A Crying Shame

A report by the Office of the Children's Commissioner into vulnerable babies in England

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Introduction

Babies are entirely reliant on their parents to keep them safe and happy. When they are born into families where they might be harmed or neglected, the risk to them is greater than to older children. They are fragile, they cannot speak, and unlike older children, they may not attend any universal services such as education, where adults outside the family have a chance to see them. Hence, despite their increased vulnerability, they can be invisible to professionals.

We know that babies are disproportionately represented in Serious Case Reviews[1], and instances of death and serious injuries to babies and young children rightly shock the country. This report looks at how many babies might be vulnerable in this way and presents the facts about the sort of risks even very young children are being exposed to. Much of the data is missing; however, we are publishing the best estimates we can give of the numbers of babies living in high-risk households. A more detailed technical report explains some of the factors which affect the calculations[2] - namely, that very little data is collected or collated about vulnerable babies, and that the data which does exist is often reported for children in age brackets (0-4) and not broken down for babies under a year old.

[1] Sidebotham et al (2016), Triennial analysis of serious case reviews. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

[2] https://www.childrenscommissioner.gov.uk/publications/assessing-infants/

Local authority data: children in need

As at 31 March 2017, the latest comprehensive local authority data available, there were 19,640 babies under a year old (0-4 year olds: 89,400) identified by local authorities as being 'in need', largely due to risk factors in the family home[3].

This means that the child is considered unlikely to achieve or maintain a reasonable standard of health or development, or their health or development is likely to be significantly impaired, without the provision of services – the statutory definition in the Children Act 1989. These babies 'in need' will likely remain living at home with their parents, whilst statutory or professional services such as social workers, health visitors, drug and alcohol workers or mental health professionals work to improve the family's parenting capacity. The professionals will be asking themselves, 'is this baby safe?' and 'what does life look like for this infant? What will it likely look like in the future?'

Among the 19,640 babies in the 'Children in Need' data, the largest category of risk factors is the risk of abuse and neglect (12,286 babies, and 54,699 of 0-4 year olds), followed by 'family dysfunction' (3,172 under 1s and 15,055 of 0-4 year olds), 'family in acute stress' (1,536 under 1s and 7,304 of 0-4s), and parental disability or illness (853 under 1s and 3,058 of 0-4s).

These are babies and very young children living with risk factors sufficiently serious for them to be registered as 'children in need' by social services. Social workers will take into consideration issues such as development, health and educational needs, stimulation, parenting capacity and environmental factors such as family and community ties, housing and employment.

Typical case study (1): Clare

Leah (20) and Jordan (22) are new parents. Their baby Clare is 6 months old. Neither of them has had significant children's services involvement in the past, but Jordan has a history of minor criminality for dealing marijuana and shoplifting from age 17-19. Leah was working at a supermarket before she got pregnant. Jordan does odd jobs for his uncle. The health visitor went to visit the family and found Leah to be tearful. She kept saying, 'I'm not sure I can cope.' Clare had a noticeably full nappy, and when the health visitor asked how often Leah was changing it, Leah told her it was once or twice a day, but sometimes she forgot to buy more nappies. Jordan arrived half way through the visit smelling of marijuana. The health visitor referred the case to social services, an assessment was carried out and Clare was placed on a Child in Need plan, with focussed support around parenting, and referrals to mental health and drug support services.

[3] DfE 'Characteristics of children in need: 2016 to 2017', available at: https://www.gov.uk/government/collections/statistics-children-in-need

Child Protection Plans

Among the 'children in need', nearly 5,000 babies under a year old (0-4 year olds: 18,520) were on child protection plans, meaning that children's services considered them to be at heightened risk – in the legal definition, 'is suffering, or is likely to suffer, significant harm'. These babies are highly vulnerable, and professionals are trained to be especially alert to the dangers around them. Unexplained bruising, cuts and fractures are taken extremely seriously and investigated. Yet the threshold for entering onto a child protection plan varies from area to area, and from professional to professional, and may be adjusted according to the money and staff available.

Typical case study (2): Magda

A nine month old baby called Magda is taken to hospital with a spiral fracture in her left arm. The doctors believe that this was caused by her arm being 'yanked' behind her back but cannot confirm that it was a non-accidental injury. Her parents, Charlie and Rachel, say that Magda's arm was fractured accidentally; she was rolling off the bed and they caught her by her arm. An urgent assessment is begun and police checks reveal a string of historical domestic abuse call outs and arrests for drug possession for Charlie. Their older child Simon, who is seven years old, was placed on a Child in Need plan two years ago following concerns about neglect, however this was closed after six months. An Initial Child Protection Conference is held and Magda is placed on a child protection plan for physical abuse.

When the risk is thought to be too great, the local authority will take the baby into care: 3,820 babies under 1 were being looked after by local authorities on 31 March 2017 (0-4 year olds: 12,990), most of them having been removed from their parents' care. The increased focus on 'permanency' in family legal proceedings means that babies and infants taken into care will have adoption recommended by social workers more frequently than older children.

A further 640 babies under 1 were placed under special arrangements with someone other than parents, usually a relative, and a further 300 babies under 1 were adopted over the year to 31 March 2017.

This gives a total of around 15,800 babies under 1 considered by local authorities to be vulnerable or highly vulnerable but still living at home on 31 March 2017, a figure which is unlikely to be much changed today. This amounts to an average of around 100 babies per local authority.

Removing babies from their families at birth

Referrals from midwives, GPs, health visitors and nurses can result in children's services undertaking pre-birth assessments of risks to unborn babies. For example, midwives might be worried if a mother doesn't attend antenatal appointments, or has bruises on her body, or is acting in a way which suggests she is using alcohol or drugs during pregnancy.

A pre-birth assessment follows the same procedure as child protection assessments for babies who are born, but occur predominantly with parents who are considered to be at particularly high risk.

Typical case study (3): Benjamin

A referral was made by a midwife to children's services. A 19-year-old mother came to her antenatal appointment at 28 weeks having missed previous appointments. A drugs test found high levels of opioids and marijuana in the mother's bloodstream. When a social worker went to visit the mum, the flat had no furniture except a mattress and blanket on the floor. It was extremely dirty, and smelt of urine. When Benjamin was born, social services issued proceedings within 24 hours of birth and were granted an interim care order in court. He was born with substance withdrawal symptoms so remained in hospital for two weeks and then went to live with a foster carer.

The number of newborns involved in care proceedings in England has increased by 2.5 times in 8 years. The likelihood of a newborn being involved in care proceedings has gone up from 15 newborns per 10,000 live births in the general population in 2008 to 35 per 10,000 in 2016. In 2007/08, 32% of all care proceedings issued for infants were for newborns but by 2016/17, the percentage increased to 42% of all cases[4].

More than 13,000 babies were subject to legal action within a month of birth between April 2007 and March 2014.[5] The majority will be removed from their parents' care. That means on any given day, we can expect 5 very young babies in England to be removed from their parents. Sadly, some parents will respond to the trauma of being separated from their baby, by getting pregnant again, leading to a cycle of repeat removals of babies into care[6].

[4] Broadhurst, K., Alrouh, B., Mason, C., Ward, H., Holmes, L., Ryan, M., & Bowyer, S. (2018). Born into Care: newborn babies subject to care proceedings in England. The Nuffield Family Justice Observatory: Nuffield Foundation, London

[5] Broadhurst et al (2015), 'Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England', *The British Journal of Social Work*, 45:8

[6] ibid

‘Missing’ babies: survey data on the prevalence of household risk

Survey data suggest it is very unlikely that the local authority numbers represent the true level of need. The Children’s Commissioner’s Vulnerability Framework gathers all available data on childhood vulnerability into one place, enabling us to cross-reference one dataset against another. NHS Digital’s 2014 Adult Psychiatric Morbidity Survey (APMS) enables us to assess the numbers of children living in households where the so-called “toxic trio” – parental mental ill-health, domestic violence and substance misuse – are present, indicating very high parental risk[7].

The APMS data suggests that there over 50,000 children aged 0-5 years old – including around 8,300 babies under 1 – living in households where all three of the most dangerous combined risk factors are present: current domestic violence and adult alcohol or drug dependency, *and* adult severe mental ill-health. Children in such households are known to be at very heightened risk of severe harm[8]. Yet the local authority ‘children in need’ data shows that we can expect just 18,500 0-4 year olds (compared with an estimated 50,000 0-5 year olds at high risk) to be on child protection plans, including 5,000 babies under 1.

This suggests there are likely to be over 30,000 young children (0-5) living in extremely high risk households but not on child protection plans, including 3,300 babies under 1.

Our analysis of the APMS dataset also suggests that a further 160,000 children aged 0-5 – including 25,000 babies under 1 – live in a household where two of the three most ‘toxic’ risk factors are present. Yet only 58,000 0-4 year olds have been identified by local authorities as being even in the lower level risk category, ‘in need’, if we exclude those who are looked after or on a child protection plan. The corresponding figure for babies under 1 is 10,840.

This suggests that there are around 100,000 young children (0-5) living in high risk households – which we define as having two out of three ‘toxic trio’ issues – who are not recognised as ‘children in need’. That includes 14,000 babies under the age of 1.

Our prevalence figures are likely to be significant underestimates, as the APMS data only surveys one adult in a household, and we have only counted the cases where the adult problems are severe. However, it is likely that some of these families may be in receipt of lower level ‘troubled families programme’ (TFP) support. We estimate that around 104,000 children aged 0-4 years are in families supported through the programme. This is based on our previous estimate that there are around 408,000 children in families receiving TFP support[9], and the fact that just over a quarter of the children in these families are aged 0-4.[10]

Funding for TFP is due to end in 2020 and no replacement funding has been announced. Meanwhile, spend on the lower-level tier of family support by local authorities has been cut by 60% since 2010 as

[7] Chowdry (2018), ‘Estimating the prevalence of the ‘toxic trio’: Evidence from the Adult Psychiatric Morbidity Survey’, Children’s Commissioner’s Office.
[8] Sidebotham et al (2016), Triennial analysis of serious case reviews. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-_Pathways_to_harm_and_protection.pdf
[9] Alma Economics (2018), ‘Measuring aggregate vulnerability in childhood’, Report for the Office of the Children’s Commissioner
[10] Ministry of Housing, Communities & Local Government (2017), ‘National evaluation of the Troubled Families Programme 2015 to 2020: family outcomes – national and local datasets: part 2’, Chart 1 (p. 10)

funds are increasingly targeted on children in crisis[11], leaving a dangerous shortfall in funding for support for children in high-risk households who are not on child protection plans.

Living in such difficult home environments is likely to damage children's physical, emotional and cognitive development. In worst scenarios, it can contribute to their early death.

Analysis of serious case reviews shows the prevalence of the so-called 'toxic trio' risk factors in cases where children have been seriously harmed or died, and abuse or neglect is suspected to have played a part. Among the 293 Serious Case Reviews (SCRs) published between 2011 and 2014, domestic abuse was present in 54% of SCRS, parental mental ill health in 53% and parental alcohol or drug misuse in 47%[12].

The triennial review also looked at the prevalence of these issues occurring together. All three factors were present in 22% of cases; two of the three were present in 30% of cases and one of the three was present in 27% of cases. Only in 21% of cases were none of these three issues present. In two thirds of cases, the children involved were not receiving any children's social care support.

[11] IFS (2018) 'Public Spending on Children in England: 2000-2020', Report for the Office of the Children's Commissioner
[12] Sidebotham et al (2016), 'Triennial analysis of serious case reviews'.

Recommendations

We recommend that the new multi-agency safeguarding arrangements, being established to replace Local Safeguarding Children's Boards, make an assessment of likely levels of need among young children in their area and draw up strategies to identify and help those children.

It is clear that local authority children's services departments at present are not sufficiently well-resourced to offer help to all children who need it. This urgently needs to be addressed by the Government in the budget this autumn and in next year's spending review.

There is insufficient information about which interventions help parents whose children are at risk. But one visible safety net is health visitors – who may be the only professionals to see a baby regularly in the vulnerable early months. The OCC recommends increasing the number of mandatory visits for families where known risk factors are present; improvement in referral pathways from health visitors to health professionals and children's services; and close monitoring of the adequacy of provision of health visitors now that funding for them has transferred to local authorities.

Adult services working with those with domestic violence, mental ill health or substance abuse present in the home, should automatically ask whether there are children in the household, and their ages, and report any concerns to children's social care. Children's services should refer vulnerable adults to help from health and other relevant services.

The Government should identify and support the spread of best practice in children's services reform across local authorities, particularly with regards to repeat removals of babies from the same birth families.

There should be an annual statistical report linking NHS and children's services data to identify levels of need and unmet need among young children and babies. This should in time be linked to interventions and outcomes data so that effective interventions with these very vulnerable families can be identified.

Appendix: care proceedings

When Children's Services initiates court proceedings for a baby, there are three possible outcomes:

- **Interim Care Order:** this last 26 weeks and the local authority is granted joint parental responsibility alongside the parents. Usually, the child will be placed in foster care and becomes a Child Looked After under s.31 of the Children Act. During this time, parents will usually undertake various assessments of their parenting, contact will be granted between the parents and children and the local authority will be expected to begin looking for more permanent solutions for the child's care.
- **Interim Supervision Order**: An ISO lasts 26 weeks. During an ISO a baby will usually remain in the care of their parents, however the process for assessing parenting skills is similar to that of an ICO.
- **No Order Principle**: The 'No Order' principle is when the courts find that the local authority has not met the thresholds for proceedings. No legal order is made, though the family is technically still in the timeframe of proceedings and may have to return to court after 26 weeks for a final hearing

After 26 weeks a final hearing is usually held. There are two possible outcomes at the hearing:

- **Full Care Order:** The local authority receives permanent shared parental responsibility for the baby. In this this instance, it is likely that permanency routes such as kinship care or adoption will be explored.
- **Interim Care Order discharged:** the local authority will no longer share parental responsibility and the baby will return to its parents care.

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