# Chapter 11: Neglect

## Good Practice Recommendations

1. Make it your practice to routinely record who is present at all healthcare contacts and how the child interacts with each of those present, including adults the child is less familiar with. This information may then be used if needed to inform future assessments of the child and family.
2. If you have concerns that a child is experiencing neglect communicate those concerns to children's social care services and request a multi-agency assessment
    - As thresholds for neglect vary between professionals, paediatricians should be prepared to challenge other professionals to ensure appropriate assessment and ongoing management of the child's needs
    - Healthcare professionals should request a multi-agency meeting to reach agreement if necessary
3. Paediatricians should contribute to the identification and assessments of children where there are concerns about possible neglect. Meet the medical needs that you are able to and refer on for those you cannot meet (e.g. speech and language therapy, special educational needs, dental examination including dental examination and treatment, audiology, vision, immunisations, infant or child and adolescent mental health service).
4. A chronology should be completed from healthcare records, including attendance rates and reasons for non-attendance, immunisation status and compliance with treatment, when there are concerns about possible neglect.
5. Ensure that the child's future growth and developmental progress are assessed on a regular basis.

## 11.1. Introduction

11.1.1. This chapter provides a guide to the recognition and assessment of all forms of neglect in children and young people, and should be read in conjunction Chapter 12, which addresses emotional abuse and emotional neglect under the heading of 'psychological maltreatment'.

11.1.2. Neglect is defined as the persistent failure to meet a child's basic physical and/or psychological needs, which likely results in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse (i.e. drug and/or alcohol abuse).

11.1.3. 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)
- Provide protection from physical and emotional harm or danger
- Ensure adequate supervision (including the use of inadequate caregivers)
- Ensure access to appropriate medical care or treatment
- Tend to the child's basic emotional needs[1].

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11.1.4. Neglect is the most common reason for being subject to a Child Protection Plan in England[2], or on a Child Protection Register in Wales[3], and the second most common reason in Northern Ireland[4]. Emotional abuse, parental substance misuse, domestic abuse and neglect are the main concerns identified at case conferences in Scotland[5]. Some experts assert that neglect is the central feature of all child maltreatment[6].

11.1.5. In 2017, the Welsh Adverse Childhood Experience (ACE) and Resilience Study was undertaken to examine individual and community factors that may offer protection from the harmful impacts of ACEs on health, well-being and prosperity across the life course[7]. ACEs are defined as stressful events occurring in childhood, including exposure to domestic violence, parental abandonment, having a parent with a mental health condition, being the victim of abuse or neglect, or growing up in a household in which there are adults experiencing alcohol/drug use problems. The study measured exposure to 11 ACEs before the age of 18 years in the Welsh adult population. Only 3.9% of those reporting physical neglect and 8.5% reporting emotional neglect identified these factors as their only ACEs; 85.3% and 76.2%, respectively, had experienced at least three other ACEs, demonstrating the high prevalence of neglect and how it often co-exists with other forms of childhood adversity[7].

11.1.6. Children and young people who experience one form of abuse often experience other forms[8], and neglect is a key and recurring theme in serious case reviews. In a recent analysis of serious case reviews, from 2011 to 2014, neglect was apparent in the lives of over half (52%) of the children who died, and in the lives of nearly two thirds (62%) of the children who suffered non-fatal harm[9]. In a systematic analysis of neglect in serious case reviews in England, it was concluded that neglect can be life-threatening and should be treated with as much urgency as other forms of maltreatment. Minimising or downgrading the harm that can be caused by neglect, or allowing cases to drift, can have serious consequences for children[10].

11.1.7. Research and experience over the last two decades makes it clear that all forms of neglect, including emotional neglect (see Chapter 12), damage children's development and have profound neurobiological consequences[11]. Parent/carer-infant interactions during the first year of life serve to regulate emotional behaviour and the neuro-endocrine stress response. Certain neurological systems have evolved to be experience expectant, which means that stimuli from the environment are anticipated and required for fine tuning. Maternal stimulation, social interaction and language input are expected. During brain development there is overproduction of neural components in a genetically determined process. Pruning of unused connections is an experience-expectant process and neural connections which go unused, as in a neglected infant, will be lost[12].

11.1.8. All types of abuse are more common in children with disabilities than in those without. The risk of neglect is increased because of the additional needs of disabled children and may be associated with the ability of the child to function in their environment, a lack of service provision, family circumstances and society's attitude towards disability. See Chapter 14

11.1.9. The risk of fatalities and morbidity from neglect may be as high as that from physical abuse, due to inadequate supervision, inadequate nutrition or lack of healthcare. In

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some cases, neglect slowly and persistently erodes self-esteem, leaving children isolated, disengaged and disconnected socially. Adolescent neglect is also widespread and associated with numerous adverse consequences, including fatality or serious injury from risk-taking behaviours[13].

11.1.10. The effects of neglect appear to be cumulative and pervasive; early recognition and intervention is necessary if long-term damage is to be avoided.

11.1.11. It may be difficult to distinguish between neglect and material poverty. Care should be taken to balance recognition of the constraints on the parents'/carers' ability to meet their child's needs for food, clothing and shelter with an appreciation of how people in similar circumstances have been able to meet those needs[14].

11.1.12. While neglect is commonly associated with poverty it can also occur in more affluent families where children have their basic care needs met and are well provided for materially. These children, however, may receive little of their parents' time and attention, supervision and guidance, and this may impact on their psychological wellbeing[15].

## 11.2. Categories of neglect and presentations

11.2.1. A number of different forms of neglect are recognised; however, there is no diagnostic gold standard test for neglect. Decision-making in situations of apparent neglect can therefore be difficult and thresholds for intervention hard to establish. The use of multi-agency tools for the assessment of neglect can be helpful in establishing thresholds and assessing improvements, or the lack of them, over time.

11.2.2. The definition of neglect includes "persistent failure" to make provision for the child and encompasses the following subcategories, as detailed in Table 1[16]:

**Table 1. Forms of neglect, with definitions and presentations**

| Form of neglect | Definition | Presentation(s) |
|---|---|---|
| Emotional neglect | Where there is persistent emotional unavailability and unresponsiveness from the parent/carer towards a child, and in particular towards an infant. See Chapter 12 | • Parent/carer may seem preoccupied (often on mobile phone) and unresponsive to, or even irritated by, their child's social cues or even distress<br>• Parent/carer may need to be prompted by professionals to respond appropriately to their child (e.g. to provide comfort and reassurance during a medical procedure) |
| Abandonment | Refers to when a parent/carer either abandons a child without any regard for their physical | • Children left home alone or with inappropriate carers |

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| | health, safety or welfare and with the intention of wholly abandoning the child, or in some instances, fails to provide necessary care for a child living under their roof | • Young children allowed to wander without supervision from the home to public places where they may be at risk |
| Medical neglect | Where parents/carers minimise or deny a child's illness or health needs, fail to seek appropriate medical care, or fail to administer medication or treatments. This may include neglect of all aspects of healthcare, including dental care | • Poor uptake of immunisations and child health promotion programmes[17], including vision and hearing checks<br>• Failure to seek appropriate medical advice compromising the health and wellbeing of the child<br>• Failure to attend initial and essential follow-up healthcare appointments, and failure to administer, or inconsistent administration of, essential prescribed medication for chronic health problems, such that the child's health and wellbeing is compromised[17,18]<br>• Persistent failure to obtain treatment for the child's dental caries (see section 11.4.1) |
| Nutritional neglect | Inadequate provision of food sufficient for normal growth, and leading to "faltering growth'", is uncommon and where it occurs is often associated with scapegoating or emotional abuse of a child. More commonly persistent failure to provide a healthy balanced diet for a child would contribute to an overall picture of neglect. Increasingly another form of nutritional neglect is being recognised; that from a persistently unhealthy diet and lack of exercise leading to obesity | • Where a child repeatedly steals, scavenges, hoards or hides food with no medical explanation, such as Prader-Willi Syndrome<br>• Obesity through inadequate attention to the child's diet and/or life style, or the persistent failure to take medical advice about diet and lifestyle modification (see section 11.4.2)<br>• Faltering growth through parental failure or inability to provide an adequate diet (see section 11.4.3) |
| Educational neglect | Includes parents/carers failing to comply with state educational requirements, but also includes the broader aspects of education, such as failing to provide a stimulating environment, not | • This could include persistently poor school attendance, or the child being persistently brought late to school, being unready to learn through the lack of necessary clothing or |

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| | showing an interest in the child's education, not supporting their learning and/or not ensuring that any additional educational needs are met | equipment, or hunger or tiredness, or due to the child being kept at home to meet the needs of a parent/carer (e.g. as a young carer for an adult with mental health problems). It might also include children whose education is disrupted by frequently changing schools, and children who are being home schooled but without adequate education being provided to them, some of whom may have extremely limited opportunities for exercise and social interaction |
| Physical neglect | Includes poor or inadequate clothing, failing to wash the child or their clothing making them different to their peers, possibly resulting in social isolation or bullying. It may also include dirty or unhygienic home conditions, lack of heating, inadequate or soiled bedding and broken or dirty furniture. It may also refer to a lack of safety in the home, such as exposing the child to hazardous substances, lack of safety equipment such as fireguards or safety gates, failure to place irons or hair straighteners out of reach, or exposed electric wires and sockets | • Signs of physical neglect may include[17,19]:<br>• Unclean and/or inappropriate clothing and/or footwear for the weather or child's size<br>• Persistently poor hygiene (smelly and dirty)<br>• Severe and persistent infestations, such as scabies or head lice<br>• Hypothermia or red, swollen and cold hands and feet due to cold damage<br>• Excessive and persistent tiredness due to inadequate sleep. explore if adequate opportunity and environment for sleep has been provided |
| Failure to provide supervision and guidance | Refers to the parent/carer failing to provide the necessary level of supervision to ensure that the child is physically safe and protected from harm and failing to provide boundaries for behaviour | • Injury in the preschool child where the explanation suggests a lack of appropriate supervision or of taking preventative action (e.g. sunburn, animal bites, burns or scalds)[17]<br>• Frequent emergency department attendances (e.g. for injuries or ingestion of harmful substances) are often as a result of exposure to danger through lack of supervision or failure to |

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| | | provide safety features both inside and outside the home<br>• Frequent attendance at the emergency department by adolescents (e.g. following intoxication through alcohol or substance misuse, associated physical and/or sexual assault or deliberate self-harm)<br>• Although neglect is pervasive and persistent, a one-off visit to the emergency department with a significant injury, such as head injury or a burn or scald, may be a marker of a continually disorganised and neglectful household. It should be standard practice to inform the primary care team of any emergency department attendance by a child or young person<br>• Leaving a child or young person in the care of a person who is unable to provide adequate care or supervision |

## 11.3. Factors that affect the future welfare of the unborn child

11.3.1. There are several maternal circumstances and behaviours which may impact negatively on the welfare of the unborn child, including exposure to domestic abuse, drug use, physical and mental health issues. Where these are identified support should be offered. If a mother fails to engage with interventions designed to reduce the risk to her unborn child, then this may constitute neglect and require a child protection referral due to concern about the risk of significant harm to the unborn child. Where these antenatal factors are present in a child's history they should be included and given due consideration when trying to assess the child's likely future outcomes.

### 11.3.2. Drug use (see Chapter 8.4)

11.3.3. Drugs can damage the foetus at any time during pregnancy, causing a wide range of abnormalities in growth and development. These can range from the immediate and catastrophic to much more subtle effects that may not emerge until many years later.

11.3.4. The British National Formulary (BNF) is the most authoritative source of information on prescribing drugs in the UK, listing over 800 prescription medications which 'should be avoided or used with caution' in pregnancy[20]. Prescribers should be wary of prescribing any of these drugs to women of child-bearing age in order to avoid causing any

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iatrogenic harm. Potentially harmful drugs include alcohol, amphetamines, benzodiazepines, nicotine and opiates, all of which are commonly used, and often in huge quantities, by problem drug users.

11.3.5. Trying to assess the effects of drugs on the foetus is difficult, even when the mother is taking a known dose of one prescribed drug and is otherwise healthy and well nourished. Such an assessment becomes virtually impossible when the mother is using several drugs in varying quantities and her general health and diet are poor. If the child's circumstances after birth are unfavourable, it may also be hard to tell whether any observed problems result from drug damage or disadvantage before or after birth, or indeed may be a combination. For example, following prolonged exposure to opiates or benzodiazepines during pregnancy, the baby is likely to be very irritable and cry constantly (neonatal abstinence syndrome). If the mother is also oscillating between drug-induced stupor and withdrawals, mother-infant bonding is likely to be poor and neglect may occur[21].

### 11.3.6. Maternal nutrition and general health

11.3.7. Nutrition is perhaps the most influential non-genetic factor in foetal development. Maternal body composition, nutritional stores, diet, and ability to deliver nutrients through the placenta determines nutrient availability for the foetus.

11.3.8. Prenatal nutrition influences foetal growth, normal development of physiological function and gestational weight gain. Accumulated evidence documents that prenatal factors predispose individuals to disease later in life. Negative environmental factors, including suboptimal maternal nutrition, may play a major role.

11.3.9. The relationship between low birth weight and disease is an imbalance between foetal demand and maternal supply. The imbalance results in metabolic and endocrine changes, which while assists the foetus in the short term by slowing growth and increasing available fuel, leads long-term to greater risk of metabolic syndrome and cardiovascular disease[22,23]. The association of a maternal diet low in folate and neural tube defects in the foetus is well established.

11.3.10. Vitamin D contributes to healthy, strong bones and helps to control the amount of calcium in the blood. Recent evidence suggests that it may also help in the prevention of other diseases and adequate levels of vitamin D are associated with other health benefits such as good immune and cardiac function[24].

11.3.11. Healthy Start (https://www.healthystart.nhs.uk/) is a UK-wide government scheme to improve the health of low-income pregnant women and families on benefits and tax credits. Women who are at least 10 weeks pregnant, and families with children under four years old, qualify for Healthy Start if the family is in receipt of certain state benefits. Beneficiaries receive vouchers which can be spent on milk, plain fresh/frozen fruit and vegetables (those with nothing added) or infant formula milk in a wide variety of local shops and supermarkets, and with milkmen, that have registered to take part in the scheme. Beneficiaries also get green vitamin coupons with their vouchers, which they can exchange for Healthy Start vitamins in their local area. While failure to participate in this scheme against the advice of healthcare professionals would not constitute neglect

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in and of itself, it may be relevant information to include in a multi-agency assessment of neglect.

### 11.3.12. Violence (see Chapter 8.2)

11.3.13. Pregnancy is a time when domestic abuse may start or escalate, and it has been estimated that 30% of domestic abuse starts in pregnancy. The effects include those which impact on maternal health (e.g. insufficient or inconsistent prenatal care, poor nutrition, inadequate weight gain, substance use, increased prevalence of depression), as well as adverse neonatal outcomes (e.g. low birth weight, preterm birth, and small for gestational age) and maternal and neonatal death[25].

11.3.14. Living as a victim of domestic abuse negatively impacts a mother's ability to consistently parent her baby and adequately meet their needs[26].

### 11.3.15. Maternal Mental Health

11.3.16. Perinatal mental illness affects around 15–20% of women in the general population and up to 40% of mothers with babies in neonatal intensive care units. The most common disorders are depression and anxiety, but women can present with a broad range of other disorders, including eating disorders, personality disorders, bipolar disorder, schizophrenia and other psychotic illnesses.

11.3.17. Babies of mothers who experience severe mental illness are at an increased risk of adverse neonatal outcomes, including congenital malformations, premature birth, foetal growth abnormalities, stillbirth, neonatal and sudden infant deaths. In general, common antenatal mental disorders are associated with statistically significant to modest increases in adverse neonatal outcomes and mainly of mild to moderate severity with no excess risk of neonatal admissions. This can cause maternal distress and impair early parent-infant relationships[27].

### 11.3.18. Antenatal care

11.3.19. Although the causal relationship between late booking for antenatal care, inadequate engagement with services and poor outcomes is as yet unknown, the 2010 National Institute for Health and Care Excellence (NICE) clinical guideline, Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors, recognises that early booking for women with complex social factors is even more important than for the general population[28]. This is partly because these pregnancies are more likely to be unplanned, are associated with greater risk of premature birth, low birth weight and stillbirth, and because the mothers are more likely to be experiencing poor nutritional status and health behaviours[28,29].

11.3.20. Concealed pregnancy has serious implications for mothers and infants and may lead to maternal and neonatal morbidity and mortality. Implications for infants include delay in detection of foetal anomalies amenable to treatment, risk of prematurity, low birth weight, mal-presentations and birth injuries. Concealment of pregnancy can be an antecedent to complicated attachment, abandonment and neonaticide.

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## 11.4. Specific issues for consideration

### 11.4.1. Dental neglect

11.4.2. Dental neglect has been defined as the persistent failure to meet a child's basic oral health needs, likely to result in the serious impairment of the child's oral or general health or development[30].

11.4.3. For optimal dental health, children need assistance with oral hygiene, use of fluoride toothpaste, the provision of a diet that is safe for teeth, and visits to the dentist so they can benefit from evidence-based preventive interventions.

11.4.4. Dental decay (or dental caries) is very common and affects the primary teeth of 31% of children aged five years, and the permanent teeth of 46% of children aged 15 years (2013 survey limited to England, Wales and Northern Ireland; more recent data is available for each home nation individually, including Scotland)[31].

11.4.5. There are marked regional inequalities in decay experience and children from low income families are more likely to have oral disease; however, this disease is both preventable and treatable. It is impossible to define a precise threshold for dental neglect based on decay experience alone. If untreated, it can have a significant impact on health and wellbeing and may cause pain, sleep disturbance, difficulty eating and changes in food preferences. It may interfere with playing, social activities, self-esteem/confidence and educational attendance. Impaired growth and quality of life have been demonstrated in pre-school children, with improvement noted following comprehensive dental treatment[32]. In rare and extreme cases, children have died because of untreated dental infections.

11.4.6. Examination of the mouth should be part of every child protection assessment that the paediatrician undertakes. If there is obvious decay or other pathology, refer for a dental opinion. Calls are gathering momentum for routine specialist paediatric dentist assessment and opinion whenever a child is assessed for possible neglect[33]. Some units have developed formal local referral pathways[34].

11.4.7. The purpose of examining the mouth is to:

- Determine the extent of caries or other oral pathology (including the use of dental radiographs or other investigations, as necessary)
- Interpret the extent to which the child's oral healthcare needs are being met
- Advise on the likely impact of current oral disease on long-term oral health
- Facilitate arrangements for future dental care.

11.4.8. Children with disabilities often need additional support to maintain good oral health yet may find it difficult to tolerate toothbrushing, making it challenging for parents or carers to meet their oral care needs. An appreciation of how people in similar circumstances have been able to meet needs can aid interpretation when oral hygiene is persistently poor.

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11.4.9. Children who are at risk of dental neglect remaining undetected include:

- Pre-school children with limited contacts outside the home
- Those whose lifestyles make access to regular dental care difficult (e.g. homeless families, travellers, asylum seekers)
- Those whose parents have mental health or alcohol/substance abuse problems
- Looked after children (LAC) who may have a range of unmet health needs, including dental health.

11.4.10. A child who is experiencing pain, discomfort, social embarrassment or medical complications, owing to dental decay, should attend a dentist for appropriate treatment. Failure to do so should prompt a full investigation[35].

11.4.11. Past dental records, if available, may hold useful information about previous uptake of dental care, including any previous concerns about dental neglect. This may be a valuable addition to a chronology (see section 11.5.7), thus contributing to the assessment process.

### 11.4.12. Obesity

11.4.13. The incidence of childhood obesity has increased dramatically, including severe childhood obesity and obesity-related co-morbid conditions[36]. The 2017 NICE clinical guideline, Child maltreatment: when to suspect maltreatment in under 18s, considered childhood obesity a public health issue[17]. However child maltreatment may be a contributory factor to or a cause of obesity in children and abuse may coexist with obesity[37]. The question remains for paediatricians: does childhood obesity ever constitute neglect?

11.4.14. Childhood obesity alone is not a child protection concern, and failure to reduce weight in an overweight child alone is not considered to be a child protection concern. Consistent failure to change lifestyle and engage with outside support does however indicate neglect, particularly in younger children.

11.4.15. Childhood obesity becomes a child protection concern when the parents/carers behave in a way that actively promotes treatment failure in a child who is at serious risk from obesity, despite understanding what is required and having been engaged with the treatment programme. Parental behaviours of concern include consistently failing to attend appointments, refusing to engage with various professionals or with weight management initiatives, or actively subverting weight management initiatives. These behaviours are of concern if an obese child is at imminent risk of comorbidity (e.g. obstructive sleep apnoea, hypertension, type 2 diabetes or mobility restrictions). Clear objective evidence of this behaviour over a sustained period is required[38].

11.4.16. Obesity may be only one part of wider concerns about a child's welfare. It is essential to evaluate other aspects of the child's health and wellbeing to determine if concerns are shared by other healthcare professionals, such as the family GP or education services. If concerns are expressed, a multi-agency meeting is appropriate.

11.4.17. To establish whether an obese child should be subject to child protection proceedings, it is essential to determine the "holistic" context in which that obesity developed, and

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the factors involved in its maintenance. The family needs to have been offered intensive support to address these issues and informed of the consequences of not implementing the changes which are necessary to obtain an improvement in weight.

11.4.18. Foster care has, in certain circumstances, been shown to be a viable option with which to attain clinically significant changes in weight for morbidly obese children, but only when all other avenues have been explored[39].

11.4.19. **Faltering Growth**

11.4.20. While there have been many definitions of faltering growth used in the past, meaning prevalence estimations vary within the UK, the term "faltering growth" is widely used to refer to a slower rate of weight gain in childhood than expected for age and sex. Epidemiological data suggest that healthy children usually progress relatively consistently along a growth centile.

11.4.21. It is common for newborn infants to lose weight in the early days of life; however, persisting or large weight losses can be a cause for concern to parents/carers and health professionals and can raise questions about the establishment of effective feeding.

11.4.22. Faltering growth in early childhood may be associated with persisting problems with appetite and feeding.

11.4.23. In older children, faltering growth can occur when nutritional intake does not meet a specific energy requirement for that individual. Often undernutrition presents as a relatively slow weight gain and is demonstrated by a downward movement across weight centiles on the growth chart. (See UK-WHO growth charts)

11.4.24. There are some health conditions which predispose children to faltering growth (e.g. cystic fibrosis or coeliac disease); however, specific treatment for such conditions can improve or restore expected rates of weight gain.

11.4.25. While in children with no specific cause for faltering growth, simple interventions to increase nutritional intake may be effective in improving weight gain, the cause of faltering growth in the absence of an underlying health condition is likely to be complex and multifactorial.

11.4.26. In the past, child neglect or socio-economic and educational disadvantage were often considered to be likely contributors. While neglected children may be undernourished, neglect is an uncommon explanation for faltering growth. Similarly, significant associations with socio-economic or educational factors have not been demonstrated[40].

## 11.5. Identification and assessment for neglect

11.5.1. Healthcare organisations should have a "did not attend/was not brought" policy to ensure a consistent approach in proactively following-up children who are not brought to healthcare appointments; particularly where there are concerns about neglect and

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sharing this information with other known professionals who are involved with the child and family on a multi-agency basis.

11.5.2. All healthcare professionals who work with children, including GPs, nurses, health visitors and therapists, as well as paediatricians have a role in the identification of neglect, appropriate information sharing and assessment of the child and family.

11.5.3. Paediatricians should contribute to the multi-agency assessment by taking a history, examining the child, arranging relevant clinical investigations and providing a report of their findings.

11.5.4. If a healthcare professional considers it appropriate to request an urgent medical assessment for the purposes of establishing supportive medical evidence, i.e. specific physical signs and symptoms of neglect or ongoing emotional abuse, then they must refer for a paediatric forensic medical assessment. In non-urgent cases, or where there is developmental delay, it is more appropriate to refer to the local community paediatric service for assessment.

11.5.5. There are several multi-agency assessment tools available for assessing neglect of children, such as the Graded Care Profile 2 (GCP2), which helps professionals measure the quality of care being given to children. Paediatricians should familiarise themselves with the tool used in the area where they practice.

11.5.6. Where a child and their family have a long, confusing and complex history the volume of information can be overwhelming. The "start again syndrome" is where professionals pay insufficient attention to this history, established patterns of behaviour, failed interventions and continuing risk, and focus instead on the present[41]. This approach has been shown to be associated with adverse outcomes for children, allowing neglect to persist unchallenged, and should be avoided.

11.5.7. Designated and Named Doctors for safeguarding children can reflect on complex cases with the responsible paediatrician and contribute an independent view of the case.

### 11.5.8. History and information gathering

11.5.9. In addition to taking a history from the parents, remember to seek "the voice of the child". As appropriate, enquire about their lives, and their views and feelings about particular events or their daily experience. For younger children this may be done through observation and play, whilst older children may be happy to speak to the paediatrician with support from parents or on their own. Use this as an opportunity to model positive interaction with the child, for the parents.

11.5.10. It is helpful to write a chronology taken from the child's healthcare records. Chronologies aid the understanding of needs and risks, including the need for protection from harm. Setting out events in sequential date order, they give a summary timeline of the child's involvement with healthcare services, the family circumstances and patterns of behaviour, and are useful tools in assessment, analysis, report and opinion writing. They are a logical, methodical and systematic means of organising,

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merging and helping make sense of information. They also help to highlight gaps and omitted details that require further exploration, investigation and assessment[42].

11.5.11. Additional information to inform the full risk assessment for neglect is outlined below. It is helpful for the paediatrician to gather as much collateral information as possible from, for example, health visitors, school nurses and therapists, and work in partnership with children's social care.

- Assess parent/carer's knowledge and understanding of the child's health, development and needs
- Family and social history: assess the parents'/carers' personal, social, financial resources, employment status, physical and mental health, support (both formal and informal networks) and their availability to the child both physically and emotionally
- Consider the relationships within the family and particularly in relation to the identified child. Was the child planned or welcome? Does the parent/carer treat other children in the family any differently? Was the child the wrong sex or born at the wrong time (e.g. born at a time of crisis within the family)? Does the child have specific needs that make them vulnerable to neglect (e.g. complex health needs or disability)?
- Assess the child's health, development (e.g. language and cognitive abilities), behaviour, schooling, past illness and accident history, and use of other healthcare services (e.g. dental and optical care). Is there a history of missing education?
- Seek out information on the behaviour of the child in a variety of settings (e.g. with siblings, peers, playgroup leaders, and teachers)
- Ask about socialising behaviours (e.g. aggression, cheating, and attitude to boundary setting)
- Ask adolescents about risk-taking, self-injurious behaviours and whether they have been involved with police or youth offending services
- Consider the known risk factors associated with neglect (e.g. domestic abuse, parental alcohol and substance misuse, parental mental health issues, learning disability and parental history of poor parenting). See Chapter 8
- Consider whether the parenting is good enough. Is the parent/carer providing an environment in which the needs of the child are likely to be met, and not compromising the child's health and wellbeing?
- Consider whether the parent/carer has the ability, motivation and opportunity to meet the needs of the child. A parent may unintentionally neglect their child due to a lack of capacity to provide good enough parenting due to, for example, a learning disability or severe mental illness. If a child has suffered neglect the paediatrician must act to protect the child regardless of the issue of intent
- Paediatricians should reflect on whether they are excusing abusive and neglectful parenting and failing to act to protect the child because of cultural misattribution.

11.5.12. When assessing a child who presents with an injury, consideration should be given to the following:

- Severity of injury
- Whether the child was given age-appropriate supervision at the time of injury

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- Whether this a one-off event or whether there have been similar injuries previously (whether there is a persistent failure to supervise)
- Whether the parent/carer sought prompt and appropriate medical care (or whether there was inappropriate delay in seeking medical help)
- Whether the parent/carer acted appropriately and provided first aid themselves
- Whether there are any other markers or indicators of neglect.

11.5.13. The paediatrician's report must include their analysis and opinion as to the likely cause of the child's injury. A comprehensive assessment of this nature will assist in deciding whether neglect has had a part to play.

### 11.5.14. Examination

- Use the whole consultation to observe interactions between the parent/carer and child
- Parent/carer
    - How do they care for and supervise the child?
    - How do they interact with the child? (hostile, uninterested, withdrawn, uninvolved)
    - Do they focus on the child and the child's needs? Are they appropriately responsive?
    - Do the parent/carer's own needs come first?
- Child
    - Observe the child's general demeanour, how they play, their behaviour, and their interaction with their parents/carer
    - Consider the child's growth, development (language, social, fine motor) and general physical examination (e.g. smelly, unwashed, dirt under nails, nappy rash, unkempt, infestation, untreated skin, eye, dental or other conditions, poor nutrition, hair loss, chronic cold injury)
    - Look for signs of anaemia (iron deficiency) and measure haemoglobin and ferritin if clinically indicated. Consider any other nutritional deficits which may present with physical signs (e.g. rickets).

### 11.5.15. Indicators

11.5.16. The RCPCH Child Protection Evidence systematic reviews reviewed the effects of neglect in several age groups, from early years through to teenage, and details the different indicators of neglect. When reviewing the effects of neglect in the different age classes it is important to also consider the parent/child interactions.

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11.5.17. **Early years neglect (0 months to 6 years)** identified the emotional, behavioural and developmental features in early childhood[43] (see Table 2)

**Table 2. Indicators of early years neglect**[43,44]

| **Infant (birth to 23 months)** | | **Toddler (18 months to 3 years)** | | **Pre-school child (3 to 6 years)** | |
|---|---|---|---|---|---|
| **Features in child** | **Parent/child interaction** | **Features in child** | **Parent/child interaction** | **Features in child** | **Parent/child interaction** |
| Infants show insecure, avoidant or disorganised attachment to the parent | Parents are not attuned to the infant's needs and provide inconsistent attention | Toddlers are withdrawn and spend more time alone than their peers | Parents are not attuned to their toddler's needs and provide inconsistent attention | Child has language delay; more syntactic delays, less complex language and reduced vocabulary | Parents do not speak to their child much |
| Infant may show developmental delay especially in development of speech and language | Parents speak little to their infant, and when they do it is often in the form of orders | Toddlers demonstrate greater negativity and aggression during play with their peers | Parents lack competence in interacting with their toddler and may be critical of them | Child has few social interactions and shows increasingly disruptive behaviour | Parents do not engage in play with their child and do not readily offer praise |
| | Parents provide little stimulation to or positive interaction with their infant | Toddlers become angry and frustrated when trying to solve problems or puzzles | Parents ignore their toddler's cues for help and may make no effort to relieve their distress | Child has low self-esteem and less ability to discriminate emotions | Parents show the child little affection and do not try to relieve their distress |
| Infants demonstrate passive and withdrawn behaviour | Parents perceive their infant as irritating and demanding | Toddlers appear angry with, or avoidant of, their parent perceiving them as unavailable to meet their needs | Parenting style lacking in affection and empathy OR hostile and controlling | Child's perception is that their parent is unlikely to relieve their distress and is not loving towards them | Parenting style hostile and controlling, with less positive parenting, and more physical punishment employed |

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11.5.18. **School-aged neglect** explored behavioural features, social functioning, emotional wellbeing and school performance[45] (see Table 3)

**Table 3. Indicators of school-aged neglect**[44,45]

| School-Aged Child (5 to 14 years) | | |
|---|---|---|
| | **Features in child** | **Parent/Child Interaction** |
| **Behaviour** | Externalising behaviours (aggressive/assaultive/destructive/anti-social/delinquent behaviour) | Neglectful mothers report being too self-involved to be able to show or tell their child that they loved them. They have fewer positive and more negative interactions with their child. They give more commands, are more demanding, and show less support or involvement with their child. They are less likely to be supportive when their child expresses emotions, especially anger. They are less likely to talk to their child about emotional experiences in an appropriate way. |
| **Social functioning** | Difficulties being accepted by other children, making friends and developing reciprocated friendships | |
| **Emotional wellbeing** | Low self-esteem, a sense of lack of control in their lives, depressive symptoms, and less emotional understanding particularly of negative emotions | |
| **School performance** | Lower IQ, poor executive decision making, poor receptive vocabulary, lower numeracy and literacy | |

11.5.19. **Teenage neglect (13 to 17 years)** explored emotional features, interpersonal relationships, general health and wellbeing, and school engagement[46] (see Table 4)

**Table 4. Indicators of teenage neglect**[46]

| | **Features in child** | **Teenagers (aged 13 to 17)** |
|---|---|---|
| **Emotional features** | • Anxiety<br>• Depression<br>• Withdrawn behaviour<br>• Somatic complaints | The majority of research studies identify an association between neglect and internalising features. |
| **Risky behaviours** | • Substance misuse<br>• Alcohol problems<br>• Early sexual debut<br>• Teenage pregnancy<br>• Criminal/gang activity | Substance misuse and alcohol related problems are more common in abused and neglected young people than controls.<br>Neglected young people have an earlier sexual debut and an increased rate of teenage pregnancy.<br>One large study showed an association between neglect and gang activity, arrest and physical assault. |

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| | | |
|---|---|---|
| **Interpersonal relationships** | • Difficult family relationships<br>• Dating violence | Neglect is associated with dating violence victimisation in boys. General victimisation is higher for girls only. Neglected adolescents are more likely to describe difficulties with their family relationships than non-neglected youth. |
| **General health and wellbeing** | • Stress related symptoms | Neglected adolescents have higher levels of daily stress than non-maltreated controls and neglect is associated with low positive social and achievement expectations. |
| **School engagement** | • Poor school engagement | Neglected boys have better school engagement than neglected girls. |

## 11.6. Implications for Practice

1. **Early Years Neglect**
    - There are clearly identifiable features in the pre-school child who is being neglected, thus it is incumbent upon all health practitioners working with these children to be aware of the indicators that they may identify
    - Careful observation and recording of the infant-carer interaction will help to identify neglected toddlers at an early stage, enabling appropriate assessment and intervention
    - Given the delay in language, both receptive and expressive, in neglected children, it is essential that all practitioners working with pre-school children are trained in normal child development
    - Important attachment disorders are recognised in young infants and toddlers and warrant formal evaluation by professionals trained in infant mental health, as many features described in neglect overlap with those found in children suffering from autistic spectrum disorder or attention deficit hyperactivity disorder

2. **School Aged Neglect**
    - Children of school-age exhibiting behavioural difficulties such as externalising or disruptive behaviour or features associated with ADHD (e.g. impulsivity) should be investigated for neglect as a possible aetiology
    - Children who are having trouble developing friendships may be experiencing neglect, thus practitioners assessing children for neglect should ask the child about the extent and nature of their friendships
    - Children as young as eight may present with depressive features as a consequence of neglect, thus consideration should be given to screening children with known neglect for these features

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3. **Teenage Neglect**
    - Although neglect in adolescents is often under-recognised, it is clear that it has a significant impact on young peoples' emotional state, well-being and interactions with others
    - Paediatricians assessing teenagers for neglect should ask them about themselves, and any problems they may be experiencing, including dating violence and gang involvement

4. **Parent-Child Interaction**
    - Careful observation and documentation of the parent-child interaction is an essential element in the recognition of the neglected child
    - It is important to determine the child's perception and expectations of their parents and what the parents' view of their child is

    - When evaluating children for possible neglect, it is essential to obtain detailed reports from all those working with them and their family, including nursery nurses, health visitors, teachers, etc.

5. **Dental Neglect**
    - Failure to attend appointments when the child is experiencing pain or discomfort, or failure to adhere to a recommended treatment plan should prompt a full investigation of the explanation for this
    - Given the varying prevalence of caries amongst young children in Western populations, it is impossible to define a precise threshold for dental neglect based on this feature. However, a child who is experiencing pain, discomfort, social embarrassment or medical complications as a consequence of caries should be attending for appropriate treatment
    - Paediatricians should always examine the mouth and are strongly encouraged to refer the child for a dental opinion if there is obvious decay or other pathology, ideally via a formal local referral pathway for specialist paediatric dentist assessment.
    - Referrals from dentists to the safeguarding/child protection team should be welcomed when concerns regarding dental neglect arise, in order to ensure that prompt and appropriate assessment takes place.

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