

Q4 rapid review analysis

1 January to 31 March 2026

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

Key stats

60* rapid reviews submitted

48% were serious harm

50% were deaths

* For incidents between 1 January to 31 March 2026

Key insights

- Death was the most common incident type
- Babies under 1 were the most affected
- Hidden males within the family were a key theme
- Young parents were a key theme

Type of incidents

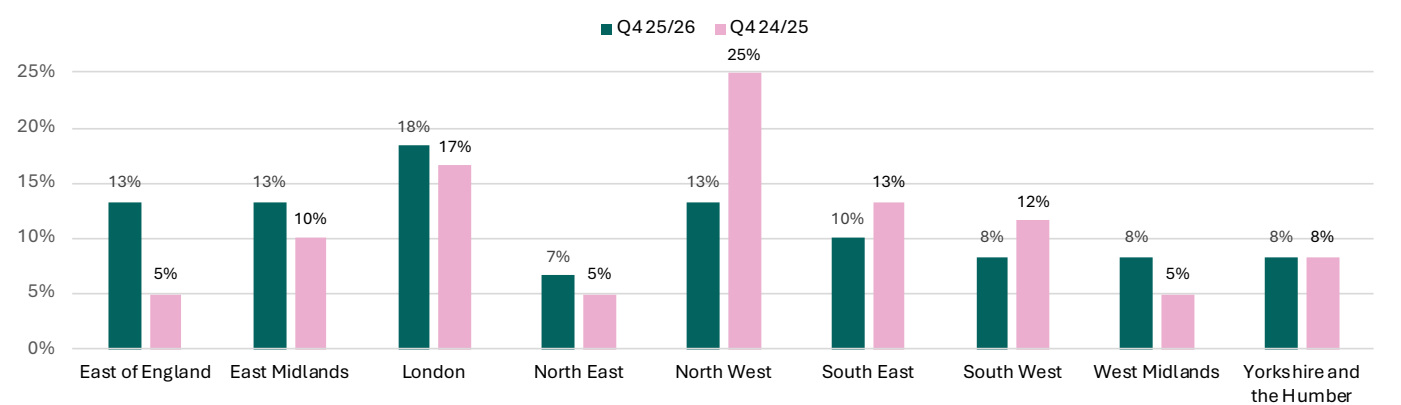
Number of rapid reviews	Q4 25/26	Q3 25/26	Q4 24/25
Death	30 (50%)	32 (43%)	26 (43%)
Serious harm	29 (48%)	38 (51%)	30 (50%)
Other*	1 (2%)	4 (5%)	4 (7%)
Total	60 (100%)	74 (100%)	60 (100%)

Deaths increased from 43% in Q3 (October to December 2025) to 50%.

Serious harm remained relatively consistent.

* Some notifications were classed as 'other' issues, for example where harm was caused by a child.

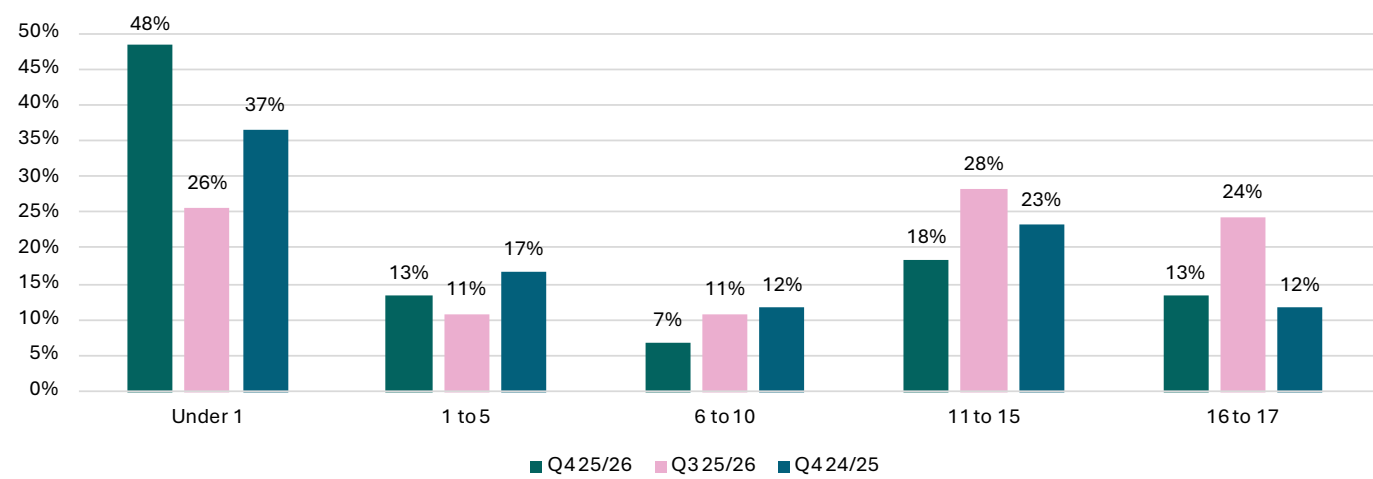
Regional breakdown



- London reported the highest number of incidents.
- Compared to Q4 2024, incidents increased in the East of England, North East, East Midlands and West Midlands
- Compared to Q4 2024, incidents decreased in the North West, South East and the South West

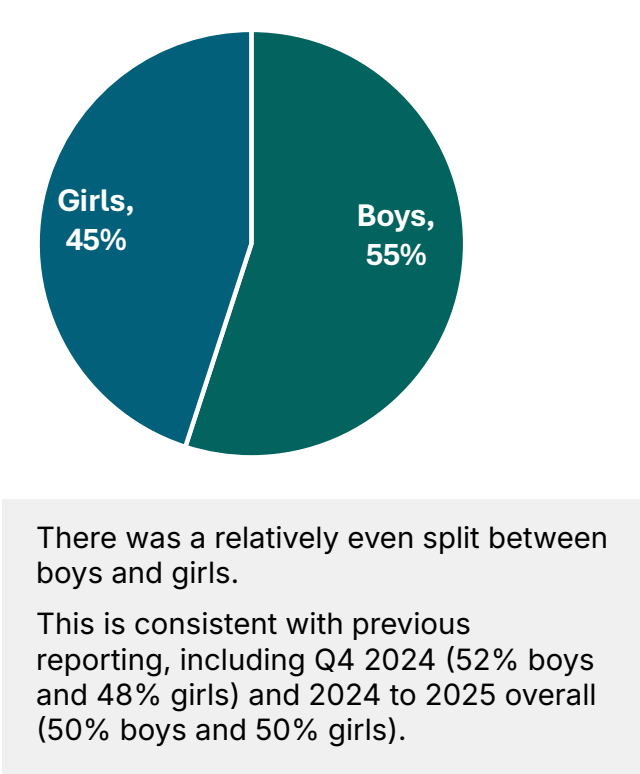
Children at the heart of the reviews

Age



- Nearly half of the incidents involved babies under 1 year old
- Incidents involving babies notably increased compared to Q3 2025 and Q4 2024
- Incidents involving children aged 11 to 17 markedly decreased compared to Q3 2025

Sex



Disability

- 18% of children were recorded as having a disability, a decrease compared to Q3 2025
- A further 5% had a possible but unconfirmed disability

Ethnicity

Ethnicity Group	Q4 25/26	Q3 25/26	Q4 24/25
White	71%	76%	73%
Mixed/ Multiple Ethnic Group	10%	7%	10%
Asian/Asian British	3%	11%	5%
Black/African/ Caribbean/ Black British	12%	7%	10%
Other ethnic group	3%	0%	2%

- 71% of reviews involved children from white backgrounds (in reviews where ethnicity was recorded)
- Compared to Q3 2025, reviews involving children from Asian backgrounds decreased

Understanding the incidents

Causes of incidents

Most common causes of death

- Unexplained SUDI/SUDC (40%)
- Suicide (13%)
- Intrafamilial fatal assault (13%)

Most common causes of serious harm

- Intrafamilial non-fatal assault (38%)
- Non-fatal neglect (17%)
- Extrafamilial child sexual abuse (14%)

Emerging themes

Hidden males within the family

Hidden males are defined as males within the family or wider family network who are involved in the life of the child but are either not known to services or are overlooked/ unseen by services.

This can include biological fathers, adoptive fathers, stepfathers, the mother's partner or wider male family members.

In this quarter, nearly a third of reviews (18, 30%) included hidden males as a theme.

Characteristics

- 10 reviews involved the death of the child and 8 involved serious harm
- In 10 reviews, both parents were identified as the likely suspects of harm
- 11 involved harm to babies under 1 year old

These findings align with those identified in our previous report on invisible men and harm to babies.

Risk factors

- Many reviews featured parents with diagnosed/undiagnosed mental health conditions and/or parents who used substances or alcohol
- Housing issues and neglect were also common

Analysis

- Professionals were frequently unaware of males within the child's life and of their involvement in the child's care
- Previous violent or offending histories of male caregivers were not always considered when assessing risk to the child
- There were missed opportunities to actively pursue professional engagement with fathers and to explore the impact of their lived experiences on care for the child

Young parents

Characteristics

- 11 reviews (18%) in Q4 2025 to 2026 involved children being cared for by young parents
- Of these reviews, one involved parents aged under 18, and 10 involved parents aged 18 to 24

Risk factors relating to young parents

- Diagnosed or undiagnosed mental health conditions and/or use of substances
- Housing issues
- Experiences of inter-generational abuse and/or adverse childhood experiences

Young parents were overrepresented in these reviews compared with England as a whole (only 6% of new birth registrations in 2025 involved parents aged 18-24, [ONS 2026](#)).

How to use this data

It can be used to:

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

Reflective questions

- What efforts do you make to proactively engage fathers and male caregivers in meetings, visits and assessments?
- How do you consider the individual support needs of families where parents or caregivers experience challenges with alcohol and/or substance use?
- How is support tailored to young parents and caregivers, particularly those with their own additional support needs?

Further resources and feedback

You can access related learning resources, newsletters and reports on [our website](#).

We welcome feedback on this report, including:

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

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

Caveats to this data

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