



# Thematic Child Safeguarding Practice Review

June 2026 – Final version

*'Why doesn't anything  
change? ...'*

**Identifying & responding  
to child neglect in  
Swindon: Our challenges  
& opportunities.**

Kevin Ball: Independent Reviewer

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## 1. Introduction to this thematic Child Safeguarding Practice Review

'Why doesn't anything change? ...,' is a powerful statement made by the eldest child, one of a large sibling group of children, when describing professional involvement with their family due to concerns about significant neglect<sup>1</sup>. The child stated, 'they don't really like it when Children's Services are involved, but it is what it is.' they shared that they have been involved loads of times and they have never found it to be any help or support and there have never been any changes.

1.1. Between May and August 2025, Swindon Safeguarding Partnership received three separate notifications about serious incidents to children; each of these three notifications resulted in a Child Safeguarding Practice Review being commissioned by the Partnership, with each set of circumstances explicitly relating to child neglect. These were preceded by three other Child Safeguarding Practice Reviews having been completed in the recent past which also examined child neglect. Whilst the Child Safeguarding Practice Review Panel<sup>2</sup> commented during the decision-making phase on each of the more recent notifications, an agreement was reached that a thematic overview would also likely be beneficial given child neglect emerging as a major concern for the Partnership. This thematic report sets out learning captured from those three more recent reviews while also recognising learning from the other recent local reviews that concerned neglect; this has then used to identify themes and opportunities to support improvement activity.

1.2. By way of setting the scene, research conducted by Daniel over a decade ago in 2013<sup>3</sup>, notes '... Of all forms of maltreatment, neglect leads to some of the most profound negative long-term effects on brain and other physical development, behaviour, educational achievement, and emotional wellbeing. Neglect is not only damaging in early years, but its effects in teenage years are often overlooked. Neglect has been identified as a background feature in many serious case reviews ...'. More recent research in 2023<sup>4</sup> highlights that despite the known impact on children, as cited above, and '... despite a history of critique, concentrated discussion and improved assessment processes, neglect continues to be a major challenge for child protection services ...'.

## 2. The decision to conduct a thematic Child Safeguarding Practice Review, and our approach

2.1. Government guidance<sup>5</sup> supports the use of a thematic approach to reviews, noting '... Analysis of the broader context within which practitioners work, for example workforce pressures, leadership challenges and thematic practice issues can support systems thinking and lead to better quality recommendations that strengthen practice (3.29) ... The learning and recommendations should clearly address the issues that have been identified to prevent future harm to children in similar circumstances ...' (4.1. – 4.6). As such, this thematic report should be read alongside the three CSPRs recently conducted; CSPR Lola, CSPR Liam, and CSPR The Willow Children.

2.2. Our approach for this thematic review has consisted of:

- To support consistency, Kevin Ball (Independent Reviewer) was appointed by the Partnership to conduct all three Child Safeguarding Practice Reviews, as well as produce this thematic report.

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<sup>1</sup> Swindon Safeguarding Partnership, Child Safeguarding Practice Review: The Willow Children, Kevin Ball, May 2026.

<sup>2</sup> Child Safeguarding Practice Review Panel is established under the Children & Social Work Act 2017.

<sup>3</sup> Daniel, B., Why have we made neglect so complicated? Taking a fresh look at noticing and helping the neglected child, 2013, Child Abuse Review, Wiley Online Library.

<sup>4</sup> Taylor, J., Dickens, J., Garstang, J., Cook, L., Hallett, N., & Malloy, E. (2023). Tackling the 'normalisation of neglect': messages from child protection reviews in England. *Child Abuse Review*.

<sup>5</sup> Child Safeguarding Practice Review Panel: Guidance for Safeguarding Partners, June 2025.

- A Review Panel meeting was convened in October 2025 involving representatives from relevant agencies. Further Panel meetings were held throughout the review process to support the smooth and timely completion of the thematic aspect of reporting.
- Single agency information reports from relevant agencies involved with the respective children were used to inform the findings of the individual CSPRs; this was an important step, allowing agencies the opportunity to formally reflect on their involvement with the children. Findings from those single agency information reports has been collated to assist in identifying themes, and the production of this report.
- Table 1 below details agencies contributing to this thematic review:

<b>Table 1: Agency contribution to the review</b>	
Swindon Borough Council Children’s Social Care	Primary School 1 and School A
Avon & Wiltshire Mental Health NHS Partnership	Secondary School B
Great Western Hospital	College C
Wiltshire Police	Swindon Borough Council Housing Service
Swindon Borough Council Early Intervention, Youth & Community Service	
Society Without Abuse (formerly Swindon Women’s Aid)	
Swindon Borough Council Child & Family Health Service	
Swindon Borough Council Safeguarding in Education	
Bath & Northeast Somerset, Swindon & Wiltshire Integrated Care Board	
GP Practices supported by Bath & Northeast Somerset, Swindon & Wiltshire Integrated Care Board	
NSPCC	
Probation Service	

- As well as holding facilitated multi-agency practitioner workshops for each of the three CSPRs, a further facilitated multi-agency workshop was held involving local senior leads in March 2026. This workshop examined emerging themes, promoted local engagement in the learning and review process, and encouraged a whole system perspective to be shared.

2.3. Our key lines of enquiry for this thematic review were:

1. As individual agencies, and collectively as a Partnership, how do we strengthen our response to child neglect?
2. What factors – relevant to these cases - have challenged the Partnership and prevented them from embedding learning from previous reviews, and what opportunities might exist to overcome these challenges, including how to deliver learning from reviews in a different way?
3. Are there any organisational factors which might have impacted the quality & effectiveness of service delivery since 2020?

### 3. The children subject to review, whose lives have been impacted by serious neglect

**CSPR Lola** (completed in March 2026) examined agency contact with Lola. In April 2025, following a referral by Swindon Borough Council Housing Services, Lola, who was under six years of age, was found by Children’s Social Care and the Police to be living in very poor and unhygienic home conditions; her living space had ants and flies everywhere, mouldy food, and broken glass on the floor. Lola was observed to be unkempt, she had bruising on her feet and face, was inappropriately dressed, and had unsatisfactory sleeping arrangements; she could not walk down the stairs unaided. There were concerns that Lola may not have been outside her home for a long time, she was overwhelmed by lots of people and pointed to birds and bicycles not knowing what they were. Lola shared that she had not eaten all day and asked for a bath. Lola was not registered with a GP surgery, had not had her immunisations and was not registered with a dentist. She had never been to nursery or school; her mother, who was living with her, reported that she was home educated. Electricity and water had been cut off by the property owner to expedite the family vacating the property, and we now know that Lola and her mother had moved at least four times, often hotel hopping, in the preceding months. Lola is described by her mother as White British although her paternal family are of Caribbean heritage. As a result of statutory intervention that day, Lola is now safe, no longer living with her mother, and embarking on a new chapter in her childhood.

#### Key learning points from CSPR Lola

1. The use of family history, captured through chronologies, should always form part of any assessment and then decision making. Ensuring database systems allow for such information to be recorded and extracted is critical to keeping children safe when concerns arise.
2. Housing agencies and providers are a relevant agency. They may have unique insights into children’s lives, and the quality-of-care children receive. Referrals from Housing agencies should always be treated with importance and respect.
3. In situations when concerns have been raised about the safety or welfare of a child, and when parents then do not provide consent for further information gathering, assessments or offers of support, professionals should always ask questions and remain child focused. Thinking about all children connected to that family or household is also important. The refusal or withdrawal of parental consent might be viewed as an additional risk to the child and should be assessed as such.
4. Alongside being professionally curious, professionals need to remain alert to not relying on, and basing their assessments on, parental self-reporting; triangulating information from all agencies is a fundamental part of keeping children safe from further harm. The refusal or withdrawal of parental consent is not a barrier to information sharing if there are concerns about a child’s safety.
5. Informal challenge and escalation, or expressing a different professional opinion has a place, however, if you continue to have concerns about a child’s safety or welfare, and no changes have occurred without a reasonable rationale being given, formal challenge and escalation must be progressed.
6. Seeking the views of a child’s father, when safe and appropriate to do so, may yield important and relevant information as part of your assessment. Thinking about the child’s extended family network can offer insights that might otherwise remain hidden.

7. Reflective supervision is important for all workers, especially those with lead and decision-making responsibilities, to help reflect on styles of working and engaging parents – helping keep an eye on relationships, power imbalances, bias and prejudices, and remaining child focused.
8. Trade-offs, or short cuts, are an inevitable consequence of a system and process managed by people – especially efficiency over thoroughness. For managers and those responsible for examining practice quality and performance, consider how busy front-line workers make short-cuts from their point of view and explore how they balance efficiency and thoroughness versus safe, child focused practices. It is important for managers to always remain alert to the impact trade-offs may have on children’s safety, welfare and decision making.

**CSPR Liam** (completed in March 2026) examined agency contact with Liam. In June 2025, who was under 10 years of age, Liam was removed from his mother’s care by the Police due to concerns about persisting significant harm, continued emotional abuse, and chronic neglect. Liam who is White British, suffered with extreme eczema, and was not effectively supported to manage his skin condition, which led him to experience pain. He had lived with his mother who had repeatedly verbally and emotionally abused him – this was evidenced through the accounts of concerned neighbours who had heard, and reported, their worries to statutory services on a very regular basis over a prolonged period. It is believed that Liam had also lived with hearing his mother being abused by someone who she described as a ‘family friend’ – an adult male who was known to have a recent history of domestic abuse with a previous partner. Liam reported to professionals feeling scared of this person and had been given advice about what action to take if he needed to keep himself safe. Liam had missed significant periods of schooling, and it was often during his school absences that his home situation seemed to be at its worse. Liam’s father unexpectedly died when Liam was young and little is known about their relationship. Liam is now making good progress, enjoying schooling and reconnecting with a friendship group.

### Key learning points from CSPR Liam

1. Eczema, whilst not life threatening, can be a serious condition if left untreated meaning the person can experience persistent severe itching and often pain. It can increase the risk of infection through scratching, impact self-esteem, and impact the overall quality of life including sleep and educational attendance. For children, it is important that they receive the right treatment at the right time and this is monitored on a regular basis. For all children, but especially younger children, it is the responsibility of parents & carers to initiate and support the child with treatment, and there should be no expectation of treatment being the child’s responsibility.
2. Housing agencies and providers are a relevant agency. They may have unique insights into children’s lives, and the quality-of-care children receive. Referrals from Housing agencies should always be treated with importance and respect. The same value should be placed on accounts from neighbours.
3. Part time timetables for children based on poor school attendance must be considered as part of a wider management strategy, ensuring that all agencies understand family history, context, and implications of reduced attendance at school. A safeguarding lens should always be considered and linking them to practice frameworks, i.e. Early Help or Child in Need Plans, may be helpful.

4. The use of family history, captured through chronologies, should always form part of any assessment and then decision making. Ensuring database systems allow for such information to be record and extracted is critical to keeping children safe when concerns arise and can promote a holistic approach.
5. Alongside being professionally curious, professionals need to remain alert to not relying on, and basing their assessments on, parental self-reporting; triangulating information from all agencies is a fundamental part of keeping children safe from further harm. The refusal or withdrawal of parental consent is not a barrier to information sharing if there are concerns about a child's safety.
6. Informal challenge and escalation, or expressing a different professional opinion has a place, however, if you continue to have concerns about a child's safety or welfare, and no changes have occurred without a reasonable rationale being given, formal challenge and escalation must be progressed.
7. Keeping children safe from harm and supporting their identified needs is a multi-agency responsibility. While single agencies might be well placed to assess and support with some needs, all children need all agencies to provide a responsive, robust, and child centred safety net that works effectively as one.
8. Child neglect can consist of educational neglect, medical neglect, nutritional neglect, emotional neglect, physical neglect and lack of supervision or guidance. Other complicating factors and forms of harm may also be present, such as sexual abuse, physical harm, emotional abuse, and a child being a victim of domestic abuse in the family home. It is important to identify and respond to all forms of harm.

**CSPR The Willow Children** (completed April 2026) examined agency contact with a large sibling group of children. The sibling group were removed from the care of their mother in 2025 due to persisting concerns about neglect and significant harm. The removal to alternative care arrangements was preceded by many years of services being involved with the family; this had included periods of being subject to Child in Need and Child Protection Plans. In the immediate weeks prior to being removed, there had been a legal planning meeting, and considerable input from the professional network. Despite this, on the day that legal protection was used, the children were found to be living with broken glass, human and animal faeces around the house, living in dirty, cluttered, and unhygienic conditions including bugs in toothpaste and flies on unwashed crockery, having no clean clothes, and the older children taking on significant caring responsibilities for their younger siblings and mother.

### Key learning points

1. Working Together to Safeguard Children reminds us of what children have said that they need:
  - Vigilance: to have adults notice when things are troubling them,
  - Understanding and action: to understand what is happening; to be heard and understood; and to have that understanding acted upon,
  - Stability: to be able to develop an ongoing stable relationship of trust with those helping them,
  - Respect: to be treated with the expectation that they are competent rather than not,
  - Information and engagement: to be informed about, and involved in procedures, decisions, concerns, and plans,
  - Explanation: to be informed of the outcome of assessments, and decisions and reasons when their views have not met with a positive response,

- Support: to be provided with support in their own right as well as a member of their family,
- Advocacy: to be provided with advocacy to assist them in putting forward their views,
- Protection: to be protected against all forms of abuse, exploitation, and discrimination.

2. Single or multi-agency chronologies are a tool to assist professionals with assessments, decision making, planning, intervention and evaluation. They can be framed and focused on different aspects, e.g. a chronology of the child's voice & views over time, an impact of previous interventions chronology. For children living with neglect, the importance of professionals using chronologies as a tool to recognise cumulative harm cannot be under-estimated.

3. Managers must ensure that they provide regular high quality reflective supervision for practitioners or oversight of children who are experiencing persisting neglect. This will help counter neglect being normalised, bias forming, new workers starting again, and over-optimism. Leaders must ensure that Managers are suitably skilled and have capacity to provide supervision and oversight to reduce the likelihood that children will be neglected by the system designed to support and protect them.

4. Assessment is not a stand-alone activity. It must be accompanied by planning, intervention, and evaluation to lead to improved outcomes for children. Assessing parental readiness or capacity to change is equally important and professionals need to be skilled in understanding and assessing the stages of the change process.

5. When concerns arise about the possibility of a child taking on caring responsibilities, either for siblings or a parent, early assessment and taking a whole family approach is important. Being a young carer can lead to a child taking on adult responsibilities too early, the child neglecting their own needs, the child having unmet needs, a lack of adult supervision, and combined have a cumulative impact on the child's overall health, development, and safety. Legislation and Regulations are in place to support young carers.

6. When assessing and intervening with persisting child neglect, professionals must remain alert to other forms of harm or abuse which may occur in the family household. Emotional or psychological harm will often be present; however, professionals must also be mindful that in households where children's safety or welfare is not prioritised because of omissions in parental care, and domestic abuse is a factor, child sexual abuse may also be a concern.

7. Alongside being professionally curious, professionals need to remain alert to not relying on, and basing their assessments on, parental self-reporting; triangulating information from all agencies is a fundamental part of keeping children safe from further harm. The refusal or withdrawal of parental consent is not a barrier to information sharing if there are concerns about a child's safety – it may, legitimately, be viewed as an additional risk factor.

8. Informal challenge and escalation, or expressing a different professional opinion has a place, however, if you continue to have concerns about a child's safety or welfare, and no changes have occurred without a reasonable rationale being given, formal challenge and escalation must be progressed.

**CSPR Tristan**<sup>6</sup>, published in April 2024, examined agency contact with a 17-year-old, white, British male. There had been concerns about his school attendance, low weight and missed health appointments. Several agencies had been involved with him, and *'... although an assessment was completed by Children's Social Care, he was not provided with support as a child in need (CIN) or made subject of a child protection plan. In December 2022, Tristan told a member of school staff that he was severely depressed and experiencing physical and emotional abuse at home ...'*. Tristan was hospitalised due to his deteriorating health needs. As a result of the CSPR, findings, learning and recommendations were made.

**CSPR Alan**<sup>7</sup>, was published in March 2023. The review detailed that, *'... Alan and his family have been well known to many of the agencies in Swindon for over 14 years. In March 2021, when Alan was 16yrs old, his school referred him to the Swindon MASH as it was considered that the current early help provision working with the family was not effectively meeting his needs nor reducing the risks he was experiencing. As a consequence a social work visit was made and that revealed that Alan was: very thin and potentially malnourished; he had muscle wastage and his movements were very slow; his skin was in very poor condition – grey with acne; his hair was unkempt; he was spending nearly all his time in bed, rarely leaving his room or the house; his dietary intake was unclear but believed not to be very healthy; he was very self-deprecatory, believing he did not matter, that he was not important; there was evidence of some (superficial) cuts to his arm as a consequence of self-harming. This visit resulted in an A&E presentation which was then subsequently followed up with a strategy meeting, a Section 47 (under the 1989 Children Act) investigation which led to an Initial Child Protection Conference and Alan and his siblings being made subject to a child protection plan. ...'*. As a result of the CSPR, findings, learning and recommendations were made.

**CSPR Bella & Ben**<sup>8</sup>, published in December 2022 examined the lives of two siblings aged four and six years. The review detailed, *'... In November 2021 Bella was admitted to hospital after concerns were raised about her physical and emotional wellbeing by the pre-school she attended; at hospital she was found to have been severely neglected by her mother and the home circumstances were found to be hazardous for children; mother lacked support from either family or professionals at this time. Care proceedings were initiated and both children are now living in safe and appropriate homes; the plan is for them both to live permanently away from their parents, but with contact being maintained. The Hospital Consultant Paediatrician and Named Nurse for Safeguarding made a referral to the Swindon Practice Review Group because the significant neglect of Bella and Ben had not been picked up or addressed by professionals working with them and there had been delays in action when safeguarding concerns became known...'* As a result of the CSPR, findings, learning and recommendations were made.

#### 4. Analysis & findings from conducting this thematic Child Safeguarding Practice Review

4.1. Against the defined key lines of enquiry set out above, findings for this thematic review have been structured using a systemic approach, which is based on four domains; these domains are used by the Child Safeguarding Practice Review Panel in their 2022 review, Child Protection in England<sup>9</sup>, as a way of understanding a whole system response to child welfare concerns, and consist of; practice and practice knowledge, systems and processes, leadership and culture, and wider service context. Findings have been informed by the experiences of the children subject to review, information reports, views from multi-agency practitioners, local senior agency leads, and research. Combined, it has allowed us greater insights and understanding of practice challenges faced in Swindon and steps needed to strengthen practice, address culture, develop systems and processes, and support leadership.

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<sup>6</sup> Swindon Safeguarding Children Partnership, CSPR Tristan, Sarah Williams, April 2024.

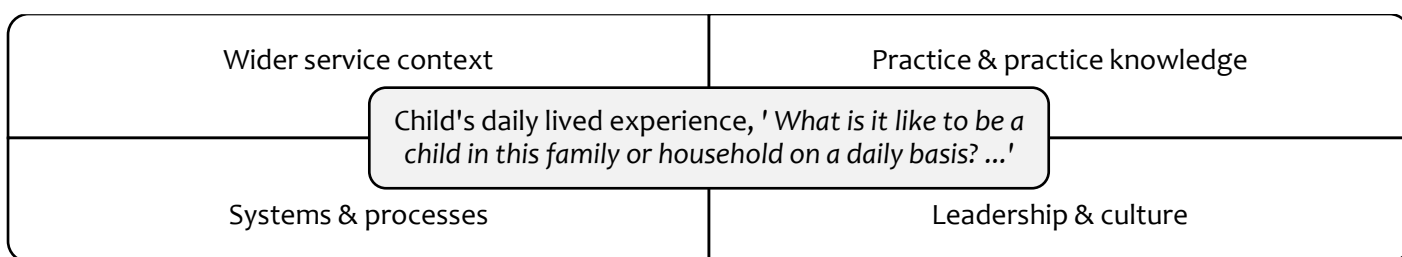
<sup>7</sup> Swindon Safeguarding Children Partnership, CSPR Alan, Mark Gurrey, March 2024.

<sup>8</sup> Swindon Safeguarding Children Partnership, CSPR Bella & Ben, Jane Wiffin, December 2022.

<sup>9</sup> Child Protection in England: National review into the murders of Arthur Labinjo Hughes and Star Hobson, May 2022, Child Safeguarding Practice Review Panel.

4.2. Research<sup>10</sup> supports the premise, that for a whole system response to child welfare concerns and especially child neglect, the individual needs and circumstances of each child who is the subject of concern must be understood, especially so when there is a complex web of disadvantage such as is caused by neglect. This includes an understanding of their individual needs and identity, their environment, the care given (or not given), and importantly an understanding of their day-to-day experiences gained through verbal and non-verbal communications. Holding the question, ‘*what is it like to be a child in this family or household on a daily basis,*’ will help guide assessment, analysis and decision making. The following illustration reflects this against the four system domains and may be a useful way of framing improvement activity for the Partnership i.e. does our practice & practice knowledge or do our systems and processes recognise and inherently allow us to know, and understand, forms of harm, disadvantage or inequality that impact children’s day to day lives?

Figure 1: Four domains with the child's lived experience as a guiding principle.



4.3. Such an approach is brought to life when reflecting on the eldest child’s comments, cited earlier, ‘... nothing ever changes ...’ (CSPR The Willow Children), or ‘... Lola may not have been outside her home for a long time, she was overwhelmed by lots of people and pointed to birds and bicycles not knowing what they were ...’ (CSPR Lola), or ‘... Liam reported to professionals feeling scared of this person and had been given advice about what action to take if he needed to keep himself safe ...’ (CSPR Liam). These children’s reflections might lead us to question how well we knew about, and understood, their daily lived experiences.

4.4. An overview of the children subject to review, as set out above, reveals strong elements of what research<sup>11</sup> refers to as disorganised neglect and / or depressed or passive neglect. The research explains, ‘... Depressed neglect is what most people tend to have in mind when cases of neglect are mentioned. Poverty is marked, both materially and emotionally ... Carers are unmindful and unresponsive to most of their children’s signals of need and distress. They appear lost in an empty world of their own. Relationships are lifeless and dull. No one seems to have much interest in anything. Neither pleasure nor anger feature in parents’ dealings with their children ... in terms of basic care, only the bare minimum takes place ...’ Importantly, research also reflects ‘... The run-down feeling that pervades passively neglectful families can affect the spirits of those who work with them. There is a sense of hopelessness, which coupled with the lack of any deliberate parental malice can produce a resigned passivity in both practitioners and their agencies ...’ Other research<sup>12</sup> considers the normalisation of neglect, ‘... we have the paradox of neglect – that for child welfare practitioners neglect is apparently ‘everywhere’, a significant cause for concern, and yet at the same time ‘nowhere’, so routine that is taken for granted and little if anything is done to tackle it ...’.

4.5. The impacts and human factors described above are important dynamics to attend to, individually for children, for those whose daily work requires them to engage with such subject matter, and for agencies to be alert to when setting expectations for their workforce and providing support. As a reviewer of serious harm caused to children

<sup>10</sup> The Child’s World: The comprehensive guide to assessing children in need, 2010, 2<sup>nd</sup> Edition, Jessica Kingsley.

<sup>11</sup> Howe, D., 2005, Child abuse and neglect: Attachment, development and intervention, p. 135, Palgrave MacMillan.

<sup>12</sup> Taylor, J., Dickens, J., Garstang, J., Cook, L., Hallett, N., & Malloy, E. (2023). Tackling the 'normalisation of neglect': messages from child protection reviews in England. *Child Abuse Review*.

by neglect, and for audiences who continually listen to similar messages about the professional response to neglect it is easy to feel overwhelmed by the persisting and pervading sense of what, if anything, can be done to make a difference to the lives of children experiencing neglect and those that work with it given it seems to ‘... be everywhere ...yet nowhere ...’. In many respects, as discussed by research<sup>13</sup> (which some may argue is dated but does still apply) given the paradox of neglect cited above, ‘... We do not need any more research to tell us that neglect is bad for children ... or that professionals in universal services are disillusioned with attempting to tell Children’s Social Care about children who they are worried about ... [or that] ... intervention has to be concrete, comprehensive, sustained and brokered by good relationships ... we need to ask ourselves ..., why have we made it so complicated to put this received wisdom into practice ... the fact is neglect is a complex phenomenon ... recognising and responded to neglected children is not a mechanistic activity, it requires empathy with a child’s plight. The process of assessment and planning, if done properly, constitutes really intense work ... proper thought and attention ... it takes time and entails prolonged proximity with mess, dirt, sadness, chaos, and distress ... however we have allowed the complexity of the phenomenon to drive us into an unnecessarily complex form of response ...’

4.6. This in mind, this thematic report argues the importance for Swindon Safeguarding Partnership of getting the basics right and focusing efforts on embedding core expectations well, as set out in statutory guidance<sup>14</sup> - something that does not appear to be happening consistently at the moment based on the findings of the three recent CSPRs. In practice, this translates to:

- There is unlikely to be one single intervention or agency that will make a difference for those children that live in families with multiple needs. The importance of having a stable, effective, coordinated, empathic yet authoritative multi-disciplinary team around the child and family which is led by a skilled worker, is critical.
- Ensuring the workforce are confident in their practice, knowledge, and skills to identify child neglect – knowing what signs and symptoms to look for across a range of scenarios i.e. large sibling groups, younger isolated children, adolescents, absence from school, not brought to medical appointments.
- Having a clear understanding about expectations about what to then do with that information once neglect might be identified – knowing and applying policy, procedure and adhering to multi-agency expectations about respectful and meaningful collaboration.
- Once identified, ensuring the workforce is confident in their practice, knowledge and skills to properly assess, understand, and work with children and families to reduce the longer terms impacts of persisting neglect – using assessment tools and techniques to gather, critically analyse information to support good, child centred decision making, and developing SMART plans that are reviewed and evaluated for impact. Keeping in mind ‘What is it like to be a child in this family or household on a daily basis? ...’.
- For leaders and managers to create and maintain organisational conditions which nurture and support such practice – practitioners being enabled, supported, and guided by leaders, managers, and supervisors, and promote conditions which allow for relationship-based work to work with children and parents.

4.7. Reviews completed highlight many of these basic and core tasks were either not achieved or not carried out with sufficient quality i.e. historical or chronological information was either not available or not fully used, child focused assessments were lacking, meaningful relationships with children and families were not forged, and multi-agency collaboration was limited or often strained. With the above comments in mind, the report now examines the four domains.

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<sup>13</sup> Daniel, B., Why have we made neglect so complicated? Taking a fresh look at noticing and helping the neglected child, 2013, Child Abuse Review, Wiley Online Library.

<sup>14</sup> Working Together to Safeguard Children, 2023, HM Government.

#### 4.1. Domain 1: Wider service context (encompassing key line of enquiry)

- Are there any organisational factors which might have impacted the quality & effectiveness of service delivery since 2020?
- What factors – relevant to these cases - have challenged the Partnership and prevented them from embedding learning from previous reviews, and what opportunities might exist to overcome these challenges, including how to deliver learning from reviews in a different way?

4.1.1. A range of wider service factors are relevant to name, as a way of understanding and framing local context and culture, which have influenced emerging practice, leadership, systems, and processes.

4.1.2. In 2019 Ofsted<sup>15</sup> inspected Swindon Borough Council Children’s Social Care and found an overall ‘good’ set out outcome judgements, with just one area that ‘required improvement to be good’. In July 2023 Ofsted<sup>16</sup> inspected the local authority again, resulting in an overall ‘inadequate’ judgement being made. Factors that appear to have contributed to this significant drop in performance appear to relate to the impact of Covid-19, changes of leadership, staffing vacancies and recruitment challenges. Instability of the workforce at practitioner and manager level meant that when training and development plans were implemented, the learning was not consistently embedded due to staff subsequently leaving – a transient workforce has meant that effective practice cultures have not been effectively or successively carried through; positive culture carriers are important to building consistent and sustainable good practice. Further to this, changes in workers for children and families is clearly an additional factor impacting service delivery, often resulting in a fracturing of trust between child, family and worker, and new workers effectively ‘starting again’ having lost any oversight and momentum that may have been present. Children’s Social Care note, ‘... A suite of good training and practice academy support is available to staff but the take up is poor with workers quoting workload pressure as one of the key reasons. Training as a result is now taking place within team and service meetings which has positively been received ... Swindon are currently seeking to review their establishment and social work caseloads to support workers to deliver consistency good quality social work. Caseloads are high and we are seeking to reduce these to support staff in delivering improved and consistently good quality social work ...’. Of relevance to this review, Ofsted noted in the 2023 report, ‘... Recognition of the impact of long-term neglect and domestic abuse is variable. The resulting plans for children are often weak. This leads to concerns not being properly addressed and a pattern of re-referrals ... [social workers] ... are not always helped well to recognise the cumulative impact of chronic risks to children, for example, neglect or domestic abuse. ...’. Since that time Swindon have been taking active steps alongside increased investment to make improvements which appear to be having a positive impact, and subsequent monitoring visits by Ofsted have commented on developments. Challenges however remain, with the monitoring visits commenting, ‘... Pockets of poorer practice are still clearly evident, but overall, inspectors have seen positive change in culture and thinking. This is particularly important for some of the longer-term child-in-need and child protection planning, where cumulative harm through long-term neglect and or domestic abuse has left children in adverse circumstances for too long ...’<sup>17</sup>, and more recently ‘... While many children now come into care at the right time in Swindon, a small number of children have waited too long, and in situations of harm and neglect, before coming into care ...’<sup>18</sup>. The most recent monitoring visit<sup>19</sup> has confirmed continued positive progress, while highlighting persisting challenges.

<sup>15</sup> Ofsted, Inspection of children’s Social Care Services, July 2019.

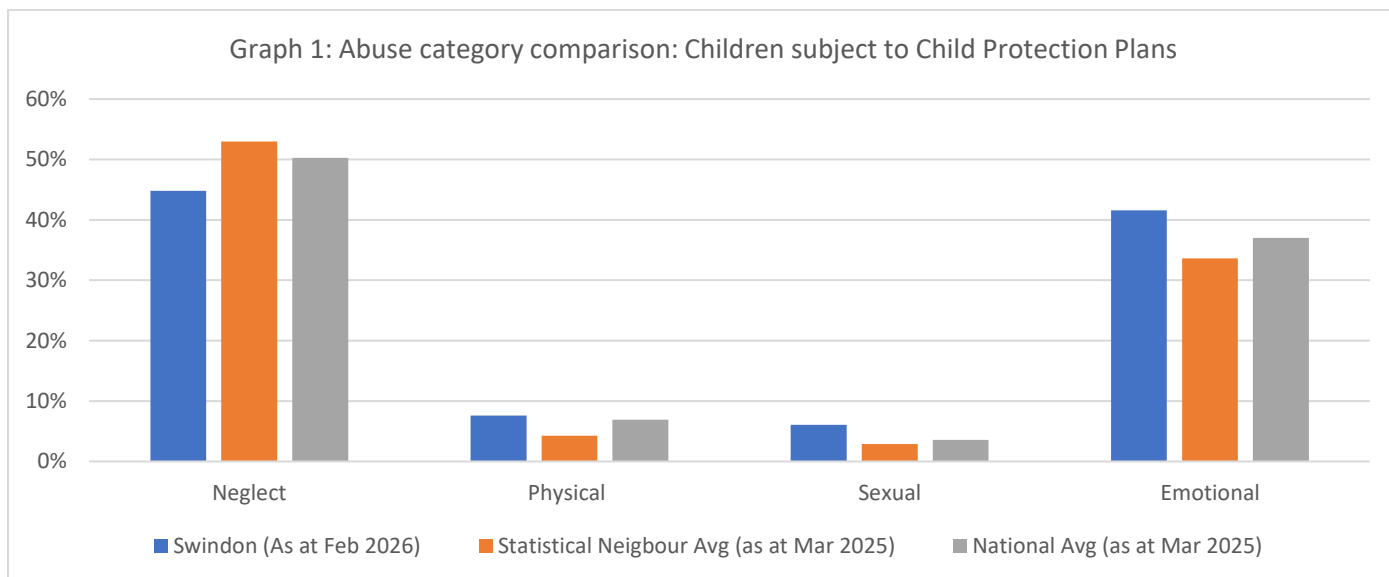
<sup>16</sup> Ofsted, Inspection of Swindon Borough Council local authority Children’s Services, July 2023.

<sup>17</sup> Ofsted, Monitoring visit to Swindon Children’s Services, July 2024.

<sup>18</sup> Ofsted, Monitoring visit to Swindon Borough Council Children’s Services, July 2025.

<sup>19</sup> Ofsted, Monitoring visit to Swindon Borough Council Children’s Services, December 2025

4.1.3. As with most other local authority areas, local data indicates that neglect is the most common form of child abuse<sup>20</sup>. Graph 1 below highlights local data, against national and statistical neighbour averages. This shows that Swindon is below both national and statistical neighbour averages of children subject to Child Protection Plans under the category of neglect. This resonates with the inspection and monitoring findings about the recognition and response to children living with neglect being longer than it might be hoped for.



4.1.4. The Early Intervention, Youth & Community Service note what is considered highly relevant contextual information which must be placed alongside information gathered through inspection activity set out above, and the findings of the CSPRs, ‘... in 2023 the Early Intervention Youth and Community Strategy was published, outlining Early Intervention priorities, which included sexual abuse, domestic abuse, physical abuse, harm outside the home, SEND and family dysfunction. Notably, both neglect and emotional abuse do not appear on this list. In addition, during this period there was a period of ‘transformation’ (June 2023 – January 2024) for Early Intervention Services, where what was previously known as the Family Service, Youth Engagement Team and Parenting Hub were brought together into Locality Teams. These launched in January 2024, but there was no guidance, no IT system and no detailed practice standards until May 2024 (interim arrangements) and November 2025 when there was the implementation of Liquid Logic. ... this, combined with working outside and above recommended threshold, led to inconsistent practice, compounded by an unclear understanding of consent application and use of the graduated response through Children’s Social Care ...’

4.1.5. In their inspection of Wiltshire Police<sup>21</sup>, His Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) graded Wiltshire Police’s performance across nine areas of policing. It found that the constabulary was good in two areas, adequate in three areas and requires improvement in four areas. It was noted that ‘... Wiltshire Police had made considerable efforts to improve its performance, particularly in force leadership and management, which were supported by clear strategic priorities, plans, and effective governance. The force had also improved the way it manages offenders and suspects, having a robust and risk-based approach in place to pursuing those that it needs to arrest. ... Inspectors also found the force was not adequately investigating crime and there remains not enough supervisory oversight over investigations. The force doesn’t routinely identify victims’ needs, which means

<sup>20</sup> NSPCC, Statistics Briefing: Neglect, March 2026.

<sup>21</sup> His Majesty’s Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) PEEL 2023–25; Police effectiveness, efficiency and legitimacy - An inspection of Wiltshire Police.

they don't receive the level of care they require. They must ensure they achieve better outcomes for victims ...'. These findings are relevant in the context of the recent CSPRs. Wiltshire Police are currently running Operation Phoenix, relaunched in April 2025, which is a strategic programme aimed at improving investigative standards across the force including their initial response, golden hour enquiries, contact with victims and witnesses, criminal justice outcomes, and data integrity. This is accompanied by a training strategy to upskill and improve practice. As part of this, daily meetings are now being held to review vulnerability linked crimes with frontline teams and provide feedback. This includes rape and sexual offences involving children. The investigation template has also been revised as part of this work alongside our Hierarchal Crime Review policy which links to supervisory oversight.

4.1.6. Swindon Borough Council Community Health Service (Child and Family Health Services 0-19) comment on relevant contextual factors, including the impacts of Covid-19, which limited face to face contacts and meetings being remotely held, staffing capacity and workload, and reliance on less experienced practitioners affecting the quality of assessments and decision-making. These pressures reduced the capacity for reflective practice and learning implementation. Additionally, the '*... transition from Capita One to Care Director, a significant amount of historical information about the children's experiences across Community Health was not transferred. As a result, key records previously held in Capita One, such as supervision notes, visit documentation, and clinic contact records, are not available in Care Director ... this has created gaps in the chronology and limits our ability to present a complete and accurate account of actions taken at the time, as the information that did transfer is insufficient to provide a clear picture ...*'.

4.1.7. The accounts set out above indicate complex organisational challenges for individual agencies - they provide a set of explanations about why responding to the 'everywhere ... and ... nowhere' of neglect may not have been as hoped for. By then layering a requirement and expectation to work collaboratively with other agencies in a loosely configured network or 'partnership,' complexity increases. Emergence<sup>22</sup> is a key property of complex systems – of which the multi-agency child protection system is one. The strength of a complex and self-organising system can often be tested against its ability to respond to emerging issues which cannot be controlled, predicted, or easily managed. Emergence as a concept is therefore relevant as it allows us, often with the benefit of hindsight, to better examine system weaknesses – rather than purely concentrating on the efforts, or errors, of individual practitioners. From a system thinking perspective and wider service context, it is possible to see the emergence of practice, system, process, and cultural issues that challenged and compromised the Partnership's response to neglect and its ability to embed learning. Importantly though, and based on more recent inspection findings, agencies and the Partnership are now making positive progress, and are developing a stronger more stable platform, on which to build greater successes when responding to the everyday challenges of neglect.

#### **4.2. Domain 2: Practice & practice knowledge (encompassing key lines of enquiry)**

- **As individual agencies, and collectively as a Partnership, how do we strengthen our response to child neglect?**
- **What factors – relevant to these cases - have challenged the Partnership and prevented them from embedding learning from previous reviews, and what opportunities might exist to overcome these challenges, including how to deliver learning from reviews in a different way?**

4.2.1. Emerging themes from the six CSPRs relating to practice and practice knowledge cover areas such as: the interpretation of threshold guidance, assessing and attending to the needs of young carers, supervision and management oversight, challenge and escalation when working with professional differences, using chronologies to inform assessment, planning and decision making especially when faced with longer standing concerns, dealing

<sup>22</sup> Emergence in organisations, Seel, R., 2006 & Caffrey, L., and Munro, E., 2017, A systems approach to policy evaluation, LSE Research Online.

with the refusal or withdrawal of parental consent, and complicating factors when working with diversity i.e. children with additional needs.

4.2.2. To support practitioners the Partnership has produced a framework, guidance and toolkit specifically aimed at working with neglect – this has been in place for some time. Findings show that this is not consistently used. Children’s Social Care note ‘... *there is a neglect tool, but it is used inconsistently and is subject to review. To ensure that practitioners are supported to use this tool it will need to be streamlined, rolled out, and embedded across the Partnership. This will give some cohesion and consistency and improve early recognition and response to neglect ....*’ This was also confirmed at a multi-agency meeting in January 2026 (Neglect Strategic Workshop – Key Findings & Priority Actions).

4.2.3. Review of the Partnership’s Children’s Neglect Framework and Practice Guidance<sup>23</sup> (February 2026, review date February 2028) highlights the guiding principles are different to those set out in the recently updated Neglect Strategy. The differences and inconsistencies in language and descriptors permeates a lot of information on the Partnership’s webpages when looking at neglect; ensuring synergy and consistency would likely help all using the framework and practice guidance. It will also assist the Partnership to intelligently measure progress and impact, through for example, audits, particularly when scrutinising the Neglect Outcomes Based Accountability Score Card, which is set out in the Neglect Strategy.

4.2.4. While much of the content of the current version of the framework and practice guidance is very useful and interesting, it is somewhat fragmented and disjointed and does not follow a logical sequence. There is, for example:

- No section about ‘*how to use this practice guidance,*’ to guide busy practitioners about when, and how to use the document. The addition of such guidance will help busy practitioners and managers untangle the potential maze of other information and guidance available on the Partnership’s webpages.
- While it does refer to the use of chronologies (with a hyperlink to the Partnership’s chronology guidance – which is not dated) there is no specific reference to developing other sorts of chronologies i.e. impact chronologies. Information about the benefits and use of such chronologies can be strengthened in both the framework and practice guidance, as well as the separate guidance on chronologies.
- There is no specific information to help practitioners identify, assess, and respond to neglect in larger sibling groups i.e. four or more children, and in turn, guidance about assessing young carers and adultification. This would be a useful addition to the guidance to help practitioners deal with such complicating factors.
- Given the increased likelihood of children with disabilities being abused or neglected<sup>24</sup>, guidance about neglect and disability can be expanded on and strengthened, with a particular focus on children with additional needs and who may, or may not, have a formal diagnosis of a neurodivergent condition.
- Guidance about the importance of properly assessing parental needs alongside assessing parenting capacity and capacity to change (or readiness to change), will be helpful i.e. the presence of mental health difficulties which may not reach a threshold for diagnosis but do impact daily functioning, or parental learning needs, parental health and medical needs, parental neurodivergence.

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<sup>23</sup> Swindon Safeguarding Partnership, Children’s Neglect Framework and Practice Guidance, February 2026.

<sup>24</sup> Jones, L. et al (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. The Lancet.

- Given the paradox of neglect ('... neglect is apparently 'everywhere,' a significant cause for concern, and yet at the same time 'nowhere,' so routine that is taken for granted ...'), a single source of guidance might usefully discuss how to assess and disentangle parental needs, poverty, and child neglect. Some families may always hover on the brink of neglect and if parents experience emotional or mental health problems that do not reach a diagnosable level, they cannot buy themselves any comfort to pay their way out, but will seek their own tried and tested stress relief activities, such as alcohol or drugs, and prioritise their own needs above those of their children. Guidance about how practitioners and agencies might respond in such scenarios may be helpful.
- Guidance could also be strengthened about recognising and using verbal, but also non-verbal communication, as a way of capturing the child's voice, views, and day to day experiences.
- A word search reveals no mention of the word 'analysis' or 'judgement' – both of which are key to the task of assessing persistent and chronic neglect in the context of other complicating factors such as those experienced by the Willow Children e.g. a large sibling group consisting of an age range that requires different parenting styles, poverty, maternal health needs, partially absent fathers, young carers.
- There is no other reference to assessment tools, such as the Graded Care Profile 2, to assist practitioners benchmark an initial assessment of neglect, and then revisit to measure change. This appears to be a major gap and one that potentially leaves practitioners either using the current 'quick' screening tool (which is referenced) or defaulting to what may be a random, subjective, or arbitrary set of measures or values to form a view about neglect. In Swindon, there was agreement for a period to use the Graded Care Profile 2, however this has now been withdrawn. Research<sup>25</sup> advises us that while the evidence base for measuring neglect using tools is limited, practitioners may also lack confidence about the tools used and their accuracy<sup>26</sup>. While this may pose a potential dilemma for the Partnership about what tools to adopt, promote and expect practitioners to use, given the local context it is arguably better to have tools, than rely on subjective and arbitrary measures of neglect.
- Many of the questions posed in the sections examining different aspects to be assessed (i.e. for a child's age grouping), are closed questions i.e. 'yes' or 'no' responses. This limits curiosity and critical analysis. While closed questions may have their place to support a quick assessment, they may then be seen as the style and format of assessment to be pursued, closing opportunities for more discursive and searching questions that allow a narrative to be formed. Open questions allow conversations to begin, relationships to be formed, and may make the difference between consent being granted or not.
- Guidance might benefit from additional advice specifically for managers and supervisors about their role to monitor work with children and families where workers might feel 'stuck' about how to move forward, or where situations are more complex i.e. multiple needs, new workers starting again, or where a sympathy bias might be forming. This may also include reference to the benefits of convening multi-agency facilitated supervision or reflective opportunities to help unblock any paralysis experienced by practitioners in situation of chronic neglect and / or where parental consent is refused or withdrawn, but concerns remain.
- With all the above points, communication, briefings, and training needs to accompany change.

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<sup>25</sup> Haworth, S., Schaub, J., Kidney, E., & Montgomery, P. (2024). A Systematic Review of Measures of Child Neglect. *Research on Social Work Practice*, 34(1), 17-40.

<sup>26</sup> Haworth, S., Schaub, J. & Montgomery, P. (2024) Exploring social workers' views on assessing child neglect in England and Wales. *Child Abuse Review*, 33(1), e2857.

4.2.5. Review of the Partnership’s neglect Screening Tool highlights ‘...The tool is intended for front line practitioners within all partner agencies to quickly identify areas of concern which may indicate a child/young person is being neglected. It is intended to complement existing assessment tools and should be used accordingly...’ Review of the Partnership’s webpages for neglect show no other assessment tools that might be used specifically to help the practitioner assess neglect in a deeper or more systematic way, beyond this quick screening tool. The webpages which reference neglect ([Swindon Safeguarding Partnership - Neglect](#)) contain a considerable amount of information, much of which is very useful, but does not match the language or guidance set out in the strategy, framework and practice guidance or screening tool. The headings, and categories to examine in the Screening Tool, i.e. emotional and behaviour, do not match those set out in the Partnership’s Children’s Neglect Framework and Practice Guidance. Again, synergy, streamlining and consistency will likely help all to intelligently measure progress and impact but also develop a shared language across the wider workforce.

4.2.6. This issue of consent remains a challenging practice area and emerges as a theme in more than one recent local CSPR. For this thematic review, it may be helpful to re-emphasise points made in CSPR Lola on this matter, given it has been shown over many years<sup>27</sup> to generate uncertainty for professionals about when to seek parental consent, when to share information with other agencies, what information can be shared, and how to approach any given situation in the absence of consent. Recent research<sup>28</sup> issued by the Child Safeguarding Practice Review Panel in 2024 highlights this as a continued challenge, reflecting ‘... Reviews often detailed ongoing problems with services being able to effectively engage children and families. Learning pointed to the need for practitioners to more thoroughly question and explore why a child may not be brought to appointments, or families might appear to be reluctant for the child to engage with services, or why a child wishes to cease engagement or parents decline consent ....’ Government information sharing guidance<sup>29</sup> helpfully explains, ‘... If you are not sure if there is a concern for the child’s safety or welfare, you should exercise your professional curiosity to find out as much as possible about the child to determine risk, before deciding on the most appropriate approach. If you are not able to determine an accurate understanding of a possible risk without sharing concerns with others, you should share the relevant information with those who need to know ....’

4.2.7. One ‘golden rule’ of the seven provided through recently updated Government guidance<sup>30</sup> may be helpful as a way of addressing the persisting challenge that practitioners face, ‘... You do not need consent to share personal information about a child and/or members of their family if a child is at risk or there is a perceived risk of harm. You need a lawful basis to share information under data protection law, but when you intend to share information as part of action to safeguard a child at possible risk of harm, consent may not be an appropriate basis for sharing. It is good practice to ensure transparency about your decisions and seek to work cooperatively with a child and their carer(s) wherever possible. This means you should consider any objection the child or their carers may have to proposed information sharing, but you should consider overriding their objections if you believe sharing the information is necessary to protect the child from harm ....’ It is important to notice that this golden rule uses language such as ‘a perceived risk of harm,’ ‘possible risk of harm,’ and critically refers to ‘harm’ rather than ‘significant harm’ - at no point does this Government guidance use the term ‘significant harm.’ On that basis, it is argued that waiting for significant harm to occur or the likelihood of significant harm occurring, as a legal basis to

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<sup>27</sup> a) Learning for the future: final analysis of serious case reviews, 2017 to 2019, December 2022, HM Government; b) Complexity and challenge: a triennial analysis of SCRs 2014-2017, March 2020, HM Government.

<sup>28</sup> Annual Report 2023 to 2024 Patterns in practice, key messages and 2024 to 2025 work programme, December 2024, p. 63, Child Safeguarding Practice Review Panel.

<sup>29</sup> Information Sharing Advice for practitioners providing safeguarding services for children, young people, parents, and carers May 2024, p. 12, HM Government.

<sup>30</sup> Information Sharing Advice for practitioners providing safeguarding services for children, young people, parents, and carers May 2024, p.4, HM Government.

share information and act, is unnecessary but also not in accordance with safeguarding children's welfare. These points do highlight the challenges in balancing the relationship and empowering based model of working alongside the need for a more timely and authoritative professional response in a child's time. It is acknowledged that recent audits completed by the Partnership report that there is now greater consistency of how guidance is interpreted and applied in respect of consent, leading to more robust decision making. However, given the persisting challenges experienced by all areas in this area, plus the local challenges faced with a less settled workforce and the need for repeated messaging about some practice areas, the Partnership will want to maintain a close eye on this crucial practice knowledge issue.

4.2.8. Professional challenge and escalation are recurring practice themes. The recognition and referral of concerns about neglect may have been timely and appropriate, but then ineffective or insufficient professional challenge and escalation when concerns are not accepted by another agency or there is a difference of opinion has not been consistently effective. This often seems to have resulted in the referring agency seemingly backing down and deferring to the perceived greater wisdom or authority of Children's Social Care. Where efforts were made to challenge and escalate these tended to be informal, with repeated attempts made via the same route, rather than a step-up of escalation and using agreed protocols to formally escalate persisting concerns. This is a recurring issue and one that needs a consistent, and concerted effort to shift the current practice culture, and embed a culture where respectful and healthy challenge is seen as routine and in the best interests of children.

4.2.9. Over-reliance on parental self-reporting is a recurring theme. Professionals continued to rely heavily on parental narratives, despite known patterns of minimisation and non-disclosure. This limited professional curiosity has contributed to repeated safeguarding oversights, particularly for those children living with domestic abuse and/or substance misuse. Revised practice guidance, accompanied by training and good quality supervision or management oversight should help counteract this bias.

4.2.10. The engagement of father's is also highlighted as a significant gap, notably the lack of outreach to the fathers, who were not contacted or actively involved in the children's lives. This absence of engagement meant that fathers were not given the opportunity to participate in their child's care or to be assessed for their potential role in providing stability and support – if recognised, they were ruled out, before being given the opportunity to be ruled in of caring for their children. This oversight contributed to a fragmented understanding of the family dynamics and limited the effectiveness of the intervention. Applying a whole family or think family approach appears to be a particular challenge for GPs, in the context of family members not always being linked on databases or registered at the same Practice. Again, revised practice guidance, accompanied by training and good quality supervision or management oversight should help counteract this gap or bias.

4.2.11. The impact of Covid-19 as a contextual factor cannot be ignored, and although many of us may now feel this is a distant memory, for many children and families it resulted in professional oversight being diminished at the time, and significantly less face-to-face contacts. Finding alternative ways to engage children and families, but also as a method for professionals to communicate may have been a positive output as a result of the Covid-19 pandemic. However, for some, there is also a legacy that has proved unhelpful to shift and transition back to face-to-face meetings. Arguably, this is an area that needs attending to – neglectful care or home conditions, and the child's day to day experiences cannot be assessed or understood by virtual engagement; expectations, set through Children's Social Care Practice Standards are already set about this issue.

#### 4.3. Domain 3: Systems & processes (encompassing key lines of enquiry)

- **As individual agencies, and collectively as a Partnership, how do we strengthen our response to child neglect?**
- **What factors – relevant to these cases - have challenged the Partnership and prevented them from embedding learning from previous reviews, and what opportunities might exist to overcome these challenges, including how to deliver learning from reviews in a different way?**

4.3.1. From a Children’s Social Care perspective, it has been highlighted that ‘... The introduction of the Family Safeguarding Model and the way that it has been interpreted /applied in Swindon has led to some confusion and misunderstanding/misinterpretation of both thresholds and consent. With previously too many children being identified as CIN, inconsistent application of Child Protection thresholds and too strong of a focus on adults and their consent /views rather than consistently keeping the child and their lived experience at the centre ....’

4.3.2. The Early Intervention, Youth & Community Service offer their perspective ‘... During discussion with [workers] it was noted that thresholds felt significantly different in January – April 2025. On reflection there has been an extended period of Early Help as a service directive request made by the senior management team at that time. The management directive was that Early Intervention Youth and Community Service should be working with a high level of risk to reduce the demand on Children’s Social Care. It is agreed that we are now working at a lower threshold of need within Early Intervention ....’ They go on to offer their perspective, ‘... we have been prevented from embedding previous learning because we have still not embedded step-down handovers from Social Care to Early Intervention. Families are more willing to engage when they are supported by the Social Worker to meet the Early Intervention Family Worker during the closure of statutory intervention and when there is a clear handover from one professional to another. It is our view that Families First will change the way that Early Intervention and Social Care work together ... [in line with expected Practice Management Standards] ... There should be clear manager oversight and direction at point of allocation. The current system allows for this, and Liquid Logic [recording database] has been built with this in mind. This was not how we practiced at the time and therefore the system did not allow for management oversight or direction ....’

4.3.3. The NSPCC comment on the interpretation of thresholds when contributing to the Willow Children CSPR, ‘... There appears to have been a perception by the professional network that the Local Authority’s thresholds had increased due to capacity issues within Children’s Social Care. This led to a perception that referrals that would ordinarily warrant a s17 assessment were being allocated to Early Help workers to deliver fixed-term support (12 weeks). The impact of this perception is evidenced in Team around the Family meeting minutes where it records that one of the objectives was to ‘Assess if children are at risk of significant harm.’ This suggests that the multi-agency network was waiting for a Child Protection threshold to be met prior to making a referral, as opposed to sharing concerns with the local authority for consideration of support under s17 (Child in Need). If this was the reason a referral was not made this is not in line with Working Together to Safeguard Children (2023), nor the partnerships threshold document ‘The Right Help at the Right Time’. The latter also provides a clear framework to escalate decision making that is not in line with the agreed thresholds, and this was not utilised by the NSPCC or members of the Team around the Family. It may be that NSPCC, and others, had normalised working beyond appropriate thresholds in this case ....’ It is worth noting that perceptions such as those articulated above can form the emergence of a narrative thereby influencing practice. Current performance data regarding numbers of Child in Need open to Children’s Social Care would not support this perception as a general trend of practice. Ensuring that ‘the system’ (or the Partnership)

receives live feedback about thresholds, blocks and barriers from the workforce is important for it to respond to emerging narratives.

4.3.4. The Safeguarding in Education Service reflect ‘...The Partnership continues to experience inconsistent threshold application across agencies and at the front-door. This in turn, leads to uncertainty about when concerns meet the criteria for Level 4 intervention, confidence in the consistency of those decisions being made and for professionals being able to formally escalate challenges to decision making. In addition, there could be exhaustion fatigue from partner agencies in having to challenge inconsistent or risk adverse decision making at this level. This results in learning from previous LSCPRs being disseminated but not embedded into practice ...’ The Safeguarding in Education team also comment on information sharing systems and the fact that Education Welfare Officers cannot access Care Director or historic safeguarding records, leaving them without the full context when working with children and families.

4.3.5. Swindon Borough Council Community Health Service (Child and Family Health Services 0-19) comment on the fragmented systems and information sharing arrangements which are due to the disconnected systems between health, education, and social care. These have led to poor access to historical records and limited visibility of family patterns. This fragmentation has prevented professionals from applying learning from previous cases and identifying repeat safeguarding risks. They also state, ‘... We should improve information flow between agencies so that missed contacts, cancellations and emerging harm are seen as cumulative evidence, not isolated events ....’

4.3.6. Timely, proactive and effective information sharing is key to keeping children safe. Statutory guidance<sup>31</sup> reminds us that ‘... no single practitioner can have a full picture of a child’s needs and circumstances so effective sharing of information between practitioners, local organisations and agencies is essential for early identification of need, assessment, and service provision to keep children safe ....’ As part of the joint functions of delegated safeguarding partners, there is an expectation for ‘... the implementation of effective information sharing arrangements between agencies, including data sharing that facilitates joint analysis between partner agencies ....’ Arrangements should include all relevant agencies and should promote respectful communications between agencies which values all information shared about a child’s safety and welfare, irrespective of their discipline or role – all information is useful, it is how it is then used that is important.

4.3.7. From a GP perspective challenges have been highlighted about the ‘... short, disconnected, time-limited interactions rarely raise enough alarm bells for people to apply the learning and seek support from screening toolkits and such-like. There is some more success with objective auditing of recorded flags such as lack of engagement with immunisations or reviews and ‘child not brought’ as these do not rely solely on clinicians in the moment and patient self-reporting. Further identification of risk factor patterns and the subsequent use of technology to search coded episodes in order to raise flags during a consultation could be a useful tool to prompt curiosity. Systems for recording established risk are already in place (such as on child protection or child in need plans), but we would need to develop ways of recording potential indicators of risk before this stage (and once children have been stepped down from these interventions), and this can be fraught with challenge ...’ In their contribution to the Willow Children CSPR the GP Practice offer helpful reflections that are applicable to all children that are experiencing neglect, ‘... Families with neglect are often subject to the ‘revolving door’ and intergenerational trauma, and we are often not surprised when the family comes back on the radar. So, if we are not surprised then as a system, we are not making the right decisions, and we are missing prevention opportunities. ... Consideration could be given to introducing a regular review of families who have been subject to or are at risk of neglect, most especially where there is a medical condition of any family member. This may create an opportunity even when discharged from early help. However, this is currently not

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<sup>31</sup> Working Together to Safeguard Children, 2023, p.18 & 28, HM Government.

funded, contracted, or supported by evidence so would need a much broader consideration. In the first instance, improving sharing of information of early intervention and other support patients' are receiving would be helpful ...'

4.3.8. Additional considerations about systems and processes are provided from a GP Practice perspective highlighting benefits, and challenges, '... Embedding learning in general practice carries its own challenges as they are a series of small independent businesses with their own differing resources. However, surgeries in Swindon increasingly work closely together and all are members of group known as Brunel which enables practices across the whole town to pull together to engage in projects. In addition, practices work in Primary Care Network groupings which can access shared funding to deliver care. All surgeries in Swindon engage with self-assessment audit and quality assurance provided by the Named GPs regarding their safeguarding provision, and many adopt and embed safeguarding policies provided for them to use. There is a training programme, which includes planned modules, safeguarding leads meetings and additional learning sessions, modelled on the Royal College of General Practitioners guidance for safeguarding training. This provides opportunity for disseminating information, usually in the form of webinars (recorded for accessibility) and supporting written documentation. It is often recognised that greater impact can be found from other education styles such as storytelling via video and role play, however there is not resource for this. In addition, practices can access education events provided by the Swindon Safeguarding Partnership. Practices as employers, and the safeguarding leads within them, are tasked with ensuring the updating and training compliance of each individual within their surgery. It is difficult to reach all clinicians consistently due to the busy nature of their workload and variability of working patterns. Expecting the implementation of change in an individual's practice following one quick summary is unrealistic but is frequently how all learning and system change is cascaded. Furthermore, each clinician may not come across many relevant cases with any frequency therefore it can be harder to apply the learning when required. It is also worth remembering that as generalists there is constant change and learning from all specialities and parts of the health care system as well as partner agencies and there is learning associated with this which may be a competing priority for a surgery or an individual. Ideally, additionally resourced time would enable practices to spend quality time on improving their processes and applying the learning and resources from reviews. There is a local Safeguarding LES which provides some financial provision to surgeries to complete work such as reports and information requests, but safeguarding is not within the national General Practice Contract or funding. There has been a motion passed by the BMA to support a request for this to be included in the next national contract negotiation ...'

4.3.9. The Police comment that Swindon Safeguarding Partnership '... have a learning and development group which has recently shifted its focus to practice themes as opposed to embedding specific learning from reviews. This is a positive change which should allow organisations to embed learning in a more effective manner. Previously, it has been raised by Partners that it is difficult to communicate changes to frontline practitioners and there has often been a reliance on delivering information through training sessions as opposed to using more creative means of communication. There has also been an apparent theme in previous reviews of partners accepting recommendations or actions which may not meet the SMART principles and are not appropriate for further action. ... From a Police perspective, it can be difficult to communicate required changes in practice due to the size of the organisation and the fact that learning may not be relevant for all officers and staff. Nonetheless, Wiltshire Police are continuously working to improve this with the recent launch of a Best Practice App which is available to all officers and staff and summarises learning from recent reviews in a easy to read format which can be accessed via laptops and Force issued mobile phones, the use of Force wide e-briefs which are sent to all officers and staff and a regular Practice Review Newsletter which is sent out across the force. Additionally, all relevant learning is fed into the Force Organisational Learning Board which is chaired by an Assistant Chief Constable for oversight. The Assistant Chief Constable is also required to sign-off any recommendations which are deemed as 'completed.' Where learning is related to a specific department or it is deemed that there needs to be change in training provision, this is shared with the relevant teams for action ...'

4.3.10. Comments set out above from Children's Social Care and the Early Intervention, the Youth & Community Service and the Safeguarding in Education Service highlight the instability caused by the introduction of different

ways or models of working with children and families – invariably, the associated systems, processes and practice expectations that accompany those new ways of working will have impacted other agencies. This instability appears to have resulted in some confusion, anxiety and potentially a loss of workforce confidence in some areas. The lack of practitioner confidence is referenced in the recent Neglect Strategic Workshop – Key Findings & Priority Actions held in January 2026 and is discussed in further detail in the next section.

#### 4.4. Domain 4: Leadership & culture (encompassing key lines of enquiry)

- **As individual agencies, and collectively as a Partnership, how do we strengthen our response to child neglect?**
- **What factors – relevant to these cases - have challenged the Partnership and prevented them from embedding learning from previous reviews, and what opportunities might exist to overcome these challenges, including how to deliver learning from reviews in a different way?**

4.4.1. While individual agencies have statutory responsibilities (as set out in primary legislation and statutory guidance), statutory guidance<sup>32</sup> sets out expectations about multi-agency working, ‘... *Strong multi-agency and multi-disciplinary working is vital to identifying and responding to the needs of children and families* (para 19) ... *Strong, collaborative leadership and timely decision-making are crucial to the effectiveness of multi-agency working and to identify and address system issues. The three safeguarding partners are responsible and accountable for this in their local areas* (para 37) ...’.

4.4.2. In their submission to CSPR Lola, Children’s Social Care have highlighted the instability of the Directorate leadership team and Principal Social Worker role as contributing to challenges implementing consistency of strategy and practice, as well as setting cultural expectations and embedding learning. Additionally noting, ‘... *silo working and a disconnect with professionals from other agencies outside of the police, health and education led to a lack of professional respect and an inability by Children’s Service professionals to take the concerns of colleagues in housing sufficiently seriously* ...’ Information provided indicates the leadership team is stabilising.

4.4.3. The Police comment about the need for a clear and up to date multi-agency neglect strategy for the Partnership, for there to be a shared language about neglect, and the need to practice in a trauma informed way to support better assessments and decision making. As referenced earlier, the Partnership has recently revised the Neglect Strategy.

4.4.4. Review of the Partnership’s updated, and current Neglect Strategy 2026-2029, shows a sound and succinct document that clearly sets out an ambition, aims and objectives, supported by guiding principles and what actions are needed to prevent neglect causing long term harm. This revised Strategy has built on and replaced the previous document covering the 2024 – 2027 period, which was less clear. Partners and leaders may wish to reflect on whether the revised Neglect Strategy (as a desktop exercise) is accompanied by the building blocks, as outlined above, for successful change on the ground, in day-to-day practice, and how this strategy actually translates and impacts day to day practice for busy professionals.

4.4.5. Review of the Partnership’s current Neglect Group Work Programme (2025 – 2026) reveals a set of objectives and actions that are not sufficiently specific, measurable, achievable, relevant or time bound (SMART) to tackle the learning captured from recent CSPRs. In discussion with Leads, this group was chaired by a representative from the charity sector for two years, however, not unreasonably, it was noted that they did not have the invested or legitimised authority in the local system architecture to drive through changes and actions. In line with the published Neglect Strategy (2026 – 2029), an opportunity exists to refresh this work programme. It is

<sup>32</sup> Working Together to Safeguard Children, 2023, HM Government.

recommended that chairing and membership of this working group is strengthened (and specifically to include representation from local Housing providers, and the Safeguarding in Education Service to represent the education sector), and that the work programme is refreshed based on the findings of this review, with SMART actions.

4.4.6. From a system thinking perspective and managing complex change (of which implementing and embedding an effective multi-agency approach to responding to neglect can be considered relevant), it may be helpful to consider the building blocks required for successful change. Table 2<sup>33</sup> below sets out one model highlighting the building blocks for successful change; where a block is missing (as shaded), it is likely to have a negative consequence. In this context successful change may be viewed as the Partnership successfully grasping neglect and consistently achieving the basic and core tasks set out above in paragraph 4.6. While not prescriptive, we can see that, as a result of, for example the period of transformation in the Early Intervention, Youth & Community Service between June 2023 and May 2024, with no guidance in place, and no effective systems and processes, it led to confusion, professional anxiety, gradual change, frustration and a false start. Similarly, when thinking about professional practice and competence, limited knowledge, confidence or understanding about how to manage professional differences, challenge and escalation, or authoritative practice to manage the challenges of dealing parental consent, there will be confusion, anxiety, and frustration.

<b>Table 2: Managing complex change – building blocks for successful change.</b>					
<b>Vision</b>	<b>Competencies</b>	<b>Incentive</b>	<b>Resources</b>	<b>Action Plan</b>	<b>RESULT</b>
					<b>Confusion</b>
					<b>Anxiety</b>
					<b>Gradual change</b>
					<b>Frustration</b>
					<b>False starts</b>
					<b>Successful change</b>

4.4.7. It seems evident that there have been frustrations within the Partnership in terms of a multi-agency response to neglect, impacting the pace of consistently successful practice. Instances of this can be seen through CSPRs Lola and Liam in respect of, for example frustrations from the Housing Service ‘... Concerns raised by housing were not taken seriously or acted on appropriately. There was a lack of professional respect and appropriate response. Housing in turn were not clear on escalation ... (CSPR Lola) ...’ Similar findings can be drawn from information submitted from the education sector. The Safeguarding in Education Service comment, ‘... Schools’ strong relational practice with families must also be supported. Trusted relationships provide a platform for honest conversations and constructive challenge regarding parenting capacity. Partnerships should ensure schools feel empowered and backed when raising concerns, including when conversations become difficult ...’ They go on to reference the use of professional escalation, ‘... Strengthening its use requires normalising challenge as part of good safeguarding practice. All agencies particularly schools need to feel confident in escalating concerns. This can be endorsed by senior leaders so that practitioners understand that disagreement is expected, welcomed, and child focused ...’ They indicate that the use of face to face reflective opportunities to discuss examples of multi-agency decision making could help schools and Partners gain a stronger recognition about the impacts of cumulative harm, also suggesting, ‘ ... For education, the development of the Education Practice group would enable learning

<sup>33</sup> Ross, B., MC Consulting, Managing complex change and the building blocks for success.

from LSCPRs to be shared fully with all education settings, where the learning is really understood and shared with practitioners. This would help promote a culture of professional challenge and further understanding of roles and responsibilities within the Partnership ...' Frustrations may therefore be linked to several issues, including no shared or common strategic vision being communicated from the top down, not feeling heard, workforce skill base and experience, workload demands and confidence or anxiety.

4.4.8. The issue of workforce confidence has arisen, notably in CSPR Lola with one more experienced practitioner being referred to as *'the parent whisperer'*<sup>34</sup> by colleagues and those less experienced, or less confident practitioners. The *'parent whisperer'* was someone often viewed as being able to bridge relationship dynamics and have difficult conversations with parents. While confidence may be viewed as a practice issue, it is arguably, a culture and leadership concern that needs addressing. Workforce confidence was discussed by the Partnership in January 2026 (Neglect Strategic Workshop – Key Findings & Priority Actions) commenting that high workloads mean practitioners are often *'busy but not present'*, thereby limiting proper assessment of the child's lived experience, with desensitisation being reported and unmet basic needs being normalised, and thresholds drifting downward over time. Professionals also reporting anxiety about difficult conversations with parents about neglect.

4.4.9. Attending to the human aspect of work undertaken by practitioners, in context may be helpful<sup>35</sup>. It is important for practitioners who have responsibility for dealing with risk, uncertainty, distress, abuse, and neglect daily to feel supported, but also experience a sense of psychological safety, rather than further uncertainty or fear. Given the expressed views about workforce confidence, especially when working with difficult subject matter, there may be a block or barrier which, although speculative, implies the need to *'... be careful ... it's not safe to practice this way ... will I be supported ...'* So, while it is important to ensure structures, systems, processes, roles, and accountabilities are attended to, this review argues that based on the issues raised, attending to the emotional undertow and human factors of any organisation is also a necessity rather than a luxury. This may be an aspect that the Partnership need to examine further given the reference in the recent Neglect Strategic Workshop *'... openly acknowledging that, despite years of activity, 'things are not changing' at the pace children need ...'*

4.4.10. Whilst arguably reductionist, but without overcomplicating matters, it seems clear that through stable and effective leadership, and the implementation and embedding of a sound practice model with associated guidance and expectations that align with a common language, more consistent practice for responding to child neglect will emerge. It would then not be unreasonable to assume that with improved workforce stability, embedding learning from reviews would follow. As previously noted, more recent inspection activity has commented positively on signs of emerging positive change, and it is hoped that the findings and learning from this review will further contribute and support the Partnership to maintain good progress.

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<sup>34</sup> The term *'whisperer'* originates from a colloquial phrase of being a horse whisperer and is often used to describe transferable skills to other scenarios but being based on skill, deep intuition, patience, and the use of non-verbal cues to understand and communicate with animals or people, resolving behavioural issues and building trust, rather than using force.

<sup>35</sup> Gibbs, J., Coughlan, B., Morgan, T., Mikushnica, A., Phippard, S., Crozier-Roche, F., Drayak, T., Graham, D., Smith, J., & Duschinsky, R. (2025). Which Factors in a Child Welfare Worker's Environment Influence Their Decision-Making About Neglect? A Systematic Narrative Literature Review. *Trauma, Violence, & Abuse*, 0(0).

## 5. Reflective questions for leaders and the Partnership

5.1. The following reflective questions are offered to help leaders and the Partnership further reflect on issues captured from this thematic review.

### Reflective questions for leaders and the Partnership

1. How can the Partnership seek assurance that the local system has the necessary building blocks to implement and embed the necessary changes required that ensure professionals and agencies achieve core practice expectations, as set out in paragraph 4.6, that reduce the likelihood of children suffering serious and significant harm through neglect?
2. How can leaders and the Partnership promote a sense of psychological safety (individually & corporately) for those working with risk, uncertainty, abuse, and neglect so that they consistently feel empowered, brave, and bold to exercise professional curiosity and judgement? Do opportunities exist to support psychological safety, through defined and distinct aspects of practice, such as assessments and decision-making arising from the Child in Need processes, that will counter professional anxiety and address limited practitioner confidence?
3. What steps can leaders and the Partnership take to promote inter-agency and multi-agency learning that is interactive and experiential that moves away from the passive sharing of updates and information to opportunities to build professional relationships, build collective confidence and a shared language, and improve the retention of learning? What different steps does the Partnership need to take to promote the mission of responding to neglect, convey the message about how to achieve this, and ensure that it is retained?
4. How can the Partnership strengthen professional understanding about challenges that may be experienced when parental consent fluctuates or is not given, or withdrawn, and yet concerns remain about the safety and welfare of a child? In strengthening professional understanding about this issue, how can the Partnership test how effectively it is being applied, but also learn and model from scenarios that have been challenging, but have resulted in positive outcomes for children?

## 6. Recommendations

6.1 This thematic Child Safeguarding Practice Review has used information gathered through three recent CSPRs commissioned by the Partnership, all concerning child neglect, whilst also recognising three other CSPRs completed by the Partnership in recent years which also relate to neglect. For each of those three separate recent reviews, agencies have provided an action plan which identifies and responds to learning they have identified; the

Partnership will have a role in monitoring the effective implementation and embedding of those single agency actions, through further review, audit, and scrutiny. The following recommendations are for the Partnership:

### Practice & practice knowledge

1. The learning from CSPRs Liam, Lola and the Willow Children, plus this thematic review should be disseminated to the workforce through a variety of mediums and methods.
2. Review, rationalise and align information available for professionals on the Partnership's webpages relating to neglect. In doing so, this should ensure a consistency of common language and values, linking to the Neglect Strategy, and which reflect the child's daily lived experience, '*What is it like to be a child in this family or household on a daily basis? ...*'. Once achieved, a communication and dissemination strategy should follow to alert all agencies about changes made.
3. Review and update the Partnership's Children's Neglect Framework and Practice Guidance (2026) and strengthen guidance as a result of the findings from this review. In turn, review and refresh the tools and approach used by Partnership's for the early identification and assessment of neglect. Opportunities to ensure synergy, consistency of language and alignment with all other materials available should be maximised. Briefings, training, and opportunities should be regularly provided to members of the workforce to support it being implemented and embedded.
4. The recently revised Swindon Safeguarding Partnership Resolution Policy should be disseminated to all agencies and all Services and Teams, with an accompanying single page 7-minute briefing that provides examples of how it might be applied, and interactive sessions to help practitioners understand how it can be applied and which model and effective process – from the perspective on being the person doing the challenging and escalating, but also the perspective of being on the receiving end of it. Attention should be given to ensuring all schools, education providers, and housing providers, in the local area.
5. The Partnership should explore options to implement and embed independently facilitated multi-agency supervision/case discussion, to assist practitioners that may feel stuck or disempowered in their work with a children and families, focusing on children who experience persisting neglect with little sustained change over time, children who live in complex circumstances i.e. large sibling groups, and children where the multi-agency network is not working effectively together. These should be set up properly rather than being seen as a quick fix – thereby creating the conditions to support quality facilitation, case discussion and decision making but also so that it becomes embedded as an available option.
6. The Partnership should promote the use of multi-agency chronologies as a means of capturing a more holistic picture about risks a child may experience, especially when child neglect is a concern. Accompanying the strengthened expectation about chronologies, impact chronologies (which chart the impact of previous interventions in families with chronic neglect) should also be encouraged, and compiled and examined at the start of every new episode of either Early Help, Child in Need, or Child Protection Planning. Systems and processes should be established which support the sharing of information to enable multi-agency chronologies to be created, with clear expectations about who would lead on updating or being responsible for the most up to date version.

## Systems and processes

7. Steps should be taken to ensure the Safeguarding in Education Service have necessary access to what was Care Director, now Liquid Logic, or other recording databases for the purposes of safeguarding and protecting children.
8. Further work should be undertaken to strengthen information sharing systems and processes that link GP Practices to statutory agencies, e.g. learning and development opportunities with Children's Social Care, via the Brunel network or the Primary Care Networks. This should strengthen links to support more timely and effective information sharing for individual children and families (as a two-way process) as well as local learning and developments that strengthen the local safety net.
9. The Partnership should introduce a system wide multi-agency audit process, that is scheduled and inclusive of practitioners and managers as a way of facilitating and promoting individual and system learning from practice. There should be clear communication about the emphasis being on learning and improvement. As an initial audit exercise, the focus should be on children that have been subject to Child Protection Plans, Child in Need Plans, or Early Help Plans for longer than 9 - 12 months and where there is little sign of sustained change or improvement in the children's lives or circumstances. Further audits relating to persisting neglect might include examining: supervision & management oversight, use of the Resolution Policy, and the impact of interventions.

## Leadership and culture

10. The Partnership should develop ways of helping everyone to understand their place within the Neglect Strategy that bridges the current disconnect between frontline practitioners, managers, senior leads, and their responsibilities to deliver on the strategy. This should include steps to improve confidence at first line manager level to support practitioners in their response to neglect.
11. The Partnership's Neglect Sub-Group work plan should be refreshed and strengthened to include SMART objectives and a clear workplan that is subject to scheduled independent scrutiny. The group should be chaired by a local senior leader who has the invested and legitimate authority to set expectations and drive pace, purpose, and momentum. Membership should also be strengthened to ensure it is representative of all agencies that can contribute to a better understanding about neglect in the local area, and ways to tackle it.
12. As set out in the Partnership's Strategic Business Plan 2025-26, a Safeguarding in Education Practice Sub-Group should be established with a clear set of impact aims that are measurable. As a priority, efforts should be focused on ensuring all educational providers understand the Partnerships Resolution Policy and are cited on the refreshed Neglect Sub-Groups work plan.