Child Safeguarding
Practice Review Panel

30 May 2022

Dear Carolyne,

Thank you for your letter dated 29th April 2022 requesting further information on our consideration of incidents where children looked after tragically died or suffered serious harm.

As you know, the independent Child Safeguarding Practice Review Panel has oversight of the national system of learning reviews about the lives of children who have experienced serious harm. This involves examining the troubling, and often complex, circumstances of these children's lives to identify learning so that the quality of safeguarding practice improves.

We draw from a rich and wide evidence base in our work. This includes confidential rapid reviews and published local child safeguarding practice reviews that we routinely consider at our fortnightly meetings. It also includes a range of other evidence including inspection reports, research reports, national reviews and our own thematic analysis. The Panel also commissions reports to analyse Local Child Safeguarding Practice Reviews and a sample of rapid reviews received on a qualitative basis. Much of this information is publicly available.

Children looked after who had died or suffered serious harm.

As part of the Panel's work, in 2020, we considered in greater detail a selection of incidents involving looked after children who had died or suffered serious harm. This focussed on 48 incidents where children had become looked after as a result of abuse or neglect. The primary purpose of this work was to inform the Panel's overall knowledge and analysis of reviews about serious child safeguarding incidents. We regularly consider incidents in a more thematic way to determine what further work we might want to undertake. These relatively small scale and internal pieces of work are intended to support our general work programme.

In this particular example, a number of the incidents involved had already been reviewed as a Local Child Safeguarding Practice Review, the findings of these are, or will be, in the public domain. We recognised that there were some general findings emerging from this piece of work that warranted inclusion in our latest Annual Report (2020). These findings highlight the importance of commissioning and sufficiency of high quality residential and foster placements for looked after child

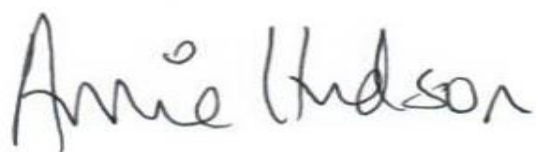
displaying high risk and challenging behaviour. Our Annual Report also provides important insights into other issues including the impact of parental mental health and children who are being electively home educated.

We are not able to provide you with a report from this piece of work. As stated above, the primary purpose was to inform the Panel's overall knowledge of incidents – the learning from which has been shared – and the work was not carried out with publication in mind.

The Panel will be continuing to share publicly evidence and insights about a range of safeguarding practice issues though our next Annual Report (due later this year) and through a new series of practice briefings. This will help ensure that, where there is evidence of an important practice theme, this is shared publicly with all key stakeholders.

I hope that this response provides clarity and reassurance about our continued commitment to do all we can to improve the safeguarding system and, ultimately therefore, the lives of children. We are also of course very happy to meet with you again to discuss specific areas of work where we share a joint interest.

Yours sincerely,



Annie Hudson, Chair

CHILD SAFEGUARDING PRACTICE REVIEW PANEL