London
safeguarding children
Partnership

London Rapid Reviews Analysis Report (2023-2024)

February 2025

Foreword

On behalf of the Executive of the London Safeguarding Children Partnership, I am pleased to introduce the first pan-London Rapid Review Analysis. Rapid Reviews provide an important learning opportunity for Local Safeguarding Children Partnerships (LSCPs) and their partner agencies, but are not published, so we are grateful to the LSCPs for sharing anonymised Reviews with us. Analysing these Reviews provides us with an opportunity to identify emerging themes at an early stage and find pan-London approaches to address them. We intend to carry out these analyses on an annual basis, which will allow us to see any changes in the challenges facing children, their families and the practitioners who support them.

Whilst the focus of Rapid Reviews and this Analysis is learning and practice improvements, we also recognise the impact of the incredible work by practitioners from a range of agencies across London which keeps children safe and with their families wherever possible. The London SCP is committed to working with LSCPs and other partners to continue to improve our safeguarding systems, procedures and practice.

The themes and recommendations from this report have been shared with stakeholders via a series of network meetings and signed off by the Executive, and we thank all those who have contributed. As a result of this analysis, the Executive has agreed to act on the first recommendation by making neglect the London SCP's third priority, alongside Adolescent Safeguarding and Child Sexual Abuse (CSA). The findings of this report, particularly the relatively low levels of identification at an early stage, and the feedback we received from stakeholders emphasised that there has been a lack of focus on neglect in recent years and there is a need for a pan-London approach to address it. The important role education plays in safeguarding children is clear throughout the report and we have plans in place to establish and education sub-group this year to ensure that the education sector is at the heart of our work.

We look forward to working with all of our partners and stakeholders through the implementation of the recommendations from this report.

Abi Gbago,

Chair of the Executive of the London Safeguarding Children Partnership

Context

Following an analysis of Rapid Reviews relating to adolescent safeguarding last year, the Executive of the London Safeguarding Children Partnership (London SCP) agreed to carry out an analysis of all rapid reviews undertaken in London between April 2023 and March 2024.

Rapid Reviews are required to be carried out by Local Safeguarding Children Partnerships (LSCPs) when they submit a Serious Incident Notification (SIN) to the Child Safeguarding Practice Review Panel (hereafter referred to as 'the Panel'). Partnerships are required to submit a SIN when a child in their area who they know or believe to have been abused or neglected dies or is seriously harmed. The purpose of a Rapid Review is to establish if there is any learning from the case and to decide whether a Local Child Safeguarding Practice Review (LCSPR) should be carried out.

LCSPRs are more thorough reports with learning recommendations, however when there are court processes involved, publication is often delayed, sometimes by several years. Whilst LSCPs will try to ensure learning is shared prior to publication in these cases, the wider system is not able to access this, which prevents timely analysis and regional learning.

Rapid Reviews are required to be completed within 15 working days of a SIN, so they provide a more current picture of themes and trends. These are not required to be published, so in order to access the Reviews for analysis, requests were made to London's 29 LSCPs. Two LSCPs did not respond, and two had not completed any Rapid Reviews in the timescale. The other twenty five partnerships completed a total of 79 Reviews, which related to 96 children. The number of Reviews completed by each Partnership varied significantly, from those who completed no reviews in the time period to those who completed nine. There is no clear correlation between population or other safeguarding metrics and the number of Reviews completed, which suggests that there are variations in the application of the SIN threshold. 38% of the Rapid Reviews recommended a National or Local Child Safeguarding Practice Review (LCSPR).

Rapid Reviews

There is guidance provided by the Panel that sets out the information that should be contained in Rapid Reviews. A significant number of the Reviews analysed did not meet these requirements; for example ethnicity and disability not being included. There was significant variation in terms of the length of Reviews; some were only 2 or 3 pages and it was difficult to establish a summary of the facts of the incident, whilst others were 30 pages. Some Reviews were focused on a very brief period of time prior to the notifiable incident, whilst others analysed the child's life as a whole. There was also significant variation in the quality of analysis, learning points and recommendations.

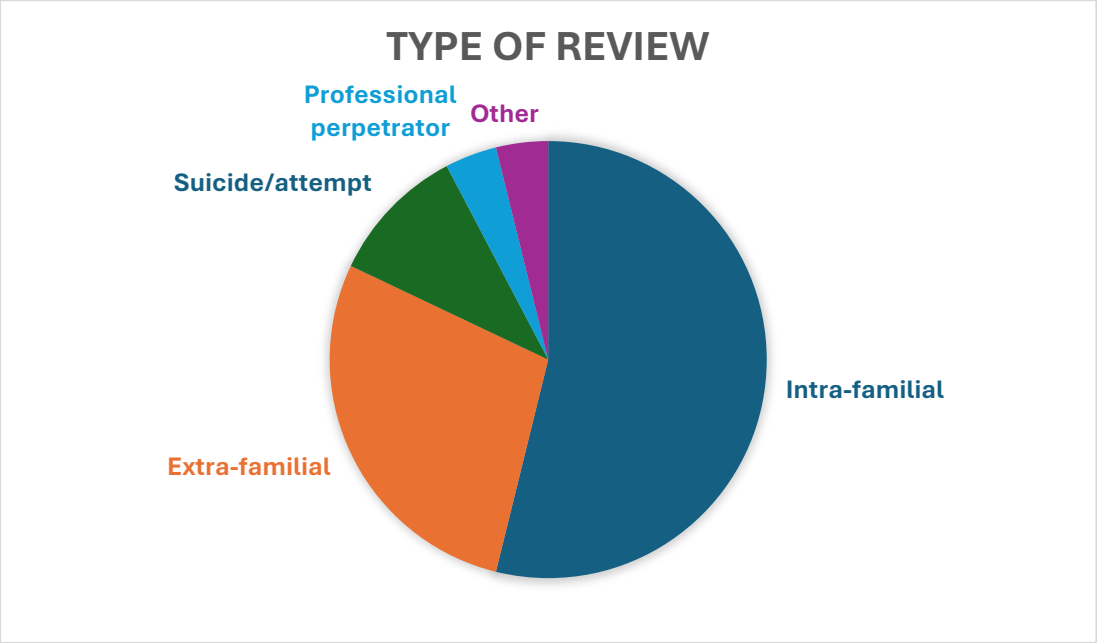
There has been a view amongst Partnership Managers, Chairs and Scrutineers in London that a template would be helpful to ensure that every Partnership is producing Reviews that meet the requirements of the Child Safeguarding Practice Review Panel.

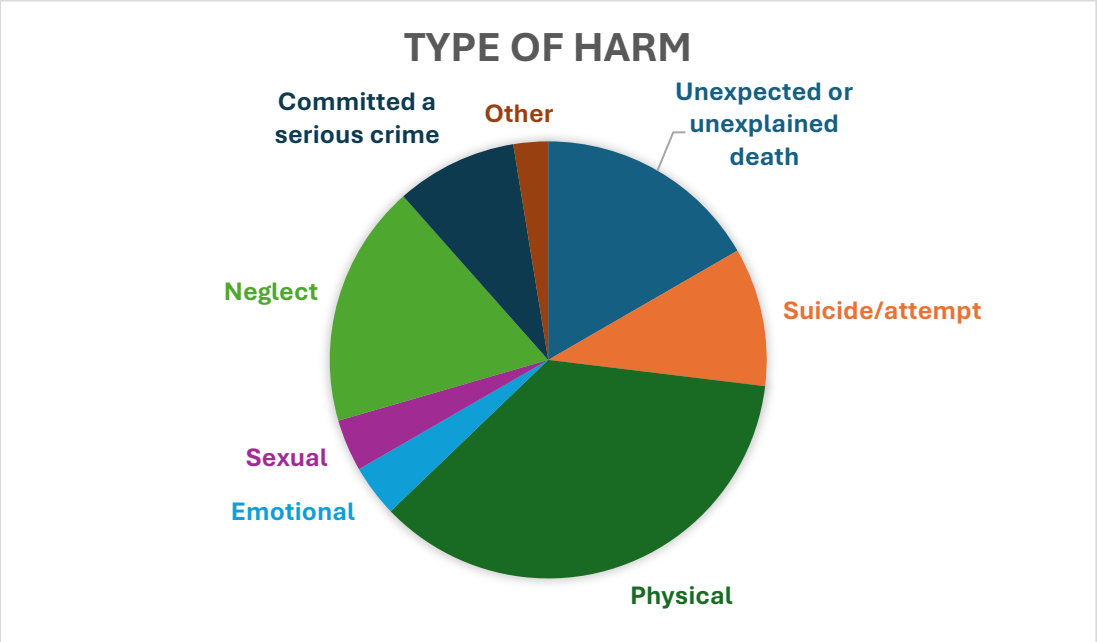
Some standardisation of information would certainly make analysis much easier. In recent years, there has been an increased focus on understanding the culture and intersectional identity of children and their families, and this is a topic that the guidance says should be covered. Whilst many Reviews asked the question as to how the child's culture had impacted decision making, in reality they were unable to fully answer the question due to the lack of information provided regarding the child's identity. Not all Reviews included the child's ethnicity and very few included the child's religion. Additional information such as whether a child was living in poverty and the families' housing situation would be helpful in understanding the context of incidents and identifying trends.

Overview

Types of Harm

The 79 Reviews received covered a range of circumstances. For the purposes of this report, they have been categorised as intra-familial harm, extra-familial harm, professional perpetrator and deaths by suicide. A third of the children who were subject to Reviews sadly died as a result of the notifiable incident. Where children died, this was most likely to be teenagers who died as a result of extra-familial harm or deaths by suicide, or babies under 1 who had unexplained deaths.

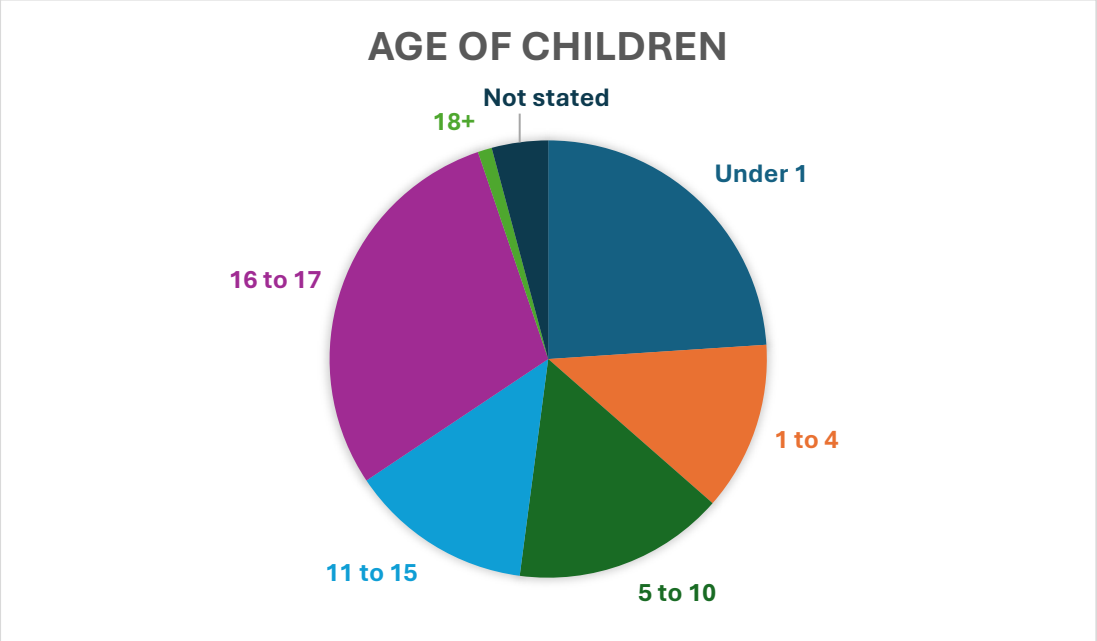




More than a third of Reviews related to physical harm, with over half of these being cases of extra-familial harm. Thirteen children who were victims of physical harm died as a result, with several others suffering life changing injuries. The majority of these were aged sixteen or seventeen years old. Whilst just under a fifth of Reviews were related to neglect, they were more likely to relate to sibling groups, therefore they account for almost a third of children. The next most common type of harm was an unexpected or unexplained death. The fact that Reviews have to be completed within fifteen working days means that often full post-mortem results are not yet available.

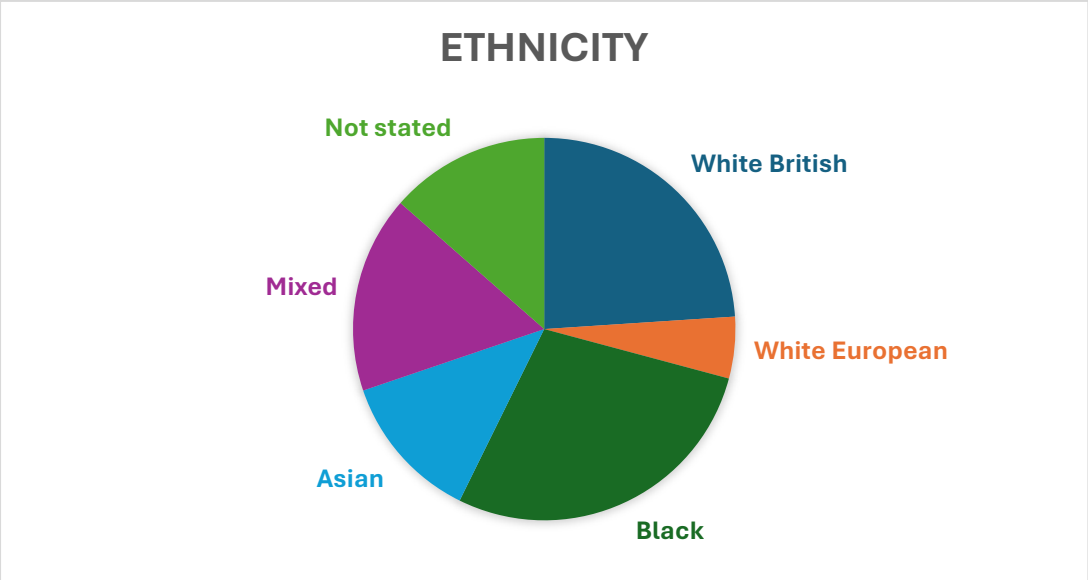
Age

The children who were subjects of these Reviews ranged from newborn to seventeen years old, along with care experienced adults, for whom it is good practice to carry out reviews in certain circumstances, whilst not mandated. The type of harm experienced varied significantly by age category; babies were more likely to have suffered non-accidental injuries (NAIs) or unexplained deaths/illnesses, school aged children were more likely to have experienced neglect and other types of intra-familial abuse and teenagers were most likely to have suffered extra-familial harm.

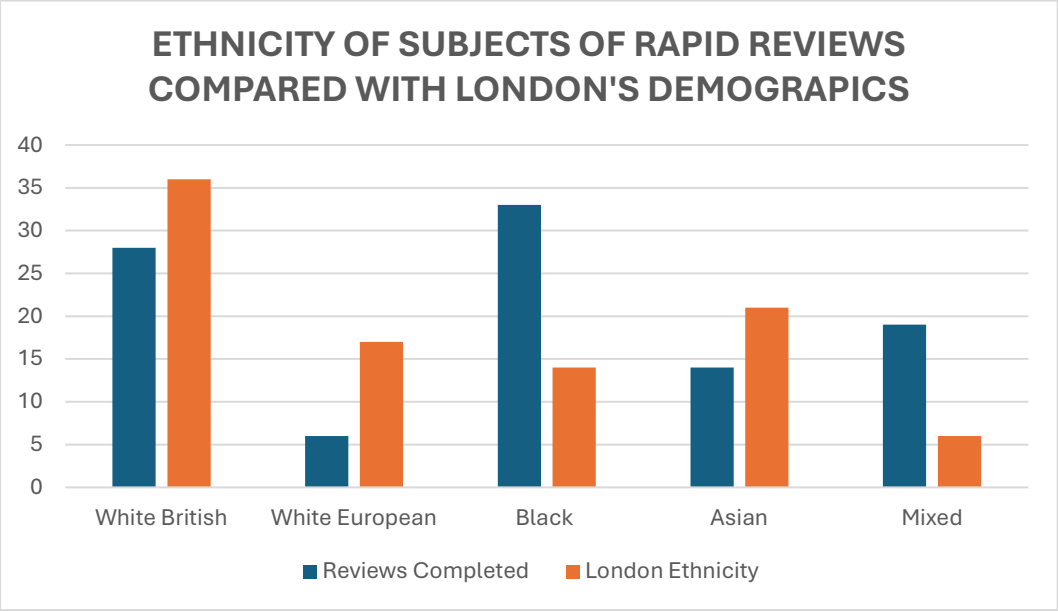


Ethnicity, Culture and Religion

Ethnicity is difficult to categorise consistently due to the range of ethnicity codes/descriptors used, whilst in some cases, ethnicity was not recorded at all. Many of the Reviews attempted to explore the impact of children's culture and identity, however very few provided any information relating to this beyond the child's ethnicity. Only twelve Reviews stated the child's or family's religion. It is important to note that authors are reliant on information provided to them by agencies, so this may be due to the information not being recorded or shared.

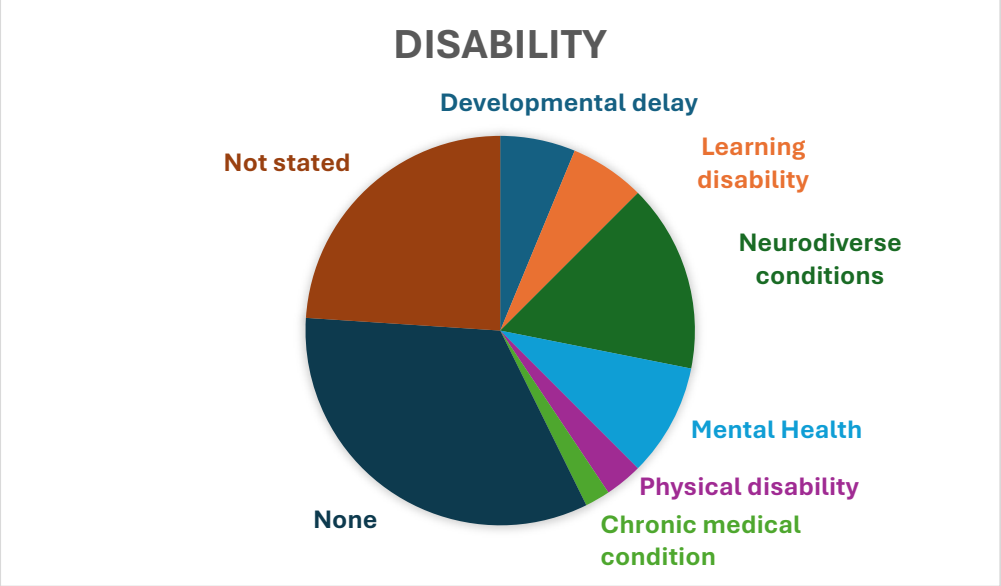


When compared with demographic data for London (removing those with ethnicity not stated), Black children are significantly more likely to be subject of Rapid Reviews, as are children from Mixed backgrounds. White European children are much less likely to be subject to Rapid Reviews and Asian and White British children are somewhat less likely to be subject to Rapid Reviews. This mirrors the national data for children subject to Child Protection plans, which shows that children from Black and Mixed backgrounds are more likely to be subject to plan, with children from Asian backgrounds less likely.



Disability

Much like religion, disability was not consistently recorded or codified, making it difficult to produce accurate data. Whilst many Reviews stated 'none' next to disability, it should be noted again that the author is dependent on agency information and therefore the number of subject children with disabilities may be under recorded here.



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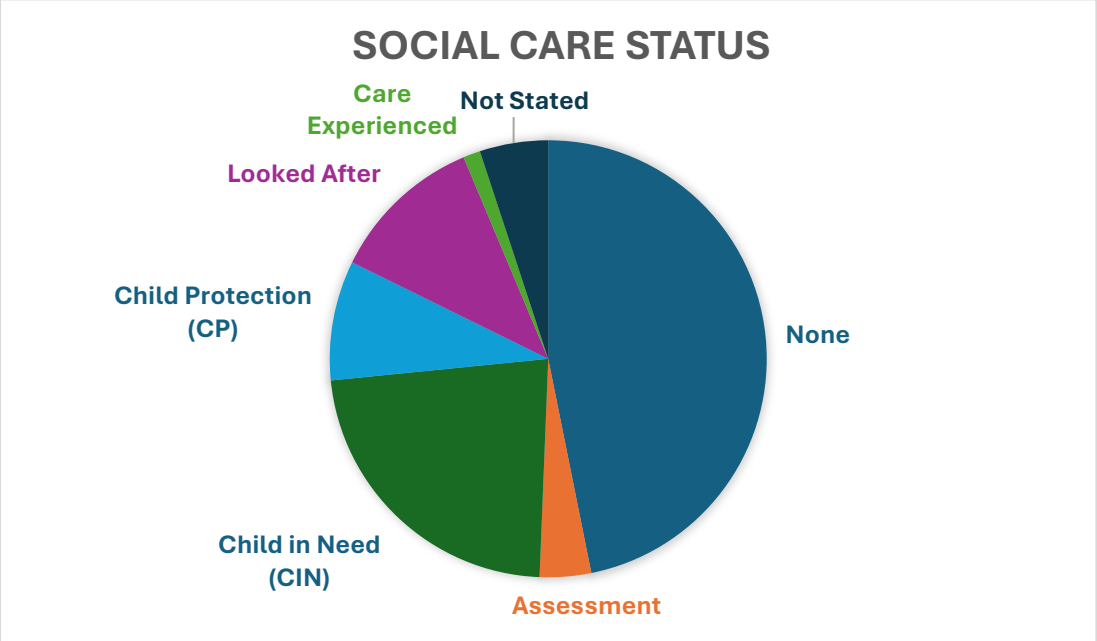
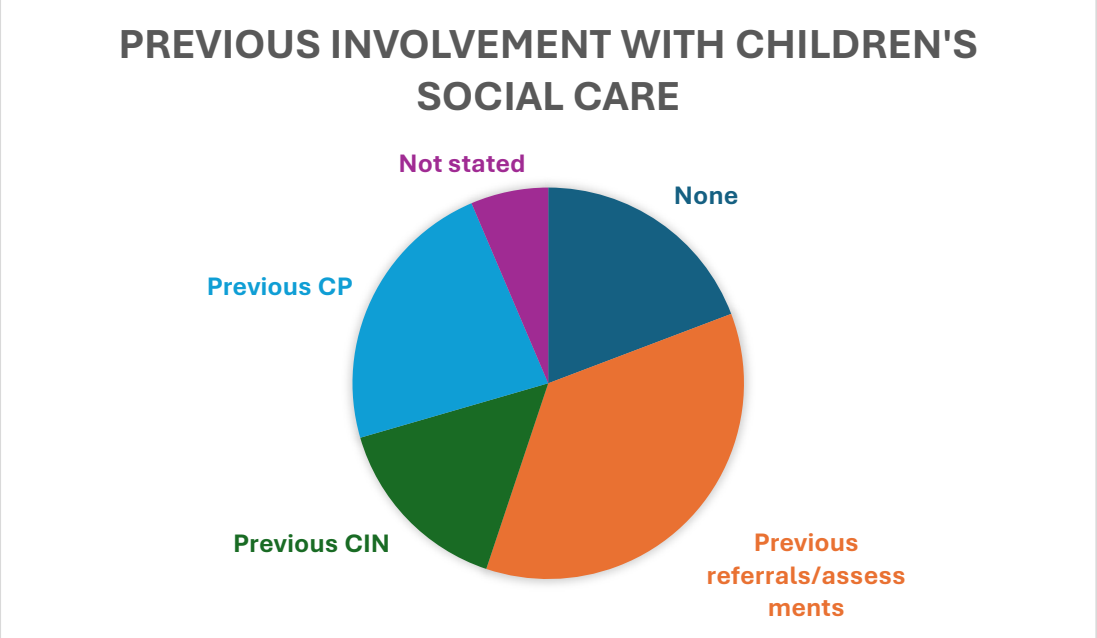
Social Care Involvement

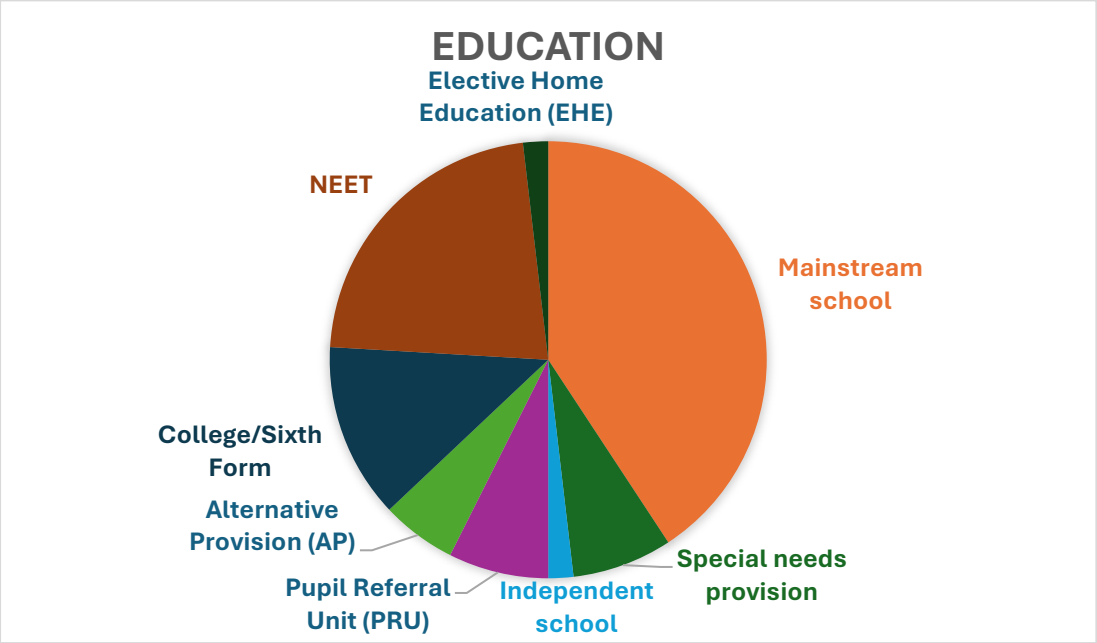
Around half of the Reviews related to children who were open to Children's Social Care at the time of the notifiable incident. Of those who were not open at the time, a quarter were previously known to Children's Social Care. Fifteen percent of Reviews related to children who had never been known to Children's Social Care, the majority of which were babies without siblings, so there was less opportunity for there to have been Children's Social Care involvement.





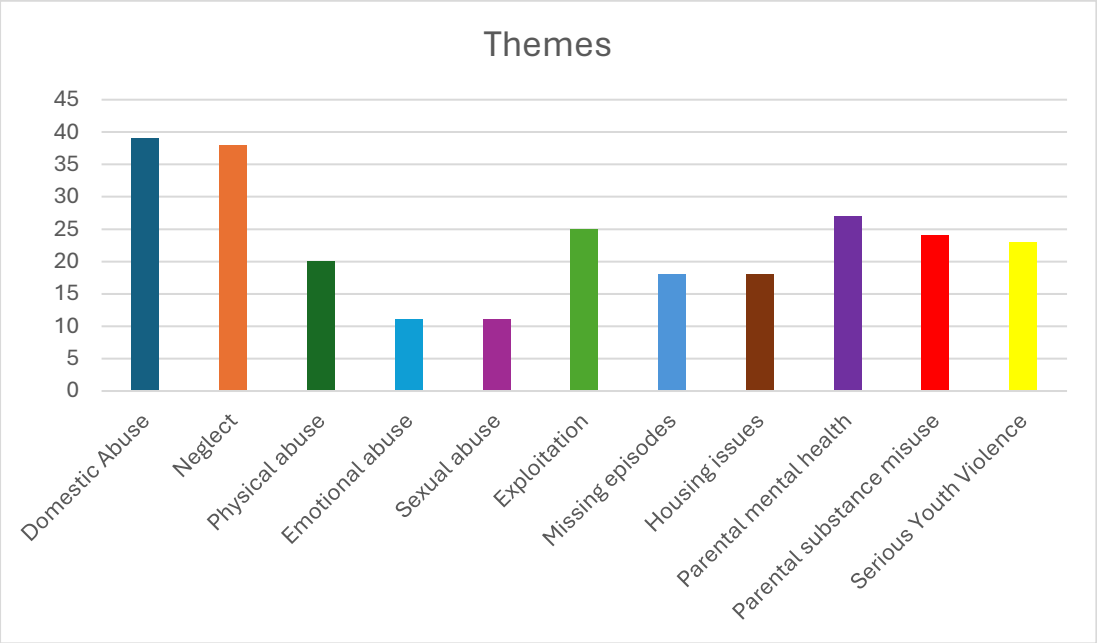
Education

Education status has been recorded for children aged 5 to 17. Almost a quarter of subject children were Not in Employment, Education or Training (NEET) at the time of the notifiable incident and they were all aged 16 or 17. An Education Health and Care Plan (EHCP) was referenced in 17% of Reviews; either in terms of the child having a Plan or an assessment for a Plan being underway. Delays in the process was a common theme, and the impact on children was notable, particularly those who suffered extra-familial harm. A fifth of Reviews highlighted issues around poor attendance, with this being a theme in Reviews relating to extra-familial harm, neglect and those who had taken their own lives or attempted too. 15% of Reviews recorded school exclusions, and this was almost exclusively in cases of extra-familial harm.



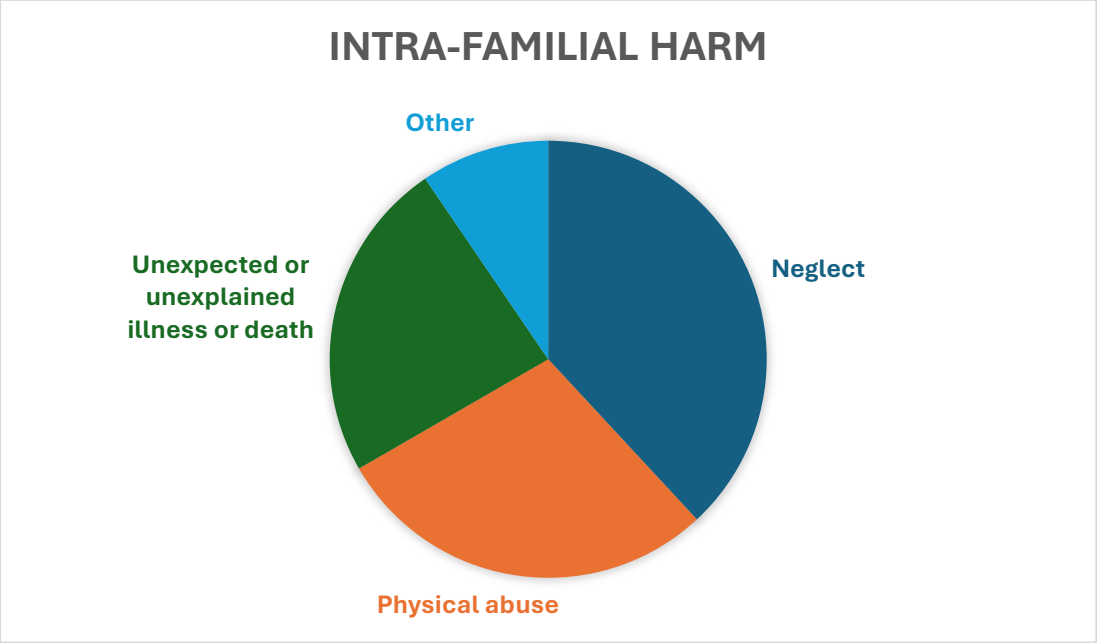
Themes

Whilst Reviews are undertaken due to a particular notifiable incident, they also explore a range of themes from a child's life that has contributed to the circumstances leading up to the incident. More than a third of Reviews included children's experiences of domestic abuse, with over a third also stating that there were concerns around neglect. These two themes could be seen across all types of Review and age groups. These themes will be explored in more detail.



Intra-Familial Harm

Just over half of the Reviews analysed for this report related to instances of intra-familial harm. Within this group, the highest number of Reviews were carried out due to neglect. Cases of physical abuse mostly related to Non-Accidental Injuries (NAIs) caused to babies under the age of 2. Whilst a third of Reviews in this group related to unexpected or unexplained illnesses or deaths, these were generally carried out due to a background of neglect concerns.



Neglect

Sixteen Reviews were carried out with neglect as the notifiable incident regarding 28 children, whilst it was a contributing factor in many more. The subject children in these Reviews aged from young babies up to older children, but school aged children were more likely to have experienced this type of harm. White Children were more likely to the subject of Reviews on neglect than other types of harm.

The lives of children who experienced this level of neglect started with challenges for professionals to engage with families pre-natally and continued with children not being brought to health appointments. There were concerns in a number of Reviews that the inconsistent application of 'Was Not Brought' (WNB) policies resulted in missed opportunities to safeguard children. A third of children had experienced medical neglect (where a parent or carer neglected the medical needs of the child), and they were also more likely to be experiencing development delays. These children were often more likely to have low school attendance and to have parents who were experiencing mental illness and/or substance misuse issues.

A high number of these Reviews highlighted the lack of clarity around the roles of these children's fathers and other men in the family home. Whilst this is an ongoing challenge across children's safeguarding, it was particularly prominent in neglect cases, where mothers were held solely responsible for improving the families' situations.

Whilst overall, around half of children were open to Children's Social Care at the time of the notifiable incident, in neglect cases this was only a quarter, suggesting that neglect has not been recognised and acted upon by professionals at the same rate as other forms of abuse. The majority of these children also had no previous involvement with Children's Social Care, beyond referrals to the Front Door.

The neglect Reviews fell roughly into two categories. The first was where professionals had long term concerns about chronic neglect. Over time, neglectful home environments and family circumstances became normalised, with practitioners losing sight of the impact they had on the lived experiences of the children. In many of these cases, schools were well aware of the issues and were going above and beyond what was required of them to support the family. Some schools had made referrals to the Front Door previously, with the children not meeting threshold or the parents declining support. It appeared that this deterred them from making further referrals regarding their concerns.

The second category was of children where the level of neglect experienced seemed to have gone unnoticed and the children's voices were not heard. A significant factor in these cases appears to have been the move to more virtual visits. This allowed for disguised compliance from parents who could engage virtually or in the community, with professionals not seeing the home environment. This resulted in a number of cases where, when professionals finally did get into the family home, they found home conditions that were not only neglectful but uninhabitable. In other cases, there was a lack of a consistent approach to what is 'good enough' with regards to home conditions, particularly from housing officers and emergency services. There were also several cases where the child was found to be clinically malnourished as a result of the neglect. Many of the issues identified in this analysis reflect those highlighted in the NSPCC report on neglect (Too little, too late: The multi-agency response to identifying and tackling neglect). This report discussed the issues relating to the identification of neglect where families are experiencing poverty, and inclusion of a family's socio-economic situation in Reviews would enable this to be explored in future analyses.

Practice issues that could be contributing to an underreporting of neglect

- Practitioners not seeing the home conditions due to a reliance on virtual visits
- An inconsistent understanding of what is 'good enough' for home conditions between practitioners
- A lack of professional curiosity regarding a child's lived experience.

Unexplained deaths, illnesses and injuries

Eight Reviews related to babies under the age of 6 months who suffered Sudden and Unexpected Deaths in Infancy (SUDI), illnesses and injuries. Due to the short timescales of Rapid Reviews, complete postmortem reports are usually unavailable. Over half were on CP or CIN plans at the time of the notifiable incident. 5 of the 8 babies involved were living in families who were experiencing issues with housing; living in temporary accommodation or other overcrowded accommodation. Many of the parents were co-sleeping with their babies but it was not always clear in the Reviews whether this was due to choice, lack of space or unavailability of a cot. Questions were raised in several Reviews about whether or not practitioners had understood families' cultures when giving safer sleeping advice and how confident they were to explore this with families.

Physical Abuse

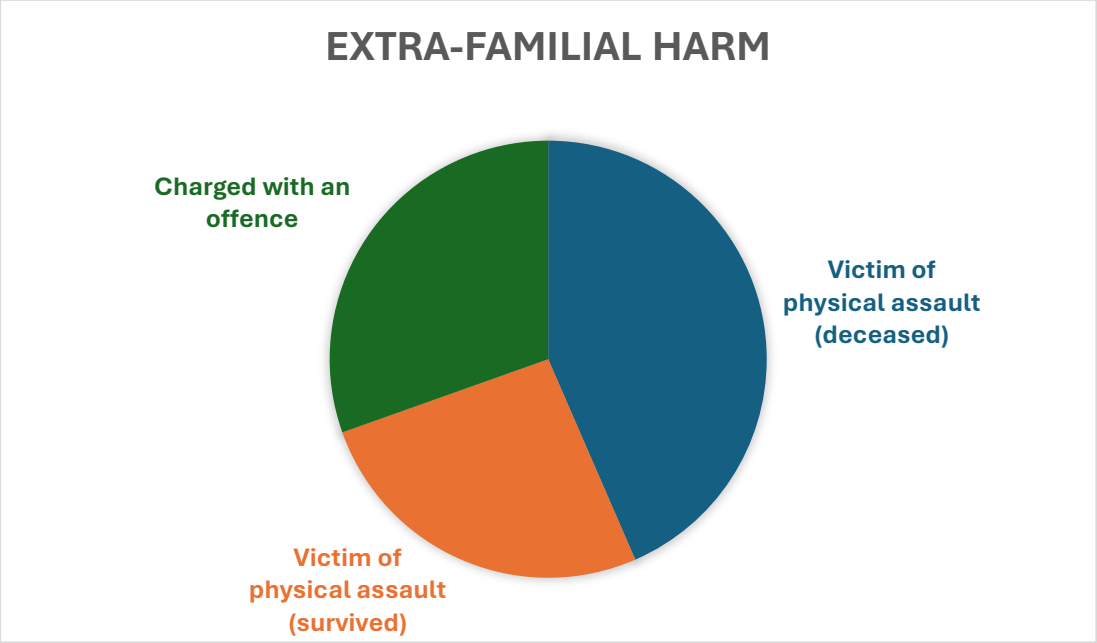
Two thirds of the Reviews relating to physical harm in an intra-familial setting were triggered by Non-Accidental Injuries (NAIs) to babies under the age of 14 months. All of these children survived. A third of the children were open to Children's Social Care at the time of the notifiable incidents, a third had previous assessments and a third had no previous contact. Due to the young age of the children and the fact that the majority of the children had not had extensive involvement with Children's Social Care, in many cases there was not a lot of context to the families' backgrounds or the children's lived experiences. Around half of the Reviews stated that the babies' mothers experienced post-natal depression or there were other parental mental health issues.

There were no strong themes relating to practice in these cases.

Extra-Familial Harm

There were 22 Reviews on the topic of extra-familial harm, relating to 23 children between the ages of 14 and 17. The majority of the children were 17 and almost all were male. Over half of the children who had their ethnicity recorded were Black, which as Black people make up only 14% of London's population, means that they were significantly over represented. Whilst this is a relatively small cohort, this does reflect other data regarding the high numbers of Black boys in particular who suffer extra-familial harm. Children who were subject of Reviews due to extra-familial harm were more likely than the other children subject to Rapid Reviews to have Special Educational Needs and Disabilities (SEND). Delays in accessing assessments for neurodiversity and support including EHCPs were common themes throughout these review.

All of the Rapid Reviews were triggered by incidents of physical harm, with the subject children either the victims of offences or charged with offences. The majority of the incidents were stabbings.



Education

It is accepted that a stable education placement is a protective factor from extra-familial harm. The majority of children were over the age of 16, so no longer of statutory school age, although there is still a requirement for children of this age to be in education, employment or training. About a third attended mainstream school or college, a third attended APs or PRUs, and a third were NEET. Almost half of the children in this cohort had experience of school exclusions, with a quarter noting issues with poor school attendance. It is important to note that the level of detail in the Reviews varied significantly, therefore this is likely to be an underestimate.

A number of the Reviews highlighted good practice from schools, with education staff recognising the increased risk for children who were permanently excluded and making every effort to prevent this. The majority of children in this cohort were over the age of 16, and it appears that whilst schools were a protective factor, once they finished year 11, they often

dropped out of further education or their attendance was poor. This is a key transition point and, whilst schools appeared to recognise this and in many cases worked hard with children to ensure they had an education placement post-16, there is not enough follow up and support to help children to maintain these placements. It is at this point that they become most vulnerable to exploitation and crime.

Practice issues:

- Vulnerable children with SEND need to get access to medical assessments and EHCP assessments as early as possible to ensure that they are appropriately supported
- Children at risk of extra-familial harm need additional support and safeguards to keep them in education, employment and training post-16

Social Care Involvement

In many Reviews, there was a lack of clarity amongst practitioners as to what role Children's Social Care was playing in the lives of the children involved and this affected multi-agency working , often leading to assumptions that more safeguards are in place than there were. This was because different Boroughs have different approaches to managing children at risk of extra-familial harm, sometimes outside of the statutory processes. 17% of children in the extra-familial harm cohort were Looked After, with another 40% on CIN or CP Plans. Over a third were open to Youth Justice Services. Two thirds of the children had previously been known to Children's Social Care through CIN or CP plans.

A common theme amongst these Reviews was of parents declining support through CIN plans for their children. Many parents appeared to underestimate the level of risk posed to their children outside the home and this prevented the children from accessing support at an earlier stage. There were also several examples where parents did not speak English and their children were used as interpreters, or they were not engaged with consistently at all due to a lack of interpreters. This resulted in practitioners not getting a full picture of the child's circumstances and parents potentially not understanding the risk posed to their children and therefore impacting their ability to safeguard them.

Children at risk of extra-familial harm often had a significant number of professionals involved with them. When children were supported by CIN plans, the CIN meetings often included too narrow a group of professionals and sometimes did not include the person with the closest relationship with the child. There was a theme of CP and CIN plans being closed prematurely when the child was still at risk and without a robust step-down plan. There was often an over reliance on specialist services to prevent harm. This supports the widely held view that the Child Protection system is designed to address intra-familial harm and is not well suited to supporting children at risk of extra-familial harm and their families.

Practice Issues:

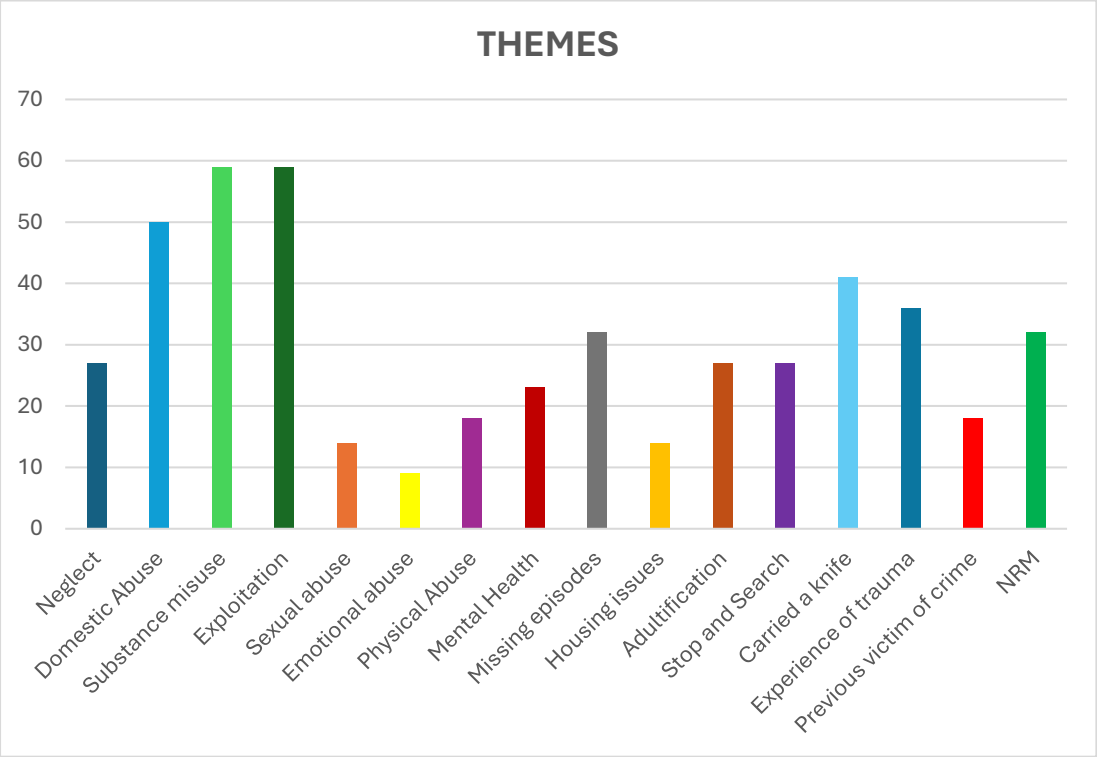
- Boroughs do not have a consistent approach to safeguarding children at risk of extra-familial harm and this causes confusion amongst practitioners and families
- CP and CIN groups do not consistently include the right practitioners who have the best information about children and their families
- There can be an over reliance on specialist services to safeguard children, with CP and CIN plans are often closed prematurely and without robust step-down plans

Themes

The majority of the children who were the subject of Rapid Reviews due to extra-familial harm were known to be victims of exploitation or at risk of exploitation prior to the notifiable incident. Over 40% had previously been known to carry a knife. A third of the children had been missing, some repeatedly and some for prolonged periods. These incidents were not always fully explored in terms of the wider context of the extra-familial risk posed. Concerns were raised in some reviews that there was a lack of focus on adult offenders who were exploiting children.

A third of the children either had a positive NRM (National Referral Mechanism)[1] or a referral had been made. There seemed to be a lack of knowledge amongst some professionals as to the purpose of the NRM and what it would do for children. This also applied to a number of multi-agency panels and meetings held to identify and discuss children at risk of exploitation or at risk of serious youth violence. Practitioners often appeared to be unclear of the purpose and remit of these panels and meetings, and overestimated the impact they will have on safeguarding the child. This sometimes led to an over optimistic view of the safety of the child.

1. [1] The National Referral Mechanism (NRM) is a framework for identifying and referring potential victims of modern slavery and ensuring they receive the appropriate support. A positive NRM is taken in to account by the criminal justice system when the individual is accused of committing a criminal offence.



A significant number of children had experienced intra-familial harm at some point in their lives. Half of the children had been victims of domestic abuse and over a quarter had been victims of neglect. Over a third of Reviews noted that the children had experienced trauma and had been victims of crime previously. Given that some Reviews only focussed on the period prior to the notifiable incident, this is likely to be an underestimate.

Whilst there were safeguarding concerns for a number of years prior to the notifiable incidents for the majority of these children, there were a number of children for whom the changes in their circumstances appeared to be more sudden, sometimes over less than a year. In these cases whilst practitioners were alive to the changing risks, the system appeared to struggle to keep up and safeguard the child. There was a small number of children where there had been few or no concerns prior to the notifiable incidents and these violent incidents appeared to have occurred over relatively minor issues.

Practice Issues:

- There is confusion amongst practitioners around the purpose of the multi-agency panels and meetings held to discuss children at risk of extra-familial harm and the actions that come from them. This can lead to an overly optimistic view on how a child is safeguarded.

Suicide/Attempts

Eight Reviews were carried out about children who took their own lives or made attempts to do so. One was a Care Experienced young adult and the rest were children aged 11-17. The majority of the children identified as Male and three of the eight children identified as Transgender. Half of the children were Looked After, with the others all known to Children's Social Care at the time of the notifiable incident.

The majority of the children in this cohort had experienced trauma in their childhoods. A majority had experience sexual abuse, despite only 18% of the overall Reviews referring to sexual abuse. It was not clear as to whether all of these children had received specialist support regarding this abuse and to what role this played in their mental health issues. All of the children were known to have had mental health issues prior to the notifiable incidents, and most had parents with mental health issues. Several of the children were young carers. It was clear in several cases that parents had struggled to access specialist services to support their children, particularly with issues around gender dysphoria. Many Reviews showed that parents of children with complex needs were experiencing burnout from caring for them and the support offered was insufficient to keep these children safe with their families.

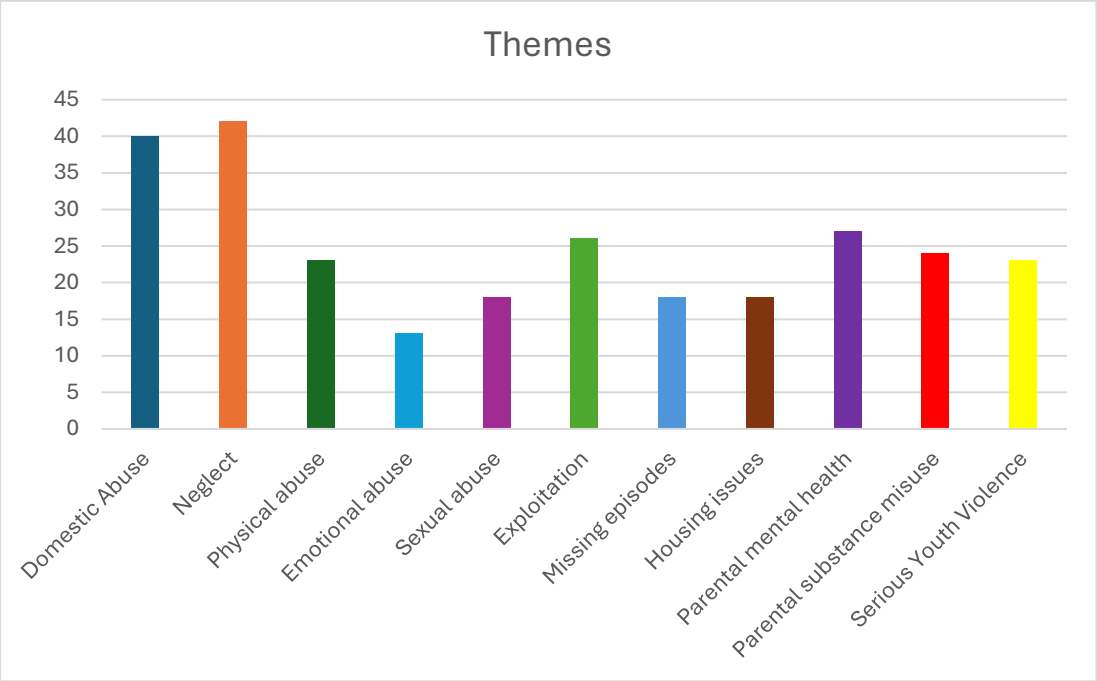
Given the relatively small number of cases for this type of harm, it is difficult to establish clear themes in terms of practice. However there were issues in several cases with placement instability and difficulty finding placements that could meet children's complex needs. This led to the use of unregulated placements and social admissions to hospital, which in at least one case caused further trauma to the child. In some cases there were communication issues between emergency services and mental health services when children were in crisis and going missing.

Other Types of Harm

The majority of Reviews fell under a few key categories, however there were some types of harm featured in only two or three Reviews, meaning it was not possible to analyse them for themes. These reviews fell under the following categories:

- Sexual Abuse
- Emotional Abuse
- Physical Abuse (Murder of family and suicide of parent)
- Harm caused by professionals
- Accidents

Themes



The most common themes across the 79 Rapid Reviews were neglect and domestic abuse. Both affected children of all ages and ethnicity and occurred in their histories regardless of the type of notifiable incident that led to the Rapid Reviews. Whilst neglect was the notifiable incident in 18% of Reviews, it was a theme in over 40% of Reviews. Children in sibling groups of 3 and above were more likely to have experienced neglect. Neglect rarely occurred in isolation; there were usually other concerns. Neglect concerns often included concerns about medical neglect, poor school attendance and children not being brought to appointments.

A significant number of children subject to Rapid Reviews were cared for by parents with their own vulnerabilities. Over a quarter of parents had their own mental health issues and 24% had substance misuse issues. Others were Care Experienced or had immigration issues.

Whilst only 4 Reviews were triggered by incidents of domestic abuse, it was a theme in almost 40% of Reviews. Even with the high number of children who had experienced Domestic Abuse, it was often included as background information and there was limited narrative and analysis around the abuse and how it impacted the children. There was also limited learning points or recommendations on this topic. Given the significant impact of domestic abuse of the lives of children and the social care system, it is important that there is more focus on learning in this area.

18% of the Reviews involved children who had suffered from sexual abuse at some point in their lives. Most of these were historic rather than the reason for the notifiable incident and therefore there was limited analysis or learning about the response the child received or the impact that support had on them.

A small but notable number of Reviews about babies who experienced neglect and unexplained illnesses referred to parents who had alternative medical beliefs and were sceptical about Western medicine. These Reviews highlighted the challenges for professionals in working with parents with these beliefs and when the line is crossed from parental choice to become medical neglect.

11% of the children who were subject to a Rapid Review were Looked After at the time of the notifiable incident. However for these children, placements were an issue. A lack of suitable placements meant that there were children experiencing significant placement instability, being placed with foster carers who were lacking the skills needed to care for them due to their complex needs, being placed in unregulated placements and being kept in hospital on social admissions.

Practice Issues

Whilst some practice issues were specific to a particular type of harm, others were found across a wide range of Reviews. A strong theme regarding practice was the lack of engagement with, and even acknowledgment of, fathers and men in the home. This was an issue in 20% of Reviews. In some Reviews, the fathers were not mentioned, whilst others highlighted that professionals had not been curious enough about the role of fathers in their children's lives. In some cases, fathers could have been protective factors if they had been properly engaged with. In others, fathers or male partners of mothers posed a risk to children, but expectations in terms of safeguarding were placed entirely on mothers. There were a number of cases where information about fathers was not shared between agencies.

Learning relating to professional curiosity, particularly around culture were common. A number of Reviews highlighted a lack of confidence in practitioners to engage with families around their culture. This was a particular issue around safe sleeping and some of the challenges around medical decisions making where parents had different beliefs. There is some connection between this and another area of concern which was the lack of consistent use of interpreters. Both of these issues resulted in a barrier between parents and practitioners and prevented the multi-agency team having a full understanding of a child's situation.

Hearing the voice of the child was another common challenge, particularly in cases where parents have complex lives. In these cases, the focus of practitioners could be drawn to addressing parents' issues at the expense of focussing on the child. This was particularly an issue with those Reviews focussed on cases of chronic neglect. There was often a theme where chronic neglect became an accepted fact of life for some families and practitioners did not focus on the impact this had on the child's lived experience.

Information Sharing

Information sharing has been a perennial issue in safeguarding and across CSPRs. There were some specific issues found across the Reviews, regardless of the type of notifiable incident or geographical area and many of these related to information sharing with and between health professionals:

- Information sharing with GPs was repeatedly highlighted as a gap, both in terms of GPs engagement with safeguarding processes but also information being shared with them. This included examples where GPs were unaware that children were subject to CP plans and had not been given important information relating to risk, such as a child being known to carry a knife.
- In some cases relating to babies, there was not always a smooth handover from midwifery to health visitors, resulting in the health visiting service not being fully aware of safeguarding concerns and the family not receiving the level of support and monitoring required.
- There were examples where children were accessing care through both NHS and private providers, and there was a lack of join up between services.
- There was a need in many Reviews to 'Think Family', and in particular better communication between Adult's and Children's Social Care.

The other key issue relating to information sharing involved families and children crossing borders, both in and out of London, and the challenges this poses. This is becoming an ever more significant issue given the housing crisis in London and the high number of families being moved away from their home Boroughs into temporary accommodation. It can also be a challenge when children go missing and are found outside of London. It can also be a barrier to children accessing services, for example Child and Adolescent Mental Health Services (CAMHS), where the children have been on a waiting list and end up back at the bottom of the list in a new area.

Recommendations

Recommendations have not been made for every issue identified in this report. This is because there is already extensive work being undertaken by LSCPs on some topics and recommendations would not necessarily contribute to this.

- For the London SCP to consider if it should add neglect as a London-wide priority on the basis of the evidence from this analysis and, if so, consult with partners as to how it can add value to the work of Local SCPs in this area
- For agencies working with families to ensure that the home environment of children is seen regularly by practitioners, particularly prior to case closure, and to consider the importance of this when reviewing policies around virtual visits. There also needs to be work to help frontline staff from any agency that has contact with children to have a shared understanding of neglect and what is good enough regarding home conditions
- For housing officers and providers to ensure that parents can practice safer sleeping with their babies when placed in temporary accommodation
- For LSCPs to support practitioners to be more confident when exploring a family's culture and beliefs, particularly about medical care and co-sleeping, as recommended in the National Panel National review on SUDI (Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm)
- For the London Adolescent Safeguarding Oversight Board (LASOB) and local authorities to consider their use of Multi-Agency Child Exploitation Panels (MACE) and other panels looking at the cases of children at risk of exploitation and the impact they have on the safeguarding and lived experiences of children
- For there to be a focus on ensuring a supportive transition from secondary school to post-16 education for children vulnerable to extra-familial harm
- For the London SCP and London's LSCPs to work with Primary care providers and Children's Social Care to improve communication and ensure that GPs are included in multi-agency safeguarding work
- For the London SCP to lead a multi-agency task and finish group to address concerns around cross border information sharing

Rapid Reviews

- Once the Panel publish their new Rapid Review Guidance in Spring 2025, London's LSCPs should consider if they would like to do further pan-London work to address standardisation of Reviews through a template and working towards standardisation of ethnicity codes
- For London's LSCPs to ensure that there is adequate focus on a child's identity and intersectionality in Reviews, along with the impact of a child's socioeconomic background

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