BEDFORD BOROUGH COUNCIL

Bedford Borough Safeguarding Children Partnership

CHILD SAFEGUARDING PRACTICE REVIEW

A focused thematic review examining the response to child neglect in Bedford Borough through the lives of seven large sibling groups, including the Jabril children.

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Executive Summary

This thematic Child Safeguarding Practice Review was commissioned by Bedford Borough Safeguarding Children Partnership following concerns about a large sibling group of children who experienced long-term neglect and were removed from their parent's care in 2025. The review examined the experiences of these children alongside six other large sibling groups where neglect had been identified, to understand how effectively local safeguarding arrangements respond to chronic neglect and the challenges associated with supporting larger families.

The review found that information was not consistently brought together, analysed or acted upon in a way that identified the cumulative impact of neglect on children's daily lives. Repeated indicators, including poor school attendance, missed health appointments, unsuitable home conditions, parental non-engagement and unmet developmental needs, were often considered individually rather than as part of a developing picture of harm. As a result, opportunities for earlier intervention were missed. The findings show that these issues were not limited to one family. Similar patterns were identified across the six additional family audits. The review also found that non-engagement by parents was frequently treated as a practical difficulty rather than a potential indicator of increasing risk to children.

The review identified strengths within the local safeguarding system. Agencies demonstrated commitment to supporting children and families, schools were persistent in raising concerns, and there were examples of effective multi-agency working and timely action where risks had become acute. The review also found evidence that agencies have already begun implementing changes to strengthen their response to neglect and improve safeguarding practice.

In too many cases, children's views, daily experiences and individual needs were not sufficiently explored or used to inform assessment and decision making. This was particularly important in large sibling groups, where professional attention could become focused on one child while the experiences of brothers and sisters received less attention.

The review also highlighted the impact of wider social and economic factors, including deprivation, poor housing and unmet health needs. While these factors do not explain or excuse neglect, they form part of the context in which families and professionals operate and should be understood when assessing risk and planning support.

The review has made detailed recommendations, summarised here

- Strengthen decision making and earlier identification of cumulative harm due to neglect
- Take a whole-family approach, with a focus on every child's lived experience.
- Treat persistent parental non-engagement as a safeguarding risk indicator.
- Improve assessment, planning and review through consistent use of tools, chronologies and measurable outcomes.
- Strengthen professional challenge, escalation and management oversight.
- Improve the effectiveness and impact of strategic neglect arrangements.
- Provide clearer leadership and coordinated multi-agency responses for large sibling groups.
- Improve support for practitioners working with complex and chronic neglect cases.

Bedford Borough Children's Safeguarding partnership has accepted the report and developed an action plan in response.

1. Introduction to the Review

1.1

In July 2025 concerns were raised to Bedford Borough Safeguarding Children Partnership (the Partnership) by Cambridgeshire Community Services (CCS) about a large sibling group of children, who had been removed via Police protection powers, from their mother's care in 2025 and placed with the father of the older two children. Prior to removal, concerns related to poor school attendance, being unkempt and in dirty clothing, poor home living conditions, the children's mother being resistant to engage with professionals and cancelling health appointments or not following health advice for her children, plus mental health concerns for two of the children who were also morbidly obese. The children had been subject to a Child in Need Plan but with no evidence of any sustained change and had then been stepped down to Early Help support. Cambridgeshire Community Services were raising concerns as the children's care had not improved and neglect persisted.

1.2

Between July and December 2025 further information was gathered by agencies and the Partnership, which resulted in a decision to commission a Child Safeguarding Practice Review. While the extensive concerns about how safeguarding partners had worked with this large sibling group of children needed to be examined, the Partnership also wanted a better understanding about how effective multi-agency arrangements were for families with large sibling groups where there were also concerns about long-term chronic neglect.

1.3

This report will initially examine the challenges faced to the timeliness, quality and effectiveness of the professional response to the large sibling group of children, who for the purpose of this review will be known as the Jabril children. In doing this it will also consider wider local practice and operating context with other large sibling groups, who similarly live with neglect. Learning points are captured, before the report concludes with recommendations to support improvement activity which complements actions and development work already underway in Bedford Borough.

1.4

For context, recent research[1] comments on child neglect being, *'… an issue that impacts children and young people of all ages, from the tiniest babies through to adolescents on the cusp of adulthood, but its many different presentations and distressing and cumulative impacts are still not universally recognised or responded to consistently well. … Child neglect's widespread prevalence, the potential for long-term harm to children's physical, emotional and social development and the challenges it presents for effective intervention make it one of the most pressing national safeguarding issues …'.*

[1] Child Safeguarding Practice Review Panel, "Why did it take so long to respond?" Child neglect: A thematic analysis, April 2026.

2. A short account of the Jabril children's story

2.1

This sibling group of children (aged between 1½ - 15 years, with two fathers involved) were removed under emergency Police protection powers due to significant neglect from their mother's care in 2025 and placed with the father of the older children. All the children are of mixed race, ethnicity and heritage being recognised as white, British, Asian. To aid anonymity, no names or specific ages of the children have been used.

2.2

Records show an extensive chronology of agency involvement over a ten-year period with long standing concerns regarding neglect. The case was stepped down from Child in Need (CiN) to Early Help in 2022. There were no contacts progressed to referral for this family between 2022 when the CiN plan ended and removal in 2025. From June 2023 to March 2025 there were eight referrals made to the Integrated Front Door (IFD) about the children and ongoing neglect concerns from a variety of referrers. Records indicate that at no point was the children's circumstances deemed to have met the threshold for Children Social Care intervention and remained at the Early Help level.

2.3

Key moments or points of interest from the multi-agency chronology of professional involvement include:

- In 2020 the mother was Cautioned for neglect due to concerns about the children being unclean, partly dressed, and living in a house with unsuitable sleeping arrangements and no food. At this time the eldest child was obese, and brought a knife into school. One of the younger children did not seem to fit in with the family, had additional needs (autism) requiring extra support, suffered with anxiety, had issues with his ears and glasses, always wanted to go home with the teacher, and always seems to be in a daze. His autism diagnosis was delayed due to the referral being rejected three times. No issues had been identified for one of the other younger children, but he was described as obese at an early age.
- Two of the children were/are morbidly obese; they were not seen by a GP or referred to the Community Dietician Service for specialist involvement. Obesity was regularly discussed with the mother by Cambridgeshire Community Services clinicians and external agencies, but she failed for years to engage or bring the children to appointments. There were also concerns that medical advice was not followed in respect of medical concerns for two of the children.
- The children's mother did not want the father of the older children to be a part of the Team Around the Family (TAF) and raised concerns regarding him negatively influencing the children against school. School shared concerns of him being aggressive to staff. The children also raised concerns regarding their mother's new partner and her partying with him and disclosed they were travelling to and from their meet ups (late at night on the train).
- Poor attendance at school (around 70 - 80%) for the three older children was a concern, with several penalty notices issued along with fines and subsequently Court summoned. Poor attendance at school was initially reported within the TAF in February 2021 and continued to be evident through subsequent TAF meetings until March 2025. The family were on an Early Help Plan for two years with regular Team Around the Child (TAC) Meetings (2023 – 2025). During these meetings, the mother consistently spoke about her anxiety, with the concerns about neglect remaining.
- Early Help involvement was opened specifically for the eldest child to complete a school-based Solution Focused Intervention aimed at improving attendance and engagement from June 2024. The scope of involvement reflected the level of consent provided by the mother during this period.

2.3 cont.

- In Sept 2024 the Early Help worker was denied access to the family home and the next day two workers from the Nursery visited the home, describing it '*… as a little unclean (sticky floors) and crowded with piles of washing (washing machine was not working) and the two youngest children were asleep on the sofa ...*' Then a month later a tradesperson submitted an anonymous referral to the IFD stating '*… concerns regarding very poor condition of the home, younger children being home and 'poorly.' There being 100 flies on the ceiling and mould around the property. Mother 'lovely' but overwhelmed, concerns for her mental health. Referrer advised mother to contact her landlord as she needed to move property …*'. In March 2025 health and school practitioners were made aware that the family home was visited by the Landlord and Housing regarding mould at the property (a Multiple Occupation Home). The mother was unable to use one of the bedrooms and was sleeping in the living room with two children, sinks were leaking and there was no hot water. Also, in March 2025 it was known that the mother was home schooling one of the children.

2.4

Following the removal of the children from their mother's care some practitioners continued to have concerns about the suitability of the children's living arrangements when placed with the father of the older children. The children continued to experience neglect (physical, environmental, educational, missed health appointments) in the father's care, as well as live in overcrowded conditions. Concerns were raised about delays in assessing the father's parenting capacity, with the children's arrangements described as 'better' but still not 'good enough'.

3. The decision to conduct a Child Safeguarding Practice Review , and our approach

3.1

The decision to commission a Child Safeguarding Practice Review was endorsed by the Delegated Safeguarding Partners in December 2025; this decision was supported by the Child Safeguarding Practice Review Panel in February 2026, also advising that the Partnership consider a wider cohort of children, including large families, being supported at an Early Help level as a way of capturing learning from a more systemic perspective.

3.2

Our approach for this review then consisted of:

- Following the appointment of Kevin Ball, the Independent Reviewer, a Review Panel meeting was convened in February 2026 involving representatives from relevant agencies. Further Panel meetings were held throughout the review process to support the smooth and timely completion of the review.

- Seeking information reports from relevant agencies involved with the Jabril children was an important step, to allow them the opportunity to formally reflect on their involvement with the children; as such, relevant agencies submitted information reports in April 2026 against the agreed lines of enquiry. Table 1 overleaf details agencies contributing to the review of the Jabril children:

Table 1: Agency contribution to the review of the Jabril children	
Bedford Borough Children's Social Care	Bedfordshire Police
Cambridgeshire Community Services (now known as East of England Community Health & Care NHS Trust	GP Practice 1
East London NHS Foundation Trust	First School A
Bedford Borough Early Intervention Service	Nursery School 1
Secondary School 1	Secondary School 2

- Alongside agencies reviewing and reflecting on their contact with the Jabril children, the Partnership commissioned an audit of six other sets of large sibling groups that were known to services in Bedford Borough and where neglect was identified as a concern. Agency involvement spanned many years thereby allowing a longer perspective to be gained. A brief profile of these families is set out in Table 2 below. In addition to those agencies listed in Table 1 above, additional schools also contributed to the audit exercise. As part of the moderation session, Auditors were asked to seek consensus about an overall judgement about the quality and effectiveness of the safeguarding network's contact and involvement with each family. As a result of the audit exercise, decisions were made about at least two sets of sibling groups that directly impacted the pathway being used, resulting in an escalation of intervention for greater safeguards needing to be in place. Table 3 sets out a summary of the collated audit judgements.

- Three multi-agency workshops were held, in April and May 2026; one with practitioners that had been in contact with the Jabril children, a second workshop as a moderation session for the six sibling groups whose records were audited, and a final session involving more senior agency leads to consider emerging themes and local issues. All three workshops were facilitated by the Independent Reviewer and encouraged a whole system perspective to be shared.

- Against the key lines of enquiry set out above, findings from the review of the Jabril children and the audits are synthesised and classified using four domains; these domains are used by the Child Safeguarding Practice Review Panel in their 2022 review, Child Protection in England[2], as a way of understanding a whole system response to child welfare concerns, and consist of; practice and practice knowledge, systems & processes, leadership & culture, and wider service context.

- The parents of the Jabril children were offered the opportunity to contribute once the Police investigation had concluded.

- The initial draft of this review report was shared with the Partnership in May 2026, with a final draft being ratified by the Lead Safeguarding Partners in July 2026.

[2] Child Protection in England: National review into the murders of Arthur Labinjo Hughes and Star Hobson, May 2022, Child Safeguarding Practice Review Panel.

3.3

Our key lines of enquiry for this review were:

a)Examine the quality and effectiveness of your agency contributions to assessment, planning and interventions during the timeframe under review, with a particular focus on examining safeguarding and neglect in a large sibling group.

b)Examine the quality and effectiveness of your agency's contributions to the identification of risk, neglect and vulnerability in the household, alongside any step-up or step-down decision making and activity.

c)Examine the quality of your agency's knowledge, understanding and use of information provided by the children in the household which might have been used to inform practitioners about the children's day to day lived experiences.

d)Examine how effectively cultural and intersecting factors, which impacted the children's lives, were recognised, understand and used to inform planning and decision making? What challenges are faced by practitioners?

e)Examine any barriers, blocks or inhibitors that may have impacted on your work with this family over the timeframe under review, with a particular focus on examining thresholds for assessing and intervening to support/safeguard the children in the household, step-up & step-down transitions, service delivery, and resourcing.

f)Consider any additional organisational or contextual issues that may have had an impact on service delivery and that you consider relevant i.e. staffing levels, communication styles and methods, team and culture, training, resources, working conditions, or organisational and strategic factors.

Table 2: Profile of six sibling groups whose agency records were audited

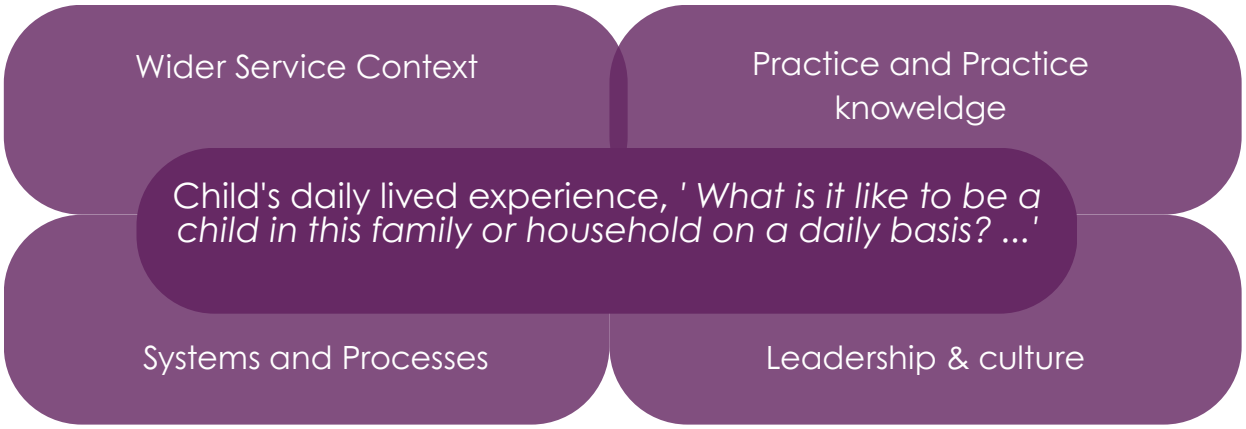
Family 1: 4 children, 1 – 10 years White – English Case status – Early Help	Family 2: 5 children, 2 – 14 years Asian British – Bangladeshi Case status – Early Help	Family 3: 4 children, 8 – 17 years White – Black Caribbean Case status – Child Protection
Family 4: 5 children, 8 months – 15 years White & British Case status – Child in Need	Family 5: 6 children, 1 – 12 years White & Black African Case status – Child Protection	Family 6: 6 children, 1 – 15 years White – British Case status – Child Protection

Table 3: Multi-agency audit judgements (ranging from inadequate, requires improvement, good, to outstanding), including overall moderated judgement						
	Family 1	**Family 2**	**Family 3**	**Family 4**	**Family 5**	**Family 6**
1. Were the referrals for action timely for the children?	Majority good	Majority good	Inadequate to good range	Majority RI	Majority good	Whole range
2. Is risk to each child identified, understood and prioritised? Do the children appear to be safe?	Majority RI	Majority RI	Majority RI	Majority RI	Majority good	Whole range
3. Has decision making matched the priority risks and needs, and resulted in the children getting help in a timely manner?	Majority good	Majority good	Inadequate to good range	Majority RI	Majority good	Whole range
4. Where an assessment has been completed, are risks, needs and strengths clearly expressed? How have assessment tools been used to support the assessment process?	Majority RI	Majority good	Majority RI	Inadequate to good range	Majority RI	Whole range
5. Is there a plan? Is it sufficient to address the risk & need, and is it making a difference and improving the child's life?	Majority good	Majority RI	Majority RI	Majority RI	Majority good	Majority good
6. Have the children been involved, seen, spoken with, views and day-to-day experiences captured, and spoken to without their parents present, where appropriate?	RI	Majority RI	Inadequate to RI range	Majority RI	Majority good	Majority good
7. Have individual needs and circumstances been taken into account e.g., age, disability, ethnicity, faith or belief, gender, sex, identity, language, race?	Majority good	Majority good	Majority RI	Majority RI	Majority good	Majority good
8. Do the agencies involved, work together effectively to protect the children and ensure they receive the right services to improve outcomes?	Majority good	Majority good	Majority RI	Majority good	Majority good	Majority good
9. How well was each child's lived experience at home captured and reflected in the work undertaken?	Majority good	Majority good	Majority RI	Majority RI	Majority good	Majority good
10. How was each child's education or early years' service delivered and supported?	Majority good	Majority good	Majority good	Equal good & RI	Majority good	Majority good
11. How well is the wider family understood, including the roles and details of fathers? Were any adults identified as having additional needs, and how effectively were these taken into account / understood.	Majority good	Majority RI	Majority RI	Majority RI	Majority good	Majority good
Moderated judgements	**Good**	**Requires improvement**	**Inadequate**	**Inadequate**	**Requires improvement**	**Inadequate**

4.1

Research[3] 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 and intersecting web of disadvantage such as is caused by neglect. This includes an understanding of their individual needs and identity, their environment and context in which they live, 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'*, in mind, 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.

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



4.2

As a snapshot, information provided about Family 3, highlight these children's lived experiences – a picture that is similarly reflected across all six families audited, and serves as a reminder about the very real impacts of neglect on later life chances; *'… All four children either have or are attending School. There are three overarching and inter-linked concerns relating to ongoing neglect within this family ... Impact for the two teenage boys - the behaviour and circumstances of the two teenage boys present a significant concern both within the home and the wider community. Their disengagement from education, reports of substance misuse, criminal activity, and lack of structured daily routine raise serious safeguarding risks. In addition, there are concerns that their own health and mental health needs are not being adequately being met. Their presentation and behaviours negatively impact the younger children, contributing to exposure to unsafe behaviours, emotional harm, and an absence of positive role models within the home. There are ongoing concerns regarding the mother's capacity to consistently set and maintain appropriate boundaries, make safe and timely decisions, and meet the children's basic, emotional, and health needs. This includes concerns relating to supervision, educational engagement, attendance at medical appointments, provision of appropriate clothing, nutrition, and safeguarding the children from exposure to substance misuse and criminal activity.*

[3] The Child's World: The comprehensive guide to assessing children in need, 2010, 2nd Edition, Jessica Kingsley.

The repetition of the same unmet needs over a prolonged period indicates a lack of sustained change and raises significant questions about parental judgement and capacity. This also includes ensuring the children's personal hygiene (including head lice, potential flea bites) needs are met. This includes the living space, ensuring the living room is available for the whole family including eating at the table and not the stairs or bedrooms and allowing access to the garden. There are reports from professionals and from the children's voices that the physical condition of the home remains a persistent concern. This is indicative of environmental neglect. Longstanding issues such as no internal doors, broken glass in the front door, damaged fixtures, and unsafe living conditions have remained unresolved for extended periods despite being repeatedly raised with professionals. These conditions pose ongoing health and safety risks and demonstrate a failure to maintain a safe and suitable living environment for the children. The children speak and act as if there is a scarcity of food. There are cats and clothing has smelt of cat urine on several occasions. Taken together, these three areas demonstrate a pattern of chronic neglect, with prolonged exposure to risk, lack of protective boundaries, and insufficient change over time. Despite professional involvement, the children's lived experience has not improved, reinforcing the need for urgent, decisive, and outcome-focused intervention …'.

4.3

By cross referencing findings captured from review of the Jabril children, it is possible to identify similar patterns from the audit exercise – thereby confirming these practice, system, process, leadership and cultural features to be systemic challenges and not just isolated to the Jabril children. In total, 14 areas have been identified; these are set out below and initially use information gathered from the review of the Jabril children, followed then by examples of similar findings from the audit of the other six families.

1. Consideration of cumulative harm (practice & practice knowledge + wider service context):

Information known and knowable to relevant agencies about the Jabril children was not pooled, assessed and analysed with a mind's eye on the cumulative impact of living with neglectful home conditions and neglectful parenting; a bigger picture view of missed health appointments for issues such as obesity, eyesight and hearing problems, poor parental mental health, and poor school attendance were not viewed cumulatively. A chronological account of these issues was not generated, resulting in professionals not identifying an emerging pathway that would further harm all the children. The Police Caution received by the mother of the Jabril children was not considered as part of the ongoing involvement with the children and appears to have sat in isolation of all other information; no reason for this has been provided. Across the timeframe, safeguarding concerns emerged gradually rather than acutely, particularly in relation to educational neglect, parental engagement and follow-through, capacity to manage the evolving needs of a large sibling group, and the ability to sustain change over time. Information suggests that the stage of assessing parental needs and parenting capacity had been missed and that the focus had jumped to offering parenting support. This then failed as the mother did not consistently engage in offers of support.

These findings resonate with the results from the audit completed for Family 1, Family 4, and Family 6, with comments, '*…Decision-making was mainly reactive rather than proactive, meaning children did not always receive timely help that matched the level of risk. Earlier opportunities to recognise and address cumulative harm and possible chronic neglect were missed …Although current planning shows improvement and better alignment with risk, this has come after a significant delay. As a result, the children experienced prolonged periods where risks were not fully recognised or responded to in a timely way …*'.

Research[4] confirms the importance of using chronologies, as a way to identify cumulative harm, capture significant events, impact and tracking the child's felt and lived experiences. The emergence of cumulative harm, only tracked and captured by review of history, would need to be seen in the wider context of some families in the local area experiencing deprivation, and the importance of professionals needing to review historical information held, and use assessment tools to understand the cumulative nature of harm.

2. Parental engagement (practice & practice knowledge + wider service context):

Information and discussion confirms that professionals struggled to consistently engage the Jabril children's mother in meaningful assessment, support and intervention which resulted in a fractured level of oversight by the professional network. This also resulted in cumulative harm to the Jabril children not being recognised. As an example of this, the Early Help Service note, '*… Between May 2021 – March 2024 (four separate episodes) the Early Help Parenting Team made repeated attempts to support mother in attending and engaging in group and one-to-one parenting intervention. Multiple planned parenting sessions and home visits did not take place due to cancellations, non-attendance, or lack of response. Two separate one-to-one parenting offers were closed due to non-engagement. Follow-up contact attempts across 2021, 2023, and early 2024 often received no response. In July 2021 Relate Family counselling was agreed at Early Help Panel but not attended by the family. In May 2024 an Early Help Practitioner was allocated to work with the eldest child for 4-6 sessions of school based BRIEF Solution Focus Intervention. Due to challenges with engagement these sessions commenced from November 2024 – January 2025. Five sessions were completed directly with him. No other children were allocated to Early Help during this period and no consent received for any other intervention. The Education Welfare Service was also open to the family (three separate episodes) between 2021-2025 …[and] … it is evidenced that school attendance concerns for the three eldest children have been persistent since 2021. Parental attendance at pre-court and other school attendance related meetings was inconsistent …*'.

East London NHS Foundation Trust (ELFT) has examined their involvement, noting that two of the children were known to the service prior to their removal in April 2025. The eldest child was known to the ELFT Mental Health & Schools Team between July and August 2021, in respect of gaining advice about improving school attendance, neglect, non-attendance at health-related appointments and concerns about weight. Additional advice was given by the ELFT Eating Disorder Team as part of the agreed TAF Plan (although no ELFT service was directly part of the Team around the Family network) but as his level of need was not judged to require a specialist mental health service, there was no further role for ELFT. Another child in the family was referred to Bedford CAMHS in June 2023 for an assessment to support his transition to secondary school, but following multiple attempted contacts, and due to non-engagement by the mother the referral was closed.

[4] Research in Practice & Dartington Trust, Completing social work chronologies, 2022.

The Trust also comment on the barrier of parental engagement impacting timely assessment and intervention, *'… In 2023, one child was referred to support his transition to secondary school. The mother did not engage with attempted contacts from CAMHS. This lack of engagement prevented the service from gaining a full understanding of the impact that neglect had had on him and reduced opportunities to assess risk or identify protective factors. The lack of engagement with CAMHS' constrained their capacity to deliver interventions at the required threshold, as key information could not be verified with the mother. Despite co-ordinated efforts from both CAMHS and the school to facilitate communication, the primary barrier impacting CAMHS involvement was the struggle to engage the mother …'*. They also comment on an important point about the mother's more recent disclosures about drug use that has received little attention by other agencies in this review (i.e. the Trust only recently finding out about this, and schools were also not aware any information about this issue), but which is highly relevant in terms of the identification, assessment, and interventions offered, *'… there is currently limited information available regarding her substance use. Although she has requested support for her cocaine use - a positive step towards accessing help - it remains unknown how long she has been using, as well as the frequency or pattern of use …'*.

These findings are reflected in the results from the audit completed for Family 3 and Family 4, with comments about working with Family 4, *'… At times it appears that parents agree to engage either with professionals or attend appointments, but the reality has been different … I do not believe the assessment team considered chronic neglect and due to Mum not willing to engage with an assessment, stepped the case down for school to complete an EHA …'*.

Research[5] supports the need for additional vigilance and care when professionals encounter problematic parental engagement, and the benefit of skilled professional intervention.

3. Processing of information at the Integrated Front Door (systems & processes):

At the time of their involvement with the Jabril children, the Early Help Service identify *'… There was limited consideration of the cumulative issues identified across multiple IFD referrals. While some responsibility may lie with individual decision-makers or those gathering information in response to specific IFDs, the case highlights a systemic challenge, whereby at the time IFD referrals were routinely linked to open Early Help episodes regardless of the circumstances or level of detail contained within the referral. This occurred despite Early Help being open to only one of the children, creating a risk that wider concerns could remain unaddressed if satisfactory follow-up was not achieved within the existing Early Help framework. Early Help remaining open post intervention with the eldest child to explore if further support would be consented to from mother allowed the initiation of further IFDs to be linked to the episode. Without the open episode, these concerns may have been followed up and acted upon by IFD directly and decision regarding overriding consent and non-engagement made more swiftly …Engagement continued to be framed primarily as a practical barrier rather than being fully recognised as a risk indicator. The longstanding difficulties in engaging the family, evident from at least 2021, became an established feature of the case and may have contributed to a degree of professional habituation. This, in turn, may have limited the extent to which more direct and challenging conversations were held with the family …'*.

[5] a) Neglect and Serious Case Reviews, A report from the University of East Anglia commissioned by NSPCC Marian Brandon, Bailey, S., Belderson, P, Larsson, B., University of East Anglia/NSPCC, 2013; b) Child safeguarding Practice Review Panel, Protecting all vulnerable babies better, National review into the broader safeguarding issues raised by the death of baby Victoria Marten, 2026; c) Child Protection in England: National review into the murders of Arthur Labinjo Hughes and Star Hobson, May 2022, Child Safeguarding Practice Review Panel.

In addition to this, the Early Help Service also note, *'… Thresholds were generally applied appropriately in response to the first two IFDs, with decisions proportionate to the information available and the absence of a single acute safeguarding incident. However, as further referrals were received, the approach became less effective in identifying cumulative risk … Anonymous referrals were afforded limited weight and at the time routinely linked to existing Early Help episodes without sufficient reassessment of threshold in light of the family's history …'*

These findings are reflected in the results from the audit completed on Family 5 with comments,' … *concerns relating to domestic abuse were raised as early as 2021, with further referrals in 2022 during pregnancy. Despite the escalation in vulnerability at these times, these referrals did not result in a Child and Family Assessment. It was not until the referral in November 2022 that an assessment was initiated, leading to escalation to a Child Protection Plan in January 2023 ... Following a lengthy period of intervention (23 months), the case stepped down to Child in Need in December 2024 and subsequently closed in July 2025. However, within three months of closure, significant concerns re-emerged (November 2025) … The application of threshold at IFD was incorrect in a number of the earlier contacts reviewed, and statutory intervention was required earlier …'. And for Family 6, '…Referrals were made in a timely and frequent manner; … responses were not consistently timely or proportionate to the … risk identified. From December 2023 onwards, multiple multi-agency referrals consistently highlighted significant safeguarding concerns, … Despite this, a number of referrals resulted in No Further Action at MASH stage, indicating inconsistent professional curiosity in IFD …'.*

The processing of information at the Front Door is a critical stage in the process of responding effectively to children in need of help, support or protection[6], and these findings do highlight the need for consistency.

4. A professional focus on one child (practice & practice knowledge + systems & processes):

Practitioners that worked with the Jabril children spoke generally about sometimes feeling overwhelmed when working with large sibling groups and a chaotic home environment and home visiting experience; unwittingly creating a practice trap, whereby it is easier to focus on one child for whom it might be easier or more convenient to engage with. The Early Help Service highlight a strong narrative about the work undertaken with the eldest child, which it seems did recognise and acknowledge risks, neglect and vulnerability but did not result in a holistic consideration of all the children's needs over time. They comment, *'… TAF meetings and Early Help panels were used to share and review concerns raised by schools and other professionals, particularly in relation to attendance, behaviour, health needs and parental engagement. … At an individual level (for the eldest child), this work was effective. Early Help developed a strong understanding of his emotional wellbeing, relationships, behaviour and school experience, and intervention contributed to measurable positive change …*[however] *… Thresholds were generally applied appropriately in response to the first two IFDs, with decisions proportionate to the information available and the absence of a single acute safeguarding incident. However, as further referrals were received, the approach became less effective in identifying cumulative risk … Anonymous referrals were afforded limited weight and at the time routinely linked to existing Early Help episodes without sufficient reassessment of threshold in light of the family's history … Across the wider family system, Early Help's ability to identify and escalate neglect was more limited. …*

[6] Ofsted, Getting the 'front door' right for children and families, June 2025, Ofsted blog post

Engagement difficulties were often treated as a practical barrier rather than consistently recognised as a risk indicator, despite a clear pattern of non-engagement evident since at least 2021 …'. The Early Help Service note that '*… Environmental concerns raised through multiple IFDs (June 2024, August 2024, October 2024 and April 2025) did not consistently prompt a coordinated reassessment of threshold, particularly when access to the home could not be achieved. … Although no single referral clearly met safeguarding thresholds during much of this period, the accumulation of indicators relating to educational neglect, deteriorating home conditions, health impacts and parental stress was not recognised as cumulative neglect until a late stage. … Within a household of multiple children, including under-fives, … environmental pressures were likely to intensify more rapidly than in a smaller family setting, increasing the cumulative impact on living conditions …'*. They comment that '*… Step-down decisions, including the December 2022 transition from statutory services to school-led TAFs, were consistent with threshold guidance at the time … Contributing factors included IFDs being routinely linked to an open Early Help episode focused on one child …'*.

These findings resonate with the audit completed for Family 1, Family 2, and Family 3, with comments, '*… The focus appeared to be on the older two children, whose behaviours were most notable throughout the casefile …EHAs and TAFs completed have tended to focus on the 'here and now' and predominantly on the children with the most visible presenting need rather than the sibling group as a whole; e.g. the EHA received in April 2023 heavily focused on T. This has meant a chronological picture of concerns was not immediately clear …'*.

The findings of this review are reflected in research[7], which reminds us that children in large sibling groups are often not seen as individuals within the family, and that neglectful care of an older child can be seen as a warning sign about the type of care given to younger children, or a new baby.

5. Parental self-reporting and working with consent (practice & practice knowledge):

It is evident that there was an over reliance on parental self-reporting in respect of the work with the Jabril children, and the use of the TAF approach rather than considering a different framework or lens, coupled with a persisting sense of over-optimism (and therefore sympathy bias). This was despite evidence clearly indicating no change or increasing concerns for the Jabril children e.g. ongoing non access, late or non-attendance, increasing anonymous concerns and escalating school worries, not knowing enough about the mother's drug use. There was also an over-reliance on voluntary parental involvement. Plans (CiN and Early Help step down plans) did not set clear, measurable targets for home conditions, routines, appointments, and attendance, nor track the youngest children's development and parental accounts of improvements were accepted. There were prolonged periods with no meaningful access to the home, despite repeated red flags about hygiene, mould, flies, and possible substance misuse. When access occurred, the observations were surface level and did not address basic care domains. As a further insight into the contacts with the Jabril children, the challenges of engagement were common, with one Parenting Practitioner reflected on attempts to work with the family, stating: '*… I made a number of visits to the flat to try to engage and begin the sessions, but there was no response. This was discussed with mum, and we agreed to start with three one-to-one sessions as a way of getting a foot in the door and building trust and momentum. Despite follow-up calls and liaison with the school, we were unable to secure engagement or meet with mum outside of the TAF meeting. We couldn't gain access to the home and communication with mum about this support then stopped …'*.

[7] Neglect and Serious Case Reviews, A report from the University of East Anglia commissioned by NSPCC Marian Brandon, Bailey, S., Belderson, P, Larsson, B., University of East Anglia/NSPCC, 2013.

The Early Help Service is a consent-based service; the withdrawal of consent by the mother brought the intervention to an end and limited the ability to progress further planning or contingency arrangements through Early Help or Social Care as a proportionate response. Learning from this set of episodes highlights the importance of recognising, through good quality supervision, when parental views are being relied on to inform decision making, but also that not gaining access to the family home, failed appointments or not brought to appointments, and withdrawal of parental consent may indicate greater risks to the children's welfare, and need escalating, rather than closure.

Additionally, there is a need to consider the ages of children and whether they have competence to be able to provide their own consent to engage, and work with professionals, rather than relying solely on parental consent.

These findings resonate with the audit completed on Family 4, and discussions during the moderation meeting.

The issue of consent remains a challenging area of practice, having been shown over many years[8] 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[9] 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 …*'. Current Government information sharing guidance[10] 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 …*'. One 'golden rule' of the seven provided through recently updated Government guidance[11] 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 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.

[8] 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.
[9] 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.
[10] Information Sharing Advice for practitioners providing safeguarding services for children, young people, parents, and carers May 2024, p. 12, HM Government.
[11] Information Sharing Advice for practitioners providing safeguarding services for children, young people, parents, and carers May 2024, p.4, HM Government.

6. The use of assessment tools to gather information (practice & practice knowledge + systems & processes):

It is evident from information submitted that in 2024, as an example, the level of concern fluctuated for the Jabril children. Assessment tools completed routinely in respect of the eldest child, such as the Youth Outcome Star, indicated evidence of positive change, including improved emotional regulation, reduced conflict, improved school engagement and strengthened relationships in and out of school. However, this assessment was completed in isolation of understanding the wider family context and the whole sibling group. Children's Social Care comment, '*…The absence of a structured neglect tool applied over time meant change was not measured, and deterioration was normalised. The safety planning did not identify safe adults, role of fathers, or contingency if the primary carer's mental health or substance misuse worsened …*'. The Graded Care Profile 2 neglect assessment tool (GCP2) was used once, but the findings of the assessment did not consider the history of information already available (linked to recognition of cumulative harm), thereby resulting in an assessment exercise that was conducted, and held, in a vacuum of information. Important factors such as daily care, hygiene, and routines for all children in this family were not tested by any one single agency. The completion of a GCP2 assessment by the Early Help Service was constrained throughout the period of service involvement due to consent limitations. Consent for intervention was provided in relation to only the eldest child, which therefore restricted the scope of both assessment and intervention activity that could be undertaken.

Children's Social Care note the presence of confirmation bias from earlier interventions and tools used i.e. a past GCP2 not highlighting concerns and appeared to temper later decisions about intervention with the Jabril children, despite contradictory evidence from schools, housing and anonymous reporters, along with it just being used once. The drift toward '*attendance problems*' becoming the narrative was also noted, yet not assessed, but resulted in an increased risk tolerance, which then normalised neglect.

Cambridgeshire Community Services considered their total involvement with the Jabril children, and also comment about the limited use of assessment tools or ways of gaining information, '*… the family were supported under a Child in Need (CIN) Plan and through both the Team Around the Family (TAF) and Team Around the Child (TAC) processes. Although multiple meetings took place, it became increasingly clear that the mother was struggling to meet the needs of her children. When these unmet needs were identified, professionals did not fully explore with the mother the underlying reasons, barriers, or challenges she was experiencing. … the TAF/TAC meetings did not consistently provide an environment that supported constructive professional challenge or the raising and escalation of health-related concerns. This was due to the inconsistent engagement by mother; the meetings were held virtually or at one school and therefore all the children were not always seen and their voices captured … There was no completed family chronology … There was limited use of the "A Day in the Life" tool … There is some evidence that the GCP2 was initiated by health and education as an action from the TAF/TAC; however, its completion was delayed due to lack of access to the family home. The subsequent decision made at the TAF/TAC that the full assessment was no longer required, this was agreed as all other sessions were satisfactory. This decision was premature, due to there being no evidence of a demonstrable or sustained positive change within the household … Although two of the children were identified as obese, there was no evidence of coordinated multi agency action, such as referral to the GP or wider system partners. … the advice provided by the hospital dietitian mirrored previous guidance that parents had not implemented … Although obesity was raised within TAF/TAC meetings, advice remained unchanged despite a lack of progress, and the level of obesity indicated a need for a more specialist pathway than the support being provided …*'.

These findings reflect audit results on Family 1 and Family 6, with comments, '…*Because structured tools like GCP2 were not used, it was harder to clearly show or measure neglect over time …*'.

Given that a core task and requirement of key agencies is to assess need and risk, the use of a structured tool to help such an assessment must be viewed as a necessary requirement, especially when working in a wider context where levels of deprivation (see section 5 below) are high. Clear expectations, coupled with training and support, must be placed on practitioners to use agreed assessment tools[12].

7. Multi-agency collaboration and information sharing (systems & processes + leadership & culture):

Information provided by the GP Practice for the Jabril children highlights that they had limited contact with individual members, and whilst they were not aware of concerns about neglect, they were informed about issues such as missed childhood immunisations, maternal and paternal physical and mental health issues which would have impacted parenting capacity, and the children's obesity. There is no information to indicate that they were aware of any other agency involved, for example, Children's Social Care or the Early Help Service, nor that they were invited or involved in assessment or planning activity to support the family. The GP Practice, which is small and busy, have also highlighted the need for further training about how to recognise and respond to neglect.

Two of the younger children started at Nursery School 1 in September 2024 and September 2025 respectively. During a home visit by the Nursery School in September 2024, home conditions were described as a little unclean (sticky floors) and crowded with piles of washing, and the two youngest children were dressed, but asleep on the sofa. Staff shared this information at a TAF meeting, and were advised that the washing machine was not working and efforts were being made to find another one.During one episode, one child's attendance was reported at 54%, as the mother reported that she was struggling to wake her in the mornings to attend the Nursery. In December 2024, the session was moved to the afternoon to accommodate this however this did not have a positive impact as expected and her attendance dropped. The Nursery School have confirmed that, despite being involved with the Team around the Family for the Jabril children, they were unaware of the historical concerns relating to neglect until December 2025, some eight months after they have been removed from the mother's care and placed with the father. This finding reflects a serious failure to share relevant information with key professionals who were well placed to gain a good understanding about the youngest children's day to day experiences.

In terms of multi-agency collaboration about the Jabril children, Children's Social Care comment that although schools consistently communicated concerns, multi-agency information was not '… *synthesised into a shared risk picture … the TAF lacked structure, measurable outcomes and escalation triggers … Health concerns did not prompt joint visits … Police information was incomplete or not obtained, limiting risk analysis … repeated concerns from different agencies were not triangulated …*'. Against the multiple factors set out above, the situation for the Jabril children went further unassessed despite the children being removed from their mother's care, '…*Placement with father has appeared to rely on availability, not a completed assessment …* [with there being] … *no evidence of a full parenting capacity assessment … limited understanding of his home environment … unclear analysis of historical domestic abuse …* [and] … *no structured safety plan …*'.

[12] Calder, C., Contemporary risk assessment in safeguarding children, 2008, Russell House Publishing.

Findings from the audit completed on Family 1, Family 2 and Family 6 resonate with the above findings, with some positive comments in respect of F*amily 1, '…All professionals involved in the TAF plan are working together to formulate a plan of support. Each professional has actions to support the family and have made onward referrals where needed …'*. Additionally, comments in respect of Family 2 are noted, *'…Delay in minutes/plan from core groups being received, Health Visitor expressed how vital this was for the parents …* [and] *… The history of domestic abuse has not been added to the RiO alert or to the category of abuse, which limits the visibility of significant risk factors. In addition, a copy of the current Child Protection Plan and core group minutes were not found within the record or requested from the Social Worker … The RiO record shows that there was good communication via phone and email with both Children social care and education. This supported a coordinated approach to understanding the concerns and ensuring that all involved were kept informed. The documented communication reflects positive partnership working aimed at promoting the child's safety and wellbeing …'. And, finally, comments in respect of Family 6 are relevant, '…multi-agency working has improved over time. In the early part of the case, communication between agencies (such as Police, Health, Probation, and Social Care) was not always clear or joined up. This meant while information was shared it was sometimes not fully used … [now] … multi-agency working is now stronger than it was earlier in the case, especially since the Child Protection plan started. Agencies are working more closely and sharing information more effectively …'.*

These results appear to reflect findings made in the 2023 Joint Targeted Area Inspection[13], which noted variability in the quality and effectiveness of the multi-agency response; citing *'…Children and their families are able to access a wide range of effective universal and targeted early help support in Bedford. … Children referred directly to the early help hub receive a timely response to requests for support. …* [but also] *… When partner agencies send a contact about a child to the IFD, information about some children's needs is of a poor quality and does not always contain sufficient detail to support well-informed decision-making. … Children do not always benefit from collaborative discussions in the IFD involving all relevant agencies to assess their early help needs and risks and to agree next steps … Management oversight of children subject to long-term neglect needs to improve, to ensure that the cumulative risk to children from long-term neglect is identified …'*. Ensuring consistency of approach by all agencies within the Partnership will be an important area to remain focus on.

8. Being efficient when working in a multi-agency context (systems & processes):

Multiple practitioners were involved with the Jabril children, which diluted ownership of whole family assessment and drifted focus away from the youngest children's basic care. Secondary School 1 for one of the older children, comment on the number of professionals and agencies involved in meetings, with 10 professionals attending one meeting, and 7 sending their apologies, reflecting that, *'… the sheer number of professionals would make managing the dynamics and the monitoring of professionals difficult … and not sustainable ... There was appropriate professional curiosity evident, but the number of agencies meant collating and sharing this information needed to be robust …'*. This point closely links to the general point made by practitioners attending the multi-agency workshop, about often feeling overwhelmed when working with large sibling groups.

[13] Ofsted, Joint Targeted Area Inspection, Bedford, March 2023.

Gaining insights about the number of professionals that might be involved with any one family, was not a specific question asked in the six audits completed, and as such has only been explicitly raised as an issue during review of the Jabril children. However, it was raised verbally during the audit moderation session and it would not be unreasonable to extend this finding, as a challenge for the professional network, when working across all large sibling groups. It is likely to be a finding that is only applicable to circumstances involving large sibling groups with a diverse age range, or situations which are especially complex needing a greater range of professional input. This highlights a potential need for the Partnership to think about how it supports busy practitioners to manage more complex scenarios, and be creative in how, for example, it might use professional time to effectively pool, channel and communicate information, use lead practitioner roles, and generate efficiencies without losing the focus on each child within a larger sibling group. The inability of the professional network to coordinate themselves and work efficiently should not be the reason children's welfare is compromised.

9. Being professionally curious, challenging & escalating (practice & practice knowledge + systems & processes):

Information and discussions confirm there was no effective challenge or escalation by any agency working with the Jabril children that resulted in a change of direction; for example, no escalation or curiosity about persisting non-attendance at school despite schools repeatedly signalling deterioration and lack of engagement, and no escalation or curiosity about continued missed health appointments or the older children potentially taking on caring responsibilities towards their young siblings or mother. Cambridgeshire Community Services comment on the lack of challenge and escalation by professionals about step-down decisions despite ongoing concerns, and the high turnover of staff resulted in multiple practitioners being involved, which contributed to a lack of continuity for the family. This often resulted in work not being coordinated with there being minimal evidence of joint working between the Health Visiting and School Nursing Teams, with limited shared consideration of risk or collective professional curiosity. This contributed to missed opportunities to identify the emerging and sustained neglect, as well as case drift.

For schools, it is evident that each knew – to varying degrees – about the wider concerns for the Jabril children, and each were providing considerable support. For example, Secondary School 1 offering the eldest child with support for his mental health through school counsellor sessions, or First School A contributing to the GCP2 assessment with health colleagues in November 2022, or multiple referrals by school for support from outside agencies i.e. Salvation Army Debt support, Relate. Schools cite timely and effective information sharing with other agencies. However, the multi-agency practitioner session for those working with the Jabril children confirmed that the critical aspect that was lacking from their overall contributions was the lack of professional challenge and escalation given that changes and improvements in the children's lives were negligible.

These findings are supported by results from the audit in respect of Family 1, Family 2 and Family 3, with comments about Family 1 from Children's Social Care, '*…Overall, the right processes were used, but they did not always lead to lasting change. The quality of management oversight is being questioned. Greater challenge and clearer direction from management may have supported earlier decision-making and more effective planning. Despite ongoing risks and limited progress, the case remained at the same level for an extended period, indicating insufficient challenge and a lack of adaptation in approach …*'. Positive comments relating to Family 2, '*…Excellent use of professional challenge to ensure the risks are fully known …*'. And, from the Family 3 audit, '*…While School has demonstrated consistent professional curiosity, persistence, and significant efforts to engage both the child and family, this has not been matched by sufficiently effective or coordinated multi-agency action …*'.

While findings are mixed on this issue, with positive examples of professional curiosity being cited above, results are also indicative of professionals operating in a pressurised environment – busy, working with competing demands and needing to prioritise – often then resulting in reduced professional curiosity[14], and potentially a reluctance to formally challenge and escalate. This is an issue examined below in paragraph 5.8 concerning emergence and trade-offs.

10. Consistency of thresholds, risk assessment and decision making (practice & practice knowledge + systems & processes):

Children's Social Care provide a pithy summary of gaps identified in work with the Jabril children, '*… Risk, neglect and vulnerability were identified repeatedly by partner agencies, but Children's Social Care did not respond with timely or proportionate safeguarding action. Thresholds were applied inconsistently, cumulative harm was not recognised early enough, and step-up decisions were delayed by an overreliance on TAF and Early Help. Single and multiagency communication highlighted clear deteriorating conditions, yet decision making often minimised these concerns as attendance or engagement issues …*'. They go on to reflect that '*… Schools, health and anonymous reporters provided consistent indicators of neglect, including: Children described as dirty or unkempt, repeated missed health appointments, children falling asleep in school, older siblings caring for younger children, concerns about housing conditions, mould, flies, clutter and inaccessible bathing facilities, possible substance misuse by mother, reports of children being left alone, parental mental health concerns and domestic abuse history. These concerns were documented but not consistently analysed as neglect within a large sibling group …* Most contacts were assessed in isolation. Risk was framed as attendance or non-engagement, rather than evidence of poor caregiving, unsafe supervision or unmet health needs. The absence of chronologies being actively used in decision making meant escalating patterns were not recognised …'. Analysis and discussions highlight a system and process issue, that most IFD decisions for this family were RAG (red, amber, green) rated 'green', '*… At the time, anonymous contacts were frequently RAG rated green. On review, and in line with current expectations, these should have been amber with multiagency input in decision making and manager oversight to consider S17 threshold for C&F assessment … Step-up only occurred once housing raised serious concerns about 'knee-deep mess', inaccessible bath and potential children being unclothed in the property. By then concerns had accumulated for over two years. This reactive approach limited earlier intervention opportunities …*'.

Police involvement during the review timeframe however demonstrates clear, timely responses to safeguarding concerns for the Jabril children, particularly in relation to the management of a large sibling group experiencing chronic neglect. Officers consistently undertook immediate risk assessments at the point of attendance, used body-worn video to evidence home conditions, and escalated concerns appropriately to Children's Services. In the April 2025 removal episode, Officers demonstrated effective decision-making by recognising significant environmental neglect—including faeces on floors and walls, blocked toilets, no food, and children unwashed - and using Police Protection Powers to remove all five children for their safety. Officers contributed relevant information through safeguarding reports, pre-assessments of children, and evidence sharing with social care. Police records show that the mother's previous caution for neglect in 2020 was known and factored into the assessment of risk during later incidents. The decision-making around placement with the father was informed by immediate checks and information gathered at the scene, with pre-assessments conducted for the older children at the father's address helping to inform early multi-agency planning.

[14] Burton, V., & Revell, L., Professional Curiosity in Child Protection: Thinking the Unthinkable in a Neo-Liberal World, The British Journal of Social Work, Volume 48, Issue 6, September 2018, Pages 1508–1523,

These findings are supported by the results of the audits of Family 1, with comments noted,

'… Decision making has mostly matched the risks identified for the children, with appropriate use of Child Protection Plans and escalation to PLO when concerns increased. This shows that professionals recognised risk and took action at key points. However, the response has not always been timely or effective enough. As a result, the children have not always received help in a timely way that led to lasting change. The case shows a repeated pattern of short improvements followed by a return of concerns. The possibility of chronic neglect has been identified … but it was not always fully recognised or responded to early enough. The long-term and repeated nature of concerns suggests that neglect was ongoing and cumulative, rather than short-term incidents …'. And from the Family 5 audit, *'…The pattern of closure followed by rapid re-escalation demonstrates that decision-making has not sufficiently accounted for chronic neglect and the need for sustained intervention …'*.

Results set out above, in respect of consistency of threshold decisions, resonate with the findings made by Ofsted[15] in 2023.

11. Gaining and using children's views to inform decisions (practice & practice knowledge):

Children's Social Care consider their involvement with the Jabril children, *'… Children's direct experiences were rarely gathered. The agency relied on school descriptions rather than direct observations, home observations and developmental (concerns) …'*. They go on to comment about how well they understood and knew of the Jabril children's day to day experiences, '… [we] *had limited knowledge and understanding of the children's lived experiences, because their voices were not consistently sought, captured or analysed. Most information about the children came second hand from schools, Early Help or anonymous reporters, rather than through direct engagement. As a result, the children's day to day experiences of neglect, care routines, emotional safety and home conditions were not fully understood and did not sufficiently influence decision making. In current practice this remains an area of weakened practice and improvements are required … School staff repeatedly described concerning behaviours such as one child falling asleep in class, appearing exhausted and not wearing glasses and the eldest child saying he was tired, angry, punching walls, caring for younger children and aware of family money problems …* [yet we] *… largely relied on the school's narrative rather than capturing the children's own accounts …'*.

Comments are also provided about the direct work with the eldest child, *' … the five 1:1 session with him between late 2024 and early 2025 … while valuable, this work focused solely on one child and did not explore his caregiving responsibilities, concerns about conflict at home (again following a thread of domestic abuse which has been referenced since 2020 but not followed up on) or the broader neglect indicators raised earlier. There is no evidence that the other children were spoken to directly about their experiences. … It is recorded that the eldest child disclosed that people were 'always arguing at home' and that he punched walls or broke things. This information was not used to assess emotional harm, parenting capacity, risk of escalating domestic abuse or family functioning. This was not explored through the lens of mother's substance misuse as a form of coping. Similarly, younger children's behaviours were not captured or analysed, despite being repeatedly described as unkempt or tired ...'*.

[15] Ofsted, Joint Targeted Area Inspection, Bedford, March 2023.

The Early Help Service have reflected on the individual work completed with the eldest child, the only child in the sibling group where Early Help had consent from his mother to progress work, '*… use of his voice was strong when the intervention started. From the commencement of Solution Focused BRIEF Intervention in school (November 2024 - January 2025), his day-to-day lived experience was explored in depth using structured, evidence-based tools. …* [it included] *… the completion of a Youth Outcome Star assessment in the first session, providing a baseline understanding of his emotional regulation, behaviour, relationships and wellbeing, regular use of scaling tools, enabling him to articulate how safe, calm and settled he felt over time and to define what change would look like for him, and a detailed exploration of his preferred future, including daily routines, school engagement, family interactions and peer relationships, which provided rich insight into his lived experience at home and in school …*'. They cite his 'best hopes' of wanting to be 'in less trouble' and 'less angry', '*… to wanting to feel calm and relaxed at both home and school. He was able to describe how change would be noticed by himself and others, including calmer interactions with siblings, improved tone of voice, better timekeeping and more positive engagement with school staff … he consistently shared examples of his daily life, including: reduced arguments within the family and a calmer home environment, improved emotional regulation and ability to step away from conflict, positive peer and romantic relationships, improved attendance, punctuality and ability to remain in lessons, pride in practical contributions at home, such as fixing devices and supporting the household …*'. The Early Help Practitioner interviewed, reflected on their involvement with the eldest child during this latter part of the time frame under review, '*I was genuinely surprised when I met him. He opened up in sessions and was fully engaged. I remember him presenting well, with no concerns around hygiene or any evident difficulties. He was easy to work with and did not raise any barriers or worries. He came across as emotionally intelligent. He spoke frequently about his girlfriend, which was clearly a significant part of his life at that time*'. The Service notes that despite the home environment and family dynamics consistently being explored during sessions, he did not disclose worries about feeling unsafe at home or concerns about his care. The Early Help Service reflect on the wider context, '*… Ongoing difficulties in engaging the family over a four-year period meant that the later phase of consistent and productive engagement with the eldest child, while clearly positive, may have unintentionally reduced professional focus on wider, underlying concerns within the household. During this time, he did not raise concerns about home life, despite being regularly reviewed during a period in which the home environment was progressively deteriorating …*'. Usefully, they comment on potential factors that might have contributed to professionals becoming distracted from the day-to-day experiences of his siblings, '*… the eldest child was spending time between his mother's and father's homes during this period, which may have reduced his exposure to, or perception of, difficulties within the primary household. Additionally, he may have become accustomed to fluctuations in the home environment over time …, where conditions moved between manageable and significantly poor, resulting in a normalisation of these circumstances and reduced awareness of deterioration. It is also possible that he chose not to raise concerns due to an awareness of the potential consequences of services becoming more involved and protecting his mother and family …*'.

Secondary School 1 for one child noted, '*… His worry for his siblings and them going into foster care. Him missing his mother and him explaining how she has no money at the moment, so it is hard for them to meet. He also said that social workers have exaggerated the condition of his house and it isn't that bad, a bit untidy but that's normal. He also shared about how he was bullied in his previous school and that some people at school had made comments about his appearance and him looking like a girl. He shared how much he hates PE and doesn't like eating in front of people. He finds crowds overwhelming and he struggles to understand and hear the teachers in classes. Discussion was had about his hearing aid being broken and it being fixed….*'.

Cambridgeshire Community Services reflect on their contact with the children, noting, '*… A review of [records] shows minimal use of the 'Day in the Life' tool with the children. … Two of the children were overweight and receiving increased growth monitoring; however, there is little evidence that professionals explored how their weight and size were affecting their physical or emotional wellbeing. The children frequently presented at school in dirty clothes, without necessary equipment, and with an unpleasant odour. There is no recorded evidence that professionals explored what this felt like for the children, the potential impact on their self-esteem, or how this may have hindered peer relationships…*'. In respect of the eldest child, '*… he was frequently noted to be defensive regarding his mother and home conditions, which may have increased his stress levels and affected his relationships with professionals due to the pressure he felt to protect his mother. He later disclosed suicidal thoughts and brought a knife into school. This information was given to the School Nurse as a case update.* [Records] *not show what the school actions were or if these disclosures were explored further by the school nursing team …*'. In respect of another child, '*… he frequently attended school without his glasses, further affecting his ability to learn. He was also repeatedly not brought to Audiology appointments. Professionals are now aware that he has moderate to severe hearing loss, and, alongside suspected/diagnosed autism, this would likely have negatively affected his social and emotional wellbeing and overall development. Although missed Audiology appointments and forgotten glasses were discussed within TAF/TAC meetings, the impact on his daily life, learning, or emotional health were not fully included considered within this forum …*'.

These findings are supported from the results of the audits completed for Family 2, Family 5 and Family 6, with comments, '*…More structured and purposeful direct work with the children would help to better understand their lived experiences and make sure their voices are fully heard …*[and] *… Child A is taking on too much responsibility for her siblings and feels like she has to help care for them. This is affecting her emotionally and she has had time off school due to feeling low and overwhelmed …*'.

The meaningful participation of children and young people in decisions that affect their lives is a widely recognized principle in international human rights. It is firmly grounded in Article 12 of the UN Convention on the Rights of the Child, promoting every child capable of forming their own views has the right to express those views freely, and that those views are given due weight in decision making. Results show a variable picture about how successful this has been achieved across the group of children reviewed and audited, with some good examples cited, alongside less successful and limited instances. This will be an area that the Partnership will wish to consider, potentially through further audits across a range of other areas of intervention.

12. Assessment of culture and intersectionality (practice & practice knowledge + leadership & culture + wider service context):

Children's Social Care provide a candid account of how effectively cultural and intersecting factors were considered in respect of the Jabril children, given the family comprised of children with different fathers, likely different cultural identities and norms, '*… cultural, racial, family-identity and intersecting factors were not meaningfully recognised or used to inform assessment, planning or decision making … with limited … evidence of: cultural exploration, genogram use, consideration of ethnicity, faith or gender roles, analysis of parental background and its impact on caregiving, consideration of protected characteristics for the children, power and control dynamics in the parental relationship given the underlying domestic abuse … views of women and the mother's substance misuse …*

There is limited evidence of community-based support being considered … There were clear gendered patterns in the children's experiences, particularly the eldest child taking on care of younger siblings and showing behavioural distress linked to this. However, this was not analysed as an equality or vulnerability issue and there was no recognition of the inappropriate care responsibilities in assessment or planning and no analysis of the emotional labour within the large sibling group. This gap weakened understanding of lived experience for each child. … Despite repeated concerns about hearing, eyesight, tiredness and missed health appointments, the children's health-related vulnerabilities were not analysed as potential disabilities or additional needs. Chronically unmet health needs were treated as 'engagement' issues, not as signs of vulnerability requiring specialist input …'.

The Early Help Service note a mixed account of how effectively cultural and intersecting factors were considered in their work with the Jabril children, stating that, *'… cultural and intersecting factors impacting the children's lives were recognised to some extent, though they were not always explicitly drawn together to inform planning and decision-making. Practice tended to focus on presenting and observable concerns such as attendance, behaviour, engagement and housing conditions. … There is limited evidence of genograms being used routinely … Consideration of family culture in relation to race, ethnicity, faith and identity was not consistently documented; however, this does not necessarily indicate that such factors were absent or overlooked in practice …'.* The Early Help Practitioner stated *'We did talk about race, faith, and identity in sessions with the eldest child. It wasn't the main focus, as he led the conversations, but we checked in on these areas and adapted our approach based on what he shared' …'*. They comment that, *'… Other intersecting factors including a large sibling group, the presence of younger children, housing disrepair, seasonal pressures, parental capacity and patterns of engagement were generally identified but tended to be considered individually rather than cumulatively. This may have limited practitioners' ability to recognise how the interaction of these factors increased stress within the household and contributed to emerging neglect. The eldest child's positive presentation, emotional insight and engagement also appeared to act as a protective factor, which may have reduced professional focus on wider household risks during this period …'.*

Findings made by Cambridgeshire Community Services reveal a similar theme to that found by Children's Social Care, in as much of there being no evidence of how cultural and intersecting factors were considered and used to inform interventions. They note, *'… Although the children are recorded at various contacts as being 'mixed White and Asian or 'mixed White and Pakistani', this information is presented with no accompanying analysis or consideration of what these identities may mean for their lived experiences. Similarly, while the family is noted to have English as their primary spoken language, there is no further exploration of cultural norms, expectations, or potential influences on parenting … The three oldest children share one biological father, while the two youngest share another. However, there is no reference to how having two paternal relationships may impact the family dynamic, nor any exploration of whether the extended families share the same faith, cultural background, or community networks. These factors could have provided valuable insight into the children's sense of identity, belonging, and support systems …'.*

From their limited involvement the Police consider how effectively they considered cultural and intersecting factors for these children, commenting, '*… Police records contain limited reference to cultural, religious, or identity-based factors influencing family functioning. There is no evidence that cultural dynamics, ethnicity, or faith were raised as barriers or considerations in police assessment or decision-making. The Officers' focus was appropriately directed towards immediate physical safety and environmental neglect. However, the lack of documented genograms or cultural mapping means that intersecting factors relating to blended family structure, paternal involvement across children with different fathers, and the differing care arrangements were not explicitly explored through a cultural lens within police records. While these factors did not impede safeguarding actions, they may have contributed to complexity in understanding family dynamics …*'.

From a school's perspective there was a general consensus that no distinctions were made in respect of differences around race, culture, or ethnicity specifically with the Jabril children and that these factors formed the daily business of their work within a multi-cultural context with all children.

Although their involvement was minimal and never direct, East London NHS Foundation Trust also comment that records contain minimal information regarding the eldest child's culture, ethnicity, faith or wider identity, which as a result, limited opportunity to contribute to the concerns raised by other agencies.

Results from the audit resonate with the above findings, in respect of Family 3, Family 4 and Family 5, with comments, '*…During a home visit … S disclosed a history of domestic abuse across multiple relationships and that she converted to Islam during this marriage. … A My Choice session was completed with S, focusing on identifying healthy, unhealthy, and abusive relationship behaviours. During the activity, S demonstrated difficulty distinguishing between these categories. For example, she identified jealousy as a healthy trait, attributing this view to her religious and cultural beliefs. Despite discussion around trust and appropriate boundaries, S maintained that such behaviours were acceptable within her belief system. …*'. And, from the Family 5 audit, '*…Individual needs and circumstances were partially considered. The October 2025 referral from school recorded that P had been wearing a hijab when she initially started to attend the school. When she stopped wearing it, school staff appropriately explored this change with her to rule out bullying; however, PL gave limited information about her reasons to school. Religion and faith were not further explored within the assessment …*'.

While the findings set out above may be the day-to-day reality of working in a multi-cultural setting, the issues identified through this review do serve as a reminder about the importance of considering the intersecting disadvantage caused by multiple interacting factors, such as cultural norms and expectations about parenting in many families with a mixed heritage – especially in an area where other depriving factors are present. Results do indicate a general picture of race, culture and ethnicity being recognised but only at a more superficial level, lacking in depth of analysis or consideration about intersecting disadvantage. Of relevance in this matter, is the concept of intersectionality - the complex ways in which systems of inequality based on gender, or race, or ethnicity, sexual orientation, gender identity, disability, class, and other forms of discrimination 'intersect' to create unique dynamics and impact.

When layered alongside organisational factors which impact service delivery, the impact on the professional response can be significant. These are explored below by considering how professionals dealt with uncertainty alongside complexity. Recently published research[16] also helps us disentangle some of these contributing features, particularly in relation to race and safeguarding. Whilst these findings link to the need for good quality assessment activity, including using structured tools, the Partnership will wish to think carefully how it supports the workforce to exercise greater cultural competence and cultural humility[17].

13. The assessment fathers/adult males (practice & practice knowledge & leadership & culture):

There was limited knowledge and curiosity around either of the father's involvement with the Jabril children, their capacity to parent, and specifically the father with whom the children were placed with, his home conditions and how he might protect the children - this impacted the effectiveness of steps taken to safeguard the children in 2025. The decision to place with one father appears to have relied on availability rather than a completed parenting assessment with safety planning and support, resulting in a reactive removal of the children from the mother's care, and then prolonged periods without verified home conditions, pre-placement checks, parenting capacity assessment, household conditions, or whole family assessment, as opposed to a planned transition and despite uncertainty about his role and a domestic abuse history. Had a robust multi-agency chronology and assessment been completed, there was arguably, no emergency needed – the father's circumstances would have been known about, his parenting capacity better understood, and the need for crisis driven placement avoided. This was then proceeded by some process and legal uncertainty about whether the children were accommodated under section 20, or a private arrangement, and who was exercising parental responsibility. It has been reported that this uncertainty was linked to poor communication between teams and the lack of clear or strong management oversight and direction at the point of key decision making. Children's Social Care also comment on the children's placement with the father, '*… The children's voices and experiences did not inform the decision to place with father as there was no structured assessment of the children's relationships with him and no recent lived experience information available to guide matching or support planning. This presented risks, given the documented uncertainty about fathers' roles and past domestic abuse …*'.

Although circumstances are not the same, results from the audit reflect similar findings, from Family 2 and Family 4 in respect of not engaging fathers. There is considerable research[18] identifying the importance of seeking the views, and working with, men and fathers. This may be an area of practice that the Partnership wish to undertake further audit to gauge how effectively this happens across other interventions.

[16] Child Safeguarding Practice Review Panel: "It's Silent": Race, racism and safeguarding children, Panel Briefing 4, March 2025.

[17] Greene-Moton E, Minkler M. Cultural Competence or Cultural Humility? Moving Beyond the Debate. Health Promotion Practice. 2020;21 (1): 142-145.

[18] a) NSPCC, Unseen men: learning from case reviews, Summary of key issues and learning for improved practice around 'unseen' men, 2022; b) Zanoni, L., Warburton, W., Bussey, K., McMaugh, A., Fathers as 'core business' in child welfare practice and research: An interdisciplinary review, Children and Youth Services Review, Volume 35, Issue 7, 2013,, pp 1055-1070; c) Research in Practice, Working effectively with men in families - including fathers in children's social care, 2017.

14. The management of transitions (systems & processes + leadership & culture):

Transition points such as stepping up or stepping down interventions for professional contact with the Jabril children, needed to be more robustly managed i.e. evidence-based decisions and handovers that are child focused and multi-agency. This can be seen through the transition of the Jabril children's care from the mother to the father, but also stepping down decisions when there was no tangible or concrete evidence of impact from support or interventions, improved circumstances for the children, or views gained from the children. The transition from mother to father need not have been treated as an emergency, but rather a planned transition based on assessed levels of need.

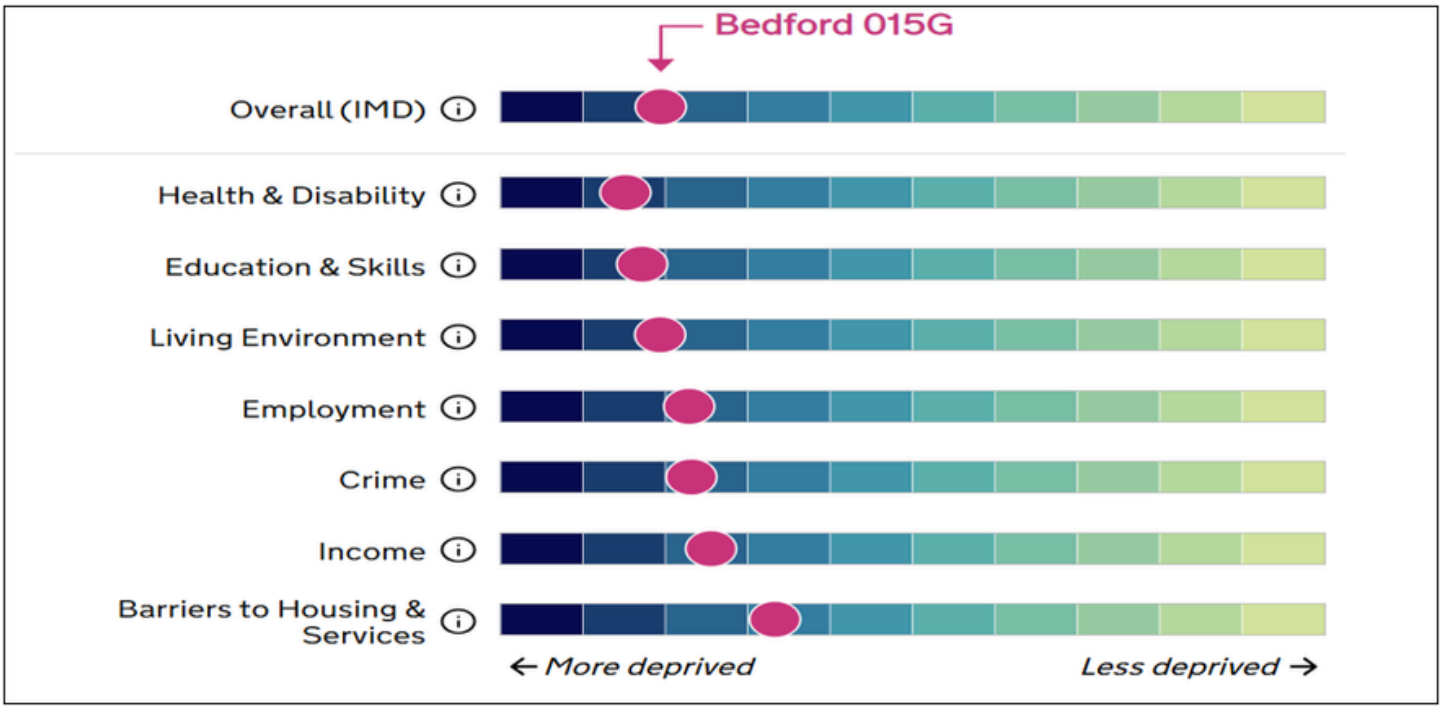
While workforce continuity has been cited as a contributory factor by some agencies, i.e. Children's Social Care and Cambridgeshire Community Services, it was not for all. For example, the Early Help Service worked with the family across four separate episodes over a five-year period and only two practitioners were directly allocated during that time. There was also continuity in management oversight, with only two managers line-managing the practitioners throughout this period. Importantly, children and families will benefit from consistency and continuity to avoid fragmented ownership and inconsistent follow-through on actions.

Findings resonate with the audit results in respect of Family 1 and Family 2, noting '… [these two families] *have been subject to significant changes in social worker allocation, with approximately 24 different social workers involved between 2015 and June 2025. This level of turnover has had a considerable impact on the consistency and effectiveness of intervention …'*. And, Family 3, noting *'…At the time of the assessment, some small improvements to the home environment were noted. However, these improvements appeared to be largely driven and managed by the social worker rather than being sustained independently by the parent. As such, the changes were not embedded or maintained over time. Following subsequent transitions between social workers, this progress diminished. The lack of continuity resulted in reduced oversight and follow-through, and the previously noted improvements were not sustained …'*. And also from the Family 3 audit, transitions for children, not just professionals, being relevant and of concern, *'…There is a deep concern that C, who is due to transition to secondary school in September 2026, may follow a similar pathway of disengagement from education without urgent and effective intervention. … Without decisive and coordinated action, the likelihood of further deterioration and harm to the children remains high …'*.

5.1

The wider service context is important to consider. In terms of the wider service context, data provided by the Government[19] regarding levels of deprivation in Bedford Borough provide important context when examining neglect. Child neglect must be considered in the broader context, and thinking beyond neglectful parenting is necessary, including, for example, the impact of poverty such as financial poverty or deprivation of opportunity – potentially leading to a depressive living context. While this deprivation data must not be used to downplay the practice, systems, process, leadership and culture issues identified through this review, it does provide an essential operating context for local agencies, especially when we keep in mind how neglect may become normalised by professionals due to daily expose. Data shows, *'…Bedford (015G) is more deprived than most neighbourhoods in England; 81% of neighbourhoods in England are less deprived …'*. Also, *'…There are different types of deprivation in Bedford (015G). The neighbourhood selected (MK42 9AP postcode) is most deprived in relation to health & disability. 85% of neighbourhoods in England are less deprived …[and] …Bedford has a higher rate of income deprivation affecting children (IDACI) than most neighbourhoods in England …'*.

Figure 2: Levels of deprivation 2025 (Government data) Bedford, using MK42 9AP postcode



[19] HM Government, English indices of deprivation 2025, How deprived is Bedford MK42 9AP?

5.2

Research[20] 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 …*'. Practitioners involved with the Jabril children and Auditors of the other six families spoke about seeing standards of child care that were not acceptable, but being accustomed to seeing such standards, and knowing that a threshold would not be met for receipt of assessment and support from statutory services. Placing the '*everywhere*' yet '*nowhere*' challenge in context, the Jabril children for example, were living in poor and over-crowded accommodation, had unsuitable sleeping arrangements, had unhealthy diets, had inconsistent school attendance, showed poor engagement with health services, and did not have a working washing machine – all factors that are likely to be representative of deprivation, and which may be commonly observed by professionals working with children and families. Further research[21] supports this, and the challenges faced responding to it, ' *… Across all agencies polled – healthcare, the police, children's social care and education – over half (54%) said they'd seen an increase in neglect cases during their professional life with 90% saying they believed the rising cost of living and poverty rates was a driving factor and 76% saying a reduction in community support to parents was also a key factor in neglect increasing …*'. Additional research[22] does nevertheless, confirm a reality for practitioners, '*…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 …*'.

5.3

Placing the findings and learning within the wider service and operating context is important. Ofsted conducted a Joint Targeted Area Inspection of Bedford in 2023[23] - a joint inspection of the multi-agency response to identification of initial need and risk in Bedford Borough for children and families who need help. While noting a range of many positives and strengths in the systems response to children, findings are relevant to consider in the context of this review, with Ofsted noting, '*…Children and their families benefit from a comprehensive range of universal and targeted early help services in Bedford, and the majority of children have timely early support when they need it. … A lack of capacity by partner agencies in the Integrated Front Door (IFD) results in some children not having a timely response to meet their needs. Not all information about children and their families is requested or shared quickly enough between partner agencies. Neither individual agencies nor the Bedford Borough Safeguarding Children's Partnership (BBSCP) have sufficient oversight of the effectiveness of early help and the IFD …*'. In their more recent inspection of local authority children's services, Ofsted, conducted an inspection[24] of Bedford Children's Services resulting in an overall 'requires improvement' set of judgements.

[20] 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.
[21] NSPCC, Too little, too late: The multi-agency response to identifying and tackling neglect, 2024.
[22] 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.
[23] Ofsted, Joint Targeted Area Inspection, Bedford, March 2023.
[24] Ofsted, Inspection of Bedford local authority children's services, July 2025.

5.3 cont.

They also made findings that are relevant to highlight as context for the findings of this review, '… *When children experience neglect, it is identified and responded to. For a small number of children, there is insufficient understanding of the impact of long-term chronic neglect on children. The local children's safeguarding partnership has appropriately recognised that collectively more is needed to improve the response to children at risk of neglect. … The identification of young carers and their support needs is inconsistent. Some children's needs remain unassessed and the impact of being a young carer is not fully considered …*'. Relevant areas to note for improvement consisted of, '… *Engagement with children's wider family networks … and …. The consistency in the understanding and response to children at risk of prolonged neglect …*'. These judgements help us understand that the local authority Children's Services and wider safeguarding partnership remain on an improvement journey, with an emphasis on ensuring consistency of approach by all agencies. The variability of response is a feature of the contacts with the Jabril children, as well as the six families audited. Examples include:

- The inconsistent use of chronologies/family history by professionals to inform assessment and decision making.
- The variability of how procedures and thresholds are applied when responding to increasing levels of need or risk.
- Being consistent when dealing with parental inconsistency i.e. missing appointments, providing consent.
- Demonstrating consistency, proportionality and timely responses when new information emerges about children, notably at the IFD.
- Reliably and constantly making efforts to gain the views of children, including their daily lived experiences.

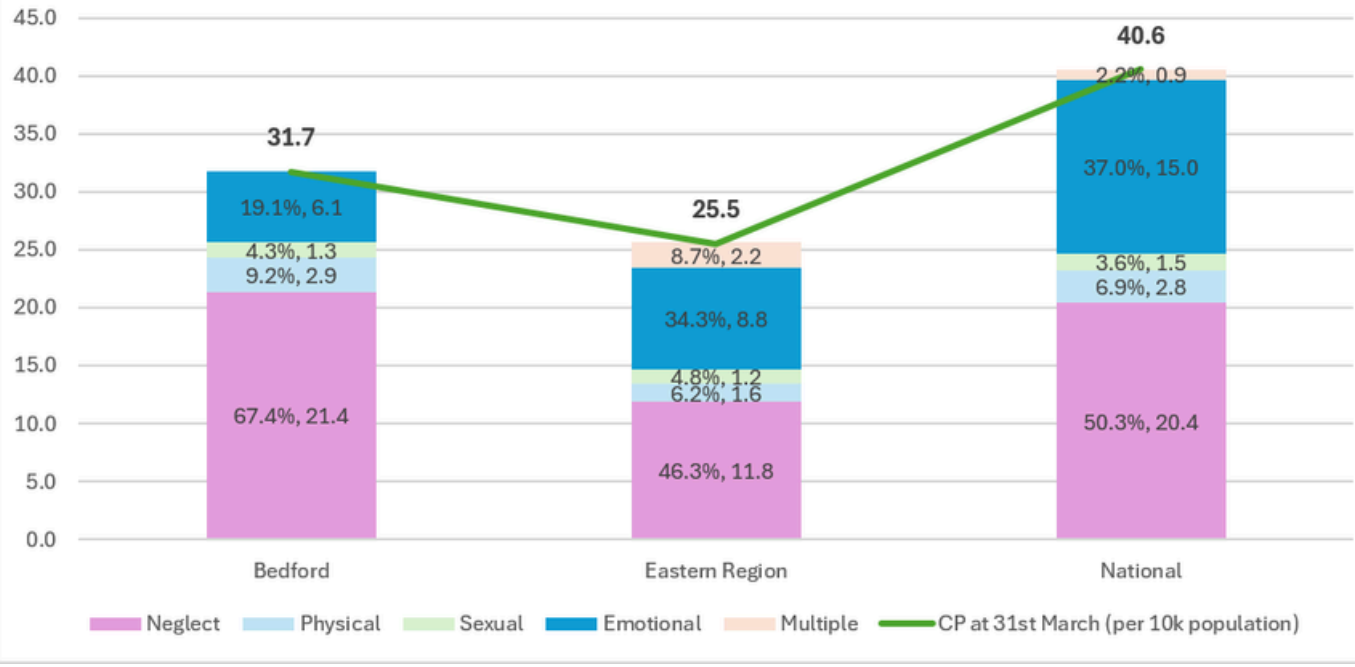
5.4

Bedford Borough Safeguarding Children Partnership form part of the Pan Bedfordshire Safeguarding Partnership, sharing resources and oversight across the region with Luton and Central Bedfordshire. In practice, this means that there is a coordinated strategic approach to the issue of neglect, supported by the Pan Bedfordshire Neglect Sub-Group. The Partnership's website contains a good range of guidance, resources, access to training, and information specifically relating to neglect – all of which appear accessible to those seeking additional information and support. However, discussions with agency Leads as part of this review has raised questions about the efficacy and impact of this pan Bedfordshire approach in terms of the specific benefits to Bedford Borough. Examples such as needing to obtain often long-winded agreement to policy and procedure changes from the three different areas, unwieldy Sub-Group meetings and activity due to the number of representatives attending, and geography often resulting in meetings taking place on-line thereby reducing input were cited as barriers which impacted Bedford Borough's ability to respond to practice, system and process issues that might be more local. The example of the pan Bedfordshire Neglect Sub-Group, which until recently comprised of 45 representatives from across agencies over the three areas, was cited as being ineffective and having limited impact. This forum has recently been subject to review and it is understood that a revised Terms of Reference are being formed – nonetheless, there were still questions being raised during the agency Leads session about how this might add value to Bedford Borough's response to neglect, in the context of resources already being very stretched and services facing considerable demands. The effectiveness of other existing forums was raised during the multi-agency Leads session. Examples of forums that were working effectively with strong governance arrangements and having impact were cited, and included Brilliant Transitions for All, the Designated Safeguarding Leads for Schools forum, and the Early Years Forum. The Partnership may wish to reflect on other forums that exist where a refresh of place, purpose and efficiencies are considered which can have a demonstrable impact of how neglect is identified and responded to as constant thread throughout the safeguarding system and arrangements.

5.5

Bedford Borough Safeguarding Children Partnership has a Strategic Plan (2025 – 2027) which details neglect as one of their strategic priorities, with a number of related actions and objectives. In terms of performance data, we can see from Figure 3 below, neglect is the category of abuse that results in the greatest number of children subject to Child Protection Plans; this reflects the regional and national trend highlighting the challenges for all local authority areas of responding to the different forms of child abuse and maltreatment and re-emphasises the opening quote from recent research conducted by the Child Safeguarding Practice Review Panel.

Figure3: Number of Child Protection Plans by category of abuse (per 10k population) as of 31/03/26



5.6

The agency Leads session discussed the Neglect Strategy, with a consensus that as a Partnership priority and strategic plan it did not translate down to day-to-day practice and that it was unlikely that practitioners were aware of it, or what it meant for them. Review of the Pan Bedfordshire Safeguarding Partnership shows no specific or separate Neglect Strategy, although the Bedford Borough Safeguarding Children Partnership (BBSCP) Strategic Plan 2025 – 2027 does refer to neglect as being a priority area. Discussions with Leads focused on what steps might be needed to make the Partnership's strategic priorities more accessible and translatable to practitioners, so that it created a collective ownership and shared ambition. When considering these steps, the Partnership will wish to think about the collective experiences of the Jabril children, and findings from this review to strengthen the consistency and timeliness of response to children experiencing neglect. Examples for consideration might include, ensuring the multi-agency network has the requisite knowledge, skill and confidence to use assessment tools, such as the GCP2 (and scrutinising its application), expectations about using historical information held to inform planning and decision making, gaining and using the child's voice, joint working arrangements for large sibling groups to aid continuity, contingency and reduce the likelihood of bias, and measures to support practitioners helping them becoming desensitised or immune to unacceptable levels of care.

5.7

A factor strongly voiced during the practitioner session, the audit moderation meeting, and the Leads session was about demand and capacity on individual practitioners, groups of professionals working with a family, and agencies providing services, and how this can impact practice and decisions made. Example of this include, the decision to place the Jabril children with the oldest children's father during what was perceived to be an emergency situation without any assessment of suitability or safety having taken place. A further example, seen through the Jabril children and other's audited concerns the inconsistent creation and use of chronologies, or using historical information to help assess or contextualise current circumstances because of it being time consuming, and instead moving straight into providing more support. A third example can be seen through the absence of professional curiosity, which requires time.

5.8

From a system thinking perspective, these can be viewed as daily life when operating in a busy system managing competing demands and having to prioritise decisions and actions[25]. Work in complex systems is impossible to assign, predict and prescribe completely. Demand fluctuates, resources are often limited and goals often conflict. Frequently, the choices available to us are not ideal and we are forced to prioritise and choose sub-optimal courses of action or short-cuts. Short-cuts or trade-offs, such as these, help us understand behaviour and system outcomes. Trade-offs, such as not spending time compiling a chronology (which for some families may be a significant piece of work) or undertaking a thorough and curious assessment can therefore be perceived, at the time, as an efficiency shortcut to getting the job done. As seen from review of the Jabril children and other sibling groups, trade-offs can become problematic and create risk and vulnerability at a practice level, but also emerge as custom and practice, thereby resulting in a culture in which cutting corners comes at a cost. Emergence[26], as a system thinking concept, is a key property of complex systems – of which the multi-agency child protection system in 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. The impact of the trade-offs detailed above, results in inadequate assessments, and a poorly informed evaluation of risk. Research[27] highlights this stating '*… a danger that can arise in such situations is cultural normalisation and professional desensitisation. This maybe a very appropriate coping mechanism by professionals overwhelmed by the volume and complexity of their task, but can result in vulnerable children being left without adequate assessment of their needs*'.

[25] Systems thinking describes this prioritising as a 'trade-off', as cited in Learning into Practice: improving the quality and use of serious case reviews, Masterclass 2: Systems thinking, SCIE & NSPCC, 2016 and Systems thinking for safety: Ten principles – A White Paper, Eurocontrol, 2014.

[26] Emergence in organisations, Seel, R., 2006 & Caffrey, L., and Munro, E., 2017, A systems approach to policy evaluation, LSE Research Online.

[27] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, University of Warwick & University of East Anglia, May 2016.

5.9

The review has already established blocks and barriers to the quality, timeliness and effectiveness of interventions in the seven families reviewed. Children's Services have taken steps to update practice standards, and expectations across a number of practice areas, including:

- Mandate amber rag-rating for all anonymous contacts plus an assertive visit plan and manager oversight within 48 hours.
- The use of escalation (e.g. introducing a neglect escalation protocol with two failed home access attempts or one explicit refusal with neglect concerns prompts step-up to statutory assessment).
- Planned usage of a neglect screening tool for agencies when referring.
- Assigning a single lead practitioner for large sibling groups to hold the whole-family picture and coordinate agencies.
- Embed a Neglect Review Loop, if tracking two or more new concerns in six-month period, repeat a neglect tool, refresh the chronology, and update the risk statement and aligning this with practice standards around Child & Family assessments.
- Supervision to test evidence of change versus promises, with spot-checks of home conditions and appointment adherence.
- Scheduled Complex Case Discussions every 8–12 weeks for all neglect cases.
- Refresher training on GCP2, disguised compliance, cumulative harm and cultural formulation.

5.10

Cambridgeshire Community Services have emphasised many of the same factors as highlighted by Children's Social Care, namely acclimatisation when working with neglect based on repeated exposure to high numbers of children living in similar circumstances which potentially shifts practitioners' views about what is acceptable, confirmation bias based on previous assessment outcomes, and professional optimism. Caseload drift, and what has been perceived as disguised compliance by the mother has also been cited as contributing to missing the timely identification of cumulative harm to the Jabril children. Additionally, a lack of supervision for staff (safeguarding supervision but also clinical supervision), despite it being offered, may have contributed to the loss of management oversight and a fresh pair of eyes to see what was happening for the children, with the Service noting, *'…There is now a new system in place to try to prevent this from happening again. This includes caseload reviews quarterly with the children's safeguarding team and Team Leads ... Although, practitioners were aware of key guidance documents, these were not always reviewed for updates. In this case it appears non access visits, were not viewed in the same way a 'was not brought' … Following the identification of this learning, Cambridgeshire Community Services has now implemented the process mentioned … It was also noted that working with large sibling groups requires significantly more time for effective assessment, planning, and review. Practitioners reported high caseloads and feeling overwhelmed, which likely impacted their capacity to consistently apply procedures and maintain reflective practice …'.*

5.11

The Police have highlighted some additional barriers, *'… The main barriers evident in the police documentation relate to parental non-engagement, repeated refusal of access to the home, and long delays in receiving third-party material from Children's Services, which slowed case progression. Police repeatedly chased TPM (Third-Party Material) from the local authority between September and December 2025 without response, which impeded timely completion of the case file and delayed charging considerations. Entrenched neglect, characterised by long-standing environmental degradation and avoidance behaviours from the mother, also created barriers to early intervention. Chronic neglect cases, especially involving large sibling groups, present inherent challenges in establishing clear changes in parenting capacity and sustaining improvements. The police responded effectively at points of crisis, but the cumulative pattern suggests that earlier multi-agency escalation might have strengthened safeguarding outcomes. Persistent operational demand and turnover of investigating officers also presented minor continuity challenges, although supervision remained active and supportive throughout …'.*

5.12

From information submitted and discussions, it is evident that agencies have, or are in the process of, taking steps to strengthen their response to neglect; engagement in the review process has been positive and strong, and there is a convincing sense about the desire to drive improvement activity.

6. What have we learnt from conducting this review?

6.1

Agencies that have contributed to this CSPR have identified single agency learning as part of the reporting process. As a result of the activity completed for this review, the following learning points are captured that apply to the multi-agency network. These should be placed alongside, what appears to be, a general trend of positive inspection judgements from Ofsted over a sustained period of time. Learning from reviews should be more than just the output of a report, it should promote leaning as part of the process; feedback and decisions made, indicates that this has been the case.

Learning points for practitioners & managers
1. The use of family history, captured through chronologies, should always form part of any assessment and then decision making. 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. For children living with neglect, the importance of professionals using chronologies as a tool to recognise cumulative harm cannot be under-estimated.
2. 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, and should be seen as an additional risk factor.

Learning points for practitioners & managers
3. 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.
4. 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 also offer insights that might otherwise remain hidden.
5. Reflective supervision is important for all workers, especially those with lead and decision-making responsibilities, and can be used to help explore relationships, power imbalances, over-optimism, bias and prejudices, and remain child focused. Managers must ensure that they provide regular high quality reflective supervision for practitioners and oversight of children who are experiencing persisting neglect. This will help counter neglect being normalised.
6. 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.
7. 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. Combined this can have a cumulative impact on the child's overall health, development and safety. Once recognised by professionals there is legislation and guidance in place to support action being taken to support
8. Assessment tools such as screening tools, and the Graded Care Profile 2 should be repeated when concerns escalate and be triangulated with other agency information. Genograms and structured family mapping must be used early to clarify family roles and identify safe adults.
9. All points of non-engagement by a family, for example repeated missed health appointments, not brought to appointments, or not gaining access to the family home should be monitored and questioned by professionals, keeping in mind the impact on the child's safety and welfare.
10. Anonymous referrals or referrals from visiting trade people, should always be treated with equal importance as a referral from a professional.
11. Cultural, racial and identity factors need to be explored and integrated into assessments and considered alongside other factors that intersect. By omitting this important aspect, it misses the opportunity to understand a child's true identity and lived experience, and as a result, true needs cannot be met or supported.
12. Assessing parenting capacity and parental capacity to change are two distinct forms of assessment activity – both of which are highly relevant when working with persisting and chronic neglect. Undertaking such assessments likely require information gathering, and relationship building over a number of visits, in order to fully and meaningfully make an informed view, and cannot
13. Large sibling groups require coordinated planning and a clear lead practitioner to prevent a fragmented response, but also prevent one single practitioner becoming overwhelmed by managing relational dynamics, or forming bias. For large sibling groups, there should always be a joint worker approach to manage relational dynamics, spread the load, and provide contingency measures

7. Recommendations

A number of actions, in response to the findings set out above, have already been identified and acted on by individual agencies as part of this review; time is now needed to embed these and then evaluate their impact. For the Partnership, the following recommendations are made:

Strengthen decision making at the Intergrated Front Door

1. The Partnership should ensure that decision making at the Integrated Front Door consistently identifies cumulative harm by requiring documented multi-agency consideration of repeat contacts and explicit recording of historical risk in all contacts involving previous referrals. Partners should agree a proportionate set of audit measures (quantitative & qualitative), including the proportion of repeat referrals where cumulative risk is identified and acted on, and report these quarterly to demonstrate improvement in decision making.

Ensure a whole-family response for sibling groups.

2. The Partnership should ensure that all assessments and plans evidence consideration of risk to each child in the household, including a clearly recorded whole-family risk analysis. Families on Child Protection Plans should be supported with multi-agency chronologies to identify patterns of harm and strengths. Families' context and social GRAACES should be evident in effective plans. This should be tested through multi-agency sample audits, with a defined measure for compliance, but also quality, to provide assurance that no child's experience is overlooked.

Reduce drift by strengthening responses to all forms of non-engagement

3. The Partnership should ensure that non-engagement is consistently recorded as a risk factor and that cases step up in response where there is a persistent lack of improvement. This should include a clear expectation that plans are reviewed and escalated within defined timescales where engagement does not improve, supported by audit activity that tracks timeliness of escalation decisions.

Improve the quality and impact of planning for neglect

4. The Partnership should ensure that escalation processes are understood and used appropriately where there is insufficient progress or disagreement about risk. Rather than focusing on volume, leaders should review a sample of escalations to understand their effectiveness and impact on decision making, and use this to improve practice and oversight.

Strengthen oversight, challenge and escalation.

5. The Partnership should ensure that escalation processes are understood and used appropriately where there is insufficient progress or disagreement about risk. Rather than focusing on volume, leaders should review a sample of escalations to understand their effectiveness and impact on decision making, and use this to improve practice and oversight.

Improve the impact of the Pan-Bedfordshire Neglect Sub-Group.

6. The Partnership should work with the Pan-Bedfordshire Neglect Sub-Group to clarify its priorities and ensure that its work programme leads to demonstrable improvement in frontline practice within Bedford Borough. This should include identifying a proportionate number of agreed priorities and reporting progress against these to provide assurance of impact (quantitative & qualitative).

7. The Partnership should update and simplify the Neglect Strategy and explore ways of communicating it to have meaningful impact on day-to-day practice, developing ways of helping everyone to understand their place within the Neglect Strategy so to bridge the current disconnect between frontline practitioners, managers, senior leads and their responsibilities to deliver on the strategy.

Response to large sibling groups.

8. The Partnership should ensure that assessments and plans for large sibling groups consistently consider the quality and impact of day-to-day care, for each child including children's access to appropriate supervision, routines and social development. Practitioners should clearly evidence how children's individual needs are met within the context of the family, including whether basic care, boundaries and age-appropriate expectations, are consistently provided. Leaders and managers should ensure that practitioners in all agencies are resourced and provided with models of working to work with large sibling groups appropriately, reflecting the additional work required.

9. The Partnership should explore options for facilitated multi-agency supervision/case discussion to assist practitioners that may feel stuck or disempowered and where there is limited evidence of change in their work with children and families, focusing on children who experience persisting neglect with little sustained change over time. Given the wider service and operating context, and levels of deprivation, the Partnership should explore options that help prevent practitioners becoming desensitised to standards or circumstances of unacceptable care and neglect.

Scrutiny, oversight and improvement activity.

10. A focused scrutiny exercise should take place to gain assurances about how effectively the findings and recommendations from a previous Child Safeguarding Practice Review (Jason & family) completed by Bedford Borough (initiated in 2020 but not concluded until 2024 and unpublished for valid reasons), have been implemented and embedded, given the similarities of findings.

11. In disseminating the lessons learned from this review, the Partnership should also consider the research, reflective questions and resources provided by the Child Safeguarding Practice Review Panel (Neglect) and how they might complement the findings from this review, from which to inform strategy, resource allocation and improvement activity.