on the previous year. The DfE are undertaking work to explore the reduction of incidents submitted, however we would ask partners to review their decision-making and policies to identify any changes in practice that may have contributed to this.

3.92 The split between deaths and serious incidents remains fairly even, with SUDI remaining the most common likely cause of death and non-fatal assaults within the family home the most common likely cause of serious harm. However, a higher proportion of notifications for deaths are submitted for younger children (10 and under), whilst older children (11-17) have a higher proportion of submissions for serious harm. There remains an over-representation of Black/African/Caribbean/Black British children within the reviews, which has been increasing over the last three years.

3.93 The needs of the child and parental needs are often multi-faceted. A fifth of children were reported to have one or more mental health conditions and nearly one in ten were receiving SEND support. School can be a protective factor, yet 45% of children were missing some of their schooling or education. A high proportion of children and their families already had some involvement with CSC prior to the incident; however rapid reviews highlighted a lack of co-ordination and handover between services, lack of professional curiosity, and weak risk assessments and decision-making as key learning and practice themes. Safeguarding partners may want to consider how to address these systemic issues to ensure that all vulnerable children receive the most effective safeguarding provision.

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Appendix A – Language and glossary

A note on language

We use ‘child in focus’ to describe the primary child involved in an incident, particularly when multiple children are affected. This term ensures the analysis of rapid reviews centres on the child who has experienced the most significant harm or is at the greatest risk. When unclear, we use criteria to determine the focus, prioritising the child who has suffered the most severe harm or, in cases of ongoing neglect and abuse, the eldest child. This approach ensures our efforts are directed towards the child most in need of immediate attention.

We use the term ‘children’ to refer to both children and young people throughout the report, reflecting the reality that those under 18 are legally recognised as children, which should always be kept in mind. We understand and acknowledge that some young people (aged 16 and 17) might prefer not to be referred to as ‘children’.

We use the term ‘serious harm’ when referring to incidents notified to the Panel and the subsequent rapid reviews and LCSPRs. This reflects the higher or more intense levels of harm experienced in these incidents. We use the term ‘significant harm’ when talking more generally about practice and legislation.

As far as possible we have tried to use person-first language. By that we mean language and phrases that place the person before any specific characteristic or feature as we think it is important to recognise the person first and foremost with any relevant descriptors after this – for example, referring to ‘children with disabilities’ rather than ‘disabled children’. We use person-first language because this promotes inclusivity and helps combat stigmas or stereotypes associated with certain conditions. Person-centred language is a step towards fostering understanding, dignity and recognition of the full range of an individual’s identity.

Term	Acronym	Definition
Care Leaver	-	A care leaver is a person who has been in Local Authority care (e.g. residential or foster care) for a period of at least 13 weeks or more, or periods amounting in total to 13 weeks or more, since they were age 14, and ending after age 16.
Child Criminal Exploitation	CCE	Where an individual or group takes advantage of a power imbalance to coerce, control, manipulate or deceive someone under 18 into any criminal activity in exchange for something the victim needs or wants, and/or for financial gain or other advantage of the perpetrator and/or through violence or the threat of violence

Child and adolescent mental health services	CAMHS	Specialised health services that assess and treat young people with emotional, behavioural or mental health difficulties.
Child in focus	-	This identifies the primary child involved in an incident, especially when multiple children are affected. This term ensures the rapid review centres on the child who has experienced the most significant harm or is at the greatest risk. When unclear, we use criteria to determine the focus, prioritising the child who has suffered the most severe harm or, in cases of ongoing neglect and abuse, the eldest child.
Child Looked After	CLA	A child who is looked after by the local authority.
Child in Need	CIN	Section 17 of the Children's Act 1989 defines a child in need as: "he/she is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a Local Authority; his/her health or development is likely to be significantly impaired, or further impaired without the provision for him/her of such services; he/she is disabled."
Child Protection Plan	CPP	A child protection plan is a written record detailing the actions and responsibilities of services and parents to protect those children identified to have been seriously harmed or to be at risk of significant harm.
Child Safeguarding Practice Review Panel (The Panel)	CSPRP	An independent panel set up under the Children and Social Work Act 2017, working with the Department for Education. The Panel commissions reviews of serious child safeguarding cases with a focus on improving learning, professional practice and outcomes for children.
Child Sexual Abuse	CSA	Child sexual abuse is all forms of sexual abuse against someone under the age of 18.
Child Sexual Exploitation	CSE	A form of child sexual abuse where an individual or group takes advantage of a power imbalance to coerce, manipulate or deceive someone under the age of 18 into

		sexual activity in exchange for something the victim needs or wants, and/or for financial advantage or increased status of the perpetrator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur using technology.
Children's Social Care	CSC	Departments within local authorities who are concerned with all forms of personal care and other practical assistance for children and young people who need extra support
Department for Education	DfE	A ministerial department responsible for children's services and education including early years, schools, higher and further education policy, apprenticeships and wider skills in England.
Domestic Abuse	-	The UK government's definition of domestic violence is '*any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to psychological, physical, sexual, financial, emotional*.' As specified in Part 1 of the Domestic Abuse Act 2021, this can include witnessing domestic abuse. Within this report, children who have witnessed domestic abuse within the family environment and children aged 16 or older who have experienced domestic abuse within an intimate or family relationship would be categorised as having experienced domestic abuse.
Early Help	EH	Provides early support and intervention to families to improve outcomes for children or to prevent escalating need or risk
Education, health and care plan	EHC plan	A plan that outlines a child's special educational, health and social care needs.
Elective Home Education	EHE	Where parents have decided to educate their children at home or in some other way instead of them attending school full-time

Extrafamilial Harm	-	Risks to the welfare of children that arise within the community or peer group, including sexual and criminal exploitation. A key element of extrafamilial harm is that in general, harm does not arise from the home environment; parents may not be aware that their child is at risk or may be struggling to protect their child and the family from harm against exploiters.
Families First Partnership programme	FFP	A national initiative aimed at transforming children's social care in England. This initiative is rolling out reforms to Family Help & Multi-agency child protection and increasing support for family networks through Family Group Decision Making and Family Network Support Packages.
Index Child	-	The child who is the focus of a rapid review and/or LCSPR because of a serious incident.
Intrafamilial Harm	-	Harm that occurs within a family environment. Perpetrators may or may not be related to the child and a key consideration is whether the abuser is seen as a family member or carer from the child's point of view.
Intersectionality	-	The concept of intersectionality describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class and other forms of discrimination "intersect" to create unique dynamics and effects.
Lesbian, Gay, Bisexual, Transgender and Queer (or Questioning)	LGBTQ+	Used to represent non-heterosexual identities and orientations.
Local Child Safeguarding Practice Review	LCSPR	An in-depth multi-agency review in response to a serious child safeguarding incident to identify system learning and practice changes to improve the safeguarding of children and young people.
Looked After Children (this may also be referred to as child looked after)	LAC	A child who has been in the care of their local authority for more than 24 hours

Not in Education. Employment or Training	NEET	A young person who is no longer in the education system and who is not working or being trained for work.
Rapid Review	RR	A multi-agency review of a serious incident where a child has died or been seriously harmed and where abuse and/or neglect is suspected to identify, collate, and reflect on the facts of the case with the aim of establishing if any immediate safeguarding action is needed and identifying the potential for practice learning.
Safeguarding Partners	-	Local safeguarding arrangements are led by three statutory safeguarding partners: the local authority, the police, and the integrated care board.
Serious Incident Notification	SIN	Local authorities have a duty to notify the Child Safeguarding Practice Review Panel (“the Panel”) and, by extension, the Department for Education and Ofsted, if a child has died or been seriously harmed and abuse or neglect is known or suspected. Local authorities must also notify the Secretary of State for Education and Ofsted where a child looked after has died, whether or not abuse or neglect is known or suspected. This is done by submitting a serious incident notification.
Sudden and Unexpected Death in Infancy/Childhood	SUDI/C	When an infant or a child dies unexpectedly and there is no obvious cause.
Working Together	WT	Statutory guidance on inter-agency working to safeguard and promote the welfare of children. The latest version was published in 2026.
Youth Justice Services	YJS	Multi-agency team that supports and diverts children from the criminal justice system.
Youth Violence		Violence either against or committed by a child or adolescent, which can impact on individuals, families, communities and society.

Appendix B – SIN and rapid review submissions

Under 16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017), a local authority in England must notify the Child Safeguarding Practice Review Panel if a child dies or is seriously harmed and it knows or suspects that a child has been abused and/or neglected. This is done by the local authority submitting a serious incident notification (SIN). A notification can also be submitted if the child has perpetrated harm but there is evidence that they have experienced abuse and/or neglect. Local authorities must also submit a SIN where a child looked after has died, whether or not abuse neglect is known or suspected. However, this analysis only includes those where abuse or neglect is known or suspected and is progressed to a rapid review.

Following the submission of a SIN, and where abuse and/or neglect of the child is known or suspected, the safeguarding partnership for that area must carry out a rapid review to establish whether any immediate action is needed to ensure a child's safety and the potential for practice learning.

Only one SIN is submitted per incident and therefore incidents may involve more than one child. Where this occurs, a primary child is often identified in the SIN and is the focus of the rapid review. In instances where this is unclear, we have followed a set criterion to identify the primary child and subsequent order of input. Following these criteria the primary child would be identified as the child who has suffered the most obvious serious harm or death, or the eldest child involved in the incident as it could be assumed that they would have suffered the longest in cases of ongoing neglect and abuse. These children have then been identified as the 'child in focus' when discussing rapid reviews.

Appendix C – Cause of death

Category of Death	Definition
Accident/injury	Where a death has occurred from an accident or accidental injury
Child Homicide – Intrafamilial	Deaths where a child is killed by someone within the family, other than a parent or primary caregiver. This would include homicide perpetrated by siblings, grandparents, aunts, uncles, cousins etc.
Child Homicide – Extrafamilial	Deaths where a child is killed by someone other than a family member, primary caregiver or other adult with caring responsibilities.
Overt Child Homicide by primary caregiver	Deaths where a child is killed by a parent or primary caregiver using overtly violent means, or with no attempt to conceal the homicide, and where there appears to have been some intent to kill the child.
Covert Child Homicide by primary caregiver	Deaths where a child is killed by a parent or primary caregiver using less overtly violent means, and with some apparent attempt to conceal the fact of homicide with some apparent intent to kill the child.
Death following self-harm	Deaths where the child has deliberately harmed themselves but there is no indication that they intended to complete suicide.
Death from Extreme Neglect	Deaths where the child dies directly as a result of severe neglect/deprivation of their needs with evidence that this has been deliberate, persistent, or extreme.
Fabricated/induced Illness	Deaths where a parent or caregiver has exaggerated or deliberately caused symptoms of illness resulting in the child's death. This includes a parent or caregiver inducing illness which led to the death, or a where a child dies from medical intervention in response to a fabrication or induction of illness and there is evidence of behaviours carried out to convince professionals of an illness where there is no objective evidence of a medical condition.
Fatal assault – Intrafamilial	Deaths following physical assaults (non-accidental injuries) where the suspected perpetrator is a primary caregiver or adult with caring responsibilities and there was no clear intent to kill the child.
Fatal assault – Extrafamilial	Deaths following physical assaults (non-accidental injuries) where the suspected perpetrator is someone

	other than a family member, primary caregiver or adult with caring responsibilities and there was no clear intent to kill the child.
Medical cause	Deaths resulting from medical causes.
Risk taking behaviour	Deaths resulting from the child engaging in dangerous activities including drug related deaths, or accidents from risk-taking behaviour where there is no evidence that the child intended to complete suicide.
Severe, persistent child cruelty	Deaths where a child dies directly as a result of a physical assault or neglect and there is evidence of previous severe and persistent child cruelty. This includes deaths where a post-mortem examination reveals previous inflicted injuries or long-standing neglect.
Suicide	Deaths where there is evidence that the child has completed suicide including cases still under investigation, but circumstances suggest suicide.
Unclear	Deaths where the cause remains completely unclear and with no obvious pointers to any of the other categories.
Unexplained SUDI/SUDC	Deaths viewed as sudden unexpected death in infancy (SUDI) or childhood (SUDC) which were not anticipated as a significant possibility 24 hours before the death, or there was a similarly unexpected collapse leading to or triggering the events with no specific cause of death found (whether natural or external).

Appendix D – Cause of serious harm

Category of Serious Harm	Definition
Accident/injury	Serious harm arising from accidents or injuries
Attempted suicide	Cases of injury or serious harm resulting only from the child's attempt to complete suicide.
Child criminal exploitation	Where an individual or group takes advantage of a power imbalance to coerce, control, manipulate or deceive someone under 18 into any criminal activity in exchange for something the victim needs or wants, and/or for financial gain or other advantage of the perpetrator and/or through violence or the threat of violence.
Child sexual abuse – Intrafamilial	All forms of sexual abuse where this was the predominant form of maltreatment or the incident which led to notification and where the suspected perpetrator is an immediate or wider family member, primary caregiver or adult with caring responsibilities for the child in the home.
Child sexual abuse – Extrafamilial	All forms of sexual abuse where this was the predominant form of maltreatment or the incident which led to the notification and where the suspected perpetrator is a person other than a family member, primary caregiver or other adult with caring responsibilities for the child.
Child sexual exploitation	A form of child sexual abuse where an individual or group takes advantage of a power imbalance to coerce, manipulate or deceive someone under the age of 18 into sexual activity in exchange for something the victim needs or wants, and/or for financial advantage or increased status of the perpetrator. This can involve violence or the threat of violence.
Emotional abuse	All forms of emotional abuse where this has been the predominant form of abuse, or the incident which led to recognition or notification of harm.
Fabricated/induced Illness	Serious harm caused when parent or caregiver has exaggerated or deliberately caused symptoms of illness in the child resulting in serious harm. This includes a parent or caregiver inducing illness which led to serious harm, or a child is seriously harmed from medical intervention in response to a fabrication or induction of illness and there is evidence of behaviours carried out to convince professionals of an illness where there's no objective evidence of a medical condition.

Medical cause	Serious harm arising from medical causes
Non-fatal Assaults-Intrafamilial	Serious harm from severe physical assaults (non-accidental injuries) where the suspected perpetrator is a primary caregiver, an adult with caring responsibilities for the child at the time of harm or another child within the family (e.g. sibling, cousin).
Non-fatal Assaults – Extrafamilial	Serious harm from severe physical assaults (non-accidental injuries) which has been caused by someone other than a family member, primary caregiver or other adult with caring responsibilities for the child within the home. Encompasses child-on-child violence by children external to the family.
Non-fatal neglect	Serious harm as a result of severe or chronic deprivation of the child's needs with evidence that this has been deliberate, persistent or extreme.
Other non-fatal incident	Any other non-fatal serious incident which does not clearly fit one of the other categories.
Risk taking behaviour	Serious harm due to the child engaging in dangerous activities including serious harm following drug related incidents, or accidents from risk-taking behaviour where there is no evidence that the child intended to harm themselves.
Self-harm	Where the child deliberately harmed themselves but there is no indication they intended to complete suicide.
Severe, persistent child cruelty	Serious harm as a result of a physical assault, emotional abuse or neglect, and there is evidence of previous severe and persistent child cruelty. Encompasses serious harm where medical examination reveals evidence of previous inflicted injuries (e.g. healing fractures) or long-standing neglect in addition to the primary cause of serious harm.
Unclear	Other non-fatal serious harm where the nature of maltreatment is not clear.

Appendix E – Rapid review figures

Table A – Regional figures

		2023-24	2024-25			
Region	**Child population estimates mid-2024**	**Rate per 100,000 pop.(1)**	**Rate per 100,000 pop(2)**	**% of region's SINs for deaths**	**% of region's SINs for serious harm**	**% of SINs for incidents occurring in regions' 20% most deprived areas**
East of England	1,394,026	1.54	1.43	50.0%	50.0%	15.8%
East Midlands	1,032,130	2.36	1.26	69.2%	23.1%	30.0%
London	1,916,086	4.05	2.87	49.1%	49.1%	31.3%
North East	542,710	2.80	2.76	60.0%	33.3%	41.7%
North West	1,627,558	3.50	3.32	34.5%	60.0%	48.6%
South East	2,023,914	2.01	1.68	50.0%	47.1%	28.6%
South West	1,114,244	2.72	2.60	44.8%	51.7%	16.7%
West Midlands	1,351,245	3.24	2.00	57.1%	42.9%	39.1%
Yorkshire & the Humber	1,181,103	2.06	2.12	32.0%	68.0%	52.4%
England	**12,183,016**	**2.91**	**2.25**	**46.7%**	**50.4%**	**34.2%**

(1) Calculated using mid-year 2023 population estimates
(2) Calculated using mid-year 2024 population estimates

Table B – Regional figures for age group

	Age Group					
Region	**Under 1**	**1 to 5**	**6 to 10**	**11 to 15**	**16 to 17**	**Total**
East of England	15.0%	20.0%	10.0%	25.0%	30.0%	100.0%
East Midlands	46.2%	7.7%	7.7%	15.4%	23.1%	100.0%
London	29.1%	12.7%	14.5%	20.0%	23.6%	100.0%
North East	33.3%	6.7%	13.3%	13.3%	33.3%	100.0%
North West	27.3%	10.9%	12.7%	36.4%	12.7%	100.0%
South East	38.2%	26.5%	5.9%	11.8%	17.6%	100.0%
South West	48.3%	13.8%	10.3%	20.7%	6.9%	100.0%
West Midlands	39.3%	21.4%	7.1%	14.3%	17.9%	100.0%
Yorkshire and the Humber	40.0%	8.0%	4.0%	28.0%	20.0%	100.0%
England	**33.9%**	**14.6%**	**4.2%**	**22.3%**	**19.0%**	**100.0%**

Table C – Regional figures for sex

	Sex of the Child		
Region	**Male**	**Female**	**Total**
East of England	55.0%	45.0%	100.0%
East Midlands	46.2%	53.8%	100.0%
London	60.0%	40.0%	100.0%
North East	53.3%	46.7%	100.0%
North West	45.5%	54.5%	100.0%
South East	58.8%	41.2%	100.0%
South West	37.9%	62.1%	100.0%
West Midlands	53.6%	46.4%	100.0%
Yorkshire & the Humber	36.0%	64.0%	100.0%
England	**50.4%**	**49.6%**	**100.0%**

Table D – Characteristics of the child

	Death		Serious Harm		Total [1]	
	N.	%	N.	%	N.	%
Total	128	*46.7%*	138	*50.4%*	274	*100.0%*
Sex						
Male	77	*60.2%*	55	*39.9%*	138	*100.0%*
Female	51	*39.8%*	83	*60.1%*	136	*100.0%*
Age Group						
Under 1	57	*61.3%*	36	*38.7%*	93	*100.0%*
1-5	20	*50.0%*	20	*50.0%*	40	*100.0%*
6-10	12	*42.9%*	15	*53.6%*	28	*100.0%*
11-15	19	*31.1%*	39	*63.9%*	61	*100.0%*
16 and 17	20	*38.5%*	28	*53.8%*	52	*100.0%*
Ethnic Group						
White	89	*46.6%*	96	*50.3%*	191	*100.0%*
Mixed/Multiple ethnic groups	14	*46.7%*	15	*50.0%*	30	*100.0%*
Asian/Asian British	6	*40.0%*	9	*60.0%*	15	*100.0%*
Black/ African/Caribbean/ Black British	16	*48.5%*	16	*48.5%*	33	*100.0%*
Other ethnic group	1	*50.0%*	1	*50.0%*	2	*100.0%*
Unknown	2	*66.7%*	1	*33.3%*	3	*100.0%*
Gender						
Different to sex	1	*25.0%*	2	*50.0%*	4	*100.0%*
LGBTQ+						
Yes	0	*0.0%*	5	*100.0%*	5	*100.0%*
MH Conditions						
Yes - diagnosed/undiagnosed	24	*44.4%*	24	*44.4%*	54	*100.0%*
Neurodiverse						
Yes	13	*36.1%*	21	*58.3%*	36	*100.0%*
Disability						
Yes	21	*48.8%*	20	*46.5%*	43	*100.0%*

(1) Total includes 8 incidents that were recorded as ‘Other’

Table E – Needs of the child

	Death		Serious Harm		Total [1]	
	N	%	N	%	N	%
Total 4-15-year-olds	35	*37.2%*	55	*58.5%*	94	*100.0%*
Education Status						
Child enrolled at a main-stream school	20	*34.5%*	36	*62.1%*	58	*100.0%*
Child enrolled at a SEN/BEN establishment	5	*62.5%*	3	*37.5%*	8	*100.0%*
Child enrolled in alternative provision	4	*30.8%*	8	*61.5%*	13	*100.0%*
Not enrolled at a school and not receiving an education	2	*40.0%*	3	*60.0%*	5	*100.0%*
Not enrolled at a school and receiving elective home education	3	*42.9%*	4	*57.1%*	7	*100.0%*
Unknown	1	*33.3%*	1	*33.3%*	3	*100.0%*
Child missing school						
Yes – regular absences/poor attendance	15	*48.4%*	16	*51.6%*	31	*100.0%*
Yes - other	2	*18.2%*	8	*72.7%*	11	*100.0%*
Total 16–17-year-olds	20	*38.5%*	28	*53.8%*	52	*100.0%*
Not in Education, Employment or Training						
Yes	6	*42.9%*	5	*35.7%*	14	*100.0%*
All children	128		138		274	
SEND support						
Yes	10	*41.7%*	11	*45.8%*	24	*100.0%*
EHCP						
Yes – EHCP in place	10	*43.5%*	10	*43.5%*	23	*100.0%*
Child previously on EHCP	2	*66.7%*	1	*33.3%*	3	*100.0%*
Child being assessed for EHCP	3	*75.0%*	1	*25.0%*	4	*100.0%*
Speech and language support						
Yes – receiving support	7	*58.3%*	5	*41.7%*	12	*100.0%*
Yes – not receiving support	3	*60.0%*	2	*40.0%*	5	*100.0%*
Yes – unknown if support being provided	3	*50.0%*	3	*50.0%*	6	*100.0%*
CAMHS						
Yes – on a waiting list	0	*0.0%*	1	*100.0%*	1	*100.0%*
Yes – open case	10	*50.0%*	10	*50.0%*	20	*100.0%*
Yes – previously	8	*33.3%*	11	*45.8%*	24	*100.0%*
Yes - referral made	4	*36.4%*	7	*63.6%*	11	*100.0%*

(1) Total includes 8 incidents that were recorded as ‘Other’

Table F – Risk factors

	Death		Serious Harm		Total [1]	
	N	%	N	%	N	%
Total	128	*46.7%*	138	*50.4%*	274	*100.0%*
Environment						
Neglect	80	*48.8%*	77	*47.0%*	164	*100.0%*
Housing issues	49	*50.5%*	45	*46.4%*	97	*100.0%*
Financial hardship	26	*54.2%*	22	*45.8%*	48	*100.0%*
Domestic abuse	60	*42.6%*	77	*54.6%*	141	*100.0%*
History of intergenerational abuse	28	*50.9%*	26	*47.3%*	55	*100.0%*
Physical abuse						
Yes - Extrafamilial	1	*10.0%*	9	*90.0%*	10	*100.0%*
Yes - Intrafamilial	30	*32.3%*	60	*64.5%*	93	*100.0%*
Yes - Both	3	*33.3%*	5	*55.6%*	9	*100.0%*
Yes - Unknown	3	*100.0%*	0	*0.0%*	3	*100.0%*
Emotional abuse						
Yes - Extrafamilial	0	*0.0%*	3	*100.0%*	3	*100.0%*
Yes - Intrafamilial	18	*36.7%*	27	*55.1%*	49	*100.0%*
Yes - Both	1	*100.0%*	0	*0.0%*	1	*100.0%*
Sexual abuse/ exploitation						
Yes - Extrafamilial	4	*19.0%*	16	*76.2%*	21	*100.0%*
Yes - Intrafamilial	2	*8.7%*	19	*82.6%*	23	*100.0%*
Yes - Both	0	*0.0%*	4	*100.0%*	4	*100.0%*
Yes - Unknown	1	*16.7%*	5	*83.3%*	6	*100.0%*
Child on child abuse						
Yes - Extrafamilial	9	*42.9%*	11	*52.4%*	21	*100.0%*
Yes - Intrafamilial	2	*66.7%*	1	*33.3%*	3	*100.0%*
Yes – Both	**0**	*0.0%*	1	*50.0%*	2	*100.0%*
Victim/perpetrator overlap						
Yes	13	*28.9%*	26	*57.8%*	45	*100.0%*

(1) Total includes 8 incidents that were recorded as ‘Other’