

# London Rapid Reviews Analysis Report (2024-2025)

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## London Rapid Reviews Analysis Report

### Foreword

I am pleased to present the second annual London Rapid Reviews Analysis Report on behalf of the London Safeguarding Children Partnership (London SCP). Last year's report provided a useful insight into emerging themes affecting the safeguarding of children across London and direction to the work of the Partnership, including by making neglect one of our three priorities, along with Child Sexual Abuse and Adolescent Safeguarding. It has also led to discussions as to how we can make better use of the information and intelligence held by Local Safeguarding Children Partnerships (LSCPs) across London.

There are a number of common themes and perennial issues in safeguarding which are a part of this year's report, as they were last year, including challenges around information sharing. However there are also some new and emerging trends in this year's report, in particular the part played by inadequate and insecure housing on already vulnerable families, along with the impact this increased transience in families has on information sharing and the availability of longer term support. The London SCP hopes to work with LSCPs across London to improve multi-agency engagement with housing to improve the safeguarding of children.

This report inevitably makes for difficult reading as it sets out the circumstances in which some of London's most vulnerable children suffered significant harm or death. It highlights potential improvements that could be made to the system to improve its response to abuse and neglect. But it is also important that we recognise the tireless work of practitioners from a range of agencies and sectors every day to keep children across the city safe. On behalf of the London SCP Executive, I would like to thank them all for their hard work, compassion and commitment.

A handwritten signature in blue ink that reads "Ade Adetosoye".

Ade Adetosoye CBE

Chair, London Safeguarding Children Partnership Executive

## **Context**

This report is the second annual analysis of Rapid Reviews carried out between April 2024 and March 2025. Inevitably, there are many very similar findings in this year's analysis when compared to last year's. Therefore rather than repeat analysis from last year's report, this year's report focuses on new themes that were not explored in last year's report. This year's areas of focus include education, housing, information sharing across borders and safeguarding children experiencing extra-familial harm.

Rapid Reviews are required to be carried out by (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 five had not completed any Rapid Reviews in the timescale (compared to two last year). The other 22 Partnerships completed a total of 63 Reviews. There was a higher number of Partnerships this year who had not completed any Reviews, and the maximum number completed by a Partnership was six, compared to nine last year. 31% 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, although some Reviews did not meet these requirements. There was variation in terms of the length of Reviews, the level of detail and the time period covered. There was also significant variation in the quality of analysis, learning points and recommendations.

There have been discussions regionally that a template may 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 and this is explored later in the report. Another area that is rarely covered in Reviews is a child's online life, likely because accessing a child's electronic devices takes time. It should therefore be noted that an absence of this as a theme does not necessarily mean online harms are not a significant threat to children.

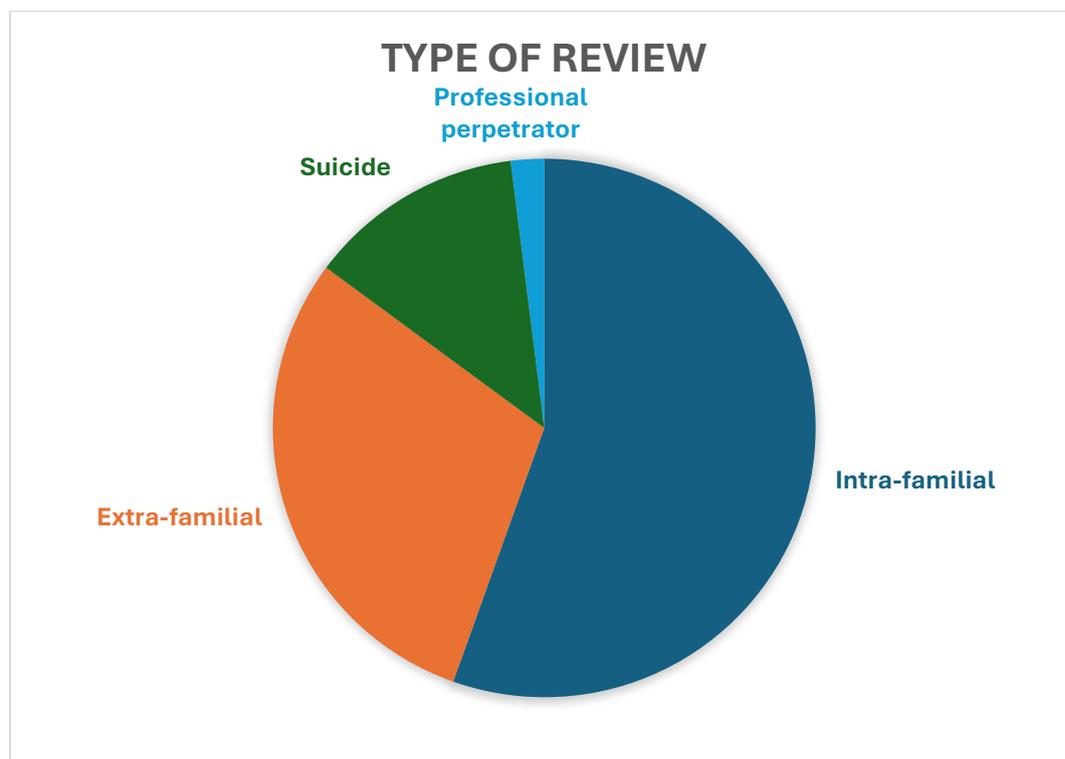
## Overview

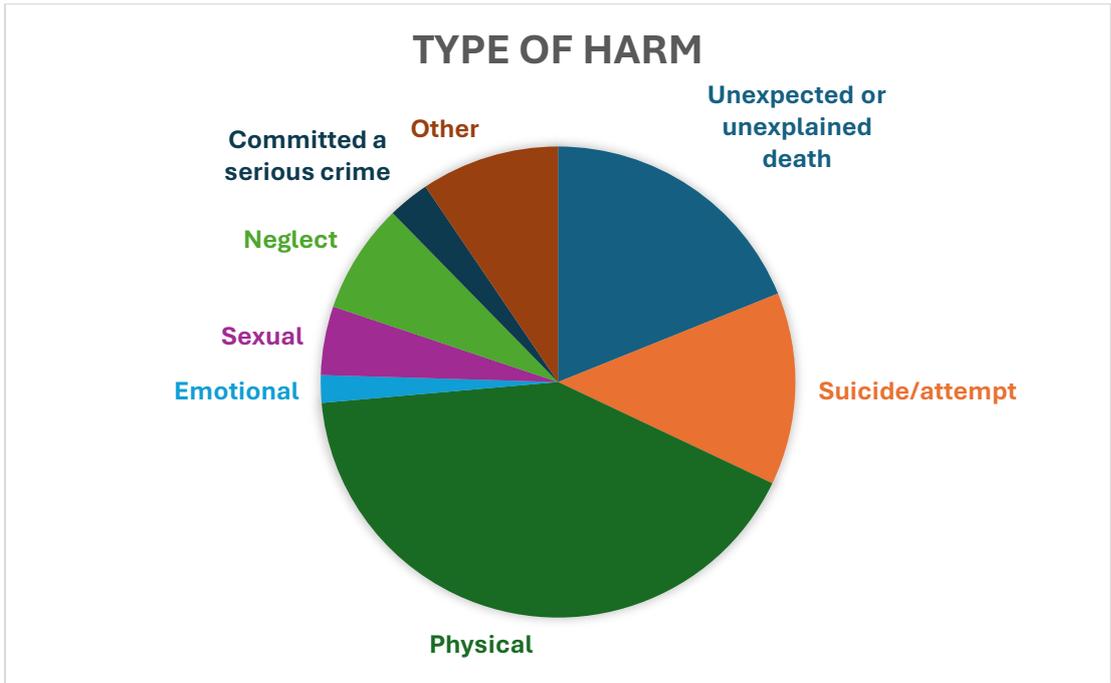
The 27 LSCPs who responded to the request provided details of 63 Rapid Reviews. There was an additional Review from one Partnership that could not be shared due to the high profile nature of the incident. One of the Reviews related to a group of children who experienced harm in a professional setting. Individual demographics for each child were not recorded, so this Review has been excluded from the demographics analysis. One Partnership only provided summary information for their five Rapid Reviews and therefore they are also not included in demographic data.

Around two thirds of children subject to a Review had siblings. It was not always clear as to whether they were full siblings, half siblings or step siblings or whether they lived in the same house. For clarity therefore, subject children are those assigned as such in their Reviews, rather than including siblings, however it should be acknowledged that siblings may also have experienced harm.

## Types of Harm

The 63 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 suicide/suicide attempt. Almost half of Reviews were about a child who sadly died. The proportion of Reviews under each category are similar to last year's analysis.

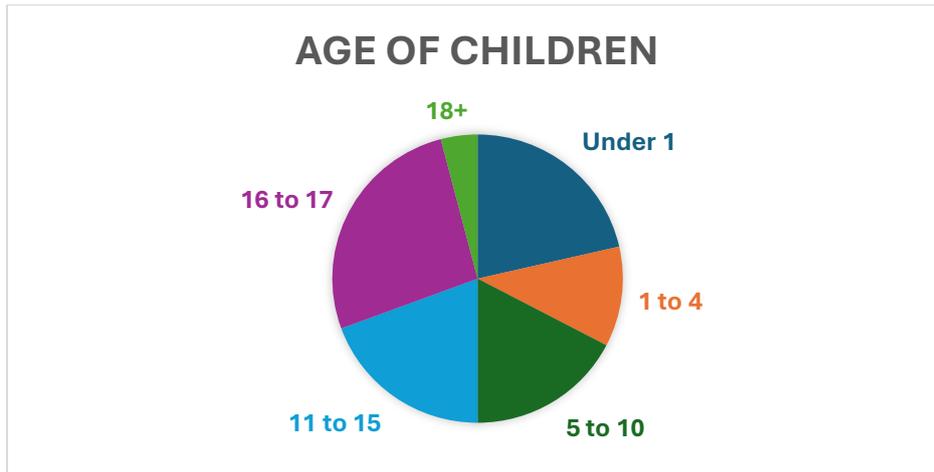




This year, a lower proportion of Reviews were carried out due to neglect, however neglect remained a feature in over a third of Reviews. There were also fewer Reviews where the subject child was accused of committing a serious crime. Close to 50% of Reviews were about children who had experienced physical abuse, with half experiencing extra-familial harm, predominantly stabbings. Thirteen children who were victims of physical harm died as a result, with several others suffering life changing injuries. 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.

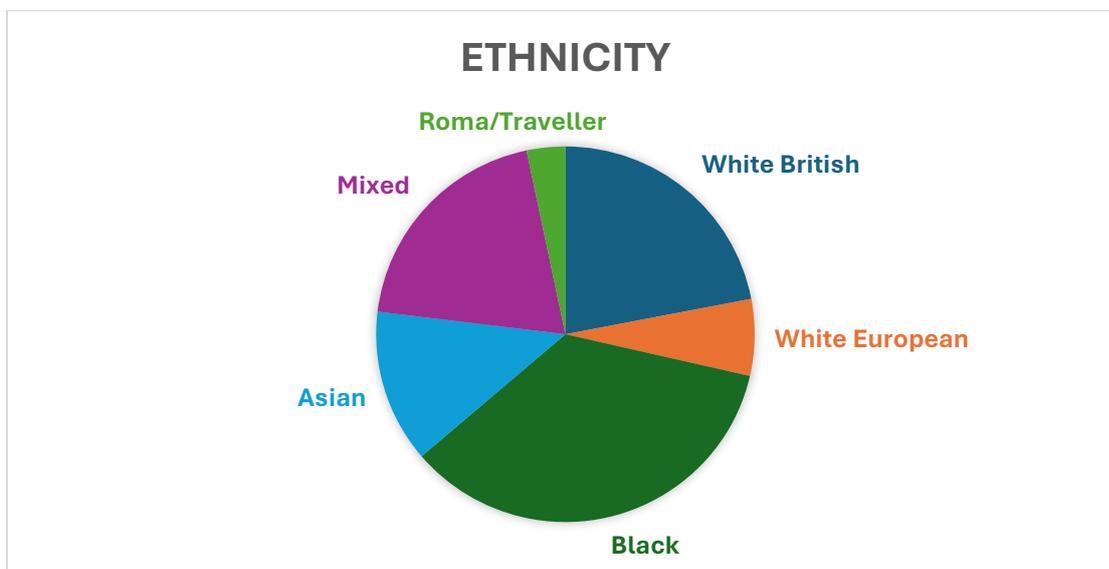
## Age

The children who were subjects of these Reviews ranged from newborn to seventeen, along with care experienced adults, for whom it is good practice to carry out reviews in certain circumstances, whilst not mandated. The proportions of children in each age category was roughly consistent with last year's Review. 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, primary school aged children were more likely to have experienced neglect and other types of intra-familial abuse and teenagers where most likely to have suffered extra-familial harm.

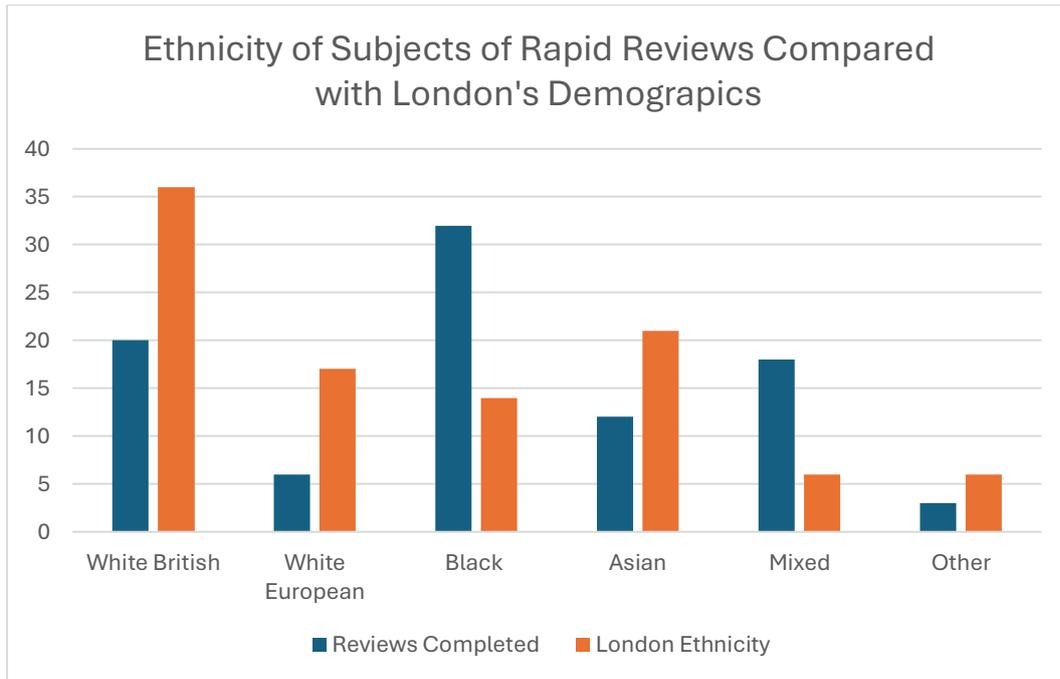


## Ethnicity, Culture and Religion

Ethnicity is difficult to categorise consistently due to the range of ethnicity codes/descriptors used. 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. The family's religion was only recorded when the family was Muslim, with the exception on one Review. 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 made available to them.

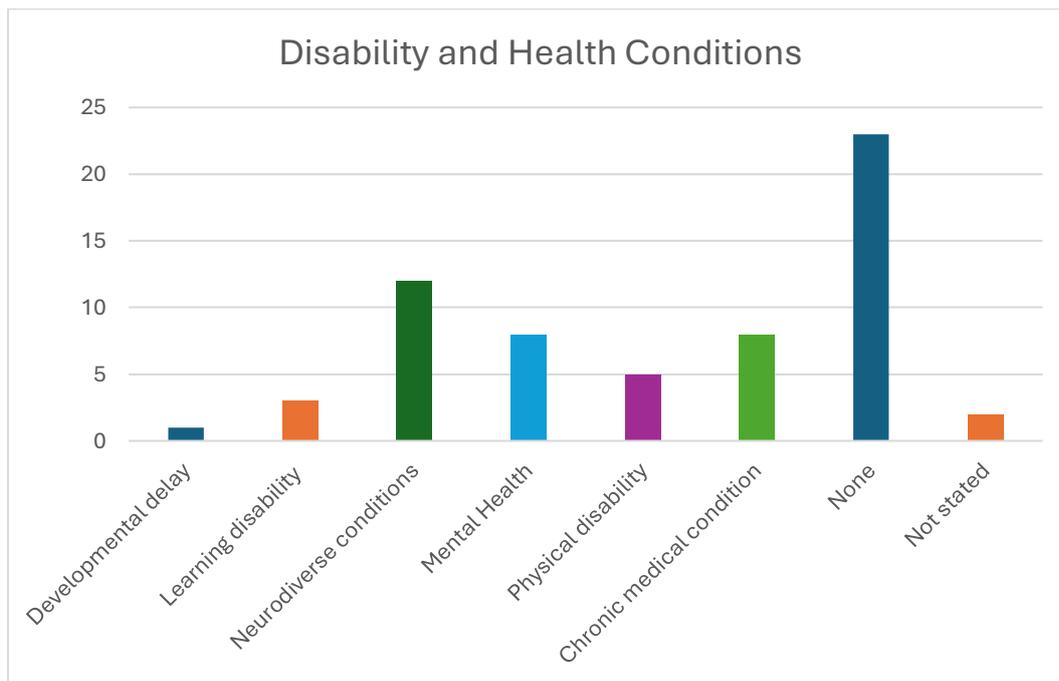


When compared with demographic data for London, Black children are significantly more likely to be subject of Rapid Reviews, as are children from Mixed ethnicity backgrounds, with this disproportionality having increased compared to last year. Last year, 28% of children subject to Reviews were Black, this year it was 35%. As was the case last year, 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 ethnicity backgrounds are more likely to be subject to a plan, with children from Asian backgrounds less likely.



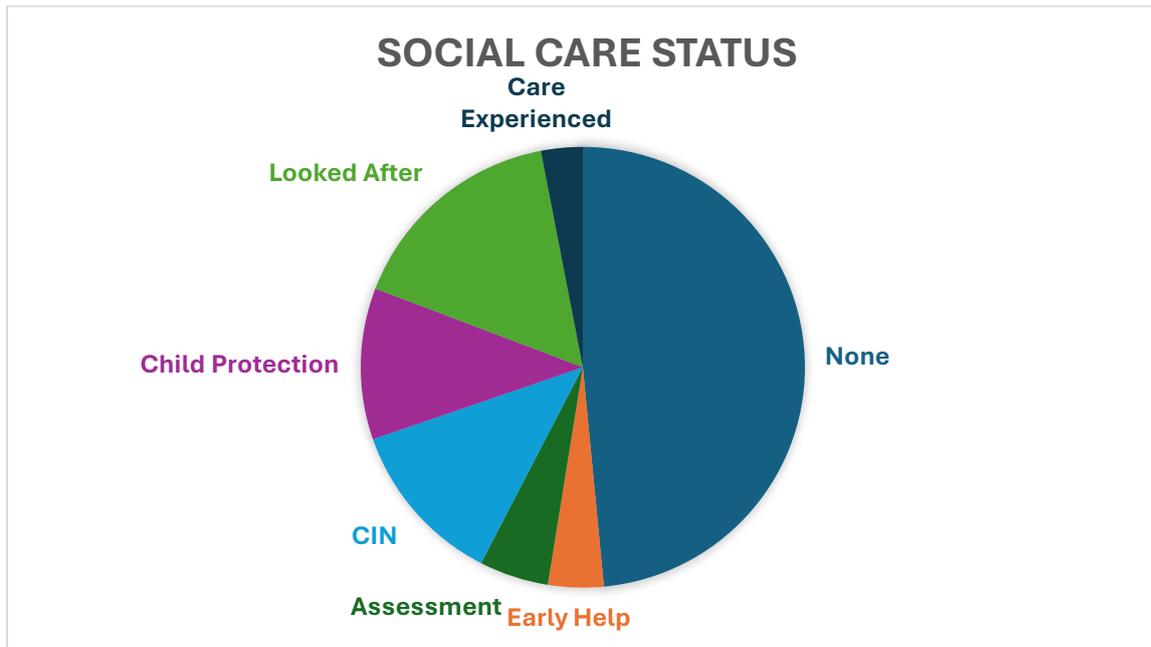
## Disability

There was a significant improvement in the recording of disabilities and illnesses in Reviews compared to last year. The increase in physical disabilities and chronic health issues suggests that these were previously under recorded. 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. It is also noted that some children had more than one disability or health condition.



## Social Care Involvement

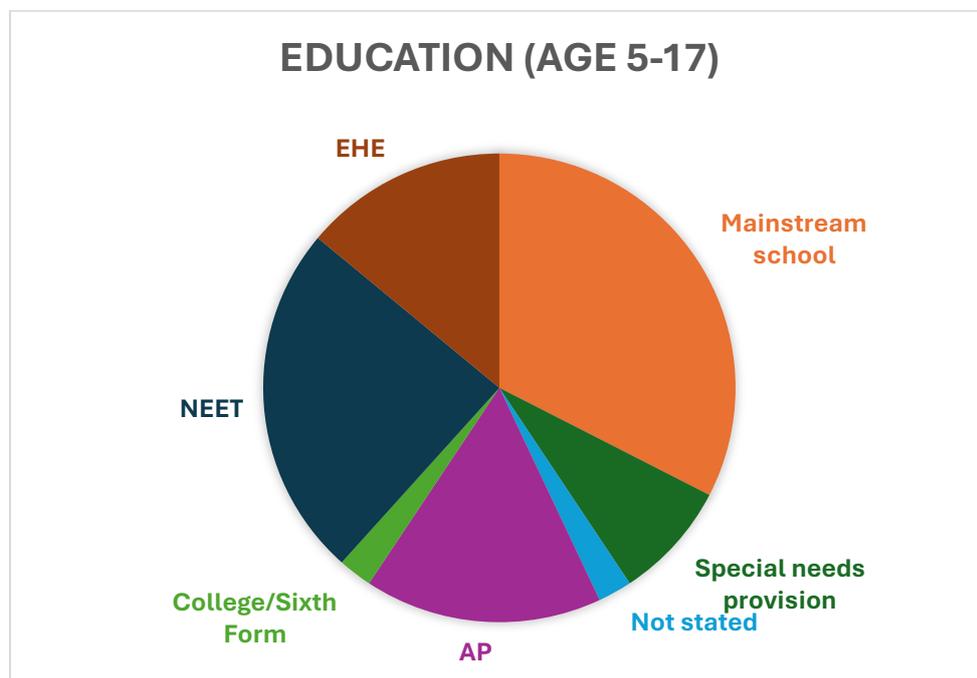
As was the case last year, approximately half of the Reviews related to children who were open to Children's Social Care at the time of the notifiable incident. 20% of Reviews were regarding children who had no current or previous involvement with Children's Social Care, an increase from 15% last year.

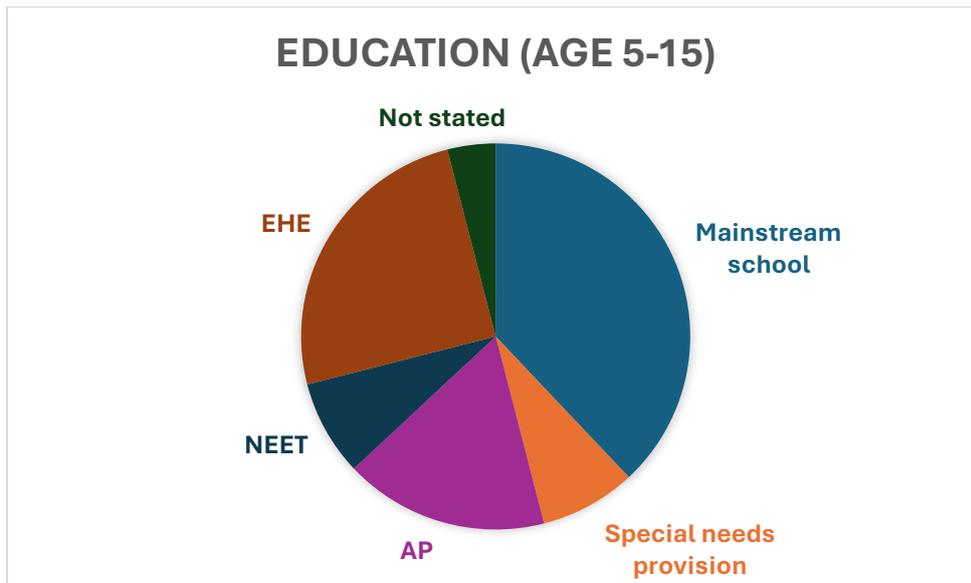


## Education

Education status has been recorded for children aged 5 to 17, as recording for children of preschool age was inconsistent. It was not always possible to establish from the Reviews what school year a child was in, so in the case of the graph for children aged 5-15 for example, some 5 year-olds in reception may be included and some 16 year-olds in year 11 may be excluded. Most of note is the fact that less than half of children aged 5-15 were attending full time school, with a significant proportion accessing some type of alternative provision, predominantly 1-1 tutoring.

Compared to last year's analysis, there is an increase in children who are Electively Home Educated (EHE). 20% of children aged 5-17 were EHE, with not all of these children registered with the Local Authority. It is important to note that none of these children were on CP Plans or the subject of section 47 (child protection) investigations during their time being Electively Home Educated. Therefore it is unlikely that these children would have been safeguarded by the proposals in the Children and Wellbeing Bill that where children are the subject of a CP plan or section 47 investigation, parents would require the approval of the Local Authority to home educate their children. These families tended to be isolated from their communities and the children were not seen by professionals.



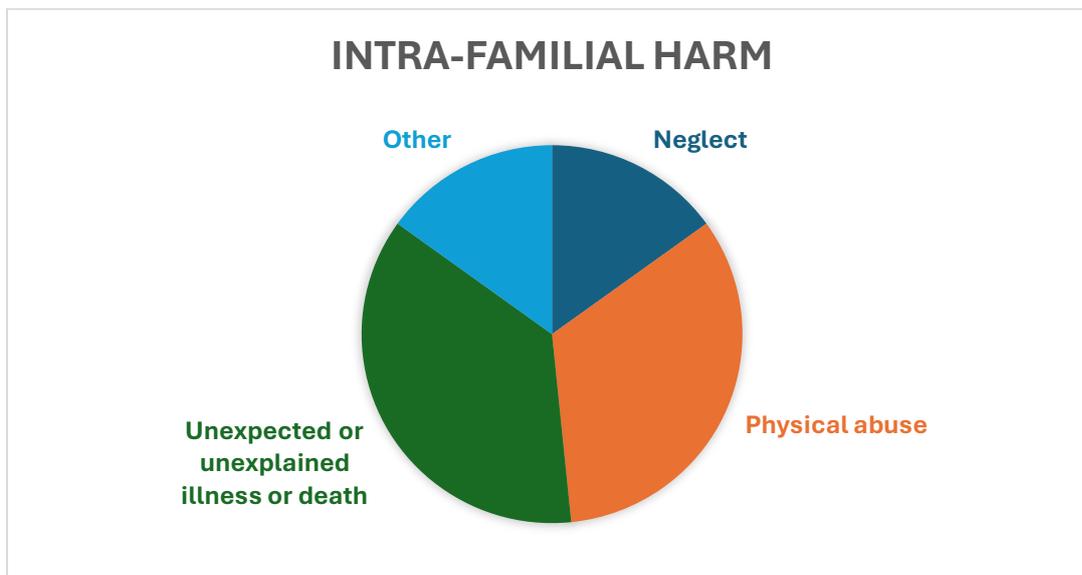


11% of children had been subject to a permanent exclusion, with only a third of these children accessing any form of education. 20% of Reviews noted issues with poor school attendance,. 16% of subject children were not accessing any type of education, employment or training at the time of the notifiable incident and they were all aged 13-17. 29% of school aged children (aged 5-17) either had an Education Health and Care Plan (EHCP) or had an assessment for a Plan underway.

16% of children subject to Reviews were Looked After and were aged between 13 and 17 years old. All of these children had complex needs that were difficult to meet in a mainstream education setting and none were in full time education. Three of the children had EHCPs. Whilst some of the children were receiving no education at all, some were receiving 1-1 tuition or accessing an alternative provision. Reviews demonstrated extensive efforts to find suitable education placements for these children. However most of the children had not consistently accessed education over the preceding year and most were believed to be victims of exploitation. It is well recognised that education is a protective factor for children at risk of extra-familial harm and so this is a concern.

The children featured in Rapid Reviews are some of the most vulnerable and many have complex needs, therefore the education issues highlighted do not represent the system as a whole. However they do highlight that the needs of these particularly vulnerable and complex needs are not being met by the education system and this has a lifelong impact on these children.

## Intra-Familial Harm



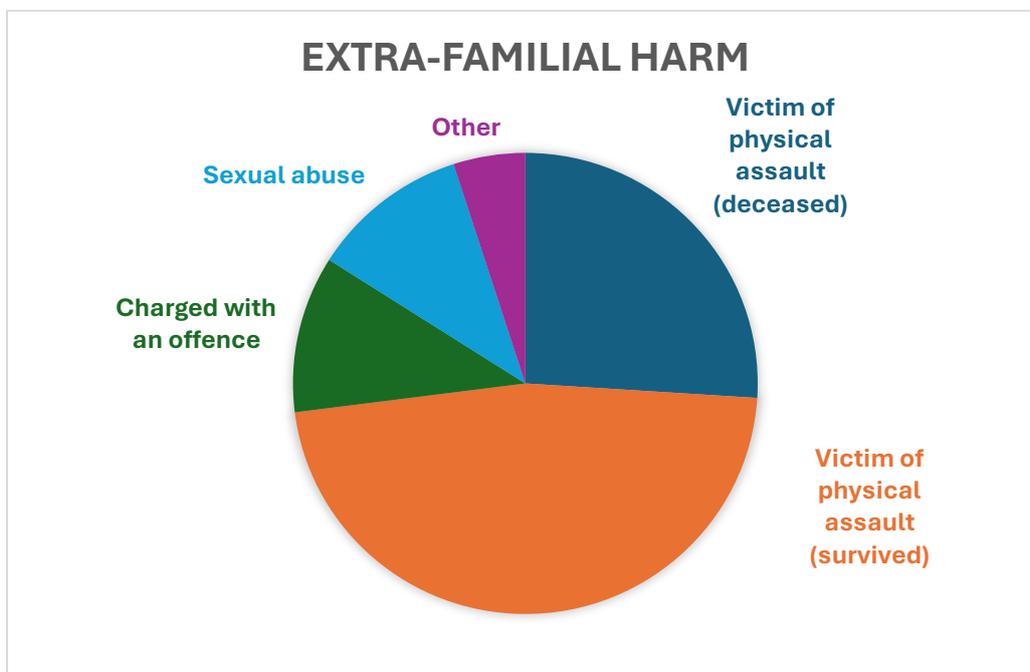
Just over half of the Reviews analysed for this report related to instances of intra-familial harm. Within this group, the highest number of Reviews were carried out due to unexpected or unexplained illnesses or deaths. Half of these children were under the age of 1 and most were believed to be cases of Sudden Unexpected Deaths in Infancy (SUDI). All of these babies had parents with vulnerabilities, particularly mental health and half were open to Children’s Social Care at the time of their deaths. The other children who died as a result of unknown causes mostly had underlying health conditions and had a history of concerns regarding neglect. Reviews carried out due to physical abuse mostly related to Non-Accidental Injuries (NAIs) caused to babies under the age of 2. Almost all of these children had grown up in homes with concerns about domestic abuse and half were living in insecure or overcrowded housing.

There were less Reviews carried out this year due to neglect, although it remained a significant factor in many Reviews. Almost all of the Reviews carried out due to neglect were about children with disabilities. Themes that were common across these Reviews were children not being brought to health appointments, poor school attendance and parents with vulnerabilities who were struggling to meet the needs of their children. Whilst a third of families were open to Children’s Social Care at the time of the notifiable incident, all of the children had previously been supported through CIN or CP plans.

## Extra-Familial Harm

There were 19 Reviews on the topic of extra-familial harm, making up almost a third of Reviews. With the exception of one much younger child, the children were between the ages of 14 and 17. There was a younger profile compared to last year's analysis, when all of the children in this cohort were aged 16 or 17. 20% were female, whereas last year, there were no girls in this cohort. Over half of the children who had their ethnicity recorded were Black, which, as only 14% of London's population are Black, means that they were significantly over represented. Only 16% were Asian and only one of the children was White. 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). Almost half of the children were Looked After and only 37% were attending school or college.

73% of Reviews in this category were carried out due to children suffering a physical assault, a third of which were fatal. A smaller number of Reviews were carried out for alleged perpetrators of serious offences when compared to last year. The majority of the incidents were stabbings.



It is unsurprising that exploitation, escalating criminality, missing episodes and a history of carrying knives are features in a high number of these Reviews. Two thirds of children had experienced intra-familial harm, particularly domestic abuse and neglect. Experiences of sexual abuse were more common in this cohort, as were experiences of trauma. Several Reviews highlighted that children had not received the support they needed for this trauma and abuse, and transience often meant that support that was planned was delayed or did not happen at all.

## Features of Practice

A difficulty in engaging parents at an early stage in cases of extra-familial harm was a feature in a number of cases. The reasons for this is unclear, but possibilities include that they may underestimate the risks posed to their children or a lack of trust in statutory agencies. The majority of children in this cohort are Black, so previous experiences of disproportionality and racism should also be considered. Several Reviews highlighted that there could have been more

professional curiosity as to why parents declined support and a more proactive multi-agency approach to supporting the children involved.

A number of children experiencing exploitation were moved out of their home Boroughs as a safety measure, however children often returned to the areas they know and the risks here were not well managed or understood. Equally in other cases, families were asking to move due to fears for their safety and there were significant delays in finding them suitable housing. Similarly where children were looked after, they were often absconding from placements to return home. In many cases, children who were looked after in this cohort were placed at home with parents for this reason, in other cases due to the lack of alternative placements. Safety planning was often not robust enough to protect children from harm.

The use of mapping of children at risk of exploitation was not used consistently and when it was carried out, it was not always used as effectively as it could be to safeguard children. Disruption of exploitation was also inconsistent. Referrals for NRM were far less common in this cohort than was the case last year.

## **Suicide/Attempts**

Eight Reviews were carried out about children who died by suicide or following suicide attempts. Two were Care Experienced young adults who had been Unaccompanied Asylum Seeking Children (UASC) and the rest were children aged 13-17. The majority of the children were female and three had neurodiverse conditions. Whereas the last year, all of the children in this cohort were known to Children's Social Care and half were looked after, this year most were not open and did not have a history of Children's Social Care involvement beyond Early Help or Children and Family Assessments (CAFAs. ).

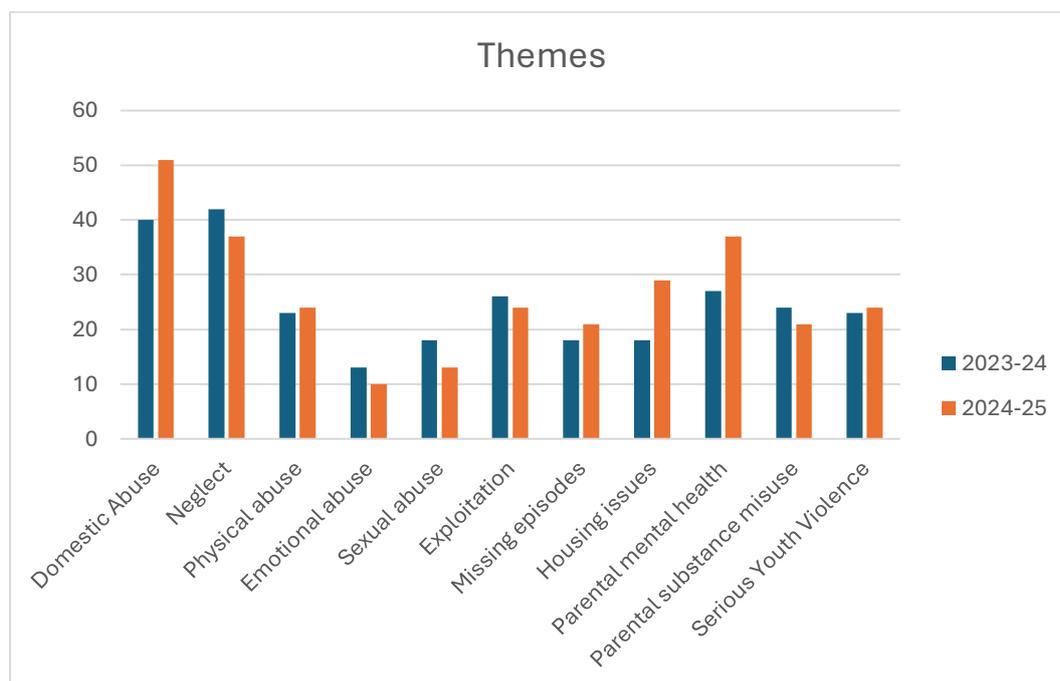
The children had all experienced long term mental health issues and most had experienced some type of intrafamilialintra-familial harm at some point, most commonly domestic abuse. As was the case in last year's analysis, half were believed to have experienced sexual abuse, which was unusual when compared to Reviews carried out for other reasons where sexual abuse only featured in 11%.

## **Other Types of Harm**

The majority of notifiable incidents 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 (witnessing the murder of a parent)
- Harm caused by professionals
- Accidents

## Themes



Whilst Reviews are undertaken due to a particular notifiable incident, they also explore a range of themes from a child’s life that have contributed to the circumstances leading up to the incident. In the case of older children, the Reviews often focussed on the few years prior to the notifiable incident, therefore themes from earlier in a child’s life may not be recorded.

Domestic abuse was rarely the trigger for a Review, and this may be due to Domestic Homicide Reviews being carried out instead. However domestic abuse was a factor in half of Reviews, an increase on last year. There was an improvement in the analysis of the role of domestic abuse in a child’s story this year, although it was still included as background information and lacked analysis in most cases. Due to the very small number of Reviews focussed on this topic, it was not possible to draw out themes.

As was the case last year, over a third also of Reviews highlighted concerns around neglect, with this being a more common feature in Reviews about younger children. Neglect rarely occurred in isolation; there were usually other concerns. Neglect concerns often included concerns related to neglect of medical needs, poor school attendance and neglect of educational needs, poor home conditions and children not being brought to appointments.

The housing crisis in London is inevitably affecting the most vulnerable children and housing issues were recorded as an issue in 50% more cases this year than last year, with 29% of families experiencing housing issues such as insecure housing and overcrowding. Housing issues affected families regardless of the age of the children or the type of harm leading to the Rapid Review, but heavily overlapped with domestic abuse. The majority of families experiencing housing issues also featured parents with vulnerabilities, in particular mental health. Families attempting to flee gang violence struggled to access housing outside of their home boroughs.

A significant number of children subject to Rapid Reviews were cared for by parents with their own vulnerabilities. Almost 40% of parents had their own mental health issues and 21% had

substance misuse issues. Others were Care Experienced or had learning difficulties. A preoccupation with addressing parents' vulnerabilities often obscured the lived experience of the child.

Only 11% 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 third of Reviews featuring sexual abuse were carried out due to suicide or an attempted suicide.

There were several other more specific issues that were highlighted in a number of Reviews:

- There were several children who did not have a GP and whose parents were using the 111 service as their primary source of healthcare. Several others did not have a local GP having moved from other areas. This meant that there was not always a holistic knowledge of a families health needs and led to gaps in the multi-agency picture of a family's vulnerabilities.
- Children's role as a young carer was often missed amongst a complex family picture and therefore they missed out on the support they needed.
- Several Reviews told the story of families who had isolated themselves from their communities. Children were Electively Home Educated or missing education, were not brought to health appointments and parents were often experiencing mental health issues. These children were often invisible or rarely seen and professional networks struggled to engage with parents.

## **Information Sharing**

Information sharing has been a perennial issue in safeguarding and across CSPRs, and this was the case in these Rapid Reviews. As was the case last year, there was an inconsistency of a Think Family approach. This was particularly the case in extra-familial harm cases. Whilst this has implications for other areas of practice, in terms of information sharing it can mean that practitioners supporting younger children in a family are unaware of the safeguarding concerns regarding older children in the home. There were also patterns of inconsistent information sharing between health providers and sharing of health information with the multi-agency team.

However by far the strongest theme was the challenge of information sharing across borders, both in and out of London. This was a feature in 15% of Reviews. Transience of families, and placements caused significant issues, particularly for those with more complex needs. In many cases, information sharing was not dexterous enough to keep up with multiple moves, and actions and interventions are delayed or missed altogether. Whilst there are robust processes in place for the transfer of cases, when children were not open to Children's Social Care at the time of a move, safeguarding histories tended to be lost. There were also information sharing challenges when multi-agency teams were working across Borough boundaries, particularly when children were Looked After and placed out of Borough.

## **Racism and Disproportionality**

The children in this report come from a range of ethnic and cultural backgrounds, and it is important to acknowledge the impact racism and disproportionality will have had on many of

these children and their families. The question as to whether these issues have had an impact was raised in a number of the Reviews, however very few explored this in any depth. 10% of Reviews asked if practitioners were curious enough to understand families' cultures and the role they played in their parenting and engagement with services. A number of Reviews involved parents declining support from services, and practitioners often were not curious enough as to why, and as to whether their previous experiences of racism and disproportionality played a role.

It is important to note the short timescales for Rapid Reviews; they have to be completed in 15 working days and families are rarely consulted as part of this process. These Reviews are carried out in the immediate aftermath of often very traumatic events and it is usually not possible or appropriate to explore a family's experiences with them. LCSPRs allow more time for discussions and deep dives of records, more practitioners to be included and families are encouraged to participate. This allows for a deep exploration of a family's experiences of disproportionality and racism, and the impact that biases play in decision making and the support a family receives. Building a repository of LCSPRs and analysing a wider range of reports and data would allow for a deeper understanding of the impact of racism and disproportionality on child safeguarding in London.

## **Practice Issues**

As was the case last year, the issue of invisible men came through in a significant number of Reviews. A particular concern was the invisibility of perpetrators of domestic abuse, particularly when there were no recent allegations of abuse the man and the perpetrator was no longer in the family home. In some Reviews, the fathers were not mentioned, whilst others highlighted that professionals had not been curious enough about the role of fathers or father figures in their children's lives.

The need to 'Think Family' was highlighted as an area for improvement in a significant number of Reviews. This was particularly the case in Reviews about extra-familial harm, where practitioners did not adequately consider the safety of other children in the home.

Children not being brought to health appointments was a theme in Reviews featuring neglect. A number of Reviews raised concerns that Was Not Brought (WNB) policies were not used consistently and that this was not being adequately considered as an indicator for neglect.

Concerns were raised in many Reviews about the robustness of Strategy discussions. Particular issues related to:

- An inconsistency in health representation at Strategy meetings
- Strategy meetings not always being held when they should have been, or held in a timely manner
- Outcomes and actions of Strategy meetings not being shared promptly with the multi-agency team
- A lack of professional challenge where there were disagreements

## Areas for improvement

Because there is no set structure or template for Rapid Reviews, areas for improvement come under different headings (eg recommendations, learning points) and are structured differently. The most commonly occurring areas for improvement can be grouped around the following themes:

- To improve cross border information sharing
- For strategy meetings to be more robust and effective in terms of the agencies represented, professional curiosity and challenge and the prompt and consistent sharing of actions
- A need for a consistent 'Think Family' approach. This was a particular issue in cases of extra-familial harm where the risks posed to younger children in the home were not always considered
- For practitioners to always consider the impact of domestic abuse on children, even when there had not been recent reported incidents. When relationships had ended, ongoing coercive control was not always considered. Additionally the potential impact of having witnessed domestic abuse in their childhoods was not considered in terms of how children perceived violence, particularly in cases of extra-familial harm
- The need for a more robust approach to engaging housing in multi-agency safeguarding work, from MASH referrals up to a strategic level

## 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 and Editorial Board to work with LSCPs and other partners to review the London Safeguarding Children Procedures with regard to cross border information sharing and case transfer and to establish if changes are required or if work is needed to improve practice
- For the London SCP and Editorial Board to work with LSCPs and other partners to review the London Safeguarding Children Procedures with regard to Strategy Discussions and to establish if changes are required or if work is needed to improve practice. The London SCP should also work ensure that improved practice in this area is embedded through the Social Care Reforms
- For the London SCP training programme to include training in their offer to help practitioners to understand the long term impact of domestic abuse on children and to have a trauma informed approach to working with families who have experienced domestic abuse, even if it is believed to be historical
- For the London SCP to work with the London Housing Directors Group and other housing agencies to develop best practice on engaging housing in multi-agency safeguarding work, both operational and strategic
- For the London SCP to work with LSCPs to build on the work of the Rapid Review Analysis to create a repository of London LSCPRs and develop real time intelligence regarding ongoing SINS and Rapid Reviews

The logo for the London Safeguarding Children Partnership is centered at the top of the page. It consists of the text "London safeguarding children Partnership" in a white, sans-serif font, enclosed within a white, stylized oval shape that resembles a protective shield or a protective embrace.

London  
safeguarding children  
Partnership

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Published: February 2026

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