A study of serious case reviews between 2016-2018: What are the key barriers for social workers in identifying and responding to child neglect?

Abstract

Child neglect is the most common form of maltreatment but is also one of the most complex. Neglect has a long-term negative impact on children and young people's development and wellbeing. This study examined 20 recent serious case reviews that had taken place in England and where neglect was a feature in order to examine the barriers which exist for social workers to identify and respond to neglect in a timely, appropriate and effective manner. Thematic analysis identified four main themes that were likely to impact upon effective interventions. These comprised challenges in terms of the definition of neglect and how to identify it, the use of toolkits when working with families when children may be at risk of neglect, the impact of organisational cultures on practice with families and the voice of the child.

Introduction

Child neglect is the most common form of maltreatment in the UK, as well as being the most common reason for a child to be made subject to a child protection plan (Action for Children, 2015). The number of children under a child protection plan in England increased by 96% between 2002 and 2016, and it is estimated that 46% of children are subject to a child protection plan due to neglect (Bentley et al., 2017). Despite it being estimated that one in ten children in the UK have experienced neglect (NSPCC, 2017), compared to child abuse and other forms of maltreatment, there exists a dearth of literature relating specifically to neglect. Much of the literature refers to 'abuse and neglect', with most of the focus being placed on abuse, which is considered easier to identify (Tanner and Turney, 2003). Research has shown that neglect is often not acted upon until a crisis has occurred, and that without such a trigger, there is a danger that vulnerable children are left in neglectful environments for too long without appropriate interventions being made (Daniel, Taylor and Scott, 2011).

A previous examination of serious case reviews (SCRs) in England from 2009 to 2011 identified neglect as a factor in 60% of SCRs, suggesting it is more prevalent than previously thought (Brandon et al., 2013). The Children Act 2004 requires that children's services authorities in England establish Local Safeguarding Children Boards (LSCB) to ensure that

key agencies involved in safeguarding children are coordinated in their work. One of the tasks of LSCBs, as set out in Regulation 5, is to undertake reviews of cases where lessons can be learned (Carr and Goosey, 2017). SCRs aim to offer lessons learned from a case in order to improve practice or the way professionals work together to safeguard children (Koubel, 2016). Working Together to Safeguard Children (WTSC, 2018, p.73) states that a SCR should take place when:

- Abuse or neglect of a child is known or suspected; and
- Either- i) the child has died; or ii) the child has been seriously harmed and there is a cause of concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

However, SCRs can also act as a medium to shame and blame the organisations and individuals involved in such cases (Warner, 2015). Through a mix of hindsight and selectivity, they have a tendency to hypothecate other judgements and decisions that could have been made, and risk creating the notion that safeguarding children is based on common sense and is something that could be performed by anyone (Warner, 2015).

Background

Defining neglect

Neglect can manifest itself in many ways in various different contexts, and is just as damaging as other forms of maltreatment (Barlow et al., 2016). Due to the complexity of neglect and the wide range of circumstances that may potentially be described as neglectful, Daniel (2017) argues that it is not unexpected that it is difficult to agree on a singular definition of neglect. Neglect generally refers to an ongoing or chronic lack of care and is linked with cumulative developmental problems for the child (Connolly and Morris, 2012). However, this is perhaps an oversimplified definition that does not capture the complexity of neglect (Daniel et al., 2011), or the fact that, for some children, neglect can either directly or indirectly lead to death, harm or serious injury (Brandon et al., 2014).

WTSC (2018) highlights the difficulty of assessing neglect as it can fluctuate in both level and duration. Additionally, the assessment of neglect may vary from one practitioner to another due to the different views about what constitutes neglect, and judgements made regarding neglectful circumstances are often value laden (Horwath, 2007; Turney and Tanner, 2001). Davies and Ward (2011) highlight a common finding in a number of studies:

that professionals apply high thresholds when working with neglect, and are reluctant to respond in cases of neglect that are not straightforward. When responding to neglect, there is also the difficulty of deciding when to intervene. Neglect is defined as being both persistent and chronic, and it is the chronic and cumulative nature of it which is so damaging to children (Daniel et al., 2011). There is a clear dilemma attached to determining when neglect can be considered persistent, in what circumstances, and over what period of time (Dickens, 2007).

Tools for identifying, measuring and monitoring neglect

Daniel (2015) argues that practitioners find it difficult to apply research to practice, and it has been suggested that social workers have little understanding of what is meant by neglect, and how to respond to it (Gough and Stanley, 2007). A series of tools have been developed to assist social workers and other professionals in identifying, measuring and monitoring neglect, such as the Graded Care Profile 2 produced by the NSPCC. According to Horwath (2007) these tools may assist practitioners in identifying the signs and symptoms of neglect, as they emphasise areas that need examining as well as measuring the different aspects and severity levels of neglect.

However, despite the usefulness of these tools, it is vital to recognise that they cannot provide a definitive answer. According to Dickens (2007), more checklists, frameworks, protocols, procedures and timescales are often proposed as the solution, but these give the false impression that recording information or following rules will provide the answers to the often very complex decisions that have to be made. For these tools to be effective, it is essential for practitioners to be appropriately trained, and to understand the value of their use, as well as acknowledging their limitations and place alongside professional judgement (Carter, 2012).

Voice of the child

The ‘Framework for the Assessment of Children in Need and their Families’ (DoH, 2000) established a theoretical and practical approach to assessment in England and Wales, which outlined the principle of effective work with children and families through child-centred practice. This approach aims to ensure that the child remains the focus of the assessment, and that the child’s perspective is taken into account (DoH, 2000). Numerous public enquiries and SCRs have highlighted the failure of professionals to sufficiently engage with

or effectively relate to the child or young person in question. This is a phenomenon which has become known as the 'invisible child' (Ferguson, 2017).

Ofsted (2014) explored the effectiveness of arrangements to safeguard children who experience neglect. It found that in chaotic and complex circumstances, children can easily become invisible and their daily lived experiences can remain unexplored, as instead of analysing the impact of the parents' behaviour on their children, the focus is placed upon the adult's needs. It has also been highlighted that professionals may minimise their concerns for a child's safety and welfare by succumbing to the 'rule of optimism', which may potentially prevent a situation from being viewed as neglectful (Calder, 2016). The 'rule of optimism' was a concept developed by Dingwall et al. (1983) and is a term used to describe situations where the practitioners see the best in people and are overly optimistic about the intervention improving the outcomes for the child and their family (Doyle and Timms, 2014). This was further highlighted in a qualitative study carried out by Horwath and Tarr (2015), which indicated that social workers struggled to be child-centred during the planning process when working with children living with chronic neglect, and only superficially engaged with them.

Organisational context

Social work is experiencing rapid changes both in practice and structure, especially in the context of financial austerity and the reduction of local authorities' budgets (Milner et al. 2015). Munro (2011) emphasised the need to move away from bureaucratic processes to enable practitioners to spend more time with children and families, and subsequently, develop the professional relationships that are required to safeguard vulnerable children. Social workers are feeling increasingly overwhelmed with administrative tasks and are under pressure to adhere to the tight deadlines of the assessment framework, child protection conferences or the courts. As a result, less time is spent with children and young people, which makes it difficult to fully understand their experiences, wishes and feelings (Diaz and Drewery, 2016). Consequently, child-centred practice is being compromised (Garrett, 2009; Broadhurst et al., 2010).

Working with children and families and directly observing the negative impact of neglect can be emotionally demanding. Coupled with having to make challenging decisions without adequate supervision and managerial oversight, as well as a lack of time to reflect, practitioners may be prevented from fully engaging with the experiences of the children they are working with (Lefevre, 2010). Due to the constraints of the bureaucratic system, austerity

and increasing caseloads, social workers and managers may prioritise meeting targets and deadlines, as opposed to producing high quality assessments (Diaz and Drewery, 2016).

Supervision is important to allow social workers to develop research-grounded practice, and to ensure that routinised practice is challenged when working with neglect (Tanner and Turney, 2003). Reflective supervision allows practitioners to consider their biases and values, as well as when concerns have reached the threshold for significant harm (Ofsted, 2014). Stone (1998) highlights the importance of giving practitioners opportunities to reflect on the details in neglect cases, as well as being able to explore the emotional aspects of working with children who are neglected. Unfortunately research consistently highlights that the supervision that practitioners experience in reality is process driven and does not provide an opportunity for reflection (Wilkens et al 2018)

Methodology

In order to examine the aforementioned barriers for social workers in identifying and responding to child neglect, this study collected data from SCRs deposited in the National Case Review Repository. In order to utilise new findings, only SCRs that had been published between 2016 and 2018 were included. Furthermore, only SCRs where neglect was known or suspected by professionals to be a factor in the child's death or serious injury or harm were selected. The National Serious Case Review Repository provides key words and an abstract for each SCR, which were used to identify whether neglect had been a feature in the child's life. The Repository contained 190 SCRs which had been published between 2016 and 2018. Of these, 86 documented neglect as a factor in the critical incident, meaning that neglect featured in 45% of critical incidents where a child had died or sustained serious injury or harm. The presence of neglect was indicated by one or more of the following factors: that the child was on a Child Protection Plan under the category of neglect, that neglect was stated as the primary category for the incident, or that neglect was discussed as a longstanding feature of the child's life.

From the 86 SCRs that featured neglect as a factor in the critical incident, 20 were selected for in-depth thematic analysis. These were purposively selected to represent children of a range of ages and genders, and from a number of different local authorities. Ethical permissions were not required for this secondary analysis of SCRs, as these are publically available and all of the SCRs utilised pseudonyms to protect the identity of all the family members and professionals involved.

Table 1. List of the 20 SCRs used in the analysis.

LSCB	Child Reference	Year	Age
Durham	Charlie and Charlotte	2018	10 and 7 years
Unnamed	Emily	2018	3 months
Sunderland	Family X	2017	Unknown
Trafford	Child N	2017	7 years
Hertfordshire	Child G	2017	Under 1 year
Derbyshire	Polly	2017	21 months
Croydon and Lewisham	Children R, S, W	2017	6 months, 1 year, 4 years
Blackpool	Child BW	2017	3 months
Kent	Child C	2017	2 years
Durham	Baby Bailey	2017	7 weeks
Manchester	Child K1	2017	3 years
Thurrock	Megan	2016	17 years
Cheshire West/Chester	Child A	2016	School age
Herefordshire	Family HJ	2016	Unknown
Devon	CN12 Thomas	2016	7 weeks
Sunderland	Baby W and Child Z	2016	11 weeks and 3 years
Luton	Child F	2016	8 weeks
Unnamed	Children U, V, B	2016	6 weeks, 13 years, 15 years
Central Bedfordshire	Bethany	2016	19 months
Sunderland	Baby O	2016	6 months

Thematic analysis is the most common approach used to examine qualitative data (Bryman, 2016). We used this approach to examine our data as it enables the extraction of key themes from large volumes of information (such as that presented in the SCRs), and allows data to be examined in greater depth (Gibbs and Hall, 2007). This approach to analysis involved the reading and re-reading of the SCRs in order to identify key themes both within and between the texts. Four key themes emerged from the thematic analysis of the 20 SCRs:

1. The usefulness of a definition in the identification of neglect
2. The use of tools to aid practitioners in identifying, monitoring and tracking neglect
3. The extent to which children's views are listened to and considered

4. The impact of organisational culture

Although there are similar themes and patterns that emerged within these 20 cases, it is important to acknowledge that the lives and experiences of the children and young people featured in the SCRs were all different and unique.

Key Findings

The usefulness of a definition in the identification of neglect

In 15 of the SCRs it was identified that social workers and other professionals had difficulties identifying and responding to neglect. This was despite four of these SCRs featuring children who were subject to a child protection plan under the category of neglect. Some reviews highlighted that professional perspectives may have impacted negatively on social workers' ability to recognise and act on indicators of neglect. Neglect is a particularly difficult area of work for practitioners; identifying multiple risks, naming concerns as potential neglect and judging potential progress all present as challenges. The uncertainty around what constitutes neglect may lead to confused opinions (Brandon, 2012). Although there are several obstacles to recognising neglect, such as limited resources or insufficient training, there are a number of professional assumptions which may prevent indicators of neglect from being acted upon. These may include the fear of appearing judgemental or overly critical. In the SCR for Child Z and Baby W (Sunderland, 2016) it was highlighted that professionals focused more on the parent than the children, and as a result, professionals had not considered the lived experiences of the children in any depth. For example, what it was like for them being passed around carers, frequently moving house or what happened to them when their parents were out drinking.

The SCR of Child BW (2017) illustrates how neglect may be subjective and professionals may vary in their views of what is 'good enough'. The review stated that due to the high level of child poverty in Blackpool, subjectivity may have affected professional judgements because other children in the local area lived in similar circumstances. There is evidence to suggest that areas where there is higher deprivation the threshold for intervention of neglect may be higher (Stevenson, 2007). Although the majority of parents who live in poverty do not neglect their children, there is a link between poverty and neglect (Bywaters et al 2017; Burgess et al., 2014) and this can be seen as a causal factor (JRF, 2016).

Jones (2016) states that neglect is not one entity, and the issues and difficulties of deciding how to respond to neglect relate to the lack of understanding or clarity about the different types of neglect, as well as differing personal perceptions of what constitutes neglect. This is highlighted in several of the SCRs in this study. In the SCR for Family X (Sunderland, 2017) there was a clear dissensus amongst professionals involved with the family about what constituted neglect, and as a result, no single agency had a clear picture of the neglect the children were experiencing. This SCR suggests that the children experienced a chaotic form of neglect and professionals were misled by the parents to believe that the children's emotional needs were being met. The records showed a range of issues, such as poor education attendance, missed health appointments, sexualised behaviour and criminality. This SCR demonstrated that the classification of neglect was generalised, and that there had been no analysis of why the different issues were present or how they was experienced by the children. Howe (1995) states that assessments of neglect must understand the type of neglect and how this impacts on the child's daily lived experiences in order to effectively intervene.

Despite the range of academic resources which are available to help professionals understand, conceptualise and recognise neglect, over half of the SCRs considered in this study described how professionals underestimated the long-term adverse impact of neglect on children. In seven of the SCRs which highlighted a lack of understanding of the impact of neglect, the children were or had previously been on a child protection plan, which is in line with other research (McSherry 2011). Due to increasing caseloads, social workers have to risk-manage their workload which often leads to physical abuse being prioritised over neglect (McSherry, 2007; Stokes and Taylor, 2014). It seems likely that neglect is still not viewed as seriously as physical and sexual abuse, and often neglect occurs alongside such abuse, which becomes the main focus of the intervention (Dubowitz, 2007; Connolly, 2017).

The SCR of Child BW (Sunderland, 2017) outlines why the impact of neglect on children should not be underestimated. The children in the family were described as 'resilient, developing independence and the ability to self-care'. However, they were of nursery and early primary school age and thus, these life skills should not have been viewed as acceptable. Importantly, as highlighted in the SCR, children should not be expected to have to become resilient to neglect. There is a danger that social workers become accustomed to chronic neglect (Horwath, 2007), and may normalise what they see when they work routinely with neglect (Ofsted, 2014).

<u>The use of tools to aid practitioners in identifying, monitoring and tracking neglect</u>

In half of the SCRs featured in this study, it was identified that neglect toolkits were not used to aid practitioners in identifying, tracking and monitoring neglect. Out of these ten SCRs, two children were on a child protection plan, and in four cases, the children were on a child in need plan. The other four SCRs reported that children's services were carrying out an assessment or had just closed the case. In all ten SCRs it was identified that there were issues with professional responses to neglect, and as a result, the cumulative impact of neglect remained unknown. Professionals tended to focus on the immediate presenting problems and there was little evidence that historical risk indicators had been considered. This meant that children were left in neglectful situations for too long. In some local authorities, although the neglect assessment tools were available, professionals were unable to use these due to a lack of training. One reason for this was a rapid and continuous turnover of staff. In a quarter of the SCRs it was identified that there was a lack of multi-agency neglect strategy in place within the local authority to increase the understanding and awareness of neglect, both within and between agencies working with vulnerable children and families.

The SCR of Baby O (Sunderland, 2016) highlights the difficulties of working with families where neglect is a feature. When the family showed slight improvements or the parents were more cooperative, it was harder for the social workers to see the full picture and the patterns of neglect. As a result of not using a neglect assessment tool, it was difficult for the social worker and other practitioners to track and monitor the neglect over time, which resulted in the cumulative impact of neglect on the children going unnoticed. In the SCR of Emily (Unnamed, 2018), it was highlighted that the absence of neglect framework and assessment tools played an important part in inhibiting the professionals' shared understanding of the neglect that Emily was being exposed to.

The SCRs in this study placed a weight on the importance of a neglect toolkit being used in the assessment of families, and a multi-agency neglect strategy to ensure that there is a common understanding of neglect between professionals. Neglect rarely manifests itself as a crisis that demands immediate action but is cumulative over time. Hence, there is a danger that professionals may become accustomed to the chronic nature of neglect and normalise what they see. When working with families where neglect is a feature, it is vital to look beyond individual episodes of neglect (Brandon et al., 2016). This was demonstrated in the SCR for Family X (Sunderland, 2017). At the time the SCR was being carried out, there was not a common approach to assessing neglect in place in Sunderland. The family had been known to multi-agency safeguarding services for over 20 years, however, practitioners spoke of the difficulties of putting a case of neglect before a Court due to the lack of evidence that chronic neglect had occurred. It was highlighted in the SCR that the introduction of a single

interagency evidence-based neglect toolkit would support the assessment of neglect, and help to recognise and evidence the long-term impact or harm.

The SCR for Child F (Luton, 2016) reports that Children's Social Care did not use a multi-agency neglect toolkit as part of an assessment of neglect. Child F was not living in a safe and healthy living environment, and although this was known to professionals, this was not addressed prior to his death. This SCR highlights that the lack of use of a neglect toolkit, which would have assisted professionals in recognising and responding to indicators of neglect, meant that cumulative impact of neglect was unknown. This led to individual practitioners making subjective, and at times, personal judgements as to whether the children's circumstances were neglectful or not.

The extent to which children's views are listened to and considered

The right for the child to participate in the assessment process is rooted within legislation and policy in England (Race and O'Keefe, 2017). The Children Act 1989 highlights that local authorities should, where possible, ascertain the wishes and feelings of the child and take these into consideration when making decisions that affect them (Carr and Goosey, 2017). In this study, 65% of the SCRs reported that the voice of the child had not been consistently heard or considered, and that children were not seen alone or seen frequently enough. The SCRs frequently emphasised that children and young people were not asked about their life and experiences, hence it was not evident from the case notes and assessments what life was like for those children who experienced neglect. There was little evidence of meaningful direct work being carried out with children and young people, and this was consistent across age groups.

The SCR of Child N (Trafford, 2017) highlights a theme that emerged within several SCRs:

> *The contacts and observations of the children made by SW2 and SW3 were limited to short visits to the home and none of the children were purposefully engaged in any direct work to ascertain how they experienced day to day life or to establish whether they wished to discuss any worries or concerns.*

This is in line with the findings from Ferguson (2016) who identified in his study that most of the time spent doing child protection work consists of relating to children and parents concurrently. His study found that a large number of children were not seen alone in everyday child protection practice, and that when time was spent with children, it was often too brief. A key theme throughout the SCRs was the difficulty for social workers to remain

child-centred when working in chaotic and complex family situations. It was found that professionals became distracted by the needs, and reliant on the views, of the parents as opposed to the views of the child, which was further highlighted in Horwath and Tarr's study (2015).

Ferguson (2016) highlighted that children may become invisible due to the increasing demands of the bureaucratic system, but also due to some social workers having a limited level of communication skills, play skills and lacking the confidence to build close professional relationships with children. It is argued that good social work practice should achieve the opposite of this, and that social workers should make children visible through their work (Ferguson, 2017). Several public enquiries and over half of the SCRs that were analysed in this study have highlighted the dangers that can occur when social workers overlook or misinterpret communication from children. Based on 20 SCRs analysed in this study, it still appears to be the case that, at times, vulnerable children are not heard or seen and hence remain invisible. The finding of this study suggest that professionals are still over-reliant on children talking about neglect and their experiences, which places too much responsibility on the children themselves to ensure that they are protected and safeguarded (Blyth, 2014). This study found that in five of the eight SCRs where the children were on a child protection plan at the time of death or serious injury or harm, children were not seen frequently enough and there was little evidence of direct work being carried out. This was also the case for children who were on a child in need plan at the time of the critical incident.

The term 'invisible child' was further highlighted in this study, as in four of the cases, no pre-birth assessment had been conducted. The aim of a pre-birth assessment is to ensure that any risks to the unborn baby are identified and that a plan is in place to address the need for support (WTSC, 2018). Young babies are extremely vulnerable and dependent on their carers for survival, which is reflected in the high number of SCRs involving children under 12 months of age (Sidebotham, 2016). This study also highlighted that in two of the families who had large sibling groups, the children were not assessed individually, and the plans were not individualised, which meant that the needs of the individual children were overlooked (Family X, Sunderland and Child N, Trafford).

It was highlighted as a common theme throughout the SCRs that professionals can succumb to the 'rule of optimism' when working with families where neglect was a feature. This was outlined in the SCR of Charlie and Charlotte (Durham, 2018), where there was limited engagement with the children and professionals thought the children's lives had improved on the basis of limited evidence. However, based on the available information from the SCR, at times, they felt unsafe and uncared for, and they suffered pain from dental decay that was

left untreated. The review outlined how Charlie and Charlotte's behaviour was a way for them to express their suffering, but this was not understood in the context of their experience of chronic neglect.

The impact of organisational culture

In 45% of the SCRs it was highlighted that organisational culture negatively impacted on the practice of social workers. Social work has become dependent on overly bureaucratic systems which has resulted in a reduction in the amount of time social workers are able to spend doing direct work with children and families (Bowyer and Roe, 2015). Within Lord Laming's progress report, he emphasised the immense pressure that children's frontline social workers are under: 'Low morale, poor supervision, high caseloads, under resourcing and inadequate training each contribute to high levels of stress and recruitment and retention difficulties' (Laming, 2009, p. 44). Bowyer and Roe (2015) report that organisational factors will contribute towards burnout amongst social workers, and it is inevitable that when local authorities have staff retention issues, caseloads will rise.

These findings were mirrored in the findings from the SCRs. Six of the 20 SCRs highlighted the presence of high staff turnover and high caseloads which caused drift and impacted on the day-to-day management of child protection plans. In the SCR of Baby W and Child Z (Sunderland, 2016) it was found that the family had had five social workers in the space of just six months. The potential negative impact of organisational culture is further highlighted in the SCR for Family HJ (Hertfordshire, 2016):

> *The wider context at the time was that the local authority was facing significant difficulties due to high levels of Looked After Children and children on child protection plans, resource issues, high staff turnover and high case-loads. This was thought to be a significant issue in the delay in determining that these children were suffering significant harm.*

The situation is illustrated further in the SCR of Child B (Staffordshire, 2017). At the time of Child B's death, the teams within the local authority's Children's Services were operating as one team due to numerous team managers being off with long-term sickness. This meant that one team manager was supervising more than 20 social workers. In addition, the local authority had difficulties retaining and recruiting staff which meant that the team consisted largely of newly qualified social workers and agency staff. It was recorded that the newly qualified social worker working with Child B and his family had 43 open cases. This would have caused a deterioration in the quality of practice, decision-making and case planning. The SCR for Bethany (Bedfordshire, 2016) reported that Bethany had five different social

workers within a period of less than two years. This led to difficulty in providing continuity of planning and monitoring, and there had been a tendency to ‘start again’ when a new social worker became involved.

The SCR of Baby W and Child Z (Sunderland, 2016) reported that the local authority had been rated inadequate and commissioners were appointed to oversee improvements to the Children’s Services. Further comments were made about the negative impact this had on staff morale, since practitioners were having difficulties working in the local authority at such a challenging time. Kelly (2015) argued that a poor Ofsted rating may cause an increase in staff turnover and workloads, which ultimately will lead to inconsistency for children and families.

It was also highlighted in just under half of the SCRs that there was a lack of supervision, and that management were failing to challenge a lack of progress in cases or request evidence of potential change in families where neglect was a feature. In some of the cases, lack of supervision and management oversight was prevalent in the initial stages of the case, while for a smaller number of cases it was evident throughout. Supervision should be a time for professionals to reflect on their values and biases, and to be challenged constructively about the progress (or lack thereof) within a case, as well as for managers to seek evidence of the actual progress (Laming 2009). Without supervision to enable social workers to receive support, reflect on their practice and have their views challenged, their professional judgement and decision-making may be negatively impacted (Munro, 2010). The SCR for Family X (Sunderland, 2017) identified that supervision was regular, however, there was little evidence of good quality reflective supervision that offered practitioners the opportunity for critical thinking. For Family X, the children’s outcomes were compromised by longstanding and repeated patterns of neglect. However, the supervision records showed a degree of professional optimism that appeared not to be challenged despite the evidence of the parents’ lack of ability and willingness to adapt and make positive changes.

Interestingly, there is limited information in the SCRs about the impact of austerity on both organisational cultures and practice. This is despite funding pressures which are preventing local authorities from intervening earlier in children’s lives. There is growing pressure on Children’s Social Care and there has been an increase in care proceedings by 145% from 2009 to 2016 (CAFCASS, 2017). Despite this growing demand, it is estimated that there has been approximately a 35% reduction in central government funding to Children’s Social Care. These cuts will undoubtedly have an impact on the quality of children and young people’s services (Action for Children, The Children Society and National Children’s Bureau, 2017; Community Care, 2017).

There was also limited information about the potential emotional impact on social workers working with reluctant and sometimes hostile families, in a context of high caseloads and staff shortages, and with children who are being neglected. Although these issues were discussed in the SCRs, there was limited in-depth discussion about their impact upon social workers' practice and decision-making in cases where neglect was a feature.

Conclusion

This study has highlighted that neglect and its cumulative impact on children's development and wellbeing must not be underestimated. Despite the wealth of research and information about the negative impact of neglect, in over half of the SCRs which were analysed in this study, the effect of this upon a child's healthy development had not been considered or understood. Due to the limited information provided in the SCRs, it has not been possible to gain a full picture of the reasons for this. However, this emphasises that additional training may be required to raise further awareness that neglect can be just as harmful as other forms of maltreatment.

The findings from this study have highlighted that recognising and responding to neglect is complex and multifaceted, and needs to be reflected upon in the context of increasing demands and pressures on agencies and the professionals within them. The numbers of children nationally who are subject to a child protection plan have risen considerably, and coupled with difficulties in the recruitment and retention of permanent and experienced social workers, this creates a picture of major challenges for agencies trying to safeguard children.

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