Child Safeguarding Practice Review

Executive summary

A review examining agency contact with Alice & family as a route to exploring opportunities to strengthen the multi-agency response to child neglect in Oxfordshire.

Independent Reviewer: Kevin Ball

Date: July 2025

1. Introduction & background to the review

1.1. This executive summary report sets out the findings and learning from a Child Safeguarding Practice Review (CSPR) commissioned by Oxfordshire Safeguarding Children Partnership (the Partnership). It builds on learning identified at the Rapid Review stage.

1.2. In July 2024 a 10-year-old child died. While the cause of death remains unascertained it was noted that the child, who for the purposes of this review will be known as Alice, was severely dehydrated, but also had a concerning number and range of bruises on her body. Whilst Thames Valley Police progress with an investigation, the criteria for conducting a CSPR was agreed given the child and three siblings were subject to a multi-agency Child Protection Plan due to concerns about neglect and there were concerns about the way in which agencies worked together.

1.3. The Rapid Review conducted by the Partnership identified considerable learning, nevertheless the Partnership determined that further examination of the following areas, taking a more systemic view, may yield additional learning at a local level. As such, these formed the key lines of enquiry.

Promoting a timely & effective response to the child

Neglect: What changes are needed within the partnership to ensure robust oversight of neglect cases, preventing drift and delay thereby ensuring timely outcomes for children?

Lived experience of the children: How effectively did the partnership understand, assess, and document all the children's day-to-day lived experiences, and who had key roles in their lives?

Parenting capacity: How did the partnership consider the unique needs of those with parenting responsibilities, and how did it influence the assessment of their ability to care for their children, and interventions offered or provided?

Partnership: How effective is the multi-agency partnership approach to problem-solving and escalation of issues when concerned about child neglect, and what difference does it make to the outcomes for our children?

2. Arrangements, and approach, to the review

2.1. The decision to conduct a CSPR followed the conclusion of the Rapid Review in August 2024 and the endorsement by the Child Safeguarding Practice Review Panel in September 2024. The following steps were then taken:

- The Partnership appointed Kevin Ball as the Independent Reviewer in October 2024.
- Review Panel meetings were held throughout the duration of the review to support local ownership.
- Information reports from relevant agencies involved with the child and family were submitted.
- A facilitated multi-agency workshop was held involving representatives from across the Partnership.
- Due to the Police investigation, it was not possible to involve family members in the review process.

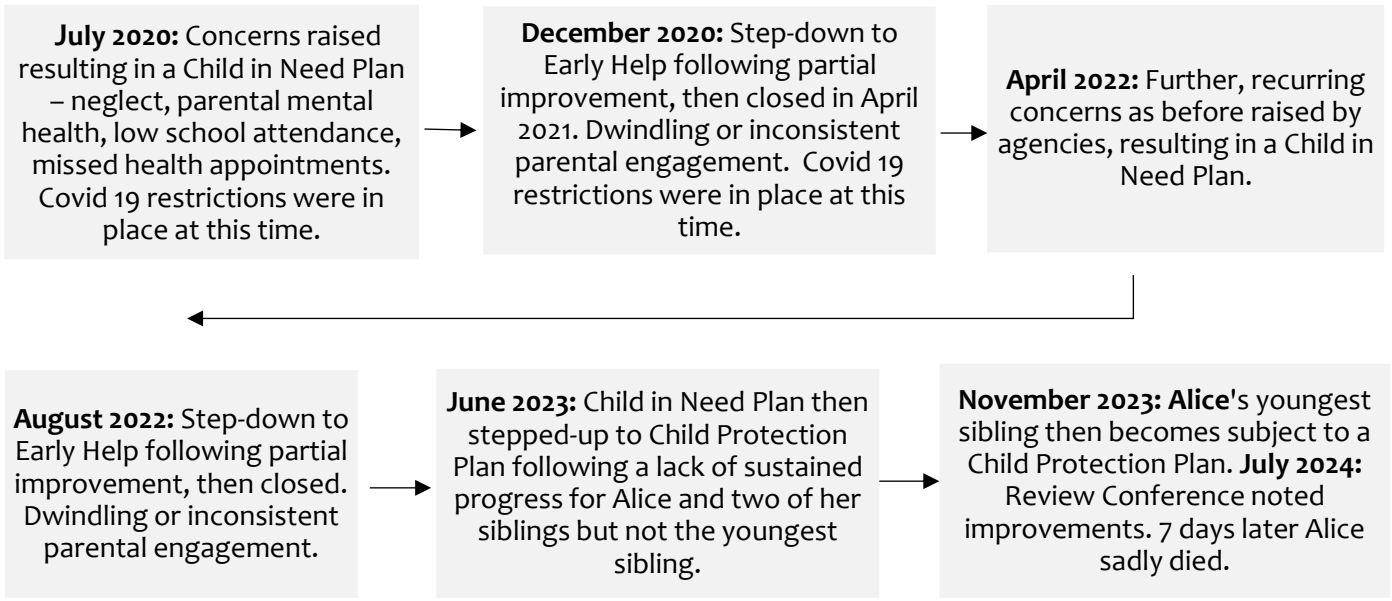
2.2. Table 1 below sets out those services and agencies have contributed to this Review:

Table 1: Services and agencies that contributed to this review	
Oxford Health NHS Foundation Trust	Oxfordshire Local Authority Children's Social Care
Oxford University Hospitals NHS Foundation Trust	Thames Valley Police
Oxfordshire Local Authority Education Services, on behalf of two schools attended	Buckinghamshire, Oxfordshire & West Berkshire Integrated Care Board (BOB ICB) supporting Primary Care

2.3. This review has kept in mind the nine protected characteristics set out in the Equality Act 2010 (age, gender, race, disability, religion or belief, sexual orientation, gender reassignment, marriage or civil partnerships, pregnancy, and maternity). The characteristic of age is relevant given the children being under 18 years of age. The characteristic of disability is relevant given one of Alice's siblings is neurodiverse. The characteristics of belief is relevant given Alice's father having a Gypsy/Roma traveler heritage. All other characteristics have been discounted as not relevant.

3. Concise account of relevant information & key events

3.1. After Alice's death it became known that she, and one older sibling, had been known to a neighbouring Local Authority Children's Services some four years before relocating to Oxfordshire and had been subject to a Child Protection Plan due to concerns of parental substance misuse by their birth mother. At the time the children moved to Oxfordshire they were not open to professionals in that other Local Authority Children's Services, but were accessing universal services i.e. GP and schools; as such, there was no transfer of information shared. Oxfordshire Children's Social Care, and other agencies, had their first contact with Alice and family in July 2020. The first contact with Oxfordshire Children's Social Care occurred in July 2020.



4. Learning captured from the review

4.1. Neglect: What changes are needed within the partnership to ensure robust oversight of neglect cases, preventing drift and delay thereby ensuring timely outcomes for children?

Practice Learning points
Missing health or medical appointments, and not attending school, can impact on a child's immediate safety, welfare, and development, but also their long-term development and life chances. Viewing medical neglect and educational neglect with equal weight as physical neglect is important (see reflective question 2 & 5, and recommendations 2 & 8).
Allowing the professional group the opportunity to come together, pause and reflect about their involvement with a child and family, can be hugely beneficial when feeling stuck or at an impasse. Conversations open discussion, and discussions have the power to act as an intervention (see reflective question 1 & 3, and recommendation 7).

4.2. Parenting capacity: How did the partnership consider the unique needs of those with parenting responsibilities, and how did it influence the assessment of their ability to care for their children, and interventions offered or provided?

Practice Learning points
Parenting capacity and parental capacity (or motivation) to change are distinctive and separate aspects of the assessment task – especially when working with parents that have had professional contact over a sustained period and there are concerns about child neglect. The use of assessment tools, at the earliest opportunity will help avoid drift and delay, and promote more timely evidenced based decisions (see reflective question 1 & 4, and recommendations 3 & 6).
The use of assessment tools can greatly aid assessment, however exercising professional curiosity and practice wisdom are also needed to support judgement and timely decision making (see reflective question 1, 4 & 5, and recommendations 2, 3, 5 & 6).

4.3. Lived experience of the children: How effectively did the partnership understand, assess, and document all the children's day-to-day lived experiences, and who had key roles in their lives?

Practice Learning points
Where there are concerns about one child in a household living with neglect, it is critical to equally consider the needs of all children in that household. If it is found that one child appears to be experiencing more, or less, care than another, questions must be asked about the reasons for this. Professionals should guard against lowering expectations about standards of care across a sibling group (see reflective question 2, 3 & 4, and recommendations 2, 4, 5 & 6).
Children who are neurodiverse are likely to require a greater level of care and attention; when there is a sibling group, questions should always be asked about whether there are children taking on a caring role and responsibilities. Professionals should guard against becoming desensitized about who is fulfilling the caring responsibility in the household (see reflective question 3 & 4, and recommendation 7).

4.4. Partnership: How effective is the multi-agency partnership approach to problem-solving and escalation of issues when concerned about child neglect, and what difference does it make to the outcomes for our children?

Practice Learning point
We all may have a different view about what is reasonable, what is safe and what might be harmful to a child. As professionals it is important for us all to gain the confidence to express differences of opinion to our peers across the professional network; expressing differences of opinion, challenging views held and having to sometimes seek support to raise your voice is a routine and healthy way of working across a complex multi-agency system. Managers and senior leaders need to empower their workforce to speak up when they have concerns about the safety of children who may be at risk of harm (see reflective question 3, and recommendations 2, 5, 6 & 7).

5. Reflective questions for managers and senior leaders across all agencies & the Partnership

1. How can senior leaders help staff feel confident and supported to work well with other agencies when dealing with child neglect—so that agreed actions are followed through and outcomes for children do not get delayed or overlooked?

2. When there are concerns about neglect, how can professionals work better together to quickly spot signs like missed appointments, poor school attendance, or parents not engaging, and respond in a way that makes sure the child's needs are met?

3. What steps are being taken to stop professionals from normalising or becoming desensitised to poor home conditions or neglectful parenting? How do we know those efforts are making a difference for children?

4. What regular checks should the Partnership carry out to make sure assessments are high quality—especially when working with families facing multiple challenges or discrimination, like Gypsy/Roma/Traveller families?

5. What can the Partnership learn from shared data about child neglect that would help professionals feel more confident about when and how to act—especially when they feel unsure or stuck about what to do next?

6. Recommendations

6.1. Individual agencies that have contributed to this review have each, where necessary, submitted their own learning and associated action plan from their own internal review. The Partnership has also generated an action plan following the Rapid Review. The following recommendations are for Oxfordshire Safeguarding Children Partnership;

1. The Partnership should consider the reflective questions for managers, senior leaders, and the Partnership, set out above. The findings from this review, including the Practice Learning Points should also be shared across agencies.

2. The Partnership should review and refresh the Neglect Strategy and associated governance and scrutiny arrangements, reaffirming their ambitions and activities to support the workforce identify and respond to child neglect.

3. The Partnership to explore how assessment tools used across the professional network, which are specifically designed to assess all aspects of neglect and home conditions could be pooled, to create a suite of multiagency assessment tools that align with one another, and share a common language. The use, quality and impact of any assessment tools should be monitored, alongside checking staff confidence to use them as a tool to aid analysis and decision making.

4. The Partnership's Threshold of Needs, last updated in September 2022, states that it is to be reviewed every two years. From the findings of this review, the Partnership should review and refresh the Thresholds of Needs document ensuring there is a clear focus on issues such as children who are neurodiverse, coupled with intersecting factors of disadvantage, and sibling groups.

5. The Partnership should gain an understanding about what barriers might exist that prevent practitioners using the Escalation and Resolving Professional Concerns and Disagreements Policy, look for ways to make the policy more accessible to all agencies and professional disciplines, and promote practitioner confidence in using it.

6. As a contingency, all multi-agency plans, whether they be Child in Need or Child Protection, should contain a named person/role and contact details for members of the multi-agency group (Child in Need or Core Group) to use should there be unresolved or ongoing professional differences, challenges, or the need to escalate issues; this should include incomplete actions and/or general drift. This should be re-stated at every formal review meeting.

7. The Partnership should provide regular facilitated multi-agency reflective group supervision to those practitioners and managers working with neglect.

8. Through the statutory scrutiny function, the Partnership should develop a schedule of scrutiny activity that lasts the lifetime of the revised Neglect Strategy to examine the quality and effectiveness of the Partnerships response to tackling neglect. Activity might include scrutiny of: persisting and emerging barriers to the effective delivery of the Neglect Strategy, the use of the Escalation and Resolving Professional Concerns and Disagreements protocol, the quality and application of specific assessment tools for neglect, workforce training needs, the impact of using data to better track and improve outcomes for those children where neglect is identified through a formal Plan i.e. Child in Need or Child Protection.