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The Role of Neglect in Child Fatality and Serious Injury

Although there is improved recognition of the pernicious long-term harm that stems from living with neglect during childhood, neglect is rarely associated with child fatality. This article offers a re-analysis of neglect in serious case reviews (cases of child death or serious injury related to maltreatment) in England (2003–11) from four consecutive government-commissioned national two-yearly studies. It draws on anonymised research information from 46 cases out of a total of over 800 cases. Each case was examined in depth using an ecological transactional approach, grounded in the child's experience, which promotes a dynamic understanding and assessment of the interactions between children and their families and the helping practitioners. The qualitative findings reported explore how circumstances came together when neglect had a catastrophic impact on the child and family presenting in six different ways (deprivational neglect, medical neglect, accidents with elements of forewarning, sudden unexpected deaths in infancy, physical abuse combined with neglect and young suicide). Each of the six categories raised particular issues over and above a common core of concerns around the relationship between the child and his or her parent or carer, and between parents/carers and professionals. Copyright © 2014 John Wiley & Sons, Ltd.

KEY PRACTITIONER MESSAGES

- There are no easy answers to curbing potentially fatal neglect – practitioners should be supported to make careful well-reasoned judgements.
- That neglect is not only harmful but can also be fatal should be part of any practitioner's mindset, as with other maltreatment.
- To guard against catastrophic neglect, children need to be physically and emotionally healthy and have a safe, healthy living environment.
- Practitioners need to be compassionate and sensitively attuned to the relationship between parents and children.

KEY WORDS: neglect; child fatality; serious case reviews

The Context of Neglect in Child Death and Serious Harm

Although there is improved recognition of the pernicious long-term, cumulative harm that stems from living with neglect during childhood, neglect is rarely associated with child fatality (Daniel *et al.*, 2010; Gilbert *et al.*, 2009). The recent distressing UK case of the death of four-year-old Daniel Pelka from starvation and abuse has brought this issue starkly to public and professional attention. Missing the possible link between neglect and child

*Correspondence to: Professor Marian Brandon, Centre for Research on Children and Families, Elizabeth Fry Building, University of East Anglia, Norwich NR4 7TJ, UK. E-mail: m.brandon@uea.ac.uk

Marian Brandon*

Sue Bailey

Pippa Belderson

Birgit Larsson

Centre for Research on Children and Families, University of East Anglia, UK

'Neglect is rarely associated with child fatality'

'Each of the six categories raised particular issues'

'Neglect is very rarely the primary and immediate cause of child death'

death has been suggested as a cause of undercounting maltreatment-related deaths in the US (Palusci *et al.*, 2010). However, neglect is very rarely the *primary* and immediate cause of child death and occurs as a direct cause in no more than two per cent of cases in England (Sidebotham *et al.*, 2011). As a significant underlying feature, especially in cases of sudden unexpected deaths of infants, neglect is much more prevalent. Neglect [Q2] was evident in the majority (60%) of serious maltreatment and fatality reviews (serious case reviews, SCRs) undertaken in England between 2009 and 2011 (Brandon *et al.*, 2012). In Northern Ireland, complex physical and emotional neglect were substantial issues in most reviews from 2003–08 [Q3] (Devaney *et al.*, 2013).

An inspection study of SCRs in England found that the most common risk factor was neglect but agencies were poor at addressing its impact and at intervening early to prevent neglect escalating (Ofsted, 2009, p. 6). In a separate national analysis, the chaos, confusion and low expectations in many neglecting families were mirrored in the agency response (Brandon *et al.*, 2009). The bewilderment and anxiety that neglect could arouse in practitioners could prompt the adoption of a potentially damaging 'start again' mentality where earlier family history and patterns of behaviour and harm are put aside (Brandon *et al.*, 2008). A group analysis of ten neglect-related child deaths in Victoria, Australia, similarly highlighted the need to understand developmental histories of children and parents to be able to work effectively with neglect (Victorian Child Death Review Committee, 2006). [Q4]

'The need to understand developmental histories of children and parents to be able to work effectively with neglect'

Research Aims and Methods

This study examined neglect in SCRs in England through a re-analysis of over 800 cases from 2003–11 (Brandon *et al.*, 2013). Ethical approval was granted by the University of East Anglia. The focus here is the qualitative analysis of material drawn from summarised overview reports from a total of 46 available SCRs selected because of the outcome of catastrophic neglect. Case summaries were prepared using a common template, and the material was coded and loaded onto NVivo. [Q5]

Each case was analysed repeating the ecological transactional approach (Cicchetti and Valentino, 2006) used in our previous studies (Brandon *et al.*, 2008, 2009, 2010, 2012). This approach is grounded in the child's experience and promotes a dynamic understanding of the interactions between children and their families and the helping practitioners in the context of their day-to-day environment. It considers the way that different risks of harm combine and interact to influence children's development and safety. Parents' capacity to nurture their child safely is understood in terms of their psychological sensitivity and availability to that child. Parents' resources and ability to keep children safe are challenged by social and economic factors such as poverty, violence and other hardships which affect their capacity to be attuned and sensitive to their developing children.

During the analysis, a six-fold typology emerged of circumstances linked to the catastrophic neglect (deprivational neglect, medical neglect, accidents with elements of forewarning, sudden unexpected deaths in infancy (SUDI), [Q6] physical abuse combined with neglect and young suicide). Although not ranked, the first two categories involve neglect as a direct rather than indirect

'Parents' resources and ability to keep children safe are challenged by social and economic factors'

cause of death or serious harm. There are links too with Sidebotham's (2013) model of maltreatment deaths.

Deprivational Neglect – Extreme Deprivation by Withholding Food or Water (6 Deaths, 2 Near Fatalities)

- Q7 Death through starvation occurs very rarely – there were only six such fatal SCRs between 2005 and 2011 and a very small number of near fatalities (Brandon et al., 2013). The children had a range of ages.

The Child's Experience

- Food being withheld or limited as a form of punishment or control.
- Partial imprisonment for older children or keeping younger children and babies out of sight and hearing for long periods.
- The relationship between the child and caregiver is so poor that for the adult the child may have ceased to exist.

Parental Experiences and Responses

Some families justified a child's restricted diet because of (spurious) health needs or a faith or lifestyle choice. One mother's eating disorder inhibited her from feeding her children nutritiously. A number of caregivers had mental health needs.

These families were socially isolated and withdrew from spheres of life where they might have previously engaged (especially health and education). This could mask the child's often rapidly deteriorating health. A pronounced deterioration in the parents' behaviour and cooperation with agencies tended to coincide with the arrival of a new (usually male) partner in the family home. Withdrawal of children from school or nursery removes the possibility of outside oversight of children; a decision to home educate children in two families might have enabled parents to isolate the family further.

A backdrop to extreme deprivational neglect is formed by concerns about emotional development and often faltering growth which can compromise the child's ultimate survival.

Professional Responses

None of the six children who died had ever been the subject of a child protection plan. The extreme neglect had either not been recognised, or previous attempts to stem lower-level neglect had been unsuccessful or halted. Families became increasingly 'invisible' to professionals who lost sight of the children. Universal services staff found it difficult to judge when their concerns merited the involvement of children's social care. Evasiveness or hostility from parents exacerbated this decision and hostile parental demeanour discouraged professionals from engaging.

Medical Neglect – Death in Circumstances Where Parents did not Comply with Medical Advice or Administer Medications (5 Deaths)

These children ranged in age from infants to teenagers and lived in families from diverse backgrounds. All had complex health needs or a disability which required long-term and often complicated care.

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'Hostile parental demeanour discouraged professionals from engaging'

'Single mothers tended to be young and vulnerable with limited assistance from the child's father'

'Professionals often overestimated the extent of parental support and coping'

'Some schools attempted referrals but did not present the information cogently, resulting in referrals being rejected'

The Child's Experience

- Not having appropriate medication or health needs attended to.
- Not receiving adequate care or supervision.
- One young person was forced to sleep in the garden shed as a form of punishment.

Parental Experience, Behaviour and Interactions

Most families only had support from the medical community and had minimal family or community support. Single mothers tended to be young and vulnerable with limited assistance from the child's father. Some parents were unwilling to accept or unable to understand their child's diagnosis or condition, although most were described as attempting to understand and meet their child's medical needs. This instinct to care was for some tinged with the shame of having a child with long-term disabilities ~~or with depression~~.

Despite initial efforts by some, most parents soon struggled to care adequately for their child and to keep up with numerous medical appointments. All five cases displayed a tipping point connected to a specific change in the family's circumstances. This was usually the introduction of a new family member – either a new baby, or a new partner. Once this new family member arrived, the medical care of the child became increasingly erratic and disrupted.

Professional Responses

Early caregiving was mostly closely monitored by health visitors but professionals often overestimated the extent of parental support and coping. Reviews emphasised a lack of engagement with fathers, and stepfathers were seldom considered.

There was undue professional optimism, especially from the medical community, where it was expected that parents wanted to and were able to care for their seriously ill or disabled child. Hospital staff were often concerned about the child's development or growth, or suspected that medication was not being properly administered long before the child's death. Schools/nurseries likewise may have noted concerns over the child's failure to grow or to socially engage. Staff rarely shared concerns with children's social care, sometimes to shelter the family from further professional involvement, or because of a lack of awareness of what these concerns might mean. Some schools attempted referrals but did not present the information cogently, resulting in referrals being rejected.

Accidents with Some Elements of Forewarning – Accidents, Both Fatal and Resulting in Serious Harm, in a Context of Chronic, Long-Term Neglect and an Unsafe Environment (9 Cases)

Accidents are sudden, unexpected events without forewarning. For these children, there were a range of factors which meant that the ~~appalling~~ incident, although not directly predictable, offered some element of forewarning. Childhood accidents are common but not often fatal. To hold a SCR, there must be suspicions about abuse or neglect, and in all these cases there were pre-existing concerns about neglect. The most common accidents concerned fire or drowning, or less frequently accidental poisoning, burns or scalds.

The Child's Experience

- Very young children died while playing unsupervised, for example, by a garden pond and when left in the bath unattended.
- Others died or suffered serious scalds or burns through house fires or when unattended in the kitchen.

Parental Experience and Responses

The impact of negative life experiences, depression and alcohol misuse made it hard for parents (often single parents) to manage the home and to adequately supervise children. Most homes were in a very poor state of repair with fire hazards, a lack of amenities and/or utilities, and in an unsuitable location.

Professional Responses

Although SCRs often concluded that the death was not predictable, they showed that the risk of accidental harm was high.

There was a lack of urgency in the work with families. Thresholds for services were deemed not to be met, or assessments were delayed and poorly completed. Years could pass with children's safety remaining compromised. Moreover, professionals often tacitly accepted domestic conditions and a caregiving environment which were hazardous. Lack of an effective response, particularly where there was a child protection plan, may have increased risks to children, since agencies assumed that their concerns would be dealt with, when in reality there was poor liaison and no clear plan.

These accidents highlighted the need for adult and community services (e.g. drug and alcohol treatment agencies, housing, fire and ambulance services) to take account of children in the family or household. Adult workers appeared slow or reluctant to make connections between adults' difficulties and vulnerabilities and their impact on parenting and children's safety.

Community-Level Implications

Accidents raise issues about environmental dangers and broader links between neglect, maltreatment and deprivation; children from deprived backgrounds have a higher risk of accidents than those from better-off households (DCSF, 2007).

The UK suffers high levels of underlying household risk factors that prompt childhood injuries (Reading *et al.*, 2008, p. 925). Reading and colleagues argue that there is a higher chance of successful prevention of accidents in vulnerable communities if interventions are focused on behavioural risks in the child, parental factors and household circumstances rather than on environmental or community-based risks.

SUDI – Unexplained Infant Deaths in a Context of Neglectful Care and a Hazardous Home Environment (10 Deaths)

While the causes of these deaths are not fully understood (Willinger *et al.*, 1991), established risk factors include placing babies to sleep on their fronts, parental smoking, premature birth or low birth weight and, in circumstances of drug or alcohol consumption, co-sleeping. Although maltreatment was not the direct cause of death, neglect seriously compromised these infants' survival.

Maltreatment figures in a very small proportion of the 200 SUDI cases per year in England and Wales (Sidebotham *et al.*, 2011), but SUDI cases account for one in six of all death-related SCRs.

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'SUDI cases account for one in six of all death-related SCRs'

'Issues were often addressed singly'

'Almost a quarter of the children with a plan for neglect who died did so as a result of physical assault'

The Babies' Experiences

- Many babies had confusing and unpredictable care, were not always tended to when distressed or ill and not always fed regularly.
- In large families, new babies tended not to be seen as individuals or be understood as especially vulnerable by parents or professionals.

Parents' Experiences and Responses

Many parents misused alcohol and/or drugs and were not honest with professionals about the extent of their dependency, so its impact was often underestimated. Other issues could be concealed from professionals, for example, one substance-misusing parent refused access to a bedroom so professionals could not see that there was no Moses basket for the baby, who slept with his mother.

Professional Responses

Interacting risk factors, for example, prematurity, parental smoking, alcohol misuse, deprivation and co-sleeping, elevated the risks to the infants – but cases were not considered in this light. One newborn baby's particular vulnerability was not treated with urgency in spite of there being a child protection plan for neglect. Issues were often addressed singly, for example, treating heroin misuse alone and not considering the impact of a pattern of poly-drug and alcohol misuse on the child's safety. In one case, where there was known substance misuse, professional judgement determined that the benefits of co-sleeping outweighed the dangers.

Community-Level Implications

Although messages about SUDI risks have been widely disseminated, there has been limited success in reducing sudden infant deaths among more vulnerable families in areas of high deprivation (Blair *et al.*, 2006; Wood *et al.*, 2012), where deaths often occur in a potentially hazardous co-sleeping environment (Blair *et al.*, 2009). National-level prevention strategies could help these children and families at highest risk.

Neglect in Combination with Physical Abuse-Physical Assault, Causing Both Fatality and Very Serious Injury, in a Context of Chronic Neglectful Care (7 Cases)

The death of the toddler Peter Connelly showed that children known to be experiencing chronic neglect can die in situations of horrific abuse. The existence of neglect does not preclude the possibility of children also experiencing other very serious maltreatment.

Our wider study showed that there was evidence of physical abuse for over a third of the children with a child protection plan for neglect (Brandon *et al.*, 2013, p. 32), and that almost a quarter of the children with a plan for neglect who died did so as a result of physical assault.

The Child's Experiences

- Some young babies experienced insensitive 'rough handling' and toddlers were smacked. Rough handling sometimes occurred in the build-up to domestic violence or when a parent had poor mental health.

- There was often verbal and physical aggression from parents to the child and to other siblings.
- Recent injuries to siblings included swelling to the head and limb injuries.

Parental Experiences and Responses

Parents were mostly secretive about their past which revealed, for example, offences of violence against children, the unexplained death of a child and adoption of a child in a context of parental violence. There was widespread hostility towards professionals and extreme distrust of workers. Hostility and violence were mostly perpetrated by males, but in one example the mother posed the greater risk of violence to the child and was the more hostile partner. There was mostly one especially controlling partner who dictated relationships with professionals and only accepted services with reluctance following complex negotiation.

Professional Responses

Past history was hard to establish but once professionals had decided that the key risk of harm was neglect or emotional maltreatment, new information about a history of violence could be discounted as a current risk. If risks of physical harm were acknowledged, professionals lacked urgency in these 'neglect' cases and could be said to be 'going through the motions' in assessments or child protection enquiries. This echoes findings in Northern Ireland (Devaney *et al.*, 2013, p. 49).

Clues about the risks of physical harm or a downturn in overall family functioning were often apparent in siblings, for example, with unexplained injuries or problems in school.

Professionals were reluctant to challenge such hostile parents who induced fear, paralysis and uncertainty in practitioners. Assessments tended to remain incomplete and cases closed prematurely, for example, after a child protection conference had been called, cancelled and not re-scheduled. Professionals felt falsely reassured if the less hostile parent appeared to cooperate. Family hostility could prompt health services to be withdrawn in spite of NICE guidelines that missed appointments should trigger greater vigilance.

There was a lack of professional skill, confidence and experience in dealing with these challenges.

Suicide Among Young People – A Long-Term History of Neglect Having a Catastrophic Impact on the Young Person's Mental Wellbeing (7 Cases)

Older young people carry with them the legacy of their experiences of care and nurture. These experiences lay the foundation of their capacity to cope with or to fail to withstand the stresses that come from outside influences and internal pressures. Young people who have lived with maltreatment are more likely to suffer from physical illness and to die early, including by suicide (Gilbert *et al.*, 2009; Meadows *et al.*, 2011).

The wider study showed that neglect featured more prominently for 11–15-year olds than for any other age group in SCRs. For the seven young people discussed here who took their own lives, neglect and rejection were prominent in their history.

Q9 Recent analysis of suicide in ~~UK child death review~~ has found that 41 per cent of these distressing deaths have factors which are 'modifiable' and hence amenable to prevention, particularly in relation to risk-taking behaviour

Q11 (Department for Education, 2012).

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'School can be a neglected young person's only reliable source of support and positive affirmation'

'It is important to remember that very few children present clear signs of such catastrophic harm'

The Child's Experiences and Responses

- Neglect began at an early age and continued sporadically or continuously into adolescence, and was combined with multiple types of maltreatment.
- Home life was characterised by bouts of parental mental ill health or violence, bouts of parental substance misuse and, for some, sexual abuse from the mothers' partners or associates.
- One young person was repeatedly left home alone from the age of two. For another, early poor weight gain continued into adolescence. One child's mother warned him that she was going to die and he would have no one to look after him so he would be better off dead. Another child's father regularly issued threats to kill himself and his son.
- Loss and death of significant adult figures (often parents) featured. One primary school-aged child had wanted to die like his father.

These young people had to fend for themselves, and often others, physically and emotionally. Unresolved issues about rejection and abandonment were perpetuated by repeated bouts of parental rejection. At the time that they died the young people had limited sources of support and most were isolated.

Professional Responses

Few practitioners appeared to know the young people's early history or to take it into account to help understand their development and behaviour. Most young people who killed themselves had long histories of involvement with numerous agencies, but one had unrecognised problems that were missed by agencies. This isolated young person's mother had restricted any access to support services.

Foster carers were not adequately supported when one young person's behaviour became 'threatening and dangerous' leading to another rejection. Children's social care closed the case at this point of heightened need, 'allowing' the young person to live with family friends. This demonstrated the 'agency neglect' apparent from our earlier SCR analyses (Brandon *et al.*, 2008).

Lack of Support in the Transition to Adulthood

School was a safe haven for two young people who tried to return there even when excluded. School can be a neglected young person's only reliable source of support and positive affirmation. School offers a good setting for suicide prevention schemes. Activities which have been found to decrease the risks of young suicide include sport and access to supportive relationships (McLean *et al.*, 2008), both of which can stem from school or from youth services, which are in serious decline.

When school ends, this leaves very few protected routes to adulthood, and out of a neglectful home life. Pressures on children's social care push help and support for vulnerable young people to rapidly diminishing lower-tier agencies.

Discussion

Not all children experiencing life-threatening neglect were receiving specialist help, nor were universal services always taken up by families. The study shows the importance of practitioners across all levels of intervention being open-minded and vigilant about where and how very serious neglect risks manifest themselves. Yet, it is important to remember that very few children present clear signs of such catastrophic harm and most, but not all, of the cases presented here would have appeared very similar to others without a

devastating outcome. Practitioners need to be well supported, within their agencies and by the public and policy makers, to make difficult judgement calls and be mindful that the best way to protect most children is to offer early help and support (Laming, 2009; Munro, 2011). However, this study does offer new learning about serious neglect.

Two strands emerged in relation to guarding against the most dangerous neglect:

- Q12** the need for children to be physically and emotionally healthy but also to have a safe and healthy living environment. In this study, the element of the ecological transactional approach that has come most to the fore is the child's safety in their physical environment (Super and Harkness, 1986). Good relationships between parents and children are essential for emotional wellbeing but cannot always protect against dangerous living conditions (e.g. fire hazard) or precarious parenting practices (e.g. dangerous co-sleeping), especially for the youngest innately vulnerable babies.
- Q13**

Public health approaches are important for preventing SUDI and accidents and can, when successful, reach whole populations, potentially encouraging professionals, families and communities to change behaviour. However, accident and SUDI prevention are at their most challenging in areas of high deprivation and vulnerability (Wood *et al.*, 2012). Targeted support for families known to be vulnerable may help to prevent accidents (Reading *et al.*, 2008). This means that services like Safe Care (NSPCC), enhanced health visiting and Nurse Family Partnerships may make a difference to the most serious neglect risks. The physical and emotional environment for vulnerable adolescents with a long history of neglect and rejection, and who may be care leavers, is also important (Finkelhor, 2008). These young people can rarely thrive living alone in isolated, poor-quality accommodation, but need a safe, supportive environment (Rees *et al.*, 2011).

- Q14**
- Q15**

Parents can wittingly and unwittingly be a source of danger rather than comfort to their child (Crittenden, 2008). Practitioners can miss the life-threatening risks that arise when relationships are so poor that care, nurture and supervision are almost non-existent. Thinking about the meaning of the child to (each) parent and the meaning of the parent(s) to the child can help to understand relationships and safety and structure impromptu observations of children with their family and with others (Brandon *et al.*, 2011). While every effort should be made to intervene early to prevent a parent-child relationship deteriorating, once the relationship is so severely damaged urgent action needs to be taken. Action is stalled when this danger is hidden, and when children, adolescents and families disappear from view.

Practitioners can also fail to pick up on children's cues and behaviour and need to be sensitively attuned to the relationship between parents and children. This is an issue for universal staff, as well as social workers. Having more social workers based in schools, or connected to schools, could provide support for universal services staff in asking key questions to help them make sense of children's development and relationships where neglect might pose or mask very serious risks of harm.

There are no easy answers to curbing potentially fatal neglect and practitioners need to be supported to make careful, well-reasoned judgements. The fact that neglect is not only harmful but can also be fatal should be part of a practitioner's mindset, as it would be with other kinds of maltreatment. This is not, of course, to imply that where neglect is found the child is at risk of death, but rather to emphasise that practitioners and managers should recognise how easily the harm that can come from neglect can be minimised or downgraded.

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'Action is stalled when this danger is hidden, and when children, adolescents and families disappear from view'

'Having more social workers based in schools, or connected to schools, could provide support for universal services staff'

In the same way, there should be recognition of the harm that arises when neglect cases drift. Practitioners need to have an open mind about the *possibility* of neglect having a fatal or very serious outcome for a child but deal with neglect in a confident, systematic and compassionate manner.

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Q5	AUTHOR: NVivo - please provide software citation details.	
Q6	AUTHOR: Editing OK (SUDI is cited at first mention in the main text?) Please see earlier related query.	
Q7	AUTHOR: Six categories of neglect are described under 'Research Aims and Methods' – OK leave as shown or insert new heading - 'Findings'?	
Q8	AUTHOR: DCSF - please give in full at first mention and provide citation details in the refs.	
Q9	AUTHOR: NICE – please give in full at first mention in the text. Also do you have citation details for the guidelines?	
Q10	AUTHOR: 'UK child death review' or 'a UK child death review' or 'UK child death reviews'? Please clarify.	
Q11	AUTHOR: Editing OK?	
Q12	AUTHOR: Editing OK?	
Q13	AUTHOR: 'their' or 'his/her'?	

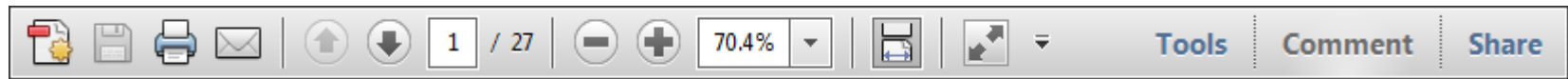
Query No.	Query	Remark
Q14	AUTHOR: ' accident and SUDI prevention are at their' – OK leave text as shown?	
Q15	AUTHOR: 'physical and emotional environment for vulnerable adolescents with a long history of neglect and rejection, and who may be care leavers, is' – OK leave text as shown?	
Q16	AUTHOR: ` the authors' (third person) is cited here but `we/our' (first person) is cited elsewhere in the paper – OK leave as shown or amend to read: ` our views and not those of the NSPCC'?	
Q17	AUTHOR: Page range? Editing OK?	
Q18	AUTHOR: Reference "Daniel et al. (2011)" has not been cited in the text. Please indicate where it should be cited; or delete from the reference list.	
Q19	AUTHOR: Please cite in text.	
Q20	AUTHOR: Ofsted - please give publishers name in full.	
Q21	AUTHOR: DOI?	

USING e-ANNOTATION TOOLS FOR ELECTRONIC PROOF CORRECTION

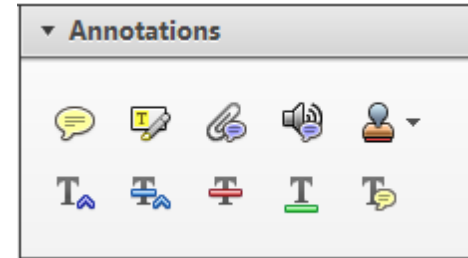
Required software to e-annotate PDFs: Adobe Acrobat Professional or Adobe Reader (version 7.0 or above). (Note that this document uses screenshots from Adobe Reader X)

The latest version of Acrobat Reader can be downloaded for free at: <http://get.adobe.com/uk/reader/>

Once you have Acrobat Reader open on your computer, click on the [Comment](#) tab at the right of the toolbar:



This will open up a panel down the right side of the document. The majority of tools you will use for annotating your proof will be in the [Annotations](#) section, pictured opposite. We've picked out some of these tools below:



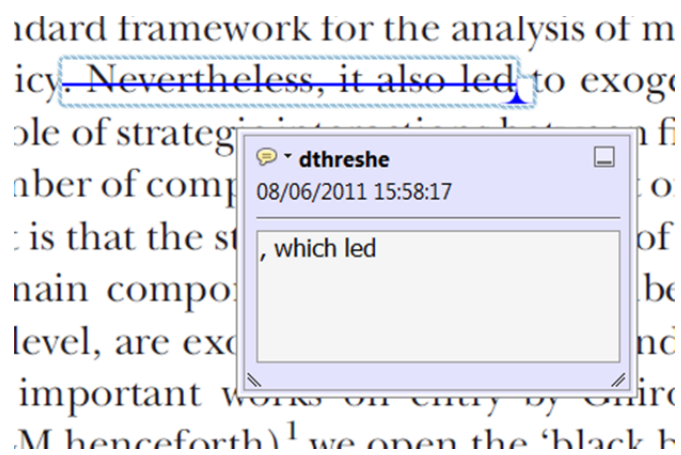
1. Replace (Ins) Tool – for replacing text.



Strikes a line through text and opens up a text box where replacement text can be entered.

How to use it

- Highlight a word or sentence.
- Click on the [Replace \(Ins\)](#) icon in the Annotations section.
- Type the replacement text into the blue box that appears.



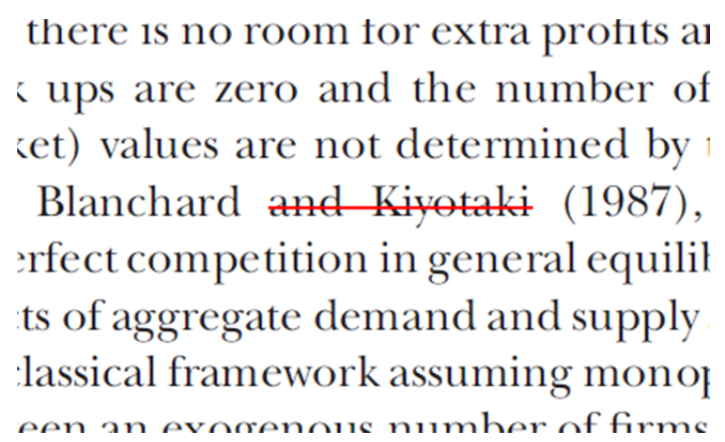
2. Strikethrough (Del) Tool – for deleting text.



Strikes a red line through text that is to be deleted.

How to use it

- Highlight a word or sentence.
- Click on the [Strikethrough \(Del\)](#) icon in the Annotations section.



3. Add note to text Tool – for highlighting a section to be changed to bold or italic.

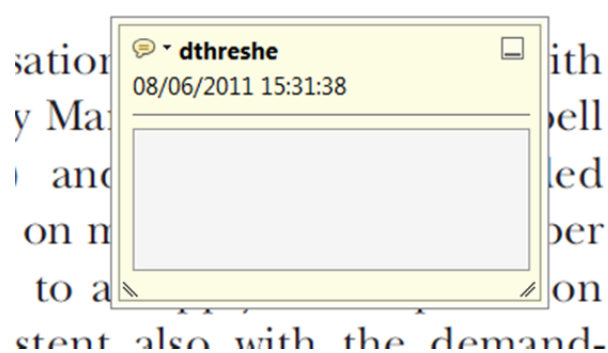


Highlights text in yellow and opens up a text box where comments can be entered.

How to use it

- Highlight the relevant section of text.
- Click on the [Add note to text](#) icon in the Annotations section.
- Type instruction on what should be changed regarding the text into the yellow box that appears.

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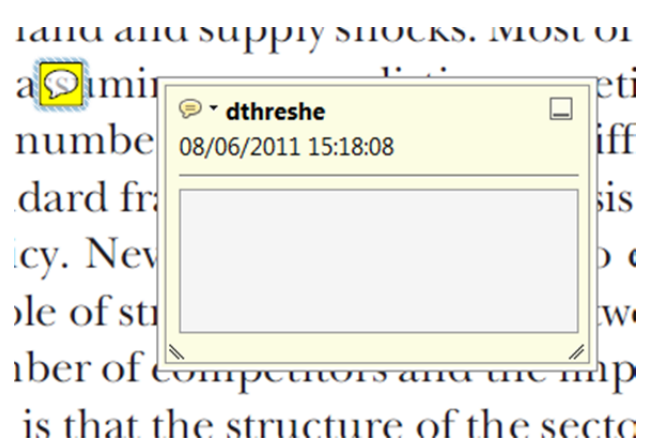
4. Add sticky note Tool – for making notes at specific points in the text.



Marks a point in the proof where a comment needs to be highlighted.

How to use it

- Click on the [Add sticky note](#) icon in the Annotations section.
- Click at the point in the proof where the comment should be inserted.
- Type the comment into the yellow box that appears.



USING e-ANNOTATION TOOLS FOR ELECTRONIC PROOF CORRECTION

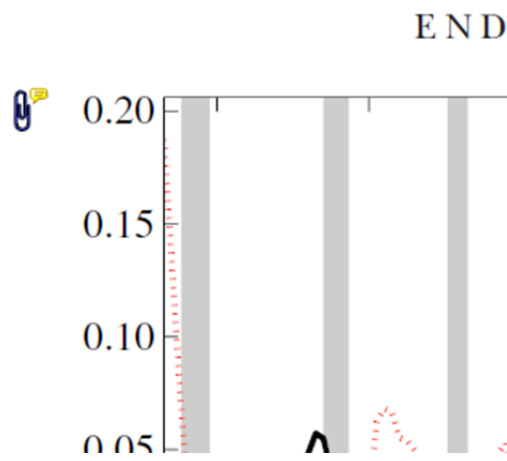
5. Attach File Tool – for inserting large amounts of text or replacement figures.



Inserts an icon linking to the attached file in the appropriate place in the text.

How to use it

- Click on the [Attach File](#) icon in the Annotations section.
- Click on the proof to where you'd like the attached file to be linked.
- Select the file to be attached from your computer or network.
- Select the colour and type of icon that will appear in the proof. Click OK.



6. Add stamp Tool – for approving a proof if no corrections are required.

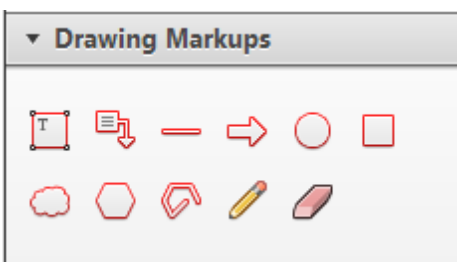


Inserts a selected stamp onto an appropriate place in the proof.

How to use it

- Click on the [Add stamp](#) icon in the Annotations section.
- Select the stamp you want to use. (The [Approved](#) stamp is usually available directly in the menu that appears).
- Click on the proof where you'd like the stamp to appear. (Where a proof is to be approved as it is, this would normally be on the first page).

of the business cycle, starting with the
 on perfect competition, constant return
 production. In this environment goods
 extra profits and the number of firms
 he number of firms is determined by
 determined by the model. The New-Key
 otaki (1987), has introduced produc
 general equilibrium models with nomin
 ed and supply shocks. Most of this literat

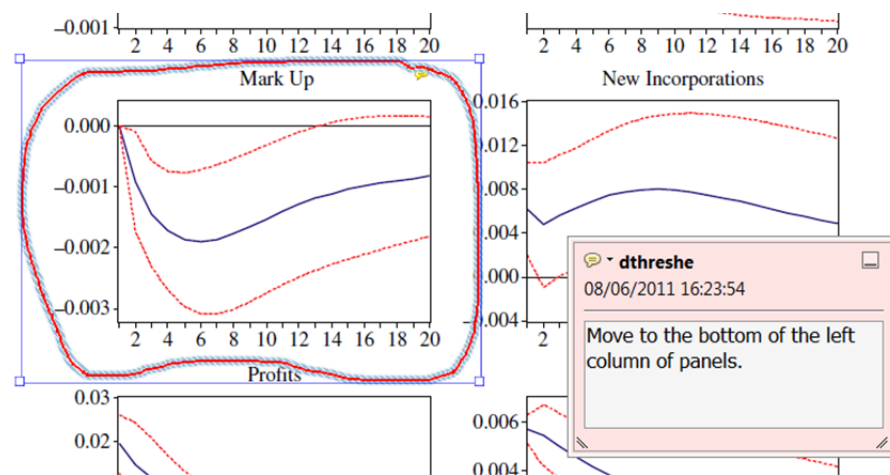


7. Drawing Markups Tools – for drawing shapes, lines and freeform annotations on proofs and commenting on these marks.

Allows shapes, lines and freeform annotations to be drawn on proofs and for comment to be made on these marks..

How to use it

- Click on one of the shapes in the [Drawing Markups](#) section.
- Click on the proof at the relevant point and draw the selected shape with the cursor.
- To add a comment to the drawn shape, move the cursor over the shape until an arrowhead appears.
- Double click on the shape and type any text in the red box that appears.



For further information on how to annotate proofs, click on the [Help](#) menu to reveal a list of further options:

