

Serious Case Reviews: What do they really tell us?



Wendy Charles-Warner

Executive Summary

There is no doubt that serious case reviews are an important means of helping to improve child protection practices, but to achieve that it is necessary for those reviews to be not only accurate, but also free from bias.

- Numerous cases of inaccuracy in reports were found including some key points being misreported.
- Even one case of bias in reporting is one too many, and many were found. Bias in reporting appeared to be concentrated in a small number of reviewers.
- Statistical analysis found a very different picture to that which Government and media rhetoric promotes. Evidence points to the exploitation of children subject to reviews in order to create emotive narrative for political gain.
- Only three cases were found of children subject to reviews for whom care proceedings or child protection plans ended more than five years previously.
- Of the 2176 cases analysed, 18.63% related to looked after children.
- Children were harmed by foster carers in 1.06% of cases.
- Very few cases (0.3%) related to harm caused by adoptive parents.
- Of those 9,176 children who were of compulsory school age, 99.08% were school children.
- Over 600 (7.85%) of compulsory school age children were harmed in schools, by teachers and/or school staff.
- Home educated children were harmed in 0.92% of cases.
- In some cases relating to children who were not, in fact, home educated, or who were suffering from harm long before becoming home educated, reviewers made recommendations for greater regulation of home education. Causal effect was attributed to home education despite this clearly not being the case.

Introduction

In order to undertake this research, it was necessary to read every available serious case review which has been published. I cannot imagine a more heart wrenching task than reading about the harm that human beings do to children, other than dealing with such abuse first hand, and we should not overlook those who undertake these reviews as it cannot be an easy task.

Serious case reviews are without doubt a highly emotive subject, but research cannot be based on emotion, just as legislation and regulation must not be based on emotive responses. Any form of regulation of families and individuals must be based on solid, factual evidence. That firm basis in fact is what this research sets out to provide.

The subject is a difficult one and readers should be aware of that before proceeding. However, this is primarily an analytical report which steers away from the use of distressing extracts of reviews as much as is possible. Rather, the report looks at how decisions are made in respect of which cases will be considered for review, the accuracy of the data held and who the children subject to these reviews are. This brings us to an answer to our question, 'what do serious case reviews really tell us?'

This research could not have been completed without the assistance of the intrepid Katherine Norman. Thank you.

Wendy Charles-Warner
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Serious Case Reviews: What do they really tell us?

The NSPCC and local safeguarding partnership repositories of serious case reviews go back to the first published review in 1945. Much has changed in the field of safeguarding in the intervening 81 years including how reviews are approached, how decisions about child protection in general are made, the vetting and assessment of foster carers and adoptive parents and the name by which reviews are known. In 2026, reviews are referred to as Local Child Safeguarding Practice Reviews (LCSPR) in England, Case Management Reviews (CMRs) in Northern Ireland, learning reviews in Scotland and Single Unified Safeguarding Reviews (SUSRs) in Wales. However, for consistency, throughout this report the term ‘serious case review’ is used.

In England, the key guidance for safeguarding practice reviews is Working Together to Safeguard Children 2026¹, in Scotland, the Care Inspectorate issues guidance on serious incident reviews² and in Wales the Single Unified Safeguarding Review guidance³ applies. Approaches are closely aligned in each nation and government guidance⁴ covers the process that authorities must follow.

A local authority must notify the relevant Child Safeguarding Practice Review Panel within five working days of becoming aware that an incident has occurred. ‘Serious incidents’ are those in which it is known or suspected that a child has been abused or neglected and dies or is seriously harmed. This can include unborn children and ‘child’ refers to anyone under 18 years of age. This also applies if a child resident in England dies elsewhere. If a looked after child or young adult up to the age of 24 years dies, the local authority must notify the Secretary of State for Education and Ofsted regardless of whether or not abuse or neglect is known or suspected.

The next step is to undertake a rapid review within 15 working days in order to collate the facts, instigate any immediate safeguarding action required, gain understanding of the children’s lives, consider any practice learning opportunity and to consider whether a serious case review should take place. Once complete, the rapid review is sent to the Panel. Once the Panel receives the rapid review it decides whether to commission a National Child Safeguarding Practice Review, based on the complexity or national importance of the case. It may also decide to commission a thematic national review, relating to different incidents in one subject area. Rapid reviews are not published or

¹ Gov.UK (2026) ‘working Together to Safeguard Children’ [Online] Available from: <https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

² Care Inspectorate (2022) ‘Serious incident review guidance’ [Online] available from: <https://www.careinspectorate.com/index.php/publications-statistics/29-professionals-registration/81-serious-incident-reviews>

³ Welsh Government (2025) ‘Single Unified Safeguarding Review’. [Online] Available from: <https://www.gov.wales/single-unified-safeguarding-review-guidance>

⁴ Gov.UK (2026) ‘Guidance: Report the Death or Serious Harm of a Child or Care Leaver’ [Online] Available from: <https://www.gov.uk/guidance/report-a-serious-child-safeguarding-incident>

open to scrutiny. They have also been found to be of poor quality in many cases, and that lack of scrutiny can raise concerns amongst practitioners.

‘Overall, we found that reviews rarely address why things happen, why practitioners make certain decisions or why children and families may respond negatively to interventions...the quality of the rapid reviews was variable...The level of analysis and reflection was an issue for many reviews...In some cases, the conclusion did not follow logically from the analysis or the facts presented.’⁵

‘We have made clear in this report that the voices of children, families and carers should be at the heart of the reviews. We know from our analysis that this is not always consistently achieved’⁶.

As noted by Dickens et al⁷, several cases have been found of conclusions which did not follow facts and reviewers are cautioned to be *‘mindful of how our biases and assumptions shape our decision making’*⁸. This research confirmed these concerns, finding cases in which conclusions did not relate to the facts of the case and a worrying level of bias in some cases.

No matter how harrowing it can be to read these reviews, it must be borne in mind that serious case reviews affect only a small proportion of children overall. For example, there were 397 serious case reviews in 2025 relating to Compulsory School Age (CSA) children in a population of 8,995,151 CSA children⁹. In short, most children are well cared for, most children are safeguarded and most parents are loving and protective; it is hard cases to which reviews relate.

Method

Reviews were primarily sourced from the NSPCC database of serious case reviews,¹⁰ published online. Reviews prior to 2013 are, almost entirely, only available online in summary. Those published after 2013 contain greater information which can be readily accessed. For pre 2013 cases in which the summaries justified further research, original

⁵ Dickens, J., Taylor, J., Garstang, J., Hallett, N., Rennolds, n. and Sorensen, p. (2021) ‘Annual review of LCSPRs and Rapid Reviews’. [Online] Available from: <https://ueaeprints.uea.ac.uk/id/eprint/82101/>

⁶ Alma Economics (2021) ‘Analysis of Rapid Reviews on Serious Incidents Involving Children in England’. [Online] available from: <https://almaeconomics.com/research-post-children-and-young/analysis-of-rapid-reviews-on-serious-incidents-involving-children-in-england/>

⁷ See 5.

⁸ See 6.

⁹ Data for school age children: Gov.UK (2025) ‘schools, Pupils and their Characteristics’ [Online] available from: <https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics/2024-25>

¹⁰ NSPCC Learning (2026) ‘Case Reviews’ [Online] available from: <https://learning.nspcc.org.uk/case-reviews>

documents were viewed at the NSPCC library. The library contains 2558 reviews, all of which were read and analysed for relevant data.

As the primary focus of this research is on children of compulsory school age or younger, cases relating to either 17 year old young people, or older young people who had been looked after children, were not included in the overall analysis. In addition, general thematic reviews not relating to individual children, and those for which collated findings from separately published reviews were available, were also excluded from analysis. After excluding these reviews, a total of 2,176 remained for analysis.

When analysing numbers of children harmed in the reviews overall, an exact number cannot be given as some reviews examine cases involving large numbers of children and exact numbers are not given. In these cases, the number used is the minimum referred to in each review. On that basis, the studied 2,176 reviews involved a minimum of 9,517 children.

A conscious decision was made to minimise quotation of sections from reviews in order to show respect for the children involved, and to reduce the likelihood of this report being difficult for the more sensitive reader. It was particularly important to avoid the exploitation of the children who had been harmed, as no child should be further abused by such exploitation. In light of this, naming of individual children has been avoided wherever possible.

In Local Authority Care

If a child is *'suffering, or is likely to suffer, significant harm and that harm, or likelihood of harm, is attributable to the care given to the child'* by the parent or is *'beyond parental control'¹¹*, a Court may make an order placing the child in the care of a local authority. These orders are made specifically to seek to ensure that the child is safe from harm, but such care is no guarantee that a child will be safe.

Given that a looked after child, or a young person up to the age of 24 who has been looked after and dies, is automatically required to be subject to a serious case review, it is to be expected that looked after children in the reviews will be in greater numbers than would be found if such criteria did not apply.

A total of 395 serious case reviews (n=2176) relate to children in care, involving 1,773 children. Consequently, 18.63% of children were harmed whilst in local authority care. Of those cases which occurred after 2013, 53 cases involving 135 children related to harm perpetrated by the children's carers, 101 of whom were harmed by foster carers, or 1.06% of the 9,517 children reviewed. A further 16 children were harmed or killed by a carer

¹¹ Children Act 1989 s31

with a Special Guardianship Order (SGO). Of the looked after children harmed, 18 were in care homes.

In addition, there were 82 children reviewed who were subject to Child Protection Plans (CPP) and not in care, but whose siblings were in care. This raises the question of how to approach children in a family in which one or more siblings is already in care as, if a sibling has suffered or is likely to suffer significant harm attributable to the parent, it logically follows that other children in the family may be at no less risk of harm. However, the matter of how decisions about care applications are made is outside the scope of this research and has not been addressed.

Time since the child was subject to Care or CPP

During debate over the Children's Wellbeing and Schools Bill¹², amendments were put forward to Clause 30 which requires parents to seek consent to remove a child from the school roll. Baroness Barran proposed that such consent should be required if a local authority is '*conducting or has ever initiated proceedings under section 31 of the Children Act 1989 (care and supervision)...or has ever conducted enquiries or has ever taken action under section 47 of the Children Act 1989 (local authority's duty to investigate).*' This was not taken forward in amendments by the House of Commons, but an earlier Government amendment was accepted, providing that such consent should be required if a local authority had '*taken such action during the period of five years ending with the date on which an application is made.*' Analysis was undertaken to ascertain the likely practical effect of such measures.

Analysis of cases in which children were harmed after they were no longer subject to a CPP or care order found 249 cases in the five years from 2020. Only three cases (1.2% of cases involving care orders or CPPs) involved a length of time over five years. Mean period since the care order or CPP ended was three months. The number of cases over two years was 12 (4.8%) and, over one year, 28 (11.24%).

It would be overly simplistic to say that the children to whom these cases relate were no longer receiving support or subject to oversight from Children's Social Care (CSC) once the CPP or care order ceased as, in most cases, a period of support continued under Child in Need or other arrangements, or further referrals were received and assessed. For example, in one of the three cases¹³ in which the care or supervision order ended more than five years prior to the serious incident, the child's circumstances had been assessed at length in private law proceedings, by CAFCASS and the family court under four years previously. In addition, referrals were made to CSC six months prior to the child's death.

¹² UK Parliament (2026) 'Children's Wellbeing and Schools Bill' [Online] Available from: <https://bills.parliament.uk/bills/3909/publications>

¹³ 2025 Sara Sharif Surrey NC53268, NC53269

Adopted children

It is important to note that prior to the Adoption Act 2002 assessment of prospective adoptive parents was considerably less detailed and thorough than it is in 2026.

Many serious case reviews tagged as relating to adoption on the NSPCC site relate to adoption which occurred after the serious incident giving rise to the report, when the children were adopted away from the perpetrator. A total of 26 serious case reviews tagged 'adoption' remained of which five were for children not in the care of adoptive parents, albeit two related to children harmed during the vetting process for adoption. Of the remaining 11 serious case reviews, two were in respect of children harmed by third parties after leaving their adoptive parents, one involved child to adult violence and the injury was found to be accidental in a further case. This left seven cases in which children were harmed by adoptive parents in the 44 years between 1981 and 2025.

The total number of reviews studied was 2,176 of which 0.3% relate to adopted children. This included seven individual children and a police investigation relating to an unspecified number of children in a large extended family. As a consequence of this, it is not possible to provide an accurate percentage of overall numbers of children. However, using 'large' as ten children this would estimate as 0.19% of all children subject to serious case reviews. Furthermore, several of the 'adopted' children featuring in reviews before 2002 were 'privately adopted', that is, under arrangements made without professional assessment of the adoptive parents. Not all of these are identifiable as such due to lack of differentiation within reports. Consequently, the actual percentage of children subject to serious case reviews who were legally adopted is less than 0.19%.

In School

Numbers of CSA children included in reviews total 7,690 minimum, of whom 7,619 were registered in schools, that is, 99.08% of the CSA total. Of these children, 240 were harmed whilst resident in children's homes^{14,15}. A further 25 children were subject to institutional abuse at a secure training centre¹⁶.

Much has been made over the years by successive governments that children are safe in schools where they have '*regular contact with adults who can safeguard and support them*'¹⁷. However, 7,619 children in 99.08% of cases in which the child was CSA and subject to serious case reviews were not saved from harm by being registered at and attending school. Clearly, we cannot say that all children are safe in school. In 2013, an unnamed

¹⁴ 2012 Wrexham County Borough Council NC043346, NC043352

¹⁵ 2017 Buckinghamshire NC048263

¹⁶ 2019 Medway NC50835

¹⁷ Gov.Uk (2026) 'Children's Wellbeing and Schools Bill' in Lords Hansard 28th January 2026. [Online] available from: <https://bills.parliament.uk/bills/3909/publications>

reviewer from an unnamed local authority¹⁸ included a statement in that review which bears repeating:

‘The LSCB understands the sentiment sometimes expressed in response to any suggestion that the current regime is inadequate that “attendance at school is no guarantee of a child’s safety”. To say otherwise would be illogical, and clearly there is evidence to suggest that school attendance certainly does not inherently prevent abuse of school age children.

That this is true is confirmed by the review’s finding that 601 children (7.85% of CSA children) were harmed in school, by school staff, including as recently as 2025¹⁹ when the volume and detail of concerns raised led to a review of Mossbourne Victoria Park Academy finding that *‘the concerns raised about practices such as shouting, public humiliation and a lack of reasonable adjustments can be substantiated’*. That same year saw sexual abuse by a school head teacher at Ysgol Friars²⁰. In 2023, approximately 79 special needs children were found to be at serious risk of harm at Harlow Academy²¹ and 133 children were found to have been harmed by sexual abuse perpetrated by teachers in three other cases in previous years²².

The fact that a child in school is in sight of staff is clearly not a protection against serious harm and it would be specious to seek to argue that any school can safeguard every child in its care, because that is simply not possible. Notwithstanding, the oft heard argument for greater regulation stands on the basis of every child requiring professional oversight, but does greater regulation and supervision prevent serious harm to all children? No system of oversight can ensure that every child is safeguarded, and it is illogical to argue that it can do so.

There are many reviews which refer to children who were closely supervised at the time of their death or serious harm, including Child W²³ who was under very close supervision from pre-birth, in hospital, with checks being made on the mother and child at least every two hours; Child C²⁴ was likewise in hospital, in a special care baby unit when murdered by his father and Joe²⁵ was subject to a *‘Youth and Rehabilitation Order, with intensive supervision and surveillance support’* when he died aged 15 years. However, the case which best highlights the point that regulation and supervision cannot prevent children from being harmed is that of Princess²⁶.

¹⁸ 2013 Family W Unnamed local authority NC043944

¹⁹ 2025 City and Hackney NC53313

²⁰ 2025 North Wales NC53263

²¹ 223 Nottinghamshire NC52787

²² 2020 Richmond NC52230, 2016 Hammersmith and Fulham NC048631, NC048637 and 2012 North Somerset NC041438

²³ 2022 Child W Barnsley NC52473

²⁴ 2026 Child C Somerset NC53334

²⁵ 2022 Joe Unnamed board NC52874

²⁶ 2025 Princess Cambridgeshire and Peterborough NC53123

Following periods in a series of foster homes during which Princess was repeatedly missing from home and threatening suicide, she was moved to a residential home. Princess' behaviour escalated significantly, placements felt that they could not support her and she was made subject to a Deprivation of Liberty Order (DoL)²⁷ in an attempt to try to protect her. Princess suffered a long series of moves between different types of accommodation, cared for by agency staff, eventually reaching a situation in which eight staff were caring for her in individual accommodation. Moves were frequent and agency staff were unable to support Princess safely. The review is clear that Princess' case must not be '*seen as something unique*' and that '*At the most basic level the system was unable to meet her needs while at the same time trying to keep her safe*'. Princess was not safeguarded, but more crucially, the intense supervision and control to which she was subject caused her intolerable harm. Professionals felt that they had little choice but there could not be a more stark example of increasing regulation not only failing to achieve its intended goal, but also significantly harming the person whom it was intended to safeguard.

Home education

We know that it is illogical to suggest that attendance at school is a guarantee of a child's safety²⁸. Likewise, it is illogical to state that no home educated child is ever unsafe:

However conversely the notion that education at home is never used to provide a cover for abuse, or a means to foster an environment in which children can be deliberately isolated and controlled away from external influences, so as to allow abuse to occur more easily, is also illogical, and not borne out by the evidence.'

However, we need to ask ourselves whether this reviewer was right in his or her statement, or whether there are differences between home educated cohorts of children and those in school. Analysis of home educated children subject to serious case reviews can inform responses to that question. However, this relies on those reviews being accurate and avoiding preconceived personal views or biases, as reviewers are not free from assumption and bias²⁹.

No logical person would deny that children from any cohort can be harmed, and yet, harm to a very small number of home educated children has been exploited over the years to promote a narrative of home educated children as uniquely unsafe. One such case is that of a young girl³⁰ whose mother had made '*A clear statement of her intention to educate them at home*'. Yet, a statement of intent to act does not create a fact of that act. In

²⁷ A Deprivation of Liberty order is a court authorised order made when restrictions are placed on a child's liberty beyond what would normally be expected for a child of the same age.

²⁸ 2013 Family W Unnamed local authority NC043944

²⁹ See 5.

³⁰ See for example: 2010 Serious case review in respect of the death of a child Case Number 14 Birmingham NC038509, NC047114

this case, no notice was given to the school and the child was in practice, a Child Missing Education (CME), not a home educated child. The relevant review was nonetheless condemnatory of home education, characterising it as '*A direct contradiction to the aspirations of safeguarding and human rights legislation and guidance.... It also represents a major safeguarding flaw.*' Despite the fact that the child was CME, and the reported '*numerous missed opportunities*' to safeguard the child in the two years prior to her death, by the school and social workers, ministers exploited the child's death in order to call for stricter laws on home education³¹. This case cannot but bring the reliability of at least some serious case reviews into question.

Analysis of the reviews finds that home education is named as a factor in 59 cases held in the NSPCC repository. This represents 2.71% of the total (n = 2176). However, of these cases, 20 did not, in practice, involve home education as a factor at all and where it was referred to, it was not conceivably relevant. This included cases of CME, a child learning at home during Covid lockdown, children receiving Education Otherwise Than at School (EOTAS) provision made by the local authority and in one case, the child was aged 18 months and recently adopted, with no mention of education in the full report³²; as would be expected in such cases of adopted children, '*The child was visited and seen regularly by professionals and extended family members.*' Cases were found in which the children subject to the reviews were babies with no mention in the report of home education. In addition, four cases involved children who had been home educated at some point prior to the relevant period but not during that period. A 2022 case³³ saw a health visitor offering what was described as '*good practice*' as '*she was aware from conversation that parents intended to home school and therefore she was the only professional visiting*'; yet both children in the family were below Compulsory School Age (CSA).

More concerning is the duplication of reports under different titles. One notable example relates to a traveller family with seven children who moved from Norfolk to Southampton. Two separate reviews are held in the repository, one for each County, both authored by the same reviewer and differing very little in real terms. As this is clearly the same family, only one of the two reviews has been included in the statistical aspects of this report. Consequently, the remaining 39 reviews were analysed.

Of the 2176 reviews, those 39 cases in which home education was found to be a factor (regardless of whether or not it was a key or causal factor) equated to 1.79% of serious case reviews. This is higher than the percentage of school age children who are currently home educated or were home educated historically (Chart 1), but data cannot be looked at so simplistically and we need to look at the children behind the number of reviews and the reliability of those reviews.

³¹ Shepherd, J (2010) 'Khyra Ishaq tragedy: ministers urged to tighten law on home education'. Guardian. [Online] available from: <https://www.theguardian.com/society/2010/jul/27/khyra-ishaq-home-education-safeguards-call>

³² 2018 CPR 04 2016 Cardiff and Vale of Glamorgan NC52526

³³ 2022 WG N60 2020. West Glamorgan

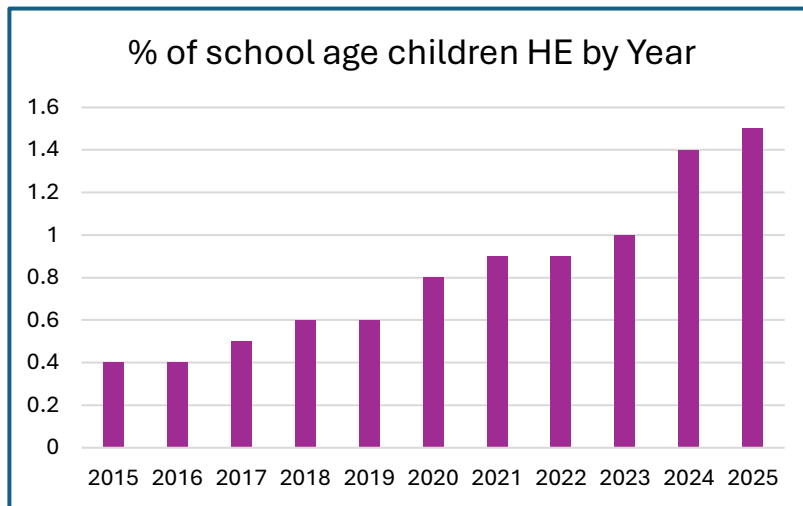


Chart 1: % of school age children home educated by year³⁴³⁵.

When Lord Crisp raised the numbers of home educated children subject to review in debate in the House of Lords³⁶ he was swiftly responded to by Baroness Barran and advised that he was not ‘*comparing apples with apples*’.

‘Peers who like data may want to know that the only figures I can find are that home-educated children add up to about 1.4% of the population of schoolchildren and they account for 1.2% of serious case reviews³⁷. As noble Lords will know, those are reviews where children are seriously harmed or die. These figures suggest that home-educated children are no more at risk than children at school and conceivably less so. My point is that home education should be seen as a risk factor only for those with a record of abuse or where there is an existing concern, but not for the generality of parents, yet the approach we see in the Bill suggests that all home-educating parents are viewed with suspicion.’

Lord Crisp

‘The noble Lord, Lord Crisp, whom I genuinely have huge respect for, I am grateful for the collaborative way he has worked on this Bill across the House, talked about serious case reviews, but two-thirds of serious case reviews are of children of preschool age, so we are not comparing apples with apples.’

Baroness Barran

Of course, it is necessary to compare like with like in so far as it is possible to do so and, referring just to numbers of reviews, 1,290, or 47%, relate to children below CSA. Even

³⁴ Numbers HE 2021 – 2025 from Gov.UK (2026) ‘Elective Home Education. [Online] available from: <https://explore-education-statistics.service.gov.uk/find-statistics/elective-home-education/2025-26-autumn-term> Numbers pre 2021 from author’s own research.

³⁵ Data for school age children: Gov.UK (2025) ‘schools, Pupils and their Characteristics’ [Online] available from: <https://explore-education-statistics.service.gov.uk/find-statistics/school-pupils-and-their-characteristics/2024-25>

³⁶ Gov.Uk (2026) ‘Children’s Wellbeing and Schools Bill’ in Lords Hansard 28th January 2026. [Online] available from: <https://bills.parliament.uk/bills/3909/publications>

³⁷ Data sourced from Merrett, J. (2025) Exeter University unpublished doctoral dissertation.

on that basis, children under CSA do not represent the 'two thirds' claimed by Baroness Barran. Furthermore, the number of individual children gives a more accurate picture.

Of the 9,517 children subject to review, 1,827 (19.19%) were under compulsory school age and this is a higher percentage than in reality as some school age children harmed in large scale abuse reports are excluded; a far cry from Baroness Barran's 'two thirds'. It appears that her statement, whether intentional or not, was little more than manipulation of the facts in order to highlight what is for many, an emotive issue for political purposes.

Despite 1.79% of reviews relating to home educated children, numbers of CSA children included in reviews total 7,690 minimum, of whom 71 were home educated, that is 0.92% of the CSA total. This is below the statistically expected number. However, further analysis found a concentration of home educated children subject to review in the last five years (Figure: 2) which requires further analysis. Clearly, this could lead to speculation that it has become more likely that home educated children will suffer harm in recent years. It is true to say that the cohort of children coming new to home education has changed since the Covid pandemic, most notably in the last two to three years^{38, 39}. However, the percentage of children who are home educated who are subject to serious case reviews is not as high as government rhetoric suggests, and lower than would be statistically expected in a normal distribution. Further examination of the cases brought to serious case review also indicates that there are complex factors at play.

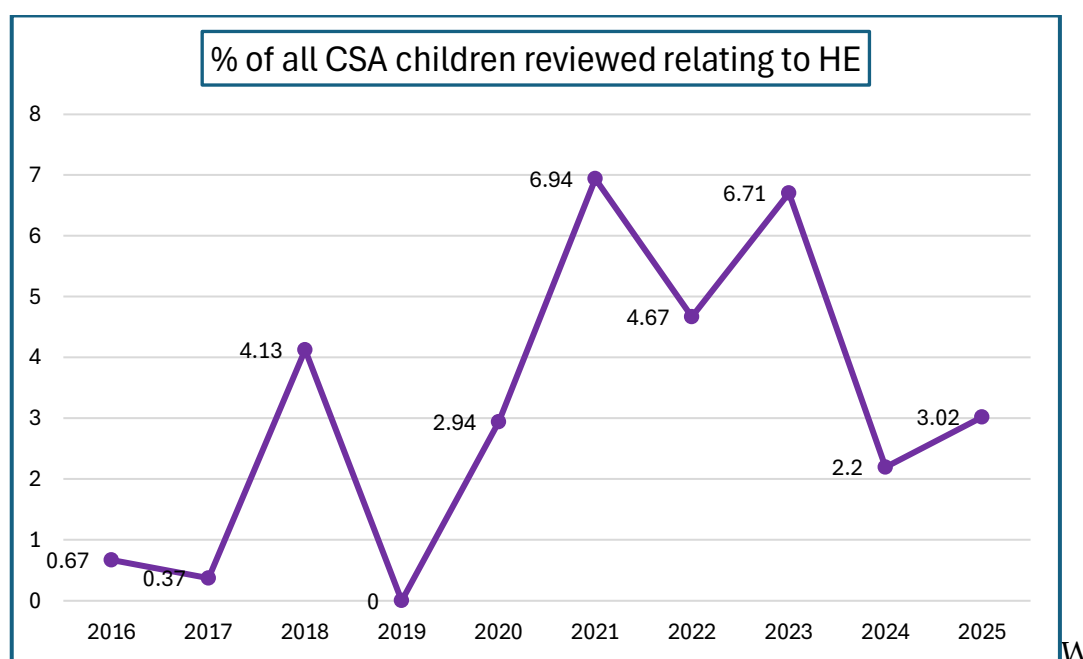


Figure 2: % of all CSA children reviewed relating to home education.

³⁸ Charles-Warner, W. (2024) 'Home Education, Picking up the Failings of Schools'. [Online] Available from: <https://www.educationotherwise.org/home-education-picking-up-the-failings-of-schools/>

³⁹ Charles-Warner, W (2026) 'Home Education Trends: A New Regime'. [Online] Available from: <https://www.educationotherwise.org/home-education-trends-a-new-regime/>

It was of particular note that reviews which refer to home education in the repository are, at times, cases which would not normally be expected to be subject to serious case review. Furthermore, these tended to be concentrated amongst a very small number of reviewers who appeared to have a special interest in home education cases. Most usually, the reviews suggest that the children are hidden or kept from sight of professionals who could safeguard children.

One such case involved a child with significant contact with health services⁴⁰ due to a chronic medical issue, who became dangerously underweight. The reviewer stated that one of the questions for the review was, *'the effectiveness of the elective home education system in both identifying children who are being educated at home and also its effectiveness in responding to their health needs'*. This is a clear case of findings not matching the facts as it is self-evident that it is not the role of the home education system to respond to children's health needs and the reviewer confirms *'Although Child K was home educated, they were not hidden from view as they had regular contact with health professionals in relation to chronic constipation.'* The incongruity of stating that a child had regular contact with health professionals, but *'That is not to downplay the significance of elective home education in reducing opportunities to monitor the wellbeing of children such as Child K who was not seen in their home environment'* is stark. The inherent implication of a reviewer referring to home educated children as being 'hidden' and attributing safeguarding risk to lack of health oversight by education staff, is one of clear if subconscious personal bias.

Cases at times provide incorrect factual information in respect of very basic aspects. One such case⁴¹ relates to a child who was reported to be involved in gun related incidents including in 2016, the child was then removed from the school roll at some point in 2017 spending the summer all that year in another country. There was some incorrect calculation of time periods skewed toward exaggerating the period of home education. More crucially, notwithstanding that the child had been found to be disruptive and physically violent whilst in school, and involved in criminal behaviour including gun related incidents prior to any home education, the review attributed his criminal vulnerability to home education, *'The current arrangements governing home education contributed to his vulnerability to criminal exploitation'*. Again, this indicates a preconceived bias which reduces the reliability of serious case reviews.

One serious case review relating to a teenager who died through suicide⁴², was subject to *'discussion with the Child Safeguarding National Review Panel as to whether this case met the criteria for a national review due to the issues relating to Elective Home Education.'* It is of particular note that the child had been receiving support services for many years and that no support was provided to the child at school due to administrative errors on the part of the school. In the words of the reviewer, *'Once Child A moved from primary to secondary school the concerns about her welfare effectively became lost in the system.'* The child

⁴⁰ 2020 Child K Oxfordshire, NC52600

⁴¹ 2020 Child C Waltham, NC52375

⁴² 2020 Child A Southend, NC52606

was not receiving support within the school, but 25% of the review recommendations relate to home education and these were noted to be similar across several reviews by the same author.

A small number of cases were found in which recommendations were made for home education where the child had not been home educated in any event, indicating an element of cut and paste in the writing of the review. Several cases were found in which home education was highlighted and recommendations made despite the child having ceased to be home educated well before the incident giving rise to the review occurred. One such case⁴³ relates to a child either approaching or having reached 18 years of age, and who had ceased to be home educated at age 14 when the elective home education team referred her case to CSC. In the meantime, proceedings were initiated for a Child Assessment Order and there was significant CSC involvement. It is of particular note that the case was selected for review on the basis that the national panel considered home education to be a feature of the case and 37.5% of the recommendations were in respect of home education. This clearly confirms selection of cases specifically because they relate to particular cohorts rather than on the basis of the seriousness or complexity of the case:

'It was decided on 12 October 2020 that the case did meet the criteria for a Local Review to be commissioned. The Child Safeguarding Practice Review National Panel has indicated that the review is of particular interest nationally, given that Elective Home Education was a feature of the case, as well as the effectiveness of certain agencies in Child A's life.'

These case examples indicate concerns in respect of the reliability of not only the accuracy or factual reporting within cases, but also the disconnect between some recommendations and the content of the review.

Conclusion

One would not be human if one could read these serious case reviews and not be moved by the harm caused to the children to whom they relate. However, we also have to look at the children who may be harmed by recommendations based on inaccurate reporting and a clear element of both selection bias and reporting bias is found in some cases. This was particularly notable in certain cohorts within the reviews, including amongst the home educated children, and more pertinently, those who were not home educated but nonetheless used as a vehicle to promote policies for home educating families.

As this report is written, home educating families are expressing fear over what are effectively mandatory meetings with their children in their homes, introduced through

⁴³ 2022 Child A Hounslow, NC52435

new Government legislation. Poignantly, a reviewer recently called for one child's legacy to be the development of such powers, a battle cry exploited at length in the media and in Parliament to achieve that goal. That reviewer authored several of the reviews highlighted in this report. More importantly, this raises the question of the emotional safeguarding of children for whom the privacy of their home is an important aspect in their feelings of safety and security.

Society needs serious case reviews in order to try to minimise harm to vulnerable children, but we need those reviews to be reliable in order that we can achieve that goal. We all carry our experiences into our professional lives, and it is incumbent upon us to be aware of the bias that this can bring to our professional duties, whether consciously or unconsciously. Nobody can deny that the investigation of the death or serious harm to a child must be a stressful one and those who undertake those investigations and reviews are no less subject to these biases.

We asked 'what do serious case reviews tell us' and we have our answer; we know from these reviews that children from any sector of society can be harmed. It is clear that society as a whole wishes to protect those children and that serious case reviews are a means of helping to improve that protection. What we also now know is that those who undertake the reviews are no less fallible than any other human being, they bring their own inherent biases, their own experiences whether good or bad and they make mistakes.

Serious case reviews require more than simplistic analysis, and they should not be used as tools of political manipulation; it is all too easy to use emotive subjects to that end, but society cannot afford to allow that to happen. We must be clear that safeguarding children includes safeguarding them from political harm and from exploitation, even in death.

May 2026

For those who ask, she grew to be strong and fearless.