NEGLECT AND SERIOUS CASE REVIEWS

A report from the University of East Anglia commissioned by NSPCC

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Cruelty to children must stop. FULL STOP.

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Disclaimer

The views expressed are those of the authors and are not necessarily shared by the NSPCC nor the Department for Education.

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Glossary

CAMHS	Child and Adolescent Mental Health Services
CPD	Child Protection Database
CP	Child Protection
CSC	Children's Social Care
LSCB	Local Safeguarding Children Board
NICE	National Institute for Health and Clinical Excellence
SCR	Serious Case Review
SUDI	Sudden Unexpected Death in Infancy

Executive Summary

INTRODUCTION

This study provides a new contribution to our learning about neglect by exploring the circumstances in which neglect can be catastrophic and have a fatal or seriously harmful outcome for a child. It provides a systematic analysis of neglect in serious case reviews (local multi-agency reviews of child deaths or serious injury where abuse or neglect is known or suspected) in England, between 2003–2011. It draws on anonymised research information from over 800 cases from the four government commissioned national biennial analyses carried out by the authors, offering further analysis of the neglect cases that formed part of the most recent biennial analysis (Brandon et al 2012).

While this examination of neglect in serious case reviews provides important new learning, it is essential to be clear about the limitations of the study. Serious case reviews are not a reflection of typical child protection practice. The constellation of neglect-related events and characteristics that came together in these cases to produce an outcome of fatality or grave injury cannot be distilled into a check list of risk factors that predict such an outcome. In most cases with similar characteristics, a child will not come to such catastrophic harm. Yet there is learning here about how risks of harm accumulate and combine and the points at which intervention might successfully have helped to contain these risks. The learning is as important for children known to universal services, where they do not see a social worker, as for children with known child protection risks.

KEY FINDINGS

- Neglect is much more prevalent in serious case reviews than had previously been understood (we found neglect in 60 per cent of the 139 reviews from 2009–2011).
- Neglect *can* be life threatening and needs to be treated with as much urgency as other categories of maltreatment.
- Neglect with the most serious outcomes is not confined to the youngest children, and occurs across all ages.

- The possibility that in a very small minority of cases neglect will be fatal, or cause grave harm, should be part of a practitioner's mindset. This is not to be alarmist, nor to suggest predicting or presuming that where neglect is found the child is at risk of death. Rather, practitioners, managers, policy makers and decision makers should be discouraged from minimizing or downgrading the harm that can come from neglect and discouraged from allowing neglect cases to drift.

- The key aim for the practitioner working with neglect is to ensure a healthy living environment and healthy relationships for children. Prevention and early access to help and support for children and their families are crucial, but so too is later stage help for older children who live with the consequences of longstanding neglect.

RESEARCH AIMS AND METHODS

The study aims to provide a systematic analysis, over time, of neglect in serious case reviews. It asks three research questions:

1. How often is neglect evident in the families of children who become the subject of a serious case review?

2. What are the characteristics of children and families where children have suffered neglect?

3. In what ways does neglect feature in these cases of child fatality and near fatality?

The questions of how often neglect is evident and what are the characteristics of the children and families are considered from a statistical perspective by examining patterns over time in relation to those cases (from 2005–2011) of children known to have had a child protection plan for neglect.

In addition we use a protocol to determine the presence of neglect more widely for children in serious case reviews (from the two year period 2009–2011) not only for cases where children had a child protection plan for neglect but also for cases of children 'in need' and children 'below the threshold' of children's social care services.

The different ways in which neglect featured and the child's likely experience of neglect are considered through a more in-depth qualitative study of themes which emerged from forty-six cases drawn from the full period 2003–2011. This provides a richer understanding of how different types and circumstances of neglect appear to result in a catastrophic outcome.

FINDINGS

HOW OFTEN IS NEGLECT EVIDENT IN THE FAMILIES OF CHILDREN WHO BECOME THE SUBJECT OF A SERIOUS CASE REVIEW?

- Looking at the six year period 2005–2011, and using a narrow definition of officially substantiated neglect, we found neglect in 16 per cent, or approximately one in six (101), of the 645 serious case reviews from this period. In each of these cases the child had been the subject of a child protection (CP) plan for neglect at some point in his or her life.

- For 59 children, a CP neglect plan was in place **at the time** of their death or serious harm, for the other 42 children the plan had been **discontinued** (see Table 2.1). This shows that some children living with substantiated neglect may be at risk of death, and not just long-term developmental damage. However, having a CP plan for neglect is NOT a predictor of likely death or serious harm and should not be interpreted in this way.

Encouragingly, the proportion of reviews where children had a CP plan for neglect at the time of the death or serious injury is gradually dropping over time from 12 per cent for the two years 2005–07 to 9 per cent during 2007–09 and to 6 per cent for the two years 2009–11. This suggests that children in the community with a child protection plan for neglect might be being better protected, especially since the overall numbers of children with a CP plan for neglect has been rising. However, the equivocal nature of neglect and the way it can be re-categorised also needs to be borne in mind. This means that we cannot be sure that the most serious cases of neglect are formally recognised and that these children will always have a plan for their protection.

Worryingly, there is no similar decline over time in the number of reviews held where the plan had been discontinued. With the benefit of hindsight it is apparent that the risks of serious harm had not stopped once the plan was removed and that these children might have needed a child protection plan again, or for longer.

CHARACTERISTICS OF CHILDREN AND FAMILIES WHERE CHILDREN HAVE SUFFERED NEGLECT

Children's Ages: Neglect features across all age ranges. Although the majority of serious case reviews undertaken concern infants and pre-school aged children, there is more likely to have been a CP neglect plan, or neglect in a wider sense, among older children, particularly those of school age (6–16). This shows that neglect with the most serious outcomes is not confined to the youngest children.

Gender: A higher proportion of serious case reviews concerned girls with a CP plan for neglect than boys (57%/43%). This is in contrast to CP plans for neglect nationally (i.e. not SCR cases) where only 44 per cent of plans are for girls.

Family size: serious case reviews tend to feature families of a larger size (with four or more siblings) than found in the general population. This is more pronounced where children had a CP plan for neglect (or indeed in any category) where almost one in five families were large in size.

Parental drug and alcohol misuse: these parental characteristics (known to be associated with neglect) were higher where children had a past or current CP plan for neglect than in reviews for other children. Rates of domestic violence were not higher.

IN WHAT WAYS DOES NEGLECT FEATURE IN THESE CASES OF CHILD FATALITY AND SERIOUS HARM?

To explore this question we looked, broadly speaking, at the ways in which the children died or suffered serious injury or harm. We also considered the ways that neglect co-existed with other types of maltreatment (particularly physical abuse).

Types of fatality

Between 2005–2011 there were 57 children with a current or past CP plan for neglect whose death prompted a serious case review.

- 13 children died from a physical assault. Most deaths (34) were related to but not directly caused by maltreatment (sudden unexpected deaths in infancy, deaths resulting from accidents, for example fires or accidental drowning, and deaths of young people through suicide). In the deaths related to but not directly caused by maltreatment, the circumstances gave rise to concerns about the child's safety before the incident.

- By contrast, none of the six children who died from extreme deprivational neglect (mostly starvation) had ever been the subject of a CP plan so the severity and dangerous nature of their life threatening neglect had not been recognised.

Neglect and physical abuse

- Where a child died, there was more often a context of known neglect (over half [56%] with a CP plan, neglect) than known physical abuse (just over a third [37%] with a CP plan, physical abuse).

Neglect and physical abuse in cases of serious harm (where the child did not die)

- Physical abuse and neglect were found together in almost half of the serious injury cases (44%) where children suffered grave harm but did not die.

NEGLECT IN ALL SCRS FROM 2009–11

To capture neglect beyond that formally recognised by a child protection plan, we used wider, but still stringent, criteria to search for neglect. There was neglect in a total of 60 per cent (83) of the 139 available serious case reviews from the two year period 2009–11. In **most** cases neglect had not been formally recognised but the experiences for the child and the consequences of neglect were as serious as when a CP plan was in place.

As in the CP plan cases, neglect featured evenly across the age ranges apart from among 11–15 year olds where it was much more common. Where children died, current or past neglect was evident for almost all whose deaths were related to but not directly caused by maltreatment (SUDI, suicide, accidents and 'other'). There was neglect in a quarter of the deaths through assault and deliberate homicide.

There was neglect in over two thirds of the 43 non-fatal cases (and in five of the seven serious sexual abuse cases). Neglect was evident for two thirds of the children who suffered non-fatal physical assault.

A DETAILED STUDY OF 46 CASES OF SEVERE NEGLECT, IN SIX THEMES

To understand more about how neglect can be life threatening, we studied anonymised case summaries from 46 neglect related serious case reviews from the eight year period 2003–2011. These included children with and without a CP plan for neglect. We found a six-fold typology of neglect related circumstances. Learning points arose in relation to each of the six individual themes and there were overriding, general points applicable to most:

Malnutrition

For this research malnutrition is defined as 'life-threatening loss of weight or failure to gain weight or serious consequences of neglecting to nourish the child'.

Learning points:

- None of the children who died or nearly died from malnutrition were in the child protection system. The family's contact with any agency was almost non-existent by the time of the child's death or serious harm.

- Increased isolation of a family adds to the invisibility of the child or children so malnutrition is not recognised (for example when children are isolated because they cease to attend school or nursery or are home-schooled). Isolation of the child from the outside world means that very poor relationships between the child and caregiver (so poor that the child may have ceased to exist for the adult) cannot be observed by professionals or the public.

- Changes in the parents' or carers' behaviour (for example an increasingly hostile manner of engagement or a complete withdrawal from services) can signal life-threatening harm for a child being severely neglected and malnourished.

Medical neglect

For this research medical neglect resulted in the child dying or nearly dying because parents neglected to comply with medical advice.

Learning points:

- The significance of changed family circumstances was not noted by professionals. This meant that increased stress on the caregiver while coping for a child with complex health needs, and their diminished willingness or capacity to administer medication, was missed.

- Professionals tended not to challenge parents' behaviour when medication was given erratically or consider reasons for parents' reduced compliance with advice.

- Undue professional optimism can mean that the impact of medical neglect and the danger for the child is missed and thus no referral is ever made to children's social care. Health professionals sometimes appear to shield parents from children's social care.

'Accidents' with some elements of forewarning

The child was harmed or killed as a result of an accident but there were elements of forewarning within a context of chronic, or long-term neglect coupled with, or producing an unsafe environment.

Learning points:

- There was drift and lack of a sense of urgency among professionals, even when the risks of harm through poor supervision had been highlighted by a CP plan in the category of neglect.

- This is a systemic problem when drift and confusion is prompted by overwhelming workloads, high staff turnover and high vacancy rates alongside numerous unallocated cases.

- Professionals were tolerant of dangerous conditions and poor care and some children's demeanour and behaviour were optimistically interpreted as 'happy and playful', when they were living in an unsafe environment and had signs of poor developmental progress.

Sudden unexpected deaths in infancy

For this research defined as ‘unexplained infant deaths, within a context of neglectful care and a hazardous home environment’.

Learning points:

- The particular vulnerability of young babies in highly dangerous living conditions can be missed by practitioners and clinicians who should be on high alert in these circumstances. This can be especially relevant when working with large families where the needs of individual children can be lost.
- Professionals can be falsely reassured about a baby’s safety even when the infant is the subject of a CP plan for neglect. A good relationship between a baby and parent cannot keep the infant safe for example when co-sleeping with a parent who has consumed drugs or alcohol.
- Intervention to prevent SUDI where there are known risk factors (smoking, substance misuse and co-sleeping) is not always followed through with families.

Neglect in combination with physical abuse

Where assumptions about neglect masked the physical danger to the life of the child.

Learning points:

- In these cases there tended to be a gradual dilution and forgetting of concerns about the risk of physical harm which would be overtaken by a ‘this is only neglect’ mindset.
- The neglect label meant that the real risks from physical assault as well as from neglect were not taken seriously.
- The danger here is that in categorising children as experiencing neglect, less attention is paid both to the neglect itself and to the other risks they face. In particular, neglect does not preclude physical abuse.

Suicide among young people

A long-term history of neglect having a catastrophic effect on a child’s mental wellbeing.

Learning points:

- Young people with long experiences of chronic neglect and rejection find it very difficult to trust and may present as hard to help.
- The root causes of young people’s behaviour needs to be understood so that the responses of carers and professionals do not confirm young people’s sense of themselves as unworthy and unlovable.

- Young people in care often feel compelled to go back home even if it means more rejection. Once back home, young people and their families need a high level, intensive support not a low level service.

- At the age of 16 young people lose the protection of school and have no equivalent protected route to adulthood and few routes out of a neglectful situation at home.

IMPLICATIONS FOR POLICY AND PRACTICE

All child protection practice involves managing risk, as the Munro Review of Child Protection reminds us (Munro 2011). Practitioners also need to be supported by a system that allows them to make good relationships with children and parents and supports them in managing the risks of harm that stem from maltreatment. This includes the harm from neglect and the way that neglect can conceal other risks and danger. This study does not provide easy answers about the difficult judgements and decisions that may need to be made where neglect is present but shows how important it is to be open-minded and vigilant about where and how these risks manifest themselves.

Maintaining a healthy environment

An important way for neglected children to stay safe is to be more physically and emotionally healthy and to have safe and healthy living conditions. A safe living environment is a basic precondition for a safe relationship between children and their caregivers. This reinforces the need for decent living conditions for all children and families across the income spectrum and for both early and late stage help, for children of all ages and not just the youngest. It is right and necessary that all children have decent living conditions but those caring for the child also have a responsibility to maintain a child friendly environment. Professionals need to make a judgement about whether parents are able to maintain a safe and healthy environment if they are given reasonable support.

If parents have a good relationship with children but their living conditions are not safe, then the child is not safe.

Messages for policy makers, decision makers, practitioners and managers

- A public health approach to neglect offers good opportunities for prevention and for spreading health promotion messages about, for example, suicide prevention, accident prevention and the risks of sudden unexpected deaths in infancy (SUDI).

- Unsafe accommodation combined with lapses in parental supervision can be life threatening and can increase the risks of infant death as well as deaths for children of older children from drowning, fire or accidental poisoning. Targeted support for families known to be vulnerable can help to prevent accidents (Reading et al 2008).

- Vulnerable adolescents with a long history of neglect and rejection, and who may be care leavers, can rarely thrive living alone in isolated, poor quality accommodation but need a safe, supportive environment.

Maintaining a healthy, safe relationship

Parents can wittingly and unwittingly be a source of danger rather than comfort to their child. Practitioners can miss the life-threatening risks that arise when relationships are so poor that care, nurture and supervision are almost non-existent. While every effort should be made to intervene early to prevent a parent–child relationship deteriorating in this way, once this has happened urgent action needs to be taken. Action is stalled when this danger is hidden, and when children, adolescents and families disappear from view.

Practitioners need to be sensitively attuned to the relationship between parents and children, even where parents present as loving but may be failing to cope, for example with the demands of their child's complex health needs or disability.

Older children carry the legacy of their experiences of neglect and rejection with them. As a consequence, threats to their own life can come from their own high-risk behaviour or from suicide. Adolescents need to maintain, or be helped to build, safe, healthy relationships with their peers and with caring adults.

Messages for policy makers, decision makers, practitioners and managers

- Routine contact between parents and professionals should be an opportunity to promote sensitive and attuned parenting. Early concerns should prompt targeted help from Children's Centres, enhanced health visitor contact like the Nurse Family Partnerships, and other school or community-based help or services for example from Child and Adolescent Mental Health Services (CAMHS).

- To understand parent–child relationships better, practitioners should ask themselves: What does this child mean to the parent and what does the parent mean to the child? Reflective supervision helps practitioners to understand complex relationships and should support them to act decisively in the unusual cases when children are in danger.

- Missed appointments should be followed up and not considered a reason to withdraw a service. Children and young people who disappear from view *may* be at risk of severe or life-threatening harm from neglect. To be safe, children need to be seen and importantly, to be known.

The fact that neglect is not only harmful but can also be fatal should be part of a practitioner's mindset as it would be with other kinds of maltreatment. Practitioners and managers should recognize how easily the harm that can come from neglect can be minimized, downgraded or allowed to drift. Practitioners should deal with neglect cases in a confident, systematic and compassionate manner.

1 The context of neglect and serious case reviews

1.1 INTRODUCTION

This report sets out to identify the learning about neglect from serious case reviews into those most serious child abuse cases where children die or are seriously injured or harmed, often as near fatalities. The four analyses of serious case reviews that we have previously carried out for the English Government have provided unique access to anonymous information from more than 800 reviews carried out in England between 2003–2011. Although these analyses all highlighted neglect, this topic could not be the central focus of the national reports. This is therefore the first study which is able to provide a systematic analysis, over time, of neglect in serious case reviews. It asks three research questions, firstly: how often is neglect evident in the families of children who become the subject of a serious case review? Secondly: what are the characteristics of children and families where children have suffered neglect? And thirdly: in what ways does neglect feature in these cases of child fatality and near fatality?

Chapter 2 addresses the first two questions by examining a dataset built over time from information in relation to more than 600 cases. Chapter 3 considers the second and third questions by examining themes emerging from the in-depth study of much fuller material about forty-six cases to provide a better understanding of how different types and circumstances of neglect play out for children, families, practitioners and helping systems to result in a catastrophic outcome. The final chapter considers implications for policy and practice.

1.2 WHAT IS A SERIOUS CASE REVIEW? WHAT IS NEGLECT IN SERIOUS CASE REVIEWS?

Throughout the four nations of the UK, the death of every child through abuse or neglect is subject to a local multi-agency serious case review. The review has a somewhat different name in each country and is carried out under somewhat different guidance and this study focuses on reviews in England. In England the guidance for carrying out the review is being redrafted, but at the time of writing, current guidance is enshrined in *Working Together* (HM Government 2010). The purpose of the review, in England, is to establish whether there are lessons to be learnt from the case about the way in which

local professionals and organisations work individually and together to safeguard and promote the welfare of children.

Unlike many other countries, who only review deaths, the four UK nations also consider carrying out a serious case review where a child is seriously injured or seriously harmed as a result of abuse or neglect. This allows learning from near misses and instances where children would have died if urgent action had not been taken, and also those cases where serious harm was inflicted on children over very many years rather than as a single incident or over a brief period of time. Neglect in serious case reviews features in all these circumstances; where children die, where there is a near fatality and where children have suffered long-term harm or where they suffer serious injury.

Neglect is defined in the statutory guidance for England in *Working Together* as follows:

> 'Neglect is the persistent failure to meet a child's basic physical and /or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance misuse. Once a child is born, neglect may involve a parent or carer failing to:
> - Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
> - Protect a child from physical and emotional harm or danger;
> - Ensure adequate supervision (including the use of inadequate caregivers); or
> - Ensure access to appropriate medical care or treatment.
>
> It may also include neglect of, or unresponsiveness to, a child's basic emotional needs'
>
> (HM Government 2010:39).

Although the national definition emphasises the serious impairment of the child's development that results from neglect, it does not spell out that the long-term impact can be linked to suicide. This type of child death in serious case reviews, among others, is often related to but *not directly* caused by maltreatment where young people have a history of neglectful care. Indeed in a number of serious case reviews the child's death is categorised as related to but not directly caused by maltreatment (Sidebotham et al 2011). These types of cases are reported in more detail in Chapter 2 and 3 and include sudden unexpected deaths in infancy where neglect was a concern, and accident cases, including where there was inadequate supervision of a child.

1.3 WHY IS THIS STUDY IMPORTANT AND WHAT ARE ITS LIMITATIONS?

In spite of better recognition of the pernicious, short term and long-term harm that stems from living with neglect during childhood (Daniel et al 2011; Gilbert et al 2009), in practice, and even in serious case reviews, neglect and harm from neglect can still be minimised and downgraded, or go unrecognised and unreported (Gardner 2008). In addition, although the long-term impact of neglect is known to be corrosive, neglect is

rarely associated with fatality. This study provides a new contribution to our learning about neglect by exploring the circumstances in which neglect has been catastrophic and can have a fatal or near fatal outcome for a child.

While this examination of neglect in serious case reviews provides important new learning, it is essential to be clear about the limitations of the study. Firstly, serious case reviews are not a reflection of typical child protection practice. The constellation of neglect-related events and characteristics that came together in these cases to produce an outcome of fatality or grave injury cannot be distilled into a check list of risk factors that predict such an outcome. In most cases with similar characteristics a child will not come to such catastrophic harm.

1.4 BRIEF LITERATURE REVIEW ABOUT NEGLECT IN SERIOUS CASE REVIEWS

Lack of recognition by practitioners of the severity and impact of neglect emerged as a recurring concern in the early government commissioned analyses of serious case reviews in England and Wales (Brandon et al 1999; 2002; Rose and Barnes 2008). Rose and Barnes' study of 40 reviews from 2001–2003 emphasised the complexity and overwhelming range of problems in families where there was neglect and the erosion this had on parents' capacity to nurture their children safely.

Ofsted's evaluation of serious case reviews began in 2008. Their first report of 50 serious case reviews included five cases of chronic neglect (Ofsted 2008:7). They noted that agencies were particularly poor at addressing the impact of chronic and long standing neglect on children and intervening at an early stage to prevent problems of neglect from escalating. In their second evaluation, a year later, the most common risk factor in the cases reviewed was found to be neglect, but the report did not make clear how this conclusion was reached or how the risk played out (Ofsted 2009:6).

A thread running throughout all five Ofsted evaluations is the failure to see, listen to or take account of the perspective of the child or children at the centre of a review and this theme formed the basis of their 2010 annual report (Ofsted 2011). The 2010 report described a single case involving neglect where it was noted that the children were only able to speak about their experiences once they had been removed from their home environment. Ofsted claimed that this underlined the importance of providing a safe and trusting environment, away from carers, for children to be able to speak about concerns (Ofsted 2011:7).

The extent of neglect in serious case reviews has hitherto been difficult for researchers to ascertain. Information about neglect taken from the prime national source, the Child Protection Database has been found to be patchy and located only in the loose category of 'factors related to the case' where it occurs most frequently as 'long standing neglect' in between 17 and 25 per cent of reviews (Brandon et al 2010:22). When the *primary* and immediate cause of child death started to be categorised in serious case reviews

(Sidebotham et al 2011, Brandon et al 2009:32) it was found to be the primary cause in no more than two per cent of cases.

Beyond the very tight categorisation of primary cause of death and the looser noting of neglect as a 'factor in the case' it was generally suspected that neglect was a significant underlying feature in many more reviews, especially among cases of sudden unexpected deaths of infants which became the subject of a serious case review. However, gauging a clear sense of how many cases included neglect was not possible until our latest biennial study, published at the end of July 2012 where the extent of neglect in reviews spanning the period 2009–2011 was found to be 60 per cent (Brandon et al 2012). The findings about neglect from this study are revisited and explored in more depth later in this report.

SUMMARY

- Although the long-term impact of neglect is known to be corrosive, neglect is rarely perceived to be associated with fatality. Until 2012, neglect was known to be a factor in no more than a quarter of serious case reviews, although it was accepted that this was an under-estimate. Recent analysis has revealed that neglect is apparent in 60 per cent of serious case reviews between 2009–2011.

- This NSPCC study provides a new contribution to our learning about neglect by exploring the circumstances in which neglect can be catastrophic and have a fatal or seriously harmful outcome for a child, and how these cases can be classified.

- The study provides a new and systematic analysis of neglect in serious case reviews (local multi-agency review of child deaths or serious injury where abuse or neglect is known or suspected) in England between 2003–2011. It draws on anonymised research information from over 800 cases from the four government commissioned national biennial analyses carried out by the authors.

- There are limitations to the important learning from this study. Serious case reviews are not a reflection of typical child protection practice and it is not possible to produce a check list of risk factors that predict such an outcome. In most cases with similar characteristics a child will not come to such catastrophic harm, however, in all neglect cases increased vigilance is needed.

2 Neglect in the lives of children who become the subject of a serious case review – a statistical overview

2.1 INTRODUCTION

Our national analyses of serious case reviews in England have offered important learning about cases of neglect. While these two yearly overviews have always incorporated information about neglect and offered a degree of critical analysis, they have not been able to include a systematic analysis of neglect over a number of years, nor across large cohorts of case reviews. Here we are able to go back over our combined dataset (of mostly statistical information) on all serious case reviews undertaken in the six year period between 2005 and 2011 and ask specific questions about neglect:

- *How often is neglect evident in the families of children who become the subject of a serious case review?*
- *What are the characteristics of children and families where children have suffered neglect?*
- *In what ways does neglect feature in these cases of child fatality and serious harm?*

The statistical answers to these questions should help us to understand the extent of neglect in serious case reviews, and to map out some profiles of children and families in these cases and the way they contrast with other groups of children not known to have been living with neglect. Seeing how neglect features in the totality of cases of child fatality and serious injury (often near fatality) provides an important backdrop to the more detailed discussion of different patterns and pathways of neglect in the next chapter.

Our information came originally from sources to which we were given access by the Government through the Department for Education and Skills, the Department for Children Schools and Families, and most recently the Department for Education, as part of our four separate commissions to carry out two yearly analyses of serious case reviews (Brandon et al 2008; 2009; 2010; 2012). These sources were primarily, the nationally held Child Protection Database (CPD) where serious case reviews were notified, and

secondly, information contained in serious case reviews (in the executive summaries and overview reports). As part of the previous research process we anonymised, coded and organised the information to create a longitudinal research database that could be further studied and interrogated. We have thus amassed information concerning a total of 645 serious case reviews conducted between 2005–2011.

For the purposes of this chapter we have re-examined the information and divided the analysis into two groupings of children creating two sub-samples for this study. Firstly we consider information from all cases over the six year period 2005–11 with a particular focus on those children where maltreatment in the category of neglect had been substantiated (a child protection plan in the category of neglect); secondly we examine the most recent cases from 2009–11 using a wider but still stringent definition of neglect. More detail about the methodology is explained at the start of the results section for each group.

2.2 RESULTS

SUBSTANTIATED MALTREATMENT IN THE CATEGORY OF NEGLECT: CHILD PROTECTION PLAN FOR NEGLECT (N=101 FROM 645 SERIOUS CASE REVIEWS FROM 2005–11)

Where professionals from different agencies have agreed that neglect is severe enough to meet the criteria for the child having a child protection plan, there are raised expectations that the child will be protected. It is therefore important that we examine these cases in greater detail. Also the clearest indication of neglect in our data set is where this has been acknowledged by the child having a child protection (CP) plan under this category. Because we know from previous studies that maltreatment is most likely to recur where there has been neglect (Hindley et al 2006), we also include in this analysis those cases where the plan has been discontinued.

> A Child Protection Plan is an agreed expression of multi-disciplinary concern about a child (with regulatory duties and responsibilities attached) where it has been decided that a child has suffered, or is likely to suffer, significant harm. The category of plan used is one or more of physical, emotional, sexual abuse or neglect, and will indicate to those consulting the child's social care record the primary presenting concerns
>
> (HM Government 2010, *Working Together*).

- **101 children from the 645 serious case reviews undertaken during the six year period 2005–11 were known to have had a current or a past CP plan for neglect.**

Information about child protection plans is required at the time that the Child Protection Database notification is completed, and using this information we were able to identify

children with substantiated maltreatment in the category of neglect (sample 1a). We compare this group with those children for whom there was a CP plan under any other category (sample 1b); but note that this comparison group includes the category of emotional abuse which can sometimes be used interchangeably with neglect. A wider comparative sample includes all children for whom a SCR was conducted who did not have a CP plan for neglect (sample 1c). Sample 1a and 1b include all children with a child protection plan. Sample 1c is all children apart from those with CP plans for neglect (including sample 1b).

- 101 children (16%), or approximately one in every six, had a CP plan for neglect.
- 59 children had a plan in place for neglect **at the time** of their death or serious harm, the other 42 children had a **discontinued** plan for neglect.
- 74 children (11%) had a current or past CP plan under a different category.

Neglect was therefore by far the most frequent category of child protection plan in our serious case review sample, as it is nationally (see Appendix A).

Table 2.1: Serious case reviews conducted where the child had a CP plan for neglect: plan at time of incident vs. a discontinued plan

Year of incident	Current CP plan for neglect at time of incident, and as % of all SCRs undertaken (n =59)	Discontinued CP plan for neglect, and as % of all SCRs undertaken (n=42)	Total number of serious case reviews (n=645)
2005–06	13 (12%)	7 (7%)	105
2006–07	10 (12%)	3 (4%)	82
2007–08	15 (11%)	10 (7%)	140
2008–09	11 (8%)	10 (7%)	140
2009–10	9 (8%)	8 (7%)	115
2010–11*	1 (2%)	4 (6%)	63

*The apparently overall smaller number of reviews in this latest year may reflect, in part, a delayed decision about undertaking a serious case review, and a potential drop in the number of serious injury cases where there is more discretion about undertaking a review, see Brandon et al. 2012 for a fuller discussion.

There are encouraging signs of a drop in the number of SCRs where a child had a CP plan for neglect in place at the time of the death or serious injury.

Although we should be careful not to over-interpret these results because of the small numbers involved, looking at two year periods, we can see a gradual decrease over time from 12 per cent during 2005–07, to 9 per cent during 2007–09 and 6 per cent between 2009–11. This could suggest that children in the community with a CP plan for neglect might be being better protected. It is possible that this reflects practice improvements and that most recently, child protection plans for neglect were being used more successfully.

This fall in the number of SCRs for children with a CP plan for neglect looks promising but the equivocal nature of neglect and the way it can be re-categorised also needs to be borne in mind. This means that we cannot be sure that the most serious cases of neglect are formally recognised and that these children will always have a plan for their protection. It may be that many neglected children are slipping through the net of protective services.

There was no similar decline in the number of reviews for children who had a discontinued CP plan for neglect – and the question remains as to why the plan was removed. With the benefit of hindsight it is apparent that the risks of serious harm had not abated once the plan was discontinued and that these children might have needed a CP plan again, or for longer. These children do seem to have fallen through the net and provide an argument for ensuring continued support and maintenance of safe care for children who have had a plan for neglect. These children should not be overlooked through the emphasis on early intervention.

DEMOGRAPHIC CHARACTERISTICS

Table 2.2 compares demographic characteristics for those 101 children with a current or discontinued plan for neglect with:

- Other children for whom there was a plan but in a different category (74 children);
- The whole sample of children for whom a SCR was conducted, excluding those with a CP plan under category of neglect (544 children). Columns 1a and 1c thus sum to the whole set of reviews in relation to 645 children.

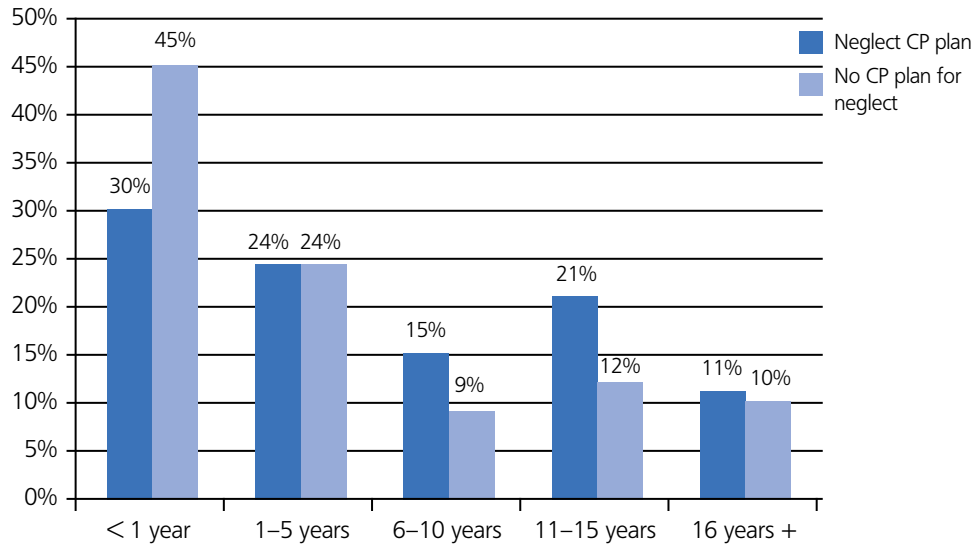
Table 2.2: Demographic characteristics

Characteristic		1a CP plan – neglect (n=101*)	1b CP plan – not neglect (n=74*)	1c Whole sample excluding CP plan – neglect (n=544*)
Age	< 1 year 1–5 6–10 years 11–15 years 16 years and over	30 (30%) 24 (24%) 15 (15%) 21 (21%) 11 (11%)	17 (23%) 19 (26%) 10 (14%) 15 (20%) 13 (18%)	242 (45%) 131 (24%) 50 (9%) 66 (12%) 55 (10%)
Ethnic group	White Asian/ Asian British Black/ Black British Mixed ethnicity Other ethnic groups	73 (75%) 3 (3%) 7 (7%) 13 (13%) 1 (1%) (n=97)	58 (78%) 3 (4%) 3 (4%) 10 (14%) 0 (n=74)	391 (76%) 24 (5%) 44 (9%) 46 (9%) 8 (2%) (n=513)
Gender	Female Male	58 (57%) 43 (43%)	39 (53%) 35 (47%)	239 (44%) 304 (56%) (n=543)
Family size	Only child 1, 2 or 3 siblings 4 or more siblings	8 (9%) 68 (73%) 17 (18%) (n= 93)	9 (12%) 51 (70%) 13 (18%) (n= 73)	139 (27%) 332 (65%) 37 (7%) (n=508)

* Unless otherwise stated.

Age: The ages of children with a current or discontinued CP plan for neglect are presented in Figure 2.1, alongside the ages for children with no plan for neglect. Although *overall*, there were more CP plan neglect reviews for infants or pre-school aged children (in keeping with the age profile of children at the centre of all SCRs), a higher *proportion* of reviews for children of school age (6–16 years) included neglect plans (over a third, 36%) in comparison with one in five reviews (21%) for children in a similar age range where there was no plan. The proportion of reviews for pre-schoolers aged 1–5 years (24%) and young people aged 16 and over (approximately 10%) showed little difference between those with or without a plan. By contrast, while 45 per cent of case reviews where there were no plans for neglect related to babies under a year old, only 30 per cent of cases with a plan for neglect concerned infants. However, interpreting this is complicated by the fact that the older the child the greater the likelihood of having a plan at some stage in their lives.

Figure 2.1: Age distribution of children with a (past or current) child protection plan for neglect compared with children with no plan



Ethnic group: The ethnicity of the children who were the subject of a child protection plan for neglect broadly matches that of the comparative samples. Although there is arguably an over representation of minority ethnic children across all samples, this looks much less pronounced in the light of new information from the 2011 census which shows higher proportions of minority ethnic children in the population of England than in earlier years.

Gender: There was a higher proportion of girls (57%) with a CP plan for neglect than boys (43%). This was in contrast to the children without a plan for neglect, 44 per cent of whom were girls, and 56 per cent of whom were boys. Recent statistics on category of plan for 2011 in England show that in contrast, nationally, there is a slightly higher proportion of boys (51%) with a CP plan for neglect, than there are girls (49%). A similar 52 per cent/48 per cent split is also apparent in the other categories of abuse, except for sexual abuse, where 57 per cent of those with this type of plan are girls (see also Appendix A).

Family size: In these SCRs, a higher proportion of children with a CP plan for neglect lived in large families with four or more siblings than would be found in the general population. This was also true for children with a plan in any other category. In their large cohort study of over 14,000 children in the west of England, Sidebotham and colleagues (2006) cited a number of authors who had shown increased risks of child maltreatment in larger families. However Sidebotham's multivariate analysis found that the marginally higher risk to the child in large families was accounted for by the confounding effects of parental background and socio-economic factors. In our analysis of serious case reviews from 2007–09 (Brandon et al 2010), we noted the additional stress, not least financial, that can come with a large family, and that professionals' focus on individual children can be lost in such circumstances.

WHETHER THE SCR CONCERNED A FATALITY OR A SERIOUS INJURY

The 645 serious case reviews from 2005–2011 were categorised as to whether the child died or was seriously injured or harmed. In total there were serious case reviews relating to 399 deaths, and 246 concerning serious injury. This was explored in relation to neglect, and results are displayed in Table 2.3.

Table 2.3: Death or serious injury by (past or current) CP plan for neglect

	CP plan – neglect (n=101)	CP plan – not neglect (n=74)	Whole sample excluding CP plan – neglect (n=544)
Fatal	57 (56%)*	27 (37%)	342 (63%)
Serious injury	44 (45%)	47 (63%)	202 (37%)

* Of which 38 children had a current plan for neglect at the time of their death, and 18 had a discontinued plan for neglect

Between 2005–11 there were serious case reviews relating to 57 deaths of children who had a CP plan in the category of neglect at some point in their lives. Thirty-eight children (two thirds) had a plan for neglect in place at the time they died, and nineteen (a third) had had a CP plan for neglect at some point in their life but it had been discontinued at the time of their death. This shows that children living with neglect may be at risk of death, and not just long-term developmental damage. However, having a CP plan for neglect is NOT a predictor of likely death or serious harm and should not be interpreted in this way.

Of the 44 children who suffered a serious injury, but survived, 21 had a neglect CP plan in place when the incident occurred, while the CP plans for neglect for the remaining 23 children had been discontinued.

CHILD PROTECTION PLANS – NATIONAL CONTEXT

The detailed breakdown of category of plan for all children who had a current or past CP plan is presented in Table 2.4. To set the results in context, national comparative figures for all children with a CP plan are given. The percentage of children with a child protection plan for neglect broadly reflects the figure for England (DfE 2011, for more detail see also Appendix A). Note that, as in the national data, some of the children categorised under neglect will be subsumed under the ‘multiple’ category where there was more than one category of concern.

Table 2.4: Category of plan; serious case review sample and national statistics

Category of abuse	SCR CP Plan data 2005–11 (n=175)	National data (England) 2005–11* Mean yearly %
****Neglect only**	73 (42%)	45%
Physical abuse only	32 (18%)	13%
Sexual abuse only	12 (7%)	7%
Emotional abuse only	19 (11%)	26%
****Multiple (including neglect)** **Multiple (excluding neglect)**	28 (16%) 11 (6%)	10% Any categories

*See Appendix A for yearly breakdown. ** 73 + 28 make up the 101 neglect cases.

A serious case review must be held in *all* cases where a child dies and abuse or neglect is known or suspected. Where a child is seriously injured or harmed there is more discretion about holding a review. However, if the child is (or has ever been) the subject of child protection plan this is one of the issues that *Working Together* lists as needing to prompt a LSCB to *consider* holding a review (HM Government 2010:236). The categories of plan shown in Table 2.4 include cases of review held for both death and serious injury.

The children at the centre of a review less often had a plan for emotional abuse, and were more often listed under multiple categories of concern than all children nationally with a plan (22 rather than 10 per cent). The multiple category cases may represent the most complex cases which we might expect to feature in serious case reviews. An alternative explanation may be that when a serious injury occurs to a child who has a plan under multiple categories, the LSCB is more likely to undertake a serious case review.

Where children had combined categories of CP plan (there were 39 SCRs where this occurred) almost three quarters included neglect. The combined plans were as follows:

Neglect and physical abuse	9 instances
Neglect and emotional abuse	8 instances
Neglect and sexual abuse	7 instances
Neglect, physical abuse and emotional abuse	2 instances
Neglect, physical abuse and sexual abuse	2 instances
Combinations of categories (but not including neglect)	11 instances

Table 2.5: Incident type and category of plan

Category of plan	Death	Serious Injury	Total*
Neglect	57 (56%)	44 (44%)	101
Physical abuse	21 (37%)	36 (63%)	57
Emotional abuse	18 (47%)	20 (53%)	38
Sexual abuse	4 (17%)	19 (83%)	23

*Children may be named in more than one category, thus the final column sums to 219 rather than 175.

Table 2.5 considers whether incidents were fatal or not, alongside the category of CP plan (current or past) for the 175 children and young people with a plan (where the category was known). Between 2005–11 there were 57 serious case reviews relating to the death of a child who had been known to be living with neglect (past or current CP plan). There were also 18 deaths of children who were emotionally abused during this period and it is pertinent to note that seven of these children were also the subject of a plan for neglect.

There were 44 serious case reviews conducted for serious injury to a child known to be living with neglect (past or current CP plan). There were also 20 reviews conducted for serious injury to children who had a CP plan under the category of emotional abuse (although again note that there is some overlap between categories – three of these were also the subject of a plan for neglect). Of those children with a past/current CP plan of any type, those who had been identified as living with neglect more often suffered a fatal incident than a serious injury. The majority (56%) of SCRs for children who had a past/current plan for neglect related to the death of a child. This compares to a lower proportion (37%) of cases of physical abuse.

When a child dies and maltreatment is known or suspected, and hence there is a serious case review, there is more often a context of known neglect (a CP plan for neglect) than known physical abuse (a CP plan for physical abuse).

THE CIRCUMSTANCES OF ALL THE CHILDREN'S DEATHS (2005–11)

To understand more about the circumstances of the deaths of all of the children and how neglect cases might differ, we analysed all 393 fatal cases from 2005–2011. (There was a total of 399 cases but information about the nature of the death was not available to us in six cases.) We examined these data in relation to whether the children were the subject of a CP plan, and if so whether or not this was for neglect. The category of death for all children was identified, using the system devised by Dr Peter Sidebotham and first tested for the SCR analysis of cases from 2006–07 (Brandon et al 2009) and subsequently adapted for later studies (Sidebotham et al 2011; Brandon et al 2012). Explanations for each category are listed in Appendix B (from Sidebotham et al 2011:300). Sudden unexpected deaths in infancy (SUDI), suicide, and some cases in the 'other death' categories are part of the wider category of 'deaths related to but not directly caused by maltreatment'. Chapter 3 gives a number of examples of cases where deaths were related to but not directly caused by maltreatment.

Table 2.6: Types of fatality and CP plan for neglect, 2005–11

Type of fatality* (see Appendix 2)	1a CP plan – neglect (n=56)	1b CP plan – not neglect (n=27)	1c Whole sample excluding CP plan – neglect (n=337)
Infanticide and covert homicide	2 (4%)	1 (4%)	18 (5%)
Deliberate – overt homicide	7 (13%)	4 (15%)	44 (13%)
Severe physical assault	4 (7%)	3 (11%)	87 (26%)
Extreme neglect, deprivational abuse	0	0	6 (2%)
Deaths related to but not directly caused by maltreatment	34 (61%)	18 (67%)	153 (45%)
Sudden unexpected death in infancy (SUDI)	*13 (23%)*	*3 (11%)*	*50 (15%)*
Suicide	*9 (16%)*	*11 (41%)*	*48 (14%)*
Other death related to but not directly caused by maltreatment	*12 (21%)*	*4 (15%)*	*44 (13%)*
Other death, category not clear	9 (16%)	1 (4%)	29 (9%)

*Information on fatality type not available for six cases, hence n=393 cases: % sum to more than 100 because of rounding.

It is noteworthy that the majority of the neglect deaths for children with a CP plan (61%) were those that were related to but not *directly c*aused by neglect. These included accidents and SUDI deaths where an unsafe living or sleeping environment or inadequate supervision may have played a role and suicide where the impact of past experiences of neglect was profoundly damaging to the young person's sense of self. This lack of a direct link between neglect and the child's death may be one of the reasons that neglect tends not to be considered dangerous.

By combining infanticide, homicide and fatal physical assault, we identified that 13 of the 56 children who had a CP plan for neglect died from a physical assault.

> Although numbers are small, perhaps the most striking point is that there is no evidence that any of the six children who died from extreme deprivational neglect (essentially starvation) had ever been the subject of a child protection plan. The potential severity and dangerous nature of the neglect they were living with had not been recognised, and at times the child had been hidden from sight. Alarm bells should ring for any child who has not been seen. This theme will be explored in the following chapter, section 3.1.

Table 2.7: Non-fatal incidents and CP plan for neglect, 2007–11

Characteristic	1a CP plan – neglect (n=28)	1b CP plan – not neglect (n=35)	1c Whole sample excluding CP plan – neglect (n=148)
Physical assault	9 (32%)	19 (54%)	88 (60%)
Neglect	5 (18%)	0	10 (7%)
Sexual assault	5 (18%)	8 (23%)	27 (18%)
Risk taking or violent behaviour by young person	8 (28%)	5 (14%)	14 (9%)
Other – including extended suicide attempt	1 (4%)	3 (9%)	9 (6%)

Table 2.7 considers the 176 non-fatal cases which led to a serious case review, using a classification developed in our analysis of serious case reviews from 2007–09 (Brandon et al 2010). Table 2.7 is based on four years of data, as compared with Table 2.6, which categorises fatal cases from a six year period.

WHAT DID NEGLECT CO-EXIST WITH?

The known prevalence of domestic violence, parental mental ill-health, drug misuse and alcohol misuse is presented in Table 2.8 for the cases of those children with a plan for neglect, alongside the two comparison groups. It is likely to have been under-recorded since this information was not always clearly listed in our key information source the Child Protection Database.

Table 2.8: Co-existence of neglect (CP plan) with evidence of substance misuse, domestic violence or parental mental ill-health

Characteristic*	1a CP plan – neglect (n=101)	1b CP plan – not neglect (n=74)	1c Whole sample excluding CP plan – neglect (n=544)
Domestic violence	29 (29%)	37 (50%)	157 (29%)
Parental mental ill-health	21 (21%)	19 (26%)	123 (23%)
Drug misuse	25 (25%)	14 (19%)	76 (14%)
Alcohol misuse	23 (23%)	11 (15%)	72 (13%)

* More than one factor may be applicable in any one child's case, so percentages do not sum to 100%. In some families none of the factors may be present.

A cautious interpretation is needed here, as there is a likelihood of under-ascertainment. Nevertheless, parental drug and alcohol misuse were higher for children with a past/current CP plan for neglect than for the other children. The incidence of parental mental ill health was approximately the same across all three groups. The incidence of domestic violence in the 'CP plan neglect' group was the same as in the wider sample, but lower than for children with CP plans in other categories. Neglect is associated with substance misuse so the higher proportion of neglect cases where this features is not surprising. The somewhat lower occurrence of domestic violence in the CP plan for neglect group is interesting and might, to some extent, be explained by neglect in these circumstances being reframed as emotional abuse or physical abuse.

THE CO-EXISTENCE OF NEGLECT AND PHYSICAL ABUSE

There is no clear evidence in England of the extent to which known neglect is present when children die or are seriously harmed through physical assault. For this reason we examined the number of cases where there was known physical assault, and related that to whether the child had a CP plan for neglect.

Physical abuse to the child was defined as having a current or past plan under the category of physical abuse, or where this information was clear from the Child Protection Database (CPD) where serious case reviews are notified. In addition we included those cases where the incident was coded as homicide or a fatal physical assault (using the Sidebotham classification discussed in Table 2.6) or as a non-fatal physical assault (using our classification discussed in Table 2.7). The figures, and proportions, given in Table 2.9 are likely to be underestimates, and further work could refine our knowledge of the overlap between different categories of abuse.

Table 2.9 Co-existence of neglect (CP plan) with evidence of physical abuse

	1a CP plan – neglect (n=101)	1b CP plan – not neglect (n=74)	1c Whole sample excluding CP plan – neglect (n=544)
Evidence of physical abuse to the child	36 (36%)	56 (76%)	317 (58%)

- Neglect co-existed with physical abuse for over one-third (36%) of reviews where children had a plan for neglect (Table 2.9).
- Of the 57 fatal cases where the child died, there was also evidence of physical abuse in 18 (32%) of these cases (Table 2.10).
- Of the 44 non-fatal, serious injury cases there was evidence of physical abuse in 18 (41%) of the cases (Table 2.10).

Table 2.10 Neglect (CP plan) with evidence of physical abuse: fatal or non-fatal cases

	Number of cases with a CP plan for neglect (n=101)	Evidence of physical abuse to the child
Fatal cases only	57	18 (32%)
Non-fatal cases only	44	18 (41%)

2.3 THE EXTENT OF NEGLECT AS A FEATURE OF THE CASE (N=83 FROM 139 CASES FROM 2009–11)

Although a CP plan for neglect denotes that there is serious neglect, it does not imply that children without such a plan are not experiencing neglect, and that in some circumstances it might be severe. Indeed the finding that none of the six children who died of extreme deprivation (starvation) had a CP plan in any category serves to reinforce this suggestion. Since one of our research questions seeks to discover how often neglect is evident in the families of children who become the subject of a serious case review, it is important to consider indications of neglect for ***all*** children at the centre of a review including those who had never had a plan in place. This includes children in need of services (s17 Children Act 1989) and children who were not getting any help from children's social care and were in receipt of lower level specialist services or only universal services.

For this part of the analysis we are using information from serious case reviews from 2009–11. We have restricted the analysis to the cases from this two year period because this offers us the fullest information from the six years of analysis, as well as being the most current available. This material was coded in SPSS and anonymised as part of the 2012 Department for Education funded study (Brandon et al 2012). Drawing from information from overview reports and executive summaries for 139 of the 184 serious case reviews from 2009–11, we were able to identify whether neglect was present, using a specifically developed protocol of indicators. This protocol includes indicators such as a child protection plan for neglect, but widens to incorporate other indications of neglect drawn from the information available on the cases (see overleaf).

Identifying neglect through this protocol was sometimes constrained by the varying form and detail of information available to us, and inherent difficulties surrounding precise definitions of neglect. While some of the information sources did mention what may be considered risk factors for neglect (for example parental substance misuse, mental health problems, domestic abuse etc.) we did not use this information alone to indicate the presence of neglect. These constraints should be borne in mind when interpreting the results. This analysis is also contained in the research team's recent biennial report on serious case reviews (Brandon et al 2012).

SAMPLE 2: STUDY PROTOCOL FOR IDENTIFYING NEGLECT

1. Current Child Protection plan (CP plan) or past CP plan for index child in the category of neglect (as per sample 1a).

2. Child Protection Database (CPD) states that long-term or recent neglect was a 'case characteristic'.

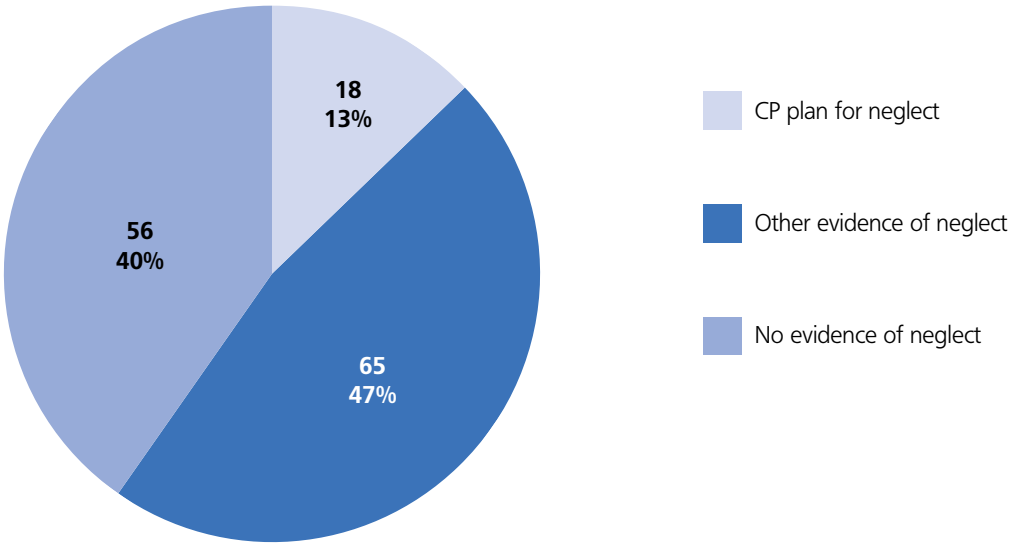
3. Indications of neglect drawn from further sources of information (including the case narrative section of CPD notification, SCR executive summaries, overview reports) from a combination of the following factors:

    - 'Neglect' directly referred to as a feature of the case
    - Child poorly nourished
    - Poor living conditions
    - Drug/alcohol misuse in pregnancy
    - Persistently not accessing health care for child/ante-natal care/not acting on medical advice/untreated ailments (including concealed pregnancy/birth)
    - Repeated missed appointments, or sustained reluctance to engage with services
    - Inappropriate supervision of a child, including inappropriate babysitter, supervision while under the influence of alcohol or drugs, accidents resulting from a lack of supervision
    - Inadequate clothing/hygiene
    - Serious school/nursery attendance concerns
    - Child accessing firearm or ingesting a harmful substance (associated with lack of supervision).

- Using this protocol we formed a judgement that neglect featured in the lives of 83 (60%) of the 139 children at the centre of these reviews.

The extent to which the neglect was already known and substantiated is highlighted in the pie chart in Figure 2.2.

Figure 2.2: Incidence of CP plan for neglect (at any time), and any other evidence of neglect, 2009–11 n=139



- 18 children had a current or discontinued child protection plan under the category of neglect.
- There was other evidence of neglect in a further 65 cases; making neglect a feature in a total of 83 (60%) of these 139 serious case reviews (Figure 2.2).

Neglect featured fairly evenly across the age ranges of children, apart from in the 11–15 year old group where neglect was a much more common feature in the child's history (Table 2.11). A better awareness of the widespread existence of neglect in the history of vulnerable adolescents has been an important consequence of Rees and colleagues' study of adolescent neglect (Rees et al 2011).

Table 2.11: Incidence of neglect by age group (2009–11)

Age group	Incidence of neglect	
	Neglect a feature of case (n=83)	No mention of neglect (n=56)
<1yr	27 (56%)	21 (44%)
1–5yrs	20 (54%)	17 (46%)
6–10yrs	10 (53%)	9 (47%)
11–15yrs	20 (87%)	3 (13%)
16+ yrs	6 (50%)	6 (50%)

NEGLECT WITHIN CATEGORIES OF FATALITY AND SERIOUS HARM

Next we considered the incidence of neglect within certain types of maltreatment and abuse, distinguishing between those cases which had a fatal outcome (n=96), and those where the child was seriously injured (n=43). The definitions for these categories, adapted from the work of Sidebotham and colleagues (2011), are provided in Appendix B. Table 2.12 shows that in the fatal cases, current or past neglect was evident in almost all of the deaths related to but not directly caused by maltreatment, where accidents were often a feature. These include most of the cases of Sudden Unexpected Deaths in Infancy (SUDI) which is perhaps not surprising since concerns about abuse and neglect are likely to trigger a serious case review in these cases. There was evidence of past neglect from eleven of the fourteen suicide serious case reviews. Neglect was also a feature in a quarter of the physical assault cases and in a similar proportion of the deliberate homicide cases.

Table 2.12: Incidence of neglect by type of fatal injury

Incident category	Incidence of neglect (n=96)	
	Neglect a feature of case (n=56)	**No mention of neglect (n=40)**
Infanticide and covert homicide	3 (50%)	3 (50%)
Deliberate/overt homicide	5 (26%)	14 (74%)
Fatal physical assault	5 (25%)	15 (75%)
Extreme neglect, deprivational abuse	2 (100%)	0
Deaths related to but not directly caused by maltreatment	37 (82%)	8 (18%)
SUDI	*12 (80%)*	*3 (20%)*
Suicide	*11 (79%)*	*3 (21%)*
Other death related to but not directly caused by maltreatment	*14 (88%)*	*2 (12%)*
Other category	4 (100%)	–

Over two thirds (27) of the 43 serious injury (non-fatal) cases showed indications of neglect (Table 2.13). In five out of the seven cases relating to serious sexual abuse, the children had also been living with neglect. Neglect was also apparent for almost two thirds of the children who suffered non-fatal physical assault.

Table 2.13: Incidence of neglect by type of non-fatal injury

Incident category	Incidence of neglect (n=43)	
	Neglect a feature of case (n=27)	No mention of neglect (n=16)
Physical assault	14 (61%)	9 (39%)
Sexual assault	5 (71%)	2 (29%)
Neglect	5 (100%)	0
Risk taking or violent behaviour by young person	3 (43%)	4 (57%)
Other e.g. extended suicide attempt	0	1

There was some evidence of neglect in the risk-taking young people's cases although it may be that family backgrounds are less to the fore in the reviews, and that a fuller picture, going further back in time, would reveal more neglect than is suggested here.

SUMMARY

HOW MANY SCRS CONCERNED CHILDREN WITH A PAST OR PRESENT CP PLAN FOR NEGLECT?

- Between 2005–2011, 101 of the 645 serious case reviews (approximately one in six) concerned children with a CP plan in the category of neglect. In other words there were 101 cases of officially substantiated child maltreatment in the category of neglect over the six year period. For 59 of the children, the plan for neglect was in place **at the time** of their death or serious harm, for the other 42 children the plan had been **discontinued**. This shows that some children living with known neglect may be at risk of death, and not just long-term developmental damage. However, having a CP plan for neglect is NOT a predictor of likely death or serious harm and should not be interpreted in this way.

ARE CP PLANS FOR NEGLECT DROPPING IN THE SCR POPULATION?

- There are encouraging signs of a drop over time in the number of SCRs where a child had a CP plan for neglect in place at the time of the death or serious injury (a decrease from 12 per cent of all SCRs during 2005–07, to 6 per cent between 2009–11). This could suggest that children in the community with a CP plan for neglect might be being better protected. It is possible that this reflects practice improvements and that

most recently, child protection plans for neglect were being used more successfully. Worryingly, there was no similar decline in the number of reviews for children who had a discontinued CP plan for neglect – and the question remains as to why the plan was removed.

DEATHS OR SERIOUS HARM WHERE CHILDREN HAD EVER HAD A CP PLAN FOR NEGLECT?

- Fifty-seven reviews concerned the **death** of a child who had ever been the subject of a child protection plan for neglect.
- Forty-four reviews concerned children with a neglect plan who suffered a **serious injury** but survived.

HOW DOES NEGLECT COMPARE WITH OTHER CATEGORIES OF MALTREATMENT?

- Neglect was by far the most frequent category of child protection plan in SCRs, and amounted to more than the other categories of maltreatment combined.
- There is more often a context of known neglect than known physical abuse. The majority of SCRs for children with a past or present plan for neglect (56%) died in comparison with a lower proportion (37%) of cases of physical abuse.
- There was co-existing physical abuse and neglect for over one-third (36%) of all children with a plan for neglect.

WHAT ARE THE TYPES OF FATALITY FOR THE 56 CHILDREN WITH A CP PLAN FOR NEGLECT?

- Most of the deaths (34) were related to, but not *directly* linked to maltreatment (13 children died as a result of SUDI, 12 following accidents, and nine young people died through suicide).
- 13 children died as a result of a form of physical assault (either ‘infanticide’, ‘homicide’ or ‘fatal physical assault’ – see Table 2.6).
- In nine cases the cause of death was unclear.

WHAT DID NEGLECT COEXIST WITH?

- Parental drug and alcohol misuse were higher for children with a past/current CP plan for neglect than for the other children.

WHAT IS THE EXTENT OF NEGLECT IN ALL SCRS FROM 2009–11?

- Neglect occurred in a total of 60 per cent (83) of the 139 serious case reviews from 2009–11.
- Neglect featured evenly across the age ranges apart from 11–15 year olds where it was much more common.
- Where children died, current or past neglect was evident for almost all whose deaths were related to but not directly caused by maltreatment (SUDI, suicide accidents and 'other'). There was neglect in a quarter of the deaths through assault and deliberate homicide.
- There was neglect in over two thirds of the 43 non-fatal cases, and in five of the seven serious sexual abuse cases.
- Neglect was evident for two thirds of the children who suffered non-fatal physical assault.

3 A thematic analysis of neglect

3.1 INTRODUCTION

This chapter is primarily concerned with the ways that neglect features in serious case reviews and provides more background, and richer detail, to understand how circumstances came together when neglect had a catastrophic impact on the child (and family). We examine the types of neglect that are detailed in serious case reviews, and the ways by which neglect can become, potentially, fatal, presenting six ways in which neglect appeared to link to a catastrophic outcome. Each way is distinct but there are also some shared features in the six pathways of neglect. This work is important since there is a common perception that neglect is very rarely fatal – and this can have the consequence of downgrading people's concerns (whether relatives', neighbours' or professionals').

A qualitative approach to the analysis is used to explore the following research question:

- *In what ways does neglect feature in these cases of child fatality and near fatality?*

We also explore the ways in which neglect co-exists with other types of maltreatment and reflect on what it might have been like to be a child living in different neglectful circumstances. The stories emerging from individual cases provide powerful learning; and although each child's case obviously has unique differences and nuances, there are also some similarities, patterns and themes. The source materials on which the analysis is based are executive summaries and summarised and coded overview reports for a total of 46 serious case reviews, held between 2003–2011. We have examined each case in depth using an ecological transactional approach, grounded in the child's experience, which promotes a dynamic understanding and assessment of the interactions between children and their families and the helping practitioners.

Scrutiny of case summaries, where neglect appeared to feature heavily, ultimately produced a six-fold typology of incidents related to catastrophic neglect which were addressed in serious case reviews. Each of the six categories raised particular issues, over and above a common core of concerns around the relationship between the child and his or her parent or carer, and between parents/carers and professionals. It is not our intention to present these categories in any kind of ranked order, although the first three of these most clearly involve neglect as a direct cause of the child's death or serious

harm. The final category considers the longer term consequences of living with neglect when the young person takes their own life.

1. Malnutrition: Extreme deprivation by withholding food or water from the child, where the child died or was close to death (8 cases).

2. Medical neglect: The child died or was seriously harmed or nearly died because the parents did not comply with medical advice or administer medications (5 cases).

3. 'Accidents' with some elements of forewarning: Accidents, both fatal and resulting in serious harm, occurred within a context of chronic, long-term neglect, lack of supervision, and an unsafe environment (9 cases).

4. Sudden unexpected death in infancy: Unexplained infant deaths within a context of neglectful care and a hazardous home environment (10 cases).

5. Physical abuse combined with neglect: Physical assault, both fatal and resulting in very serious injury, in a context of chronic, neglectful care, where the assumptions about neglect masked this danger to the life of the child (7 cases).

6. Suicide of a young person: A long-term history of neglect or extreme isolation having a catastrophic impact on the young person's mental wellbeing (7 cases).

These six themes were drawn from the cases and not constructed from the definition in *Working Together* (HM Govt. 2010). However it is interesting how closely they connect with this official definition, with the exception of the theme of physical abuse combined with neglect. Another difference is 'accidents' with elements of forewarning which similarly do not feature in *Working Together*.

Having established this framework, further analytical work was then undertaken, examining cases applicable to each category. The selection of cases was based on pragmatic consideration about the availability of source documents and also on their relevance to each of the identified themes. Analysis involved both revisiting previously completed case summaries where neglect was prominent (for 2003–09) and creation of new summaries for SCRs from 2009–11. The case summary structure included an outline of the case, the child and family background, the child's experience, agency involvement, and lessons learned.

Four researchers were involved in the analysis, and regular team meetings were held to discuss and identify emerging themes. Results are presented in the form of case vignettes. Care was taken to change identifying details and to use a combination of sources, so that each vignette was based on a number of cases which shared similar features. Thus each vignette, as presented, is a composite but credible case, and the actions, circumstances and agency responses do not refer exclusively to the history of any one child. Instead they allow for the investigation of key themes, in a manner which

maintains anonymity for the children, families and agencies involved in the serious case reviews. Each vignette was set out as follows:

- key features of the case,
- the event prompting the serious case review,
- background to the family and case,
- types of neglect experienced,
- an interpretation of what it might have felt like to be a child in this family/these circumstances,
- agency involvement,
- learning from the serious case review(s).

Each vignette is also accompanied by a thematic discussion and learning points which draw on our broader knowledge from previous work on serious case reviews. Many of the themes and messages overlap across more than one of the incident types, but we have tried to limit discussion of each theme to where it is of particular relevance.

Throughout this discussion it needs to be borne in mind that the learning has come from unusual cases where children have died or been seriously injured through abuse or neglect and for whom a serious case review was undertaken. While these reviews provide rich learning about families and into the system of everyday practice, we need to remember the limits of transferability of this learning to practice.

3.2 EXTREME MALNUTRITION AND NEGLECT

Withholding of food represents neglect of the most basic physical need and cases of starvation in children are very rare. The number of serious case reviews undertaken where the baby or child was dangerously emaciated has been low; typically only one or two per year. Table 2.6 in the previous chapter estimated that there had only been six serious case reviews undertaken in relation to fatal cases of malnutrition over a six-year period between 2005–11. In addition there were a small number of non-fatal cases, where malnutrition had been so severe that the child was within days of death, but had fortunately survived after intensive hospital treatment. However, long-term physical damage, for example to the liver, is likely to have occurred, in addition to the psychological harm caused to the child. The qualitative analysis in this section is based on eight serious case reviews (six deaths and two near fatalities).

As discussed in Chapter 2, it was noteworthy that none of the six children who had died as a result of malnutrition (and about whom a serious case review was held) had ever been the subject of a child protection plan – let alone for neglect – at any stage in their lives. The extreme neglect they had experienced had either gone unrecognised, or previous attempts to stem the neglect had been unsuccessful. In both these circumstances the child was 'invisible' and this theme in particular is explored in the vignette presented below. The vignette incorporates elements from a number of serious case reviews and is thus able to create an illustrative case which raises a number of important issues. It draws material from mostly fatal, but also non-fatal, serious case reviews, relating to babies under the age of one year, and older children of varying ages.

COMPOSITE VIGNETTE – 'AMY' AGED 4 – EXTREME MALNUTRITION AND NEGLECT

Key features of the case:

- Severe malnutrition – starvation over a period of several months, leading to death.
- Three older siblings in the household; also malnourished and had stolen food at school.
- One younger half-sibling who after (delayed) 6-week check/immunisations had not been seen by any professional.
- Parents opted to home-educate some of their children, thereby increasing the family's isolation. Amy had been withdrawn from pre-school nursery education.
- Dominant, older step-father – controlling the children's lives, including diet and discipline.
- Domestic violence rendered the mother fearful and unable to meet the children's needs.

Event prompting the Serious Case Review:

Emergency services were called to the child's home, but Amy was pronounced dead on arrival at hospital. Her weight was below the 0.4th centile, and she had suffered significant starvation for a number of months. The surviving siblings were malnourished, but survived.

Background to the family and case:

The family comprised two adults and five children under secondary school age. Amy was the youngest but one, and her father had left the family shortly after her birth; he was also the father of the three older siblings. The mother had a new partner, who was significantly older than her, and he

was the father of the youngest, one-year old child. A number of incidents of domestic violence had been reported to the police, and mentioned by the mother to her GP. The new partner was controlling of many aspects of the mother's and the children's lives, including what they ate, and discipline/ punishment of the children.

Amy's younger half-sibling (the only child from the mother's new relationship) had been born at home, after a history of poor ante-natal care during the pregnancy. The appointment for the baby's six-week check and immunisations had not been kept and, subsequent to the delayed GP visit for these, the baby had not been seen again by any health professional. Amy had attended a pre-school nursery for part of a term, but had been withdrawn, with unpaid fees outstanding.

The three older children were of school age. Prior to their father leaving the household, the children's school attendance had been adequate and both parents had engaged, at least to some extent, with the schools. When the new partner became part of the household, relationships with the schools had deteriorated, resulting in two siblings being removed and home-educated, while only the eldest child remained in school. Prior to their removal, the schools had noted that the children often appeared hungry, and on occasions had stolen food from other pupils. Following the decision to home-school, a member of the authority's home educator support service had attempted to monitor the two children's education at home, but was rebuffed by the mother.

The mother had, in the past, suffered from an eating disorder, and had a very low body mass index (BMI). She had sought help for anxiety and depression from her teenage years onwards. Amy's birth father had been known to youth offending services, and he and Amy's mother were both aged under 18 when the first of their four children were born. The mother's partner at the time of Amy's death had experienced domestic violence as a child, and the death of a sibling. He had a number of children from previous relationships, with whom he had minimal contact. He was some 20 years older than Amy's mother. There was no recorded misuse of either alcohol or drugs by either parent. The family experienced financial problems, and had moved house with some frequency, although within the same city. This had exacerbated the isolation of both the parents and the children.

Types of neglect experienced:

- The adequate provision of food is the most basic of a human's physical needs. All the children in this family suffered from malnutrition and hunger, and Amy died from starvation. Medical help had not been sought during the recent months that this had been happening.

- There had been a lack of proper ante-natal care in the last pregnancy, and increasingly poor engagement with health professionals. In the context of this family, the decision to home educate two of the children would have led to a neglect of their intellectual development, and little opportunity to socialise with other children of their age.

What it was like to be a child in this family:

Amy would have felt helpless and hopeless and endured immense physical suffering. She lived in extreme isolation, indeed virtual imprisonment. When not shut away Amy would have done her best to forage for food wherever she could find it. Her 'caregivers' were no longer caring for Amy, and by removing Amy from their sight it is likely that over time, she was ceasing to exist for them.

Agency involvement:

Health visiting: attempted visits by the health visitor had largely been unsuccessful, and on one occasion when a health visitor gained access to the house, she was told that the youngest two children were at a relative's for the day, whereas it subsequently emerged that they had been upstairs at the time, and access deliberately withheld. The older three children were at school when this visit took place. The part of the house the health visitor entered was adequately clean, if rather sparsely furnished; she was not given access to the children's own rooms.

GP: the children had rarely been seen by a GP, and the youngest child, who was by that time over a year in age, had not been seen since the initial 6-week check and first immunisations, which in any case had been rearranged because of non-attendance. The mother had confided in her GP regarding incidents of domestic violence, but had been advised to contact children's social care herself.

Home educator service: an agency that assisted with homeschooling unsuccessfully attempted to engage with the parents. Given their concerns regarding the two children's education, the case was referred to children's social care.

Children's social care: during a ten month period, following the referral from the home education service, a social worker, along with an elective home education officer, were allowed into the home once. An initial assessment was made, but a core assessment was never completed following the parents' lack of cooperation, and the case was closed after ten months. The children were never spoken with.

Learning:

Themes emerging from the serious case reviews included:

- **Isolation and invisibility of the child:** this was an increasingly 'invisible' family where, because of the isolation of the household, professionals largely lost sight of the children, both literally and in the sense of being aware of their needs. Two children ceased to be seen at school, Amy was no longer seen at nursery, and universal health services had rarely seen the baby. There were a number of unsuccessful visits to the home by health visitors and a home education support staff member. No agencies were aware of the increasingly unsuitable living conditions and inadequate care of the children.
- **Changes in the parents' behaviour:** insufficient attention was paid to, or due weight given to, changes in the parents' behaviour and their level of cooperation with professionals and agencies. The family withdrew from spheres of life where they had previously engaged. Withdrawing from health services **and** schools (including in this case pre-schooling) is a potentially dangerous omission for children. Children also miss out on school medical appointments – an opportunity for them to have their health, development and welfare independently assessed and for them to express a view. Prior to the new partner's links with the mother, she had been considered by professionals to be a sufficiently engaged and protective mother of the children. Her behaviour altered after she formed this new relationship, and decreasing contact with professionals concealed the influence of this much older, controlling man. An opportunity to intervene was missed when the mother disclosed domestic violence to her GP, but the safeguarding risk that this posed was not communicated to children's social care.
- **Home education:** the quality of education received at home by the siblings was not known; but the move to home education may have been a deliberate ruse to isolate the family further, and the children's educational development was also likely to have been neglected.
- **Non-compliant and hostile parents:** it can be difficult for staff, particularly those in universal services such as health or education, to judge whether their concerns merit the involvement of children's social care. If parents are evasive, untruthful and manipulative this decision is made more difficult, and professionals may be unable to understand the degree of harm to the child that the parents pose. The facade presented by the parents prevented professionals from engaging with them, or being able to intervene in the children's lives.

In reading the set of serious case reviews where malnutrition was a feature, a number of issues arose. Given the small number of malnutrition cases in total, it is likely that some of the issues below may have pertained to only one or two children's cases:

- Withholding of food as a form of punishment – limiting food being used as a way of establishing adult authority;
- A relationship between the child and caregiver that is so poor that for the adult the child had ceased to exist;
- Restricted diet resulting from faith/lifestyle choices; diets which are appropriate for adults may be deficient in certain nutrients for small children, and can increase the possibility of diet-related conditions such as rickets (insufficient calcium in the diet);
- Mother's eating disorder impacting on her ability to feed her children nutritiously;
- For the small number of older children, an additional feature of their lives was the virtual imprisonment in which they were held.

THEMES AND LEARNING POINTS

Emotional development and faltering weight gain in babies and young children

While cases of life threatening malnutrition were rare, a number of other serious case review reports addressed concerns about faltering weight gain. These cases revealed complex and differing reasons as to why parents or carers appeared not to be nurturing their child. There was also a pattern of professionals failing to recognise that a key part of the baby or child's faltering growth could lie in a problematic relationship between the child and his or her caregiver, which hindered the child's emotional development. What happens during feeding provides powerful clues to the parents' reactions to their child, and to the child's responses to his or her caregivers. In addition to their physical needs to be properly fed, these babies had an emotional need to feel connected with their mothers, which was not being met. More detail about feeding is found in our recent study of child development in serious case reviews (Brandon et al 2011).

Neglect in children given a low priority

On occasions this had prevented emergency action. In one instance a community paediatrician had to convince a colleague in hospital to admit a child with life threatening malnutrition – the colleague's view initially had been that 'neglect is not a medical emergency'. A number of more recent serious case reviews have provided evidence of more positive practice and, in the set of SCRs we analysed here, speedy hospital admission saved at least two children's lives.

Changes in families' behaviour and willingness to engage not recognised

The significance of a changed pattern of cooperation with professionals and agencies was, in some instance, not noted, or not ascribed due weight. Withdrawal from a sphere of life where the family had previously engaged can decrease the ability of, and the opportunities for, professionals to safeguard a child. It can also mask rapidly deteriorating home conditions, and signs of potential harm to the child. This withdrawal can be from involvement with health professionals. There can be marked changes over time with good attendance for immunisations and check-up appointments for earlier children, but over time, a withdrawal from regular contact with health services, to the point of avoiding most medical assistance with a subsequent pregnancy and following the birth.

Children who are absent or excluded from school are also particularly hidden from view and therefore vulnerable. Children who go missing from education are noted in *Working Together* to be vulnerable to risks of significant harm (HM Government 2010:317). In the vignette it was the sudden lack of cooperation with schools which was highlighted, and the decision to educate at home – a feature not picked up as a risk in *Working Together*. The responsibility for a child's education rests with the parents, and while education is compulsory school is not. A parent's right to educate their child/ren at home is upheld by Section 7(b) of the Education Act 1996. Once the decision to home educate has been notified, there is a lack of a strong, mandatory framework to monitor, assess or inspect the quality of home education provision. Moreover there is no agreed route for the children involved to formally express their views as to where they wish to be educated, or to give feedback on their experiences of being educated at home. This would appear to contravene Article 12 (respect for the views of the child) of the United Nations Convention on the Rights of the Child:

> *'When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account'.*

There is no statutory requirement for a local authority to maintain a register of pupils being educated at home, the authority cannot insist on regular contact with parents, and the latter are under no obligation to accept home visits. Parents do have to provide evidence of the education they have provided for their children, by way of written reports, samples of work, or the endorsement of a third party. We would argue that respect for parents' wishes, and their right to home educate their children, should not come at the cost of children's education, health, welfare or safety. One serious case review overview report noted: *'a lack of clarity about when cases should be referred to CSC on children who are home educated'.*

3.3 MEDICAL NEGLECT

The children who were the subject of serious case reviews involving medical neglect ranged in age from infants to teenagers and lived in families from diverse socioeconomic status, cultural, and educational backgrounds. The analysis presented in this section is based on five serious case reviews.

The SCRs drew our attention to undue professional optimism – in particular from the medical community. In general, it was expected that parents wanted to, or were able to, care for their seriously ill or disabled child. In some instances, however, this instinct to care was tinged with the shame of having a child with long-term disabilities, in some cases cultural stigma, and in others depression. Maintaining the family's emotional health and resilience is as vital as directly following up on the child's physical progress since one directly affects the other. This was especially important for families whose child was never referred to children's social care for support or protection and for families who did not reach the threshold for this service.

Many of the families whose children were the subject of a serious case review lacked any support beyond that provided by the medical community. Parents either had limited extended family and friends nearby, or in the case of single parents, the mother was sometimes young and vulnerable herself with little or no assistance from the child's father. Social workers, health visitors, and the medical community, according to the SCRs, often failed to document who else was available to care for the child, or believed the parents had more support than they actually did. The SCRS, in particular, emphasized professionals' lack of engagement with fathers, and in the cases where step-fathers were involved, their level of involvement or influence was seldom noted or considered important. The following vignette of a child with a chronic illness touches on some of these community and parenting issues. It draws upon material from cases involving infants and teenagers and demonstrates the escalation of medical neglect, and the child's ultimate death.

COMPOSITE VIGNETTE – 'BEN' AGED 6 – MEDICAL NEGLECT

Key features of the case:

- Ben had an epileptic seizure when unsupervised and drowned.
- Ben was born prematurely to a young mother who had limited extended family support.
- After Ben was diagnosed with epilepsy, numerous health care professionals became involved with the family.
- A pattern of missed medical appointments, and concerns that medication was not always being administered properly.
- A caring mother who, when prompted, improved care, attendance at appointments – as a result of which health services never referred to children's social care.
- After the birth of Ben's sibling, his mother's administration of Ben's medication was increasingly erratic.
- The health visitor was concerned about Ben's slow weight gain, developmental delays and seizures after his sibling's birth but there was no contact with Children's Social Care (CSC).

Event prompting the serious case review:

This serious case review was conducted following the drowning of six-year-old Ben, after an epileptic seizure.

Background to the family and case:

Ben was born prematurely to a mother in her early 20s. Not much was known about Ben's father although he was intermittently involved with the family and sometimes lived with Ben and his mother.

Ben's epilepsy required regular hospital visits and medication. Although judged to be aware of her child's complex medical needs, his mother had difficulty attending all of Ben's medical appointments and was not always consistent with administering his medication. The health visitor observed that she was struggling to cope but also had a loving bond with her son. Medical professionals who cared for Ben noted that he had a sunny disposition and that his mother tried her best. When medical appointments were missed, professionals responded by making new appointments but did not puzzle over the reason for the missed appointments or consider making a referral to children's social care.

When Ben was five years old, his mother gave birth to a second child. It is not clear whether this child had the same father as Ben, as the mother had recently told her GP that she and Ben's father had separated. After the sibling's birth, Ben's mother took him to fewer medical appointments. Hospital staff were increasingly concerned about Ben's failure to grow and suggested that his mother was not appropriately administering his medication, which she denied. Despite suspicions, hospital staff failed to follow-up on these concerns and did not contact children's social care. When the health visitor suggested a referral to a social worker, the mother refused the health visitor access to her home but still no referral was made.

Types of neglect experienced:

Ben's mother failed to act on medical advice regarding her child's complex health needs and had a longstanding difficulty in keeping up with medical appointments, including specialist visits, and a history of not always administering Ben's medication when he 'seemed better'. When prompted by professionals, these patterns improved for a while but inevitably deteriorated again. The mother's failure to act on medical advice put her child at risk of developmental difficulties and seizures such as the one which preceded the drowning.

Whether Ben's mother's failure to administer his medication was accidental or deliberate is hard to say. Lapses in essential supervision while she cared for her new baby suggest that Ben had possibly become less of a priority

or more of a burden to his mother, or that she could not cope with Ben's complex needs as well as the demands of a young baby.

What it was like to be a child in this family:

Ben was secure in his mother's love and interest and he enjoyed and benefitted from playing with her and singing songs. His life was not always predictable however and things at home were different when his father was around, when his mother did not play with him so much and there were sometimes arguments. When Ben's baby brother was born things changed and Ben's mother had less time for him and forgot to give him his medication more often. He knew he had to look after himself now and was on his own more often and didn't go to the hospital or see the doctor so often. Without regular medication Ben had more seizures, and in the days that followed, less energy and more impaired function. Life was harder, more confusing, and at times frightening.

Agency involvement:

- **GP and specialists:** Many medical professionals including specialists remained involved with Ben throughout his life because of his diagnosis and saw him frequently in spite of numerous missed appointments. Although hospital staff were concerned that Ben's mother was not managing Ben's health related needs, they did not refer the case to children's social care as they felt the otherwise loving mother was complying with their concerns and attempting to improve.
- **Health visiting:** Two health visitors were involved in Ben's life. The first health visitor observed that the relationship between him and his mother was warm, and that Ben seemed happy and confident. The home, although small, was clean and comfortable with adequate food. Although the relationship between the mother and the health visitor was initially good, it deteriorated when the health visitor became concerned about Ben after his sibling's birth. She discussed involving social care, and as a result Ben's mother stopped seeing the health visitor. The second health visitor did not follow up on her colleague's suggested referral.

Learning:

Themes emerging from the serious case reviews included:

- **Undue professional optimism:** While Ben received adequate medical treatment and was prescribed medication, medical staff did not follow up his failure to grow and thrive. Even when staff suspected the mother might not be administering medication appropriately, the case was not referred to CSC as they wanted to give her more time to improve. The

SCR suggests that medical professionals may be overly optimistic that families will be able to care for a child with a long-term illness even when there is evidence to the contrary.

- **Non-compliant parent(s):** Ben's mother refused to continue working with the first health visitor when she expressed concerns over Ben's deterioration after the birth of his sibling. Rather than follow up on the health visitor's intentions of involving social care, however, she was replaced by a second health visitor who again allowed the mother time to improve. The SCR suggests professionals did not appropriately challenge the mother's behaviours in order to safeguard Ben.
- **Changing family circumstances:** Professionals (health care and second health visitor) did not seem to have considered the impact of another child's arrival in a family unit, where the mother was already struggling to care for a child with a long-term serious medical condition and a newly ended relationship. While allowing the mother more time to cope might have been an adequate response for a limited period of time, the changing family circumstances should have prompted a change in approach.
- **Failure to involve father/partner:** There was no sign that professionals included the father of the child in any assessment or asked about his involvement with Ben. For a long time, the identity of the father seemed unknown to professionals. This led the SCR to highlight the importance fathers/partners have on children's wellbeing.

THEMES AND LEARNING POINTS

Child with complex medical needs or disability

Children in this category might have been born with complex health needs or disabilities, or they may have developed a serious childhood illness. All of these children, however, required long-term and often complicated care.

Parental responses to complex medical needs and disability

While some parents in these medical neglect cases responded to their child's long-term medical condition with frequent hospital visits and attentive parenting, others displayed a less attentive, more clumsy way of interacting with the child or the child's siblings and this was flagged as a point of concern by hospital staff or children's social care. In some instances, parents were unwilling to accept their child's diagnosis, or were not fully capable of understanding their child's condition. Early care of a child with an illness was often closely monitored by health visitors and in some cases by children's social care. In most of these particular SCRs, parents were described as attempting to keep up with and fully understand their child's medical needs.

Parental learning disability

Parental learning disabilities are rarely highlighted in serious case reviews although our analysis of these reviews has shown that there are often indications that parents had learning problems which were not assessed or addressed. The rigorous demands of these children's highly complex health care needs present serious challenges to parents with a learning disability.

Parents struggling to keep up with medical care

Despite initial attempts to address the child's health needs, some parents soon began to struggle to care adequately for their child. This was often noticed through difficulties keeping up with numerous medical appointments. This was sometimes attributed to an overwhelming number of appointments with specialists and GPs; to a lack of transport, or difficulties balancing work and medical appointments. Some parents attended general medical appointments but failed to appear at specialist appointments, for example eye tests, or hearing aid fittings. There was a pattern of frequently rescheduled appointments which tended not to be kept.

Professionals shielding parents from children's social care

In several of the cases, hospital staff were concerned about the child's development or growth, or suspected that the parent(s) were not properly administering the child's medication long before the incident which prompted the SCR. Schools/nurseries likewise may have noted concerns over the child's failure to grow or to socially engage with other children. In nearly all of these cases, however, staff did not share their concerns with CSC, sometimes in an attempt to shelter the family from further professional involvement, or due to a lack of awareness of what these concerns might mean. Some schools attempted referrals but filled in forms incorrectly or did not present the information cogently resulting in CSC rejecting the referrals prior to investigating the case further.

Tipping points in family circumstances

This small sample of medical neglect cases all displayed a negative turning point, or tipping point, in the child's life connected to a specific change in the family's circumstances. This was particularly true after the introduction of a new family member – either a new baby, or a new partner. Once this new family member arrived, the ill (or disabled) child's needs were increasingly neglected. Sometimes the neglect was deliberate as in one case where the child was forced to sleep outside in the garden shed, ostensibly because of bad behaviour, and was thus physically and symbolically excluded from the family. In other cases, neglectful care came in the form of lack of supervision as well as a failure to appropriately administer medication and attend to health needs.

3.4 'ACCIDENTS' WITH SOME ELEMENTS OF FOREWARNING – NEGLECTFUL SUPERVISION AS KEY FACTOR

Accidents are generally understood as sudden, unexpected events taking place without forewarning. In the cases studied here there were a range of factors that meant that the appalling accident that happened, although not directly predictable, offered some element of forewarning. Accidents in childhood are a common occurrence, and data from child death review teams are revealing more about those much rarer accidents that result in fatality to a child. Very few of these cases of accidental death, however, will lead to a serious case review.

To hold a serious case review following an accidental death or serious injury arising from an accident there must be suspicions about abuse or neglect. In the cases we examined for this section there were pre-existing concerns around the conditions in which children were living; for example the poor state of repair of their homes, fire hazards, lack of amenities and/or utilities and unsuitable location. There were also concerns around the quality of the supervision and parenting that the adults in their lives were able to give. The accidents that occurred were most likely to feature either fire, drowning, or less frequently accidental poisoning, burns or scalds. Fires and other accidents raise important issues about environmental dangers and about the broader links between neglect, maltreatment and deprivation. The analysis in this section is based on nine serious case reviews.

The composite vignette presented below explores issues around neglect, poor supervision and squalid and unsafe living conditions, within the context of a house fire which led to a child's death.

COMPOSITE VIGNETTE – 'CHLOE' AGED 2 – HOUSE FIRE

Key features of case:

- Chloe, who was 2 years old died in a house fire; her siblings managed to escape.
- Both Chloe and her three siblings were the subjects of child protection plans under the dual categories of neglect and emotional abuse, at the time of the incident.
- Long history of severe neglect and inadequate response by agencies.
- Maternal alcohol abuse.

Event prompting the serious case review:

A young child died in a house fire at their home. The fire service were able to rescue the mother and her other three children. The fire was attributed to the use of candles in the house as the pre-payment meter had been disconnected and there was no electricity. The mother was found to be in a highly intoxicated state. The smoke detector at the property was not working, and investigation by the fire service showed that this was not the first incident of a fire at the address. Following an earlier incident the risk to the children from a house fire had already been discussed with the children's mother by a fire officer.

Background to the family and case:

The mother, who was in her mid-twenties, was living on her own with her four children at the time of the incident. Chloe was the third child in the family – she had two older siblings of primary school age, and a baby brother. As the family size grew, the mother was increasingly unable to cope and home conditions and the children's physical care steadily worsened. There were also an increasing number of reports from neighbours of instances of violence and alcohol abuse.

The mother's own experiences of being parented were poor and she had endured many negative experiences throughout her life and had been in care as a teenager due to both sexual and physical abuse at home. She had experienced depression for many years and attempted to manage her personal distress through the harmful use of alcohol. Chloe's mother had a number of partners, from the birth of her first child onwards, some of whom had lived at the family home. Little information was available about Chloe's father, although the mother had said that domestic violence had been a feature of this relationship.

Types of neglect experienced:

The children experienced physical neglect; there was mention of decayed teeth, matted hair, and the children smelt of urine. Their health needs were neglected, with a number of missed medical appointments, including antenatal and postnatal attendance.

There was a lack of safe parental supervision; the children were left unsupervised, or left with unsuitable carers. The home environment was disorganised and unsafe. There was a lack of hygiene in the house, a state of disrepair and the accommodation posed a fire risk. Old food and faeces were on the floor. There were also concerns about the number of pets at the property and minor bites and scratches caused by the animals to the children. There were overflowing ashtrays and matches around the house.

What it was like to be a child in this family:

The mother's capacity to care for the children had decreased with each new birth, and she became increasingly emotionally detached from her children. Basic needs were poorly met, and the children often went hungry, had no bed linen, and hardly any toys. The lack of supervision, the squalor, frequent house moves and, above all, the mother's alcohol intake must have made all the children's lives very bewildering and distressing.

Agency involvement:

Over time a large number of social workers and family support workers had been involved with the family, and concerns over the care of the children had been voiced by health visitors, police, a nursery assistant, a school nurse/ school staff and neighbours. Following a domestic violence incident, police were concerned about the conditions in which the children were living, and subsequently a child protection enquiry was initiated and a core assessment undertaken. All the children ultimately became the subject of a plan for emotional abuse and neglect. Initially the mother was noted to be making an effort to cooperate and to attend appointments with social workers, however her engagement became increasingly sporadic and unsatisfactory.

Health appointments for the children were not kept, including for spectacles, dental care, and speech and language therapy. These specialist services responded by closing the case instead of treating non-attendance as a warning sign, triggering greater vigilance.

The oldest two children were at primary school, where repeated absences, dirty clothing and hunger were noted but the information was not always passed through to children's social care in a timely manner. Chloe attended nursery, where health visitor concerns about an injury to the child were discussed and passed on to the mother, but not to children's services. Chloe was noted to play happily at nursery, as were her siblings at school, and the clean and stimulating play environment provided predictability and a respite from the chaos and lack of play facilities at home.

Learning:

Themes emerging from the serious case review included:

- **Drift:** At one point, there was no social worker allocated at all and concerns reported by other agencies were not responded to. Assessments were often not completed and there were recording gaps in the CSC files. There was no sense of urgency regarding this family even when heightened concerns resulted in a child protection plan for all the children. Key staff rarely attended core group meetings and tasks were undertaken by a social work assistant rather than

a qualified and experienced social worker. There was confusion and delay in responding to the threat of homelessness, and the critical housing issues that the family faced. Even after this tragic accident, this sense of lack of urgency continued, and a year passed without any formal multi-agency review of progress in safeguarding the surviving children. This practice was set within a broader context of overwhelming workload, high staff turnover and vacancy rates alongside high numbers of unallocated cases.

- **Tolerance by professionals of dangerous conditions and poor care:** The older siblings had been described as 'happy and playful' despite smelling of urine, glasses frequently missing or broken, minor illnesses, and school absences. This sense that the children were happy seems to have allowed agencies to avoid action. This was combined with a professional tolerance of extremely poor, cramped and unsafe living conditions. The children's welfare was thought to be 'good enough' and the mother considered to be 'just about' coping without any clear sense of what this meant in relation to the children's development or immediate safety.

THEMES AND LEARNING POINTS

'An accident waiting to happen'

'An accident waiting to happen' was the way that many of these cases were described. The overview reports for this group of serious case reviews often conclude that 'no-one could have predicted the chain of events leading to (the child's) death'. While the precise circumstances of these accidents were often unpredictable, the reports do convey the sense that the risk of accidental harm from some source was high, due to either the precarious living conditions and/or the inadequate level of supervision from the caregiver. Deprivation and unsafe care provided a dangerous environment for these children as one overview report noted:

> *'Children from deprived backgrounds are at a much higher risk of accidents than those from better off households – 13 times more likely to die from accidental injuries and 37 times more likely to die because of smoke, fire or flames'* (Staying Safe: a consultation document: DCSF, 2007).

Many reports commented on chaotic living conditions, and unsuitable housing, which in at least one case included inappropriate and dangerous temporary accommodation for the family, which posed a particular fire risk. High rise accommodation created problems regarding lack of play facilities, and supervision of children 'playing out' in the communal areas, or in the street. There was often a sense of a lack of boundaries; both in the physical sense of inadequate fences and gates, but also in relation to what the children were allowed to do, and the times they were allowed to stay out until. There were serious case reviews undertaken where young children were playing unsupervised

by a garden pond, or in the family's car, and a fatal accident occurred. While indoors, accidents occurred when children were left in the bath unattended, or suffered scalds or burns when unattended in the kitchen.

Reading and colleagues have pointed out that despite childhood injury rates which compare reasonably well with other developed countries, recent international comparisons have shown that the UK suffers high levels of underlying household risk factors (Reading et al 2008:925). In the cases studied here, household factors and factors in the immediate vicinity of the household, like the garden, played a part in the accident as well as concerns about parental capacity to keep the child safe. Reading and colleagues re-examined neighbourhood level influences on the risk of accident and injury in the first five years of life of the 14,063 children in the Avon Longitudinal Study of Parents and Children (Reading et al 2008). Although at the outset their prime concerns had been the link between poverty and deprivation and risk of accident, they concluded that interventions to prevent pre-school accidents should focus more on vulnerable families than vulnerable communities. They found that preventing accidents carried more chance of success if interventions focused on behavioural risks in the child, parental factors and household circumstances rather than on environmental or community-based risks. Although this general population study is very different than the cases of children who feature at the centre of a serious case review, where the safe supervision of a child is known to be compromised, it highlights the importance of taking into account all family and household considerations if we are to keep children safe.

Drift

Serious case reviews often alluded to a lack of urgency in the work undertaken by professionals with the families. Thresholds for services were deemed not to be met, assessments were delayed and poorly completed. Years could pass, with the children's safety remaining compromised. Moreover, professionals often tacitly accepted domestic conditions and a caregiving environment which were hazardous to the child. A lack of an effectual response, particularly in those cases where the child had a child protection plan, may well have actually increased the risk to these children, since other agencies made their concerns known under the assumption that they would be dealt with, when in reality there was a lack of liaison between agencies, and no clear plan.

Adult and community services' responsibility

A number of the cases highlighted the need for adult and community services to consider safeguarding issues for the children in the family, when working with the parents. Comments were made, in different cases, with respect to drug and alcohol treatment agencies, housing, the fire services, and the ambulance service. On occasions, the failure of professionals to regard their clients as parents, and to make the connection between the adult's difficulties and vulnerabilities and the effect that these have on their parenting capacity was noted: '*(Parent) never took up the support she was offered to bring her use of alcohol under control; absence of any recognition of the impact this was having on her child's welfare. She continued to drink and to neglect child Y. This was entirely predictable though the incident could not itself have been predicted'*.

3.5 SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)

The term SUDI, sudden unexpected death in infancy, can be defined as the death of an infant (aged younger than one year) which was not anticipated as a significant possibility by any professionals or carers involved with the child 24 hours prior to the death (Fleming et al 2000). Sudden infant death syndrome (SIDS) is a subcategory of SUDI, where the cause of death remains unexplained following a thorough case investigation (Willenger et al 1991). While the causes are not fully understood, established risk factors include placing babies to sleep on their fronts, parental smoking, premature birth or low birth weight and, in some situations, co-sleeping. In contrast to some of the other categories of clearly neglect-related incidents discussed in this chapter, maltreatment was not considered to be the direct cause of death of these infants. As in the 'accidents with elements of forewarning' category, neglect was instead a background factor that seriously compromised the child's safety.

It should be stressed that these maltreatment related cases represent a very small proportion of unexpected infant deaths – there are currently over 200 SUDI per year in England and Wales (Sidebotham et al 2011). However, these cases do account for one in six of all death-related serious case reviews. The cases analysed here relate to instances of sudden infant death where there were other serious concerns, usually surrounding neglect and agency practice, sufficient to warrant initiation of a serious case review. The following discussion is based on analysis of ten of these reviews.

COMPOSITE VIGNETTE – 'DANIEL' AGED 3 MONTHS – SUDDEN INFANT DEATH SYNDROME: CONTEXT OF NEGLECT

Key features of the case:

- Sudden infant death of a three month old baby, which occurred while he had been co-sleeping on a sofa with his father, who had been drinking.
- Family history of alcohol and drug misuse. Chaotic household with poor living conditions.
- Large family – Daniel was the fourth and youngest child. He had been born prematurely.
- All the children in the family were the subject of child protection plans under the category of neglect.

Event prompting the serious case review:

This serious case review was conducted following the death of Daniel, who was found lifeless after co-sleeping with his father on a sofa. The circumstances were deemed suspicious due to heavy alcohol consumption at the time by the parents, while the environmental conditions observed

by police and medics also gave rise to the question of whether the home environment was compatible with the health and wellbeing of a three-month-old premature child.

Background to the family and case:

The family comprised two adults and four children aged under six years. The parents, who had a history of misusing alcohol and drugs, had been in an enduring relationship for some years. The child's mother had herself experienced neglect in her childhood and had episodes in care. Her partner, Daniel's father, had witnessed domestic violence as a child and had experienced mental health difficulties throughout his adult life. Both parents had convictions for alcohol-related crime.

Although warm relationships between the children and parents had been observed by some professionals involved with the family, it was also noted at times that the parents were withdrawn and reluctant to be involved in direct care, and the standard of care received by the children was erratic. Daniel, their fourth child, had been born prematurely and had required neonatal intensive care at birth. The mother had been distressed by his poor condition at birth, and his special care needs placed high demands on a family who were already struggling to cope.

Types of neglect experienced:

There were serious concerns about the parents' capacity to provide appropriate physical and emotional care for their children. The home conditions were described as dirty, overcrowded, untidy and in a state of disrepair. Poor hygiene was noted for all four children and Daniel was found to have very severe ammonia burns from unchanged nappies. Substance misuse affected the parents' ability to adequately supervise their children and there had been reports of the children wandering alone. Furthermore, the SCR notes many missed health appointments and poor school attendance for the oldest sibling. There had also been concerns around the failure to follow advice from professionals in relation to feeding Daniel (special feeding requirements for a premature baby).

What it was like to be a child in this family:

The care the children experienced was confusing and unpredictable. The parents' alcohol consumption adversely affected their ability to attend to their children's physical care needs or to be emotionally available to their children. In the presence of a drunk parent the child is likely to feel emotionally abandoned and frightened. For the baby, his need to be tended to when distressed or ill, fed when hungry, or being held close when fed was not always met.

Agency involvement:

There had been substantial and sustained contact with a number of universal, targeted and voluntary services, including health, social care, education welfare, probation and drug and alcohol services. A child protection plan for neglect had been made for Daniel prior to his birth and his siblings were already the subject of a plan under the category of neglect. The child protection plans arose from the negative impact of parents' alcohol consumption on their ability to provide safe care. Despite the high level of agency involvement there was a lack of dependable, continuous professional involvement. For example during the six years that the health visiting service was providing care to the family, a total of 13 health visitors were involved. Likewise, social work involvement also fragmented and included an unqualified social worker who did not have the skills and knowledge of child protection issues needed to address the increasingly complex needs of the family.

There was evidence within the SCR of both good and hostile engagement with professionals on the part of the family. Their repeated assurances about their commitment to stopping misusing alcohol also made any assessment more difficult.

Learning:

Themes emerging from the serious case reviews included:

- **Large family – children not seen as individuals:** The large family tended to be regarded as a single entity and not as individuals with differing needs and risks of harm. The particular vulnerability of a premature baby in these highly dangerous living circumstances was missed by professionals who should have been on high alert. Although there was a child protection plan for the baby in the category of neglect, professionals were falsely reassured about the baby's safety, not least because relationships between children and parents mostly appeared to be good. The history of neglectful care of the older siblings was not used as an indication of current capacity to care for Daniel, who had special health care needs.
- **Many agencies involved, but lack of clear allocation of case responsibility:** There were numerous multi-agency meetings and whilst information was shared at these meetings and plans reviewed, there was little evidence that all the relevant information available within the professional network was brought together, analysed and new plans made. There was also disagreement between agencies about the extent of the neglect and its impact on the children – even though there was a child protection plan for neglect. The parents' professed keenness to stop drinking meant that some professionals

minimised its impact and had an over optimistic view of their ability to care safely. The situation was exacerbated by the fragmented nature of health and social care involvement in terms of key workers and managers. Amid this confusion and lack of clarity, the risks to the new baby in the family went unrecognised.

- **SUDI prevention: strategies for targeted intervention:** At no point had the presence of interacting risk factors associated with SIDS been assessed and the possibility of intervention considered. The GP and health visitor were aware of Daniel's vulnerability due to prematurity. However, records do not indicate that this was linked with other risk factors, which included parental smoking, parental alcohol misuse and co-sleeping, to identify the need for any specific intervention in that area.

THEMES AND LEARNING POINTS

Children not seen as individuals within a large family

This was a recurring theme, which is illustrated in the vignette above. The risks associated with the known history of neglect of the older siblings were not reassessed in relation to the new infant. As one SCR commented *'the children were not seen as individuals and their individual needs, nutrition and sleeping arrangements were not recorded by any professional'*. The potentially life threatening nature of the neglect would have been especially relevant to a newborn baby, whose particular vulnerability was not considered or treated with urgency in spite of a neglect plan being in place.

Interacting risk factors in relation to SUDI risk

Our previous work (especially Brandon et al 2008) has emphasised the importance of an interacting risk perspective. This holds true for these cases of SUDI, where interacting risk factors, for example prematurity, parental smoking, alcohol misuse, deprivation, and co-sleeping, would have elevated the risk to the infants. However, there was little indication that a combination of risk factors was considered in this light.

Parental substance misuse in the context of neglect

Parents tended not to be honest with professionals about the extent of their alcohol or drug dependency, and its impact was therefore often underestimated by professionals involved with the family. In one case a mother's keenness to stop drug taking meant that professionals minimised her continuing substance misuse and its impact on the children. In another, drug misuse was addressed narrowly without thinking of the pattern of drug use on a child's safety, and there was *'a tendency for professionals to concentrate on one feature of drug misuse (heroin) without an understanding of the more complex effects of chaotic or polydrug/alcohol misuse – a combination of drugs that is likely to induce drowsiness/deep sleeping and impair parenting capacity'*.

SUDI RISKS AND TARGETED INTERVENTION

Whilst stating that these deaths were not predictable, these serious case reviews did allude to missed opportunities to intervene which may have made a difference. Although the presence of neglect had been recognised, the potentially fatal outcome for the infant had not. The kind of issues arising are summarised below:

- In one case advice about reducing the risk of SIDS was not formally recorded in midwifery or health visiting records, so may or may not have been delivered to the parents.
- Lack of basic health promotion regarding cigarette smoking and SUDI risk, for example in one case there was no evidence that the 'reducing risks of cot death' leaflet (designed to be given if anyone in household smokes) was given.
- An SCR relating to an incident that took place over the Christmas period highlighted that although there was a need to be especially alert to alcohol abuse by the parents and the children being put at risk, there was no evidence of any assessment by the health visitor in respect of this. The report writer suggests that this should have been part of the child protection plan.
- In a further example, the health professionals had recognised the possibility of co-sleeping as a potential risk, advice had been given accordingly. However, in this case professional judgement had been made that the benefits of parental care for the child outweighed what were understood to be the possible rather than probable dangers of co-sleeping.
- Another overview report describes how although these issues had been discussed with the mother, who stated that a Moses basket had been provided for the baby its existence was not checked, as access to the bedroom was refused. In the event, she revealed following the baby's death that he had slept with her.

Sudden infant death is one of the more preventable of child deaths, and indeed since the 'Back to Sleep' campaign of the early 1990s there has been a dramatic reduction in incidence. However, a higher proportion of residual sudden infant deaths now occur among more vulnerable families living in areas of high deprivation (Blair et al 2006, Wood et al 2012). A recent case-control study of SIDS in south west England showed that many of these deaths occurred in a potentially hazardous sleeping environment, including sofa sharing with an adult who had recently consumed alcohol or narcotics (Blair et al 2009). The authors conclude that the major influences on risk '*are amenable to change and specific advice needs to be given, particularly on use of alcohol or drugs before co-sleeping and co-sleeping on a sofa*'.

These are new findings and efforts need to be made for this knowledge to become incorporated into professional practice. One example of innovative work in this respect is a recent campaign in Lancashire developed in response to the high number of Sudden Infant Deaths across the county. The campaign centred around safeguarding messages, aiming to raise awareness of associated risk factors as well as the preventative measures

parents or carers can take to reduce those risks. Among other things, this has involved delivering training sessions to professionals working directly with children and families to increase knowledge of the risk factors (Cooper and Pemberton 2009). Although campaigns such as this have been developed on a local level, there are also implications for national-level strategies about how best to target those children and families who may be at highest risk.

3.6 NEGLECT IN COMBINATION WITH PHYSICAL ABUSE

High profile cases like the death of the toddler Peter Connelly have shown that where children are known to be experiencing neglect at home they can die in situations of horrific abuse. Neglect is associated with sub-optimal and indeed poor development but the existence of neglect does not preclude the possibility of children also experiencing other very serious maltreatment.

Chapter 2 has shown that there was evidence of physical abuse for over a third of the children with a plan for neglect (Table 2.9). Moreover, our examination of serious case reviews where children died revealed that almost a quarter of the children with a plan for neglect died from a physical assault (see Table 2.6). In this section we offer an in depth analysis of themes drawn from seven reviews which offer some important messages for understanding.

The vignette that follows is based on features from seven cases where neglect was the key concern but the child also experienced very serious physical injury, leading to either death or very serious harm.

COMPOSITE VIGNETTE – 'EVIE' AGED 4 MONTHS – NEGLECT AND PHYSICAL ABUSE

Key features of the case:

- Death of a 4 month old baby from a head injury. There were numerous other fractures.
- The case was considered to be 'low level' neglect, with concerns about emotional maltreatment in the older sibling – even when a history of violent offences was revealed for both parents.
- The family moved house frequently.
- Home conditions were disorganised but not poor.
- The children's mother was dominant and controlling and the father was the main carer.

Event prompting the Serious Case Review:

The baby's post mortem revealed numerous fractures in addition to the head injury which caused the death.

Background to the family and case:

The family of two children (the older sibling was aged five) moved house regularly and had only been in the new area for three months. Parents were reluctant to provide information about themselves and their children but it was gradually discovered that both parents had a number of convictions, including for drugs and violence. The family appeared self-contained and socially isolated with no contact with family or other friends and no social supports. The mother was the dominant parent and was suspicious of professionals, hostile and resistant to advice. Her history was known to be difficult but she would not divulge any information about her past. The father was the children's main carer and his past included drugs related offences including for violence. He worked from home. His partner took the lead in any interactions with helping agencies, while he appeared quiet and mild mannered. The mother had a job outside the home but also worked from home and was the major earner.

Types of neglect experienced:

There was very little ante natal care and the pregnancy was not notified until six months gestation. Although booked into hospital, Evie's mother gave birth to the baby at home with no medical attendance (as had been the case with the birth of the older sibling). Evie was born healthy and her early care was said to be 'good'. Her parents would not allow her to receive any immunisations and took her to the 6 week check with the GP with some reluctance. After this first check, all appointments and immunisations were missed. No health professional saw Evie after the age of 6 weeks.

Evie's sister had been found crawling outside unattended by a health professional when she was nine months old. At the age of two years Evie's sister was described as 'desperate for attention'. Later, at school, the sister was said to not know how to play and appeared 'resigned' and 'measured' but was always compliant, presenting as charming and smiling, but occasionally rocked in a foetal position. She sometimes came to school without any lunch and without a coat in cold weather. Concerns about emotional neglect were prompted by her behaviour at school.

Conditions at home during Evie's life were disorganised and cluttered but not poor. There were no toys visible in the home. When Evie was three months old a female relative expressed concern to children's social care about the family's social isolation, the lack of toys and the lack of any stimulation for the children at home.

What it was like to be a child in this family:

Clues about Evie's experience as a baby at home come from details about her older sibling's behaviour. The older sibling's charm and compliance at school coupled with reticent, anxious behaviour suggest that home could be a frightening place where it's safer to placate your parent(s) than to risk provoking their anger. It's safer to behave this way at school too, because you never know when people might turn on you. When your clothes are uncomfortable, when you feel cold and you don't have enough to eat it's hard to concentrate at school. It's also easy to be bullied because you are always the one who is different and new, and so you stand out.

Evie would probably have been in the process of learning (unconsciously) that her crying to be fed or comforted, or any sign of need, made her mother shout and become angry. She would have been intuiting, like her sister, that she increased her chances of being cared for and staying safe by smiling and being an 'easy' baby – but this would not have always succeeded in getting her father to notice and attend to her. In order to survive she needed to be fed and to signal hunger and the need to be fed to her carers – as such she did not have the option of keeping quiet, nor could she be emotionally self-contained. Cries for nurture risk assault – especially when in these circumstances, parents are fraught and anxious in a new environment with no support systems and the demands of a new baby.

Agency involvement:

Children's social care became involved because the school were concerned about the sibling's behaviour at school and were concerned she might be suffering emotional neglect. Evie was a few weeks old at the time. Concerns about physical and emotional neglect were not felt to cross the threshold to tip the case into child protection and the family were worked with, minimally, as a child in need case. By the time the parents' offences of violence became known, professionals had already formed a view that this was a low level neglect case and that the key concerns were about emotional and physical neglect in relation to the older child. During the assessment period there had been one medical examination of Evie's sibling to follow up an injury to her arm but no clear evidence of non-accidental injury was found and the explanation for the injury was accepted as plausible.

Although the parental engagement with most agencies was hostile, there was sufficient contact between the father and the school to indicate a satisfactory level of compliance and to sufficiently allay concerns. There was no multi-agency response to the family's refusal to accept any health services or to their refusal of any help for parenting difficulties. The lack of a multi-agency response was largely due to the mother's hostility and refusal to engage with services.

Learning:

This case highlights the problems of gaining a full understanding of a case when the family moves around regularly and their history is unknown, or only partially known. However it also shows that when new information becomes available professionals are reluctant to reappraise the case and change their view. It shows how powerful the label of 'low level neglect' can be and the way that it can downgrade thinking and activity. The combination of a mindset about low level neglect and parental hostility kept professionals at bay.

THEMES AND LEARNING POINTS

Not taking account of a history of violence

In a number of these cases the past history represented very serious risks of harm to the child but was not present in the minds of the professionals. This history was sometimes not taken seriously because professionals had decided that the key risk of harm to the child was neglect or emotional maltreatment and so the risk of violence was effectively discounted. Evidence of serious past physical abuse from a parent included: putting a pillow over a child's face, previous unexplained child death, a history of a previous child being adopted because of a prosecution for assault by a parent, and very serious offences of parental violence, including offences against children.

Hostility to professionals

These cases of combined physical abuse and neglect often included parental violence and hostility towards professionals as well as extreme distrust of workers. In most instances the hostility and violence was perpetrated by the father or male figure, but in other cases, as in the case vignette, it was the mother who posed the greater risk of violence to the baby or child and was the most hostile part of the couple. Sometimes both parents were hostile but in most of these cases there was one especially controlling partner who tended to dictate the terms of the relationship with professionals. Any services were usually only accepted on the controlling parent's terms, with considerable reluctance and following much negotiation. In some cases parents insisted on following their own idiosyncratic beliefs about how to meet children's health and dietary needs as well as refusing immunisations and medical treatments. Professional concern about the family tended to dissipate however if the less hostile parent appeared to cooperate, even if there was no cooperation from the more hostile parent.

Our first two biennial reviews noted that the level of cooperation or hostility between families and agencies had an impact on the way that practitioners understood the families and the risks of harm to the child (Brandon et al 2008, 2009). In the cases here there was a reluctance to challenge hostile parents who appeared to induce fear, paralysis and

uncertainty in the practitioners. In these circumstances assessments tended to remain incomplete and cases could be closed without a full assessment. In one case the reason for a children's social care core assessment not being completed was said to be the family's unwillingness to cooperate. This was in spite of this being a section 47 child protection enquiry (under the Children Act 1989) and a child protection conference having been called, cancelled and not re-scheduled. Where families were hostile or resistant it was not uncommon for services across any sector, especially health, to be withdrawn in spite of NICE guidelines indicating that missed appointments should trigger greater vigilance. Withdrawal or a pulling back of services occurred in a number of these neglect cases where physical abuse had been overlooked or downplayed by professionals.

Lack of support for staff

A recurring theme in these cases was a lack of skill, confidence and experience in dealing with the challenges that the case presented. Muddle and confusion permeated planning and decision making especially when there was a high turnover of staff and numerous professionals involved in a single case. There was little evidence of adequate management support and back up for staff to make sense of complex cases and make sound assessments, decisions and judgments. Management of these cases was not pro-active.

Development of a sibling or harm to a sibling as a clue to harm in babies

Where parents keep babies and young children away from developmental checks and immunisations, they are potentially lost from view. In these and indeed other circumstances, concerns about older siblings from nursery or school should trigger the need to carefully assess other children in the family and especially babies who are innately the most vulnerable. Staff who see children regularly, for example at school or in nursery, are well placed to notice problems with their development or changes in their behaviour. Noticing changes can provide a warning in relation to the individual child at school, but the changes in an individual child might also provide a sign of a downturn in overall family functioning which is likely to affect all other siblings. Being able to pick up on these clues requires school and nursery staff to have, firstly, a good grounding in child development and secondly, the confidence to discuss these concerns with a supervisor or child protection designated staff member.

Similarly, recent previous injury to a sibling may indicate physical abuse as a risk for all children in the family. Previous injuries to siblings in these cases included swelling to the head (in more than one case) and limb injuries, but in each case the possibility of physical abuse was discounted and not borne in mind in later planning or decision making.

Bruising and rough handling

An understanding of child development is also important in interpreting the significance of any bruising in children living with neglect who may be known to have less than optimum supervision. These children are sometimes believed to bruise themselves more often, but any bruise needs to be carefully considered and explained in relation to the child's age and developmental capability. A bruise also needs to be considered in relation to the parent's capacity to supervise in a way that is appropriate to the child's developmental needs. These issues are considered in more depth in our recent small scale study of child development and serious case reviews (Brandon et al 2011, 2012). Any bruising on a pre-mobile baby has to be considered suspicious as prior to around six months babies have very limited control of their own movements. Older babies are more able to bruise themselves through falls and tumbles but where there are pre-existing concerns about neglect and emotional development, for example faltering growth and failure to thrive, workers are right to be worried about bruising, especially facial bruising which needs specialist assessment by a paediatrician rather than a GP.

In some of these cases professionals had noted insensitive 'rough handling' of babies, and parents being verbally aggressive and smacking a toddler, and other inappropriate behaviours that imply physical aggression. In some families this rough handling was frequent behaviour and formed part of the child's everyday experience, while in others it occurred in the build up to an incident of domestic violence or when the parent was experiencing a bout of poor mental health.

Professional confusion and downgrading of harm

In some of these cases the risks of physical harm alongside neglect had been acknowledged to some degree, but professionals did not act with any urgency and were sometimes said to be 'going through the motions' in carrying out an assessment or child protection enquiry. In these cases there tended to be a gradual dilution and forgetting of concerns about the risk of physical harm which would be overtaken by a 'this is only neglect' mindset. This would mean that re-arranging missed appointments or ensuring a proper medical examination of a child would no longer be seen as urgent as a sense of urgency did not fit with this neglect mindset. The danger here is perhaps that in categorising children as experiencing neglect (or any single form of harm) less attention is paid to the other risks they face. In particular, neglect does not preclude physical abuse.

3.7 SUICIDE AMONG YOUNG PEOPLE

When the child at the centre of a serious case review is an older young person he or she will have carried with them the legacy of early experiences of care and nurture. These experiences lay the foundation of their capacity to cope with or to fail to withstand the stresses that come from outside influences and internal pressures. A number of UK researchers have increased our awareness of the vulnerability of older young people who have lived with maltreatment and how easy it is to regard them as resilient, primarily

because they are older and have survived into their teens (Stein et al 2009, Rees et al 2011, Wade et al 2011, Brandon and Thoburn 2008). Rees and colleagues' recent work has also given us powerful evidence of the types of neglect that contribute to young people's long-term social, emotional and psychological damage. There is some evidence that young people who have lived with maltreatment are more likely to suffer from physical illness and to die early, including by suicide (Meadows et al 2011).

The analysis presented in Chapter 2 showed that neglect featured more prominently for 11–15 year olds than for any other age group (see Table 2.12). When older young people are the subject of a serious case review because they have taken their own lives, neglect and rejection feature prominently in their history. A history of neglect and the thread of neglect run through almost all of the cases of young suicide in serious case reviews.

There is increasing awareness of the problem of suicide among young people. Establishing the numbers of young people who die in this way is difficult however since coroners are reluctant to give a verdict of suicide without corroborating evidence like a suicide note. A recent statistical release from the Department for Education (DfE 2012) presents an analysis of the 4,012 childhood deaths reviewed by child death overview panels between April 2011 and March 2012 and the extent to which these deaths have factors which are 'modifiable' and hence more amenable to prevention. Modifiable factors were identified in a higher proportion of deaths of older children (nearly a third of all deaths in children aged 15–17 years having modifiable factors) compared to younger children (18 per cent of deaths in children ages under one year). The deaths from suicide were found to have modifiable factors in 41 per cent of cases, particularly in relation to young people's risk taking behaviour. This underlines the interest in suicide prevention strategies.

For many young people at the centre of a review the impact of neglect was compounded by experiencing the whole gamut of maltreatment types at various times through their life. A number of those who had long histories of agency involvement, were identified in the 2003–2005 biennial report as 'hard to help', and consequently found themselves to be neglected by agencies (Brandon et al 2008). The case vignette below is a composite of seven cases and exemplifies a profile of young people in serious case reviews who took their own life.

COMPOSITE VIGNETTE – FRAZER AGED 15, SUICIDE AND LONG-TERM NEGLECT

Key features of the case:

- Long-term neglect.
- Serious abuse and rejection.
- Hard to help young person.
- Suicide.

Event prompting the Serious Case Review:

The review was held because of Frazer's suicide in the context of a history of long-term neglect and severe maltreatment. At the age of fifteen Frazer had been discharged home from residential care because of persistent running away. He was living at home, and although still on a care order, was getting very little support at the time of his death.

Background to the family and case:

Frazer was the oldest of three half siblings and was 'on and off' a child protection plan from the age of five because of neglect, physical and later suspected sexual abuse. He started to run away from home at the age of ten and by the beginning of adolescence he started to harm himself seriously, misuse substances (drugs and alcohol) and to talk of suicide. Frazer's behaviour at school and at home was described as 'unruly' and, from the age of thirteen, 'threatening and violent' including the use of weapons, which prompted numerous exclusions from school. When he moved into foster care at age 13, he ran away repeatedly and experienced numerous placement breakdowns. He was in and out of care regularly but return home was never successful because he was always rejected by his mother.

Frazer's mother experienced depression and low self esteem and had been subject to domestic violence over many years from different partners including Frazer's father (who died when his son was five). There had been serious concerns since Frazer's birth about his mother's parenting ability. Her own history was one of severe abuse and neglect. After his father's death, Frazer had a number of step father figures, the most recent of whom had been a heavy drinker, with convictions for physical assault. Domestic violence was a recurrent feature of Frazer's home life.

Types of neglect experienced:

From an early age Frazer attempted to look after himself and his siblings. Domestic violence (and the emotional neglect and abuse associated with this) as well as intermittent rejection formed the backdrop to his childhood. Frazer felt responsible for keeping his siblings safe even when he was in care and they were still living at home.

What it was like to be a child in this family:

As he matured and entered adolescence the effects of many years of neglect and abuse at home became apparent in Frazer's behaviour. His responses typified those of young people with similar experiences where his feelings switched between hostility and aggression, and fear and helplessness. Frazer's lack of trust in others and need to feel in aggressive control

is a characteristic response to the kind of caregiving that he experienced over many years. In addition, his early adverse experiences are likely to have increased his sensitivity to stress leaving him vulnerable to stress related psychiatric disorders, self harm and suicidal ideation (Howe 2005: 163). Discharging Frazer home to his mother's care catapulted him into danger as he was reminded that he was unwanted and bad and this left him unable to cope with the feelings this evoked. His mother was also helpless to contain his powerful and self destructive urges.

Agency involvement:

Children's social care were involved with Frazer's family on and off from the time of his birth. He had a child protection plan intermittently between the ages of five and nine (in the categories of neglect and physical injury). He was accommodated at the age of 13 and later made the subject of a care order. From the age of eleven he was known to Child and Adolescent Mental Health Services and from age 14 to the youth offending service. He was assessed as 'not mentally ill with no real suicidal intent' numerous times.

Learning:

Themes emerging from the serious case reviews included:

- **Young people who are hard to help:** Frazer will have transferred his unsuccessful coping strategies from home to his placements. Those helping him interpreted his behaviour as sabotaging attempts to contain him and offer safe and trusting relationships. Good quality support and training for his carers might have helped them to understand the complexities of his behaviour and how helpless and angry Frazer made them feel. Strategies for dealing with and anticipating his behaviour and understanding why he could not trust anyone but himself, might have helped them to stick with him for longer and perhaps reduce Frazer's need to run away.
- **The danger of return home.** Although it may be the worst place for them, many young people in transition, like Frazer, feel compelled to go back home and will push for it relentlessly. Once back home Frazer and his mother needed a high level, intensive support not a low level service.

THEMES AND LEARNING POINTS

The long-term adverse effects of chronic neglect

This section offers a longer term perspective and illustrates the impact of neglect over time.

Whilst the previous vignettes have focussed on more immediate catastrophic consequences of neglect, this vignette illustrates the appalling long-term effects of chronic neglect and of neglect in combination with other maltreatment. Gilbert and colleagues' systematic review notes that of itself the consequences of childhood neglect may be more serious than those of other types of maltreatment (Gilbert et al 2009:16). Obviously when neglect and other maltreatment are combined, the impact is even more severe.

By adolescence the impact of neglect on development very often presents as described in the vignette, namely: conduct disorder, alcohol abuse, drug abuse, risk taking behaviour and recurrent victimisation (MacMillan 2009). Over time there is a moderate to strong link between maltreatment and attempted suicide, especially when the harm is cumulative, including neglect (Gilbert et al 2009).

History of caregiving and current caregiving

For these young people neglect often began at an early age and continued sporadically or continuously into adolescence, combining often, with other types of maltreatment. One child had on a number of occasions been left home alone at the age of two, then when a little older was sometimes not collected from nursery. For another young person a pattern of poor weight gain and failure to thrive from the age of two continued throughout childhood, and as an adolescent this young person talked of being hungry with access to limited and poor quality food at home. At the age of nine another child was found out alone at night, wandering, with no shoes on. One child's mother warned him she was going to die and he would have no one to look after him so he would be better off dead. Another child's father regularly issued threats to kill himself and his son.

Loss, death of significant adult figures (often parents) and rejection were a feature of many childhoods. One adolescent was reported when at primary school to want to die like his father. As children these young people had to fend for themselves physically and emotionally and were described variously as 'left to his own devices' 'seen out late without mum' and experiencing 'no emotional warmth'. As well as looking out for themselves many, like Frazer, also took on caring roles for siblings. One adolescent had been a carer for a sibling during childhood because of her mother's mental ill health and at one stage the home she shared with her mother and siblings was declared unfit for habitation. Although things improved somewhat during her middle years, during adolescence the problems at home recurred.

As they grew up these young people experienced either an unpredictable, or a frightening family life characterised by inconsistent bouts of parental mental ill health or violence towards them and their siblings and between adults; bouts of parental alcohol and or drug misuse abuse, and for some, sexual abuse from their mothers' partners or associates.

All seven young people had experienced multiple types of maltreatment, multiple losses, separation and feelings of abandonment. For most there was evidence of unresolved issues about this abandonment – with one young person always seeking out his mother and wanting to be reunited but experiencing repeated bouts of rejection. Most had limited sources of support and were isolated. There was little evidence in the reviews that practitioners working with these young people knew their early history and took it into account to understand their development and their behaviour as an adolescent.

Professional Responses

Many of the older young people, like Frazer, had long histories of involvement with a number of agencies (especially children's social care [CSC], child and adolescent mental health services [CAMHS] and youth offending teams [YOTs]). Serious professional concerns about neglect and its impact on the child's emotional health were often apparent from when the child was very young or were picked up when the child first started school. An example of this is when a teacher spoke of, *'an angry, frightened little boy who would wait at school for his mother, but she would often not come, be late or be under the influence of alcohol or drugs.'*

Athough some young people had been the subject of neglect child protection plans over long periods and were in and out of care, it was also possible for some to do well (intermittently) at school and perhaps to have an excellent attendance record. School could be a place of safety that young people might try to return to even when they were excluded from school. There could be good engagement between the young people and both school staff and CAMHS workers, *'the CAMHS worker was in frequent and regular touch for the subsequent three years, developing a strong therapeutic relationship despite X's reputation for being difficult to engage.'*

Carers were not adequately supported to cope with one young person's behaviour especially when he became 'threatening and dangerous' leading to another rejection. Children's social care closed the case at this point of heightened need, when the young person was aged 14 'allowing' him to live with family friends. Serious offending led to custody but at the point of discharge from custody, children's social care still maintained the decision that he was 'No longer a priority' for a service and would not have received support had he lived long enough to be discharged. The consequences of a 'wait and see' approach (Gardner 2008) are as damaging and dangerous to young people of this age as they are with much younger children.

Lack of support in the transition to adulthood

There was evidence of young people asking children's social care to be accommodated, in one instance because at the age of 16 the young person could no longer tolerate his mother's alcohol abuse and lack of food and care at home. Such requests for help from older young people tended to be refused by children's services who thought these were lower level cases more appropriate to be referred for support to other agencies. At the age of sixteen many vulnerable young people lose the protection offered by school and struggle to find any other protected routes to adulthood, and no routes out of a neglectful

situation or dangers posed by, for example dangerous links to local gangs. There is little support for neglected young people in the transition to adulthood.

Suicide and young people with unrecognized needs

While most of these young people who took their own lives had been well known to agencies over a number of years, there were others who killed themselves whose problems were largely missed by agencies and whose needs went largely unrecognized by professionals, *'… even the schools did not get to know her well enough to identify other problems (other than non school attendance)'*.

Young people's experience of neglect was less likely to be known by professionals when they were isolated and effectively abandoned. Multiple family moves could mean the young person was rarely in school or always the newcomer with few opportunities to socialize or make friends. Being constantly on the move could also mean that access to medical and mental health support was restricted or appointments missed. In some cases where young people were particularly isolated, parents restricted any access to support services so that young people had no one to confide in. School is often the only potential source of support which can be accessed without parental knowledge and the only way a young person can find someone outside of the family to confide in. In situations where the neglect is combined with control and psychological maltreatment, parental hostility can mean adolescents are completely off the professional radar.

SUMMARY

Anonymised case summaries from 46 SCRs from 2003–2011 where serious neglect was known to be a prominent feature, were analysed within a six-fold typology of neglect related circumstances which had a catastrophic impact on the child (and family). A vignette made up of a number of cases was used to illustrate themes for each typology. There are learning points in relation to each of the six 'routes' to a catastrophic outcome involving neglect and some overriding, general point applicable to most.

Malnutrition

For this research malnutrition is defined as 'life-threatening loss of weight or failure to gain weight or serious consequences of neglecting to nourish the child'.

Learning points:

- None of the children who died or nearly died from malnutrition were in the child protection system. Their links with any agency were almost non-existent by the time of their death or serious harm.

- Increased isolation of a family adds to the invisibility of the child or children within that family so malnutrition is not spotted (eg when children cease to attend

school or nursery or are home schooled). Isolation of the child means that very poor relationships between the child and caregiver (so poor that the child may have ceased to exist for the adult) cannot be observed by professionals or the public.

- Changes in the parents' behaviour (an increasingly hostile manner of engagement or a complete withdrawal from services) can signal life-threatening harm for a severely neglected and malnourished child.

Medical neglect

For this research medical neglect resulted in the child dying or nearly dying because parents neglected to comply with medical advice.

Learning points:

- The significance of changed family circumstances was not noted by professionals. This meant that increased stress on the caregiver while coping for a child with complex health needs and their diminished willingness or capacity to administer medication was missed.

- Professionals tended not to challenge parents' behaviour when medication was given erratically or consider reasons for parents' reduced compliance with advice.

- Undue professional optimism can mean that the impact of medical neglect and the danger for the child is missed and thus no referral is ever made to children's social care. Health professionals sometimes appear to shield parents from children's social care

'Accidents' with some elements of forewarning:

The child was harmed or killed as a result of an accident but there were elements of forewarning within a context of chronic, or long-term neglect coupled with, or producing an unsafe environment.

Learning points:

- There was drift and lack of a sense of urgency among professionals, even when the risks of harm through poor supervision had been highlighted by a CP plan in the category of neglect.

- This is a systemic problem when drift and confusion is prompted by overwhelming workloads, high staff turnover and high vacancy rates alongside numerous unallocated cases.

- Professionals were tolerant of dangerous conditions and poor care and some children's demeanour and behaviour were optimistically interpreted as 'happy and playful', when they were living in an unsafe environment and had signs of poor developmental progress.

Sudden unexpected deaths in infancy

For this research defined as 'unexplained infant deaths, within a context of neglectful care and a hazardous home environment'.

Learning points:

- The particular vulnerability of young babies in highly dangerous living conditions can be missed by practitioners and clinicians who should be on high alert in these circumstances. This can be especially relevant when working with large families where the needs of individual children can be lost.
- Professionals can be falsely reassured about a baby's safety even when the infant is the subject of a CP plan for neglect. A good relationship between a baby and parent cannot keep the infant safe for example when co-sleeping with a parent who has consumed drugs or alcohol.
- Intervention to prevent SUDI where there are known risk factors (smoking, substance misuse and co-sleeping) is not always followed through with families.

Neglect in combination with physical abuse

Where assumptions about neglect masked the physical danger to the life of the child.

Learning points:

- In these cases there tended to be a gradual dilution and forgetting of concerns about the risk of physical harm which would be overtaken by a 'this is only neglect' mindset.
- The neglect label meant that the combined risks from physical assault with the accompanying neglect were not taken seriously.
- The danger here is that in categorising children as experiencing neglect less attention is paid to the other risks they face. In particular, neglect does not preclude physical abuse.

Suicide among young people

A long-term history of neglect having a catastrophic effect on a child's mental wellbeing.

Learning points:

- Young people with long experiences of chronic neglect and rejection find it very difficult to trust and may present as hard to help.
- The root causes of young people's behaviour need to be understood so that the responses of carers and professionals do not confirm young people's sense of themselves as unworthy and unlovable.

- Young people in care often feel compelled to go back home even if it means more rejection. Once back home, young people and their families need a high level, intensive support not a low level service. They also need to have their strengths recognised and to have safer and more protected routes to adulthood and independence.

- At the age of 16 young people lose the protection of school and have no other protected routes to adulthood and few routes out of a neglectful situation at home.

GENERAL LEARNING POINTS

- Uncertainty from staff in universal services about whether the case warrants referral to children's social care can leave children who are neglected in any of the ways described, at risk of death. Professional disagreement about the extent and impact of neglect can allow over-optimism about parental capacity to dominate.

- Some adult and community services staff lack awareness of safeguarding and do not make the connections between the parents' difficulties and vulnerabilities and the impact these have on their capacity to keep the children safe from potentially predictable and preventable harm.

- When many agencies are involved there may be unclear lines of responsibility. In these circumstances information is not brought together and analysed and new plans are not made or followed through with sufficient energy.

- When families move it may be difficult to gain a full understanding of the family history, for example a history of violence against a child.

- Parental hostility can keep professionals at bay and discourage them from following up missed appointments.

- The worrying demeanour and development of one sibling can signal harm, including physical harm, to another sibling – especially babies who are at the most vulnerable age. Similarly, a history of neglectful care for older siblings can be a warning sign of the pattern of care a new baby will receive.

- Failure to involve men/fathers as potentially protective influences who contribute to children's wellbeing.

- It is important for professionals to know the history of the child and family and to take it seriously.

- Strong management support is needed to help practitioners manage, monitor and think systematically about a case where neglect is, or might be an issue.

4 Implications for policy and practice

All child protection practice involves managing risk, as the Munro Review of Child Protection reminds us (Munro 2011). This study does not provide easy answers about the difficult judgements and decisions that need to be made where neglect is present but shows how important it is to be open minded and vigilant about where and how neglect related risks manifest themselves. We have shown here that neglect is much more prevalent in serious case reviews than had previously been understood. We have tried to describe the different ways in which neglect can contribute to a catastrophic outcome for a child and how neglect can function to mask, conceal or deflect signs of other danger to a child. Overall, the study offers a strong message, that in rare circumstances, neglect *can* be life threatening and needs to be treated with as much urgency as other categories of maltreatment. Although neglect rarely results in a catastrophic event it very often leads to developmental damage so vigilance is needed with all cases of neglect.

There are a range of interconnecting ways of considering implications for policy and practice. The response to neglect can be understood in relation to the age and development of the child; it can also be considered in relation to the kinds of help and types of services the child and family or young person attract. From whichever angle the problem of neglect is seen however, there is usually a common thread of severe difficulties in the relationship between the child and their caregivers, and the impact of that relationship on the child over time. However, a child is not necessarily safe even when there is a good relationship with parents or carers if home conditions leave the child in danger. For the child to stay safe and healthy they also need a safe and healthy environment in which to live.

Understanding the implications of children's experiences of neglect in age related 'ecological niches' (Finkelhor 2008, Super and Harkness 1986, Stein et al 2009) fits with the ecological transactional approach that we have used for the study and offers a way of examining the developmental vulnerabilities, risks and protective factors that children carry with them and also encounter in their environment. The same ecological approach also underlines the importance of taking account of the way that practitioners respond to and make sense of the children, their parents and the family's circumstances. The learning from this re-examination of neglect in serious case reviews has illustrated, in many respects, a life course profile of children.

The circumstances of children who experience grave neglect which can result directly or indirectly in death or very serious harm, appear to be somewhat different at various age related stages. Considering the experience of neglect for children along a broadly developmental continuum can help to frame each child's experience as an individual. This is particularly important in large families when the needs of the children in a family may tend to be considered more as a sibling group than individually. Similarly, although understanding broad developmental norms and expectations provides the best way to gauge the impact of neglect on the individual child, each case is unique and each child's experience of neglect transcends their age and developmental stage. There is no substitute for knowing the child well.

MAINTAINING A HEALTHY ENVIRONMENT

Not all children experiencing severe neglect were receiving specialist help nor were their families making sure children took up available universal services. Where professionals were involved their interventions were not always effective. The evidence from this study suggests that one important way for these children to stay safe was to be more physically and emotionally healthy and for their living conditions to be safe and healthy. For this to happen there needs to be a safe living environment as a basic precondition for a safe relationship between children and their caregivers. This reinforces the need for decent living conditions for all children and families across the income spectrum. It also reiterates the importance of both early and late stage help, for children of all ages and not just the youngest. However, serious case review findings underline the vulnerability of the youngest babies, especially in their first six months of life.

Messages for decision makers, policy makers, practitioners and managers

- A public health approach offers good opportunities for prevention. This includes continued emphasis on the importance of basic health promotion messages about, for example, suicide prevention, accident prevention and the risks of sudden unexpected deaths in infancy (SUDI). SUDI risks include cigarette smoking and a potentially hazardous sleeping environment, like sofa sharing with an adult who has recently consumed alcohol or narcotics, or a baby not having their own cot or Moses basket (Blair et al 2009).

- Substandard accommodation combined with lapses in parental supervision can be life threatening and result in drowning, fire or accidental poisoning. Targeted support for families known to be vulnerable, including where children experience neglect, can help to prevent accidents (Reading et al 2008).

- Vulnerable adolescents with a long history of neglect and rejection can rarely thrive living alone in isolated, poor quality accommodation and may dangerously neglect themselves. They need a safe, supportive environment and protected routes to adulthood and independence.

MAINTAINING A HEALTHY, SAFE RELATIONSHIP

Crittenden has written extensively about the importance of maintaining a safe, healthy relationship for a child and ways that parents can be helped to comfort and protect their children from external danger rather than being a source of that danger themselves (Crittenden 2008). There were numerous examples in this study where parents were wittingly and unwittingly a source of danger to their child. We have shown that when signs of neglect are evident, practitioners can be blinkered to the physical danger that a parent or carer poses to a child. Similarly we have shown that a child's life can be at risk when the relationship between the child and caregiver is so poor that care, nurture and supervision are almost non-existent.

Situations this severe usually evolve over time but they can also develop rapidly with the onset of severe parental mental illness or the arrival of a dangerous but unknown adult in the household, or with an intolerable accumulation of stress. While every effort should be made to intervene early to prevent a parent–child relationship deteriorating in this way, once this happens urgent action needs to be taken. Action is stalled when this danger is hidden, when children and families disappear from view, when appointments are missed and potentially, when children do not get the ordinary oversight offered by attendance at school or nursery.

Parent–child relationships are often highly complex and practitioners need to be sensitively attuned to this relationship, even where parents present as loving but may be failing to cope, for example with the demands of their child's complex health needs or disability. Neglect of medical care can become fatal or cause life-long damage.

Understanding how an adolescent with a history of neglect feels and behaves is also complex. Older children carry the legacy of their experiences of neglect and rejection with them and need sensitive practitioners to understand that the impact of their experiences can be life threatening as a result of their own high-risk behaviour or from suicide. Like younger children, adolescents need to maintain safe healthy relationships with their peers and with caring adults.

The Munro Review has reminded us that practitioners need to be supported by a system that allows them to make good relationships with children and parents and supports them in managing the risks of harm that stem from maltreatment. This includes the harm from neglect and the way that neglect can conceal other risks and danger.

Messages for decision makers, policy makers, practitioners and managers

- Use routine contact between parents and professionals as an opportunity to promote sensitive and attuned parenting (Hibbard et al 2012). Where there are early concerns, targeted help should be offered by services like Children's Centres or enhanced health visiting services like Nurse Family Partnerships. Older children should have ready access to school- or community-based help or services from CAMHS.

- To understand parent–child relationships better, practitioners should ask themselves: what does this child mean to the parent and what does the parent mean to the child? (Brandon et al 2011). Reflective, challenging supervision helps practitioners to understand relationships and should support them to act decisively when children are in danger.

- Missed appointments should be followed up and not considered a reason to withdraw a service.

- Children who disappear from view may be at risk of severe or life threatening harm from neglect. This may include children who are not in school and older adolescents who go off the radar of helping professionals and may be a risk to themselves. To be safe children need to be seen.

CONCLUSION

The fact that neglect is not only harmful but can also be fatal should be part of a practitioner's mindset as it would be with other kinds of maltreatment. This is not to be alarmist nor to suggest predicting or presuming that where neglect is found the child is at risk of death, but rather to suggest that practitioners and managers should recognize how easily the harm that can come from neglect can be minimised or downgraded. In the same way there should be recognition of the harm that arises when neglect cases drift. Practitioners need to have an open mind about the *possibility* of neglect having a fatal or very serious outcome for a child but deal with neglect cases in a confident, systematic and compassionate manner.

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Appendix A

CHILDREN AND YOUNG PEOPLE WHO WERE THE SUBJECT OF A CHILD PROTECTION PLAN (CP PLAN), BY CATEGORY OF ABUSE, YEARS ENDING 31 MARCH 2005–2011. NATIONAL FIGURES FOR ENGLAND (DFE 2011).

Appendix Table A.1 Category of abuse by year, CP plan at year ending 31 March, 2005 through 2011

Category of abuse	2005	2006	2007	2008	2009	2010	2011
Neglect	11,400 (44%)	11,800 (45%)	12,500 (45%)	13,400 (46%)	15,800 (46%)	17,200 (44%)	18,700 (44%)
Physical abuse	3,900 (15%)	3,600 (14%)	3,500 (12%)	3,400 (12%)	4,400 (13%)	4,700 (12%)	4,500 (11%)
Sexual abuse	2,400 (9%)	2,300 (9%)	2,000 (7%)	2,000 (7%)	2,000 (6%)	2,200 (6%)	2,300 (5%)
Emotional abuse	5,200 (20%)	6,000 (23%)	7,100 (25%)	7,900 (27%)	9,100 (27%)	11,400 (29%)	12,100 (28%)
Multiple	3,000 (12%)	2,700 (10%)	2,700 (10%)	2,500 (9%)	2,900 (9%)	3,400 (9%)	5,000 (12%)
Total	**25,900**	**26,400**	**27,900**	**29,200**	**34,100**	**39,100**	**42,700**

Column percentages sum to 100%

Appendix Table A.2 Category of abuse by gender, CP plan at year ending 31 March 2011. National figures for England (DfE 2011)

Category of abuse CP plan as at 31.03.11	Males	Females
Neglect	9,310 (51%)	8,780 (49%)
Physical abuse	2,450 (52%)	2,260 (48%)
Sexual abuse	1,000 (43%)	1,340 (57%)
Emotional abuse	5,830 (52%)	5,470 (48%)
Multiple	2,830 (52%)	2,580 (48%)
Total	**21,420**	**20,420**

Row percentages sum to 100%

Gender of approximately 800 unborn children not known – hence total of males + females is lower than the 42,700 for 2011 in the first table.

Appendix B

CLASSIFICATION OF FATAL CHILD MALTREATMENT

1. INFANTICIDE AND COVERT HOMICIDE

Fatalities, usually of very young infants, many shortly after birth and typically perpetrated by the mother using 'less violent' means, or in which the cause of death is not immediately apparent. These differ from the group of severe physical assaults. This category would include deaths as a result of exposure, asphyxiation, drowning, strangulation or poisoning where there is some indication that there was some intent to kill (as distinct from accidental deaths from these causes). Also includes deaths following concealment of pregnancy where there was any suspicion that the mother may have killed the child.

Exclusion criteria

Exclude deaths where there are obvious severe physical injuries e.g. non-accidental head injury or multiple injuries (category 2); or evidence of homicide which is apparent from the start, e.g. stabbings, obvious strangulation, multiple killings (category 4). Exclude deaths which are considered to be a result of accidents (category 5).

2. SEVERE PHYSICAL ASSAULTS

Includes cases of severe physical violence including where there is known associated neglect. The mode of death in these cases is typically a violent assault, most commonly an inflicted head injury, including shaking and shaking-impact injuries, but also multiple injuries and abdominal injuries. Other deaths may include the use of firearms, beatings, stabbings and strangulation but where there was not an obvious intent to kill.

Exclusion criteria

Exclude deaths where there is some indication that the perpetrator set out to deliberately kill the child (category 4).

3. EXTREME NEGLECT / DEPRIVATIONAL ABUSE

Cases where the direct cause of death is extreme neglect or deprivation of the child's needs, e.g. through starvation or exposure, or where there is evidence of deliberate failure to respond to medical needs of the child.

Exclusion criteria

Exclude deaths in which the neglect appears be a reflection of parental incompetence, related to learning difficulties, physical or mental ill-health, or other environmental circumstances (treat as deaths related to but not directly caused by maltreatment – category 5). Exclude abandonment of very young infants (category 1). Exclude accidental deaths related to poor parental supervision (category 5). Exclude cases where neglect contributed to the death, but there is no evidence of persistent neglect in other areas (category 5).

4. DELIBERATE / OVERT HOMICIDES

This overlaps with the first category of infanticide/covert homicide, in that there would appear to be an intent to kill the child; but differs from that and other groups in the age profile, in the victim and perpetrator characteristics and in the typical mode of death. In these deaths, the fact of homicide is likely to be immediately apparent. Include deaths caused by stabbings and firearms; include severe beatings where there appears to be an intent to kill. Include homicides with associated sexual assaults; include cases of killings of multiple family members or of multiple killings with subsequent suicide of the perpetrator ('extended suicides'). This may include deaths from house fires with evidence of arson with intent to kill.

Exclusion criteria

Exclude severe injuries where there is no evidence of intent to kill (category 2); cases where the homicide is not immediately apparent (category 1).

5. DEATHS RELATED TO BUT NOT DIRECTLY CAUSED BY MALTREATMENT

Deaths which are felt to be related to maltreatment, but in which the maltreatment cannot be considered a direct cause of death. Include sudden unexpected deaths in infancy (category 5a) with clear concerns around parental care, but not sufficient to label as extreme or persistent neglect (category 3). Include fatal accidents where there may be issues of parental supervision and care, including accidental ingestion of drugs or other household substances; drownings; falls; electrocution; gunshot wounds; and fires. Includes those children dying of natural causes whose parents may not have sought medical intervention early enough. Include deaths of older children with previous maltreatment, but where the maltreatment did not directly lead to the death, e.g. death from an overwhelming chest infection in a child severely disabled by a non-accidental

head injury; suicide or risk taking behaviours including substance abuse in young people with a past history of abuse.

Exclusion criteria

Deaths covered by any of the preceding categories.

5A. SUDDEN UNEXPECTED DEATH IN INFANCY (SUDI)

Include all SUDI under the age of 1. May incorporate some cases of covert homicide (category 1), or any of the other categories. Include SUDI cases where there was some evidence of poor parenting, abuse or neglect, but the death was not a direct consequence of injury or severe neglect.

Exclusion criteria

Deaths with features suggestive of any other categories 1–4.

5B. SUICIDE

Include all suicides

Exclusion criteria

Exclude cases where it is not clear whether or not the death was a suicide. Deaths covered by any of the preceding categories.

6. OTHER DEATH, CATEGORY NOT CLEAR

Include Serious Case Reviews where a child has died, but there is no indication from the case summary as to which category it should fit into.

Photography by Jon Challicom, posed by a model.

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