Buckinghamshire BSCB Safeguarding Children Board

Learning from Serious Case Reviews
Neglect

Summary of risk factors and learning for improved practice around Neglect

Neglect is a factor in 60% of Serious Case Reviews Nationally

Neglect is a serious form of harm. Both families and professionals can become overwhelmed and demoralised by issues of neglect. Children may experience repeated attempts by professionals to try and improve the situation

Published national case reviews highlight that professionals face a big challenge in identifying and taking timely action on neglect.

The learning from these reviews highlights that professionals from all agencies must be able to:

- Recognise physical and emotional neglect
- Understand the impact of cumulative and long term effects of neglect
- Take timely action to safeguard children

Reasons case reviews were commissioned

This briefing is based on case reviews published since 2014, where neglect was a key factor. It pulls together and highlights the learning contained in the published reports.

In these case reviews, children died or suffered serious harm in the following ways:

- Chronic neglect over a long period sometimes co-existing with physical, emotional and sexual abuse
- Death or serious harm from physical or sexual abuse where neglect was a feature or preceded the abuse
- Sudden Unexpected Death in Infancy (SUDI) related to neglect risk factors such as malnutrition, poor social circumstances or parental substance misuse
- Accidents, sometimes with an element of forewarning when long-term neglect in a family resulted in an unsafe environment
- Attempted suicide of a young person as a result of the effect of long term neglect on mental health.

Risk Factors for Neglect in Case Reviews

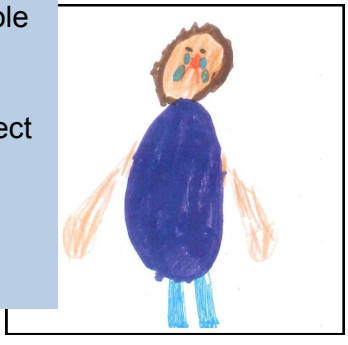
Risk factors highlighted in these case reviews impact on the parents' ability to provide safe and appropriate care and to meet their children's needs:

- Living with domestic abuse, drug and alcohol misuse, and parents with mental health problems
- Young parents
- Postnatal depression. Maternal depression was also linked to social isolation
- Patterns of improvement in parental care, followed by deterioration
- Financial problems including housing problems, homelessness, poverty and unemployment
- Lack of resources. High caseloads and understaffing may result in absence of supervision and support for social workers. High staff turnover makes it difficult to establish meaningful relationships with families.

Learning for Improved Practice

Be aware of children who are more vulnerable to neglect

- Newborn babies, premature babies and babies with ongoing health needs are particularly vulnerable. Neonatal professionals have a key role in identifying neglect
- Teenagers' needs can be missed especially where there are younger siblings. Professionals should understand the impact of long term neglect on a teenager's emotional wellbeing and consider the risk of self-harm and suicide
- Tooth decay may indicate neglect. Dental services should consider initiating further enquiries or making a safeguarding referral.



Monitor missed appointments

Professionals in all agencies should understand the significance of missed medical appointments for children. In one case, the only indication of a sudden change in parenting capability was an emerging pattern of non-attendance at appointments.

A system should be in place that allows:

- Missed appointments to be monitored
- Professionals to know what action to take when there are concerns.

Pay attention to accidents and injuries

Frequently accidents may be an indicator of poor quality parenting through lack of supervision or living in an unsafe home.

- Repeated visits to A&E should raise concern
- Lack of supervision may include inappropriate supervision such as unacceptably young babysitters or unsuitable adults.

Have the confidence and knowledge to effectively assess parental capacity to change

- Be clear with parents about what needs to change and by when. Parents should be respectfully challenged when they fail to follow formal agreements.
- When there's no long term positive change, the lead professional should co-ordinate support and services. Doing this will help agencies work effectively together.
- Warm relationships between parents and children shouldn't override concerns about neglect.
- Maintain focus on the best interests of the child rather than the immediate needs of a parent who may be dominant or very needy.
- Improvements to poor home conditions should be regularly reviewed, especially if the family is unlikely to sustain them.
- Be aware of the possibility of disguised compliance.

See the bigger picture and understand the long-term impact of neglect

- Always take the full history of the family into account and patterns of previous episodes of neglect. Include background information of the parents' own childhood to better assess parenting capability.
- Record all circumstances which may affect the level of care the child receives, for example substance misuse, and establish any patterns of care, such as the child being left with neighbours.
- As well as ensuring a healthy physical environment, make sure the child is helped to build healthy relationships.
- Alongside proactive case management and decision-making, identify and record all incidents of neglect to build a picture of what is going on in the child's life.
- Emotional neglect is particularly difficult to evidence. Individual observations of emotional neglect should be systematically collated.
- GPs and other GP practice staff should be more actively curious when engaging with a family where there are concerns about neglect.

Support families though early evidence based assessment & intervention

Where there is risk of neglect, families should be supported within a model of early intervention

(For Buckinghamshire, professionals can link to the BSCB Thresholds Document.
A Home Conditions Assessment can be completed by anyone using the Early Help Toolkit)

Work closely with other agencies to identify concerns and plan interventions

- Compile a multi-agency chronology of key events.
- Invite health professionals such as the health visitor or school nurse to meetings.
- Thresholds for intervention should be clearly understood across agencies so that professionals can challenge each other with confidence.
- Ensure terminology is free from jargon and clearly understood by the family and all professionals involved.
- Roles and responsibilities must be clearly understood.
- When undertaking multi-agency assessments all agencies must be aware of which agency is leading and what action is being taken.
- Where families refuse to engage with early assessments, this shouldn't prevent professionals from sharing information or making referrals about child protection concerns.

- Where neglect coexists with physical or sexual abuse, a criminal prosecution for abuse shouldn't be viewed as the only means of child protection. Where criminal cases don't result in a prosecution, child protection proceedings may still be necessary to keep the children safe from harm.

Undertake robust and comprehensive assessments

- Use a risk assessment toolkit and approach such as the Graded Care Profile (GCP), which seeks to prevent case drift by focusing on specific areas of need.
- Ensure the assessment is timely.

Keep focus on the need to improve outcomes for the child's daily lived experience

Feelings of hopelessness in families experiencing neglect for a long time may also be felt by professionals. Where there is no change for the better, professionals may sometimes struggle to know how to proceed. The reviews show that sometimes cases were transferred to a colleague or even closed.

- A review should always take place before a case is closed or transferred
- Interventions must be linked to specific improved outcomes. Professionals should undertake regular reviews to check improvements are being made. Where improvements are not being sustained, professionals must decide whether legal proceedings are necessary to protect the child.

Keep focus on the need to improve outcomes for the child's daily lived experience

Hope for change for families must be balanced with the absolute need to avoid case drift. Effective and reflective supervision should enable practitioners to assess children's development and behaviours in families with high levels of need.

- If a case becomes 'stuck', there should be a process where practitioners can escalate the situation to senior managers. This may help to provide a fresh, objective approach to address the problems.
- There should be an opportunity to stop and review the whole case. Supervision should assist practitioners with the discipline of reflective thinking.
- The main focus should always be whether the child's needs are being met and how that can be achieved to prevent significant harm.

Information source: **NSPCC Preventing Abuse - Neglect**

Published September 2015. Accessed by BSCB on 19th September 2017

Further Reading

Brandon, M. et al (2013). Neglect and serious case reviews: a report from the University of East Anglia commissioned by NSPCC. London: NSPCC.

Brandon, M. et al (2012). New learning from serious case reviews: a two year report for 2009-2011 (PDF). London: Department for Education.

Horwath, J. (2013) Child neglect: planning and intervention. Basingstoke: Palgrave Macmillan.

Learning specific to Buckinghamshire from local Serious Case Reviews

At the end of September 2017, 59% of child protection plans were for neglect; this is an increase of 16% based on the same time period from the previous year.

An audit of child protection plans for neglect carried out in April 2016 recommended:

- Social Care professionals should ensure that the recording of the detail of child protection plans is clear and specific, and is focused on desired outcomes. The detail of the work agreed to by all individuals at the conference and core group (and accompanying timescales) should also be precisely and clearly set out.
- All partner professionals should be reminded of their responsibilities - and the different options available ranging from informal to formal - to challenge drift and delay in care planning.

Image used is an example and is not from a home within Buckinghamshire

A Serious Case Review was carried out for Baby L in June 2015.

Although neglect was not the reason for the SCR, it was found that housing conditions were not ideal.

"In this situation the family were living in privately rented, shared accommodation which was unsanitary, unsuitable and cramped. Cupboards were hanging off the wall in the shared kitchen, other communal areas were dirty and smoky and there were times when the water supply was cut off.
The small bedroom had only just room for a moses basket for the baby as well as a bed for the parents.
As the mother then spent time away from the accommodation it led to some confusion about when and where she was seen and some delay in professionals being able to properly assess home conditions. It also had an adverse impact on the parents' relationship".

It is important for professionals to access the main home where a family lives and ensure the property is suitable for the family and not be distracted by families insisting on visits away from the main home.
In this case a Graded Care Profile assessment may have flagged up the unsuitable housing conditions.

Buckinghamshire Policies and Procedures

Additional information can be found by accessing the following Policies & Procedures, which are all readily available on the new BSCB online manual: BSCB online Policy & Procedures manual

⇒ Neglect Strategy
⇒ Neglect Guidance
⇒ Pre Birth Procedures
⇒ Abuse of Disabled Children

To find out more about the Buckinghamshire Safeguarding Children Board, you can visit our website: www.bucks-lscb.org.uk