



## Factsheet

### Briefing on Key Learning from “Neglect and Serious Case Reviews: A Report from University of East Anglia commissioned by the NSPCC” Brandon et al (UEA/NSPCC January 2013)

#### **Introduction**

This report outlines the findings from a systematic study and analysis of Serious Case Reviews (SCR) between 2003 and 2011 and built upon the analysis of previous Biennial studies undertaken by Marion Brandon and her colleagues.

The study asked 3 questions

1. How often is neglect evident in the families and children who become subject of a SCR?
2. What are the characteristics of children and families where children have experienced neglect?
3. How does neglect feature in cases of child fatality and near fatality?

The briefing paper will consider the first and third question and concludes with the key learning and implications for practice and policy

#### **How often is Neglect Evident in SCR's**

Between 2005 and 2011, officially substantiated neglect (Been, or are, subject of a CP Plan due to neglect) was found in 16% of SCR's (101 out of 645) – For 59 (9%) of these children a CP Plan was in place at the time of death and for the other 42 the CP Plan had been discontinued. There has been a proportionate drop in children having a CP Plan for neglect at time of death or serious injury as below

- 2005-07 : 12%
- 2007-09: 9%
- 2009-11: 6%

This suggests that children in the community with a CP Plan for neglect might be better protected, especially since the overall numbers of children with a CP for neglect has been rising.

However, using stringent criteria the research team identified that in 83 of the 139 SCR's that took place between 2009 and 2011 neglect that had not been formally recognized was a feature and the experiences for the child and the consequences of neglect were as serious as when a CP Plan was in place. This indicates some learning about recognition and response to cases of neglect; especially where a CP Plan has previously been in place.

Neglect features across all age ranges, however whilst the majority of SCR's concern infants and pre-school aged children, there is more likely to have been a CP Plan for neglect in SCR's for older children and so an important learning point is that neglect with serious outcomes is not confined to the youngest children.

## **How Neglect Features in SCR's**

The research found that when neglect was identified in the SCR's reviewed it could be considered across six themes. There are specific learning points for each theme

### **1. Malnutrition** – defined as a life threatening loss of weight or failure to gain weight

- The family's contact with agencies was almost non-existent at the time of death, and they were children being harmed but outside the child protection system
- The families were very isolated and the children were "invisible" and isolated from the "outside world" of the family home, including ceasing to attend school or nursery. Rarely observed, but when seen, there appeared a poor relationship between child and caregiver.
- Changes in the parents' or carers' behaviour in respect of increasing hostility to professionals, or a complete withdrawal from services can signal possible life threatening harm for a child who is neglected.

### **2. Medical Neglect** – defined as child dying, or nearly dying because parents neglected to comply with medical advice

- The significance of changed circumstances, or increased stress on the caregiver of a child with complex health needs, which diminished the caregivers capacity to administer medication safely was not noted by professionals
- Professionals often struggled to challenge erratic or reduced parental compliance with medical advice
- Undue professional optimism meant the impact of medical neglect and danger for the child was missed

### **3, "Accidents" with some element of forewarning** – defined as a child harmed or killed by an accident, within a context of chronic long-term neglect producing an unsafe environment

- There was drift and a lack of urgency to address a risk of harm through poor supervision, even when highlighted in a CP Plan
- Intervention to address the needs of children in cases of poor supervision were allowed to drift due to overwhelming caseloads, high staff turnover and high vacancy rates alongside numerous unallocated cases
- Professionals were found to be tolerant of dangerous conditions and poor care, when children's demeanour and behaviour was seen as

“happy and playful”, even if they lived in a unsafe environment and had signs of poor developmental progress

4. **Sudden Unexpected Death in Infancy (SUDI)**– defined as “unexplained” infant deaths in a context of neglectful care and a hazardous home environment
  - Professionals should be on high alert to the risks of harm for young babies living in dangerous living conditions, this is especially relevant when working with large families where individual children can be lost
  - Professionals should not be falsely re-assured about a baby’s safety when a “good” relationship is observed between baby and parent cannot keep the child safe. Particular attention should be given to possible co-sleeping with a parent who has consumed alcohol or drugs
  - Interventions to prevent SUDI where there are known risk factors should be followed through with families.
  
5. **Neglect in Combination with Physical Abuse** – defined as where assumptions about neglect masked the physical danger to the life of the child
  - Overtime there was a diluting and forgetting of the concerns about the risk of physical harm, which was overtaken by a “this is only neglect” mindset
  - When children were categorized at risk of harm from neglect less attention was paid to other risk factors however neglect does not preclude physical abuse
  
6. **Suicide Among Young People** – This was where a long term history of neglect had a catastrophic effect on a child’s mental wellbeing.
  - Young people with long term experiences of neglect and rejection find it difficult to trust and may present as “hard to help”
  - Professionals should take time to analysis the root causes of young people’s behaviour so as to ensure professional responses do not confirm young people’s sense of themselves as unworthy and unlovable
  - Young people in care often feel compelled to go back home. Once home, young people and their families need a high level of intensive support not a low level service
  - Professionals should be mindful that post 16 or school young people loose the protection of school and have limited equivalent protected routes out of a neglectful home situation

## Implications for Policy and Practice

Below is a table with key learning and this is focused on 2 key messages to ensure children are safe from harm due to neglect. These messages are:

- Maintaining a Health Environment
- Maintaining Healthy Safe Relationships

. Whilst the learning is important across all agencies providing services to children and adult members of their family, the table details specific agencies/services that need to ensure practitioners and managers are aware of the learning.

Key learning	Agency/ Service
<b>Maintaining a Healthy Environment</b>	
The system needs to be able to support practitioners to make good relationships with children and parents, and supports them in managing risk of harm that stems from neglect or maltreatment. This is a reminder of the findings from the Munro Review of Child Protection (2011)	All Agencies that work directly with children and their families, including services that work with adults who are parents
For neglected children to stay safe they require a physically, and emotionally safe and healthy living environment, as a pre-condition of a safe relationship between a child and their caregiver. Therefore practitioners should be attuned to the safety of a child's living conditions and environment	All Agencies that work with children and their families. Specifically this will be particularly relevant to services/agencies who visit families in their home such as: <ul style="list-style-type: none"> <li>• Social Work Services,</li> <li>• Health Visiting and other Community Health Workers</li> <li>• Housing Providers</li> <li>• Schools</li> <li>• Early Years Settings</li> </ul>
A Public Health approach to neglect offers good opportunities for prevention, particularly in respect of suicide prevention, accident prevention, and SUDI prevention messages	Solihull MBC Public Health Team and other health and community services The messages are also relevant to all agencies /service who work directly with children and their families
Targeted support should be considered for families that are known to be	All agencies/ services that provide early help and should be considered in

<p>vulnerable that can help to prevent accidents and risk of harm, including death, when unsafe accommodation is combined with lapses in parental supervision</p>	<p>the Early Help Strategy</p> <p>Agencies providing targeted support to families such as Families First, Health Visiting, Social Work Services, CAMHS, extended school services, Youth Service, SIAS, Children Centres, Fire Service and SC Housing</p>
<p>Vulnerable young people with a long history of neglect and rejection, who may be care leavers, can rarely thrive living alone in isolation, poor quality accommodation, but need a safe supportive environment</p>	<p>Social Work Services, Housing providers Health providers Schools/ Post 16 education providers Connexions Youth Service YOS CAMHS</p>
<p><b>Maintaining Healthy Safe Relationships</b></p>	
<p>Practitioners should be mindful of the danger to a child from deteriorating parent/child relationships, where care can become so poor that care, nurture and supervision are almost non-existent. Intervention can be stalled when children, young people and families disappear from view, such as missed appointments, failed visits, and children not seen</p>	<p>All agencies that work directly with children and their parents – including services that work exclusively with adults and with children</p>
<p>Practitioners needed to be attuned to the relationship between parents and children, even when parents appear to be loving they may be struggling to cope</p>	<p>All agencies that work directly with children and their parents</p>
<p>Older children carry the legacy of their experiences of neglect and rejection. They require support to build, and maintain, healthy relationships with peers and caring adults</p>	<p>Agencies working with vulnerable older children and young people, including Education, including schools and colleges Youth Service YOS Connexions CAMHS</p>

	Social Work Services
Routine contact between parents and professionals should be an opportunity to promote sensitive and attuned parenting. When concerns are noticed these should be prompts to ensure targeted help from services such as Children's Centres, Nurse Family Partnerships, school or community based services such as CAMHS	All agencies that come into contact with children and their parents, specifically as stated Children's Centres Health Visiting Service (including NFP) Schools CAMHS
Practitioners should be asking what does this child mean to the parent, and what does the parent mean to the child? Reflective supervision should be available to help understand complex relationships and act decisively when children may be in danger	All agencies and services who work with children and their parents
Missed appointments should be followed up and not considered a reason to withdraw a service. To be safe children need to be seen and importantly to be known	All agencies/ services that work directly with children and young people and their families

### Action Taken

1. The LSCB has reviewed the findings from this study and this briefing is made available to all partner agencies and their workforce to consider the practice implications when working with vulnerable children and their parents/caregivers
2. The Findings from this study have been used to inform LSCB Multi-agency Level 2 safeguarding training and Level 3 Neglect Training
3. The LSCB recommends that its partner agencies consider the learning from this study in their workforce development plans

Briefing: Neglect & SCR's Report (UEA & NSPCC 2013)

The full report of the research can be viewed at

[Neglect and serious case reviews: a report from the University of East Anglia commissioned by the NSPCC \(PDF version\)](#)

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