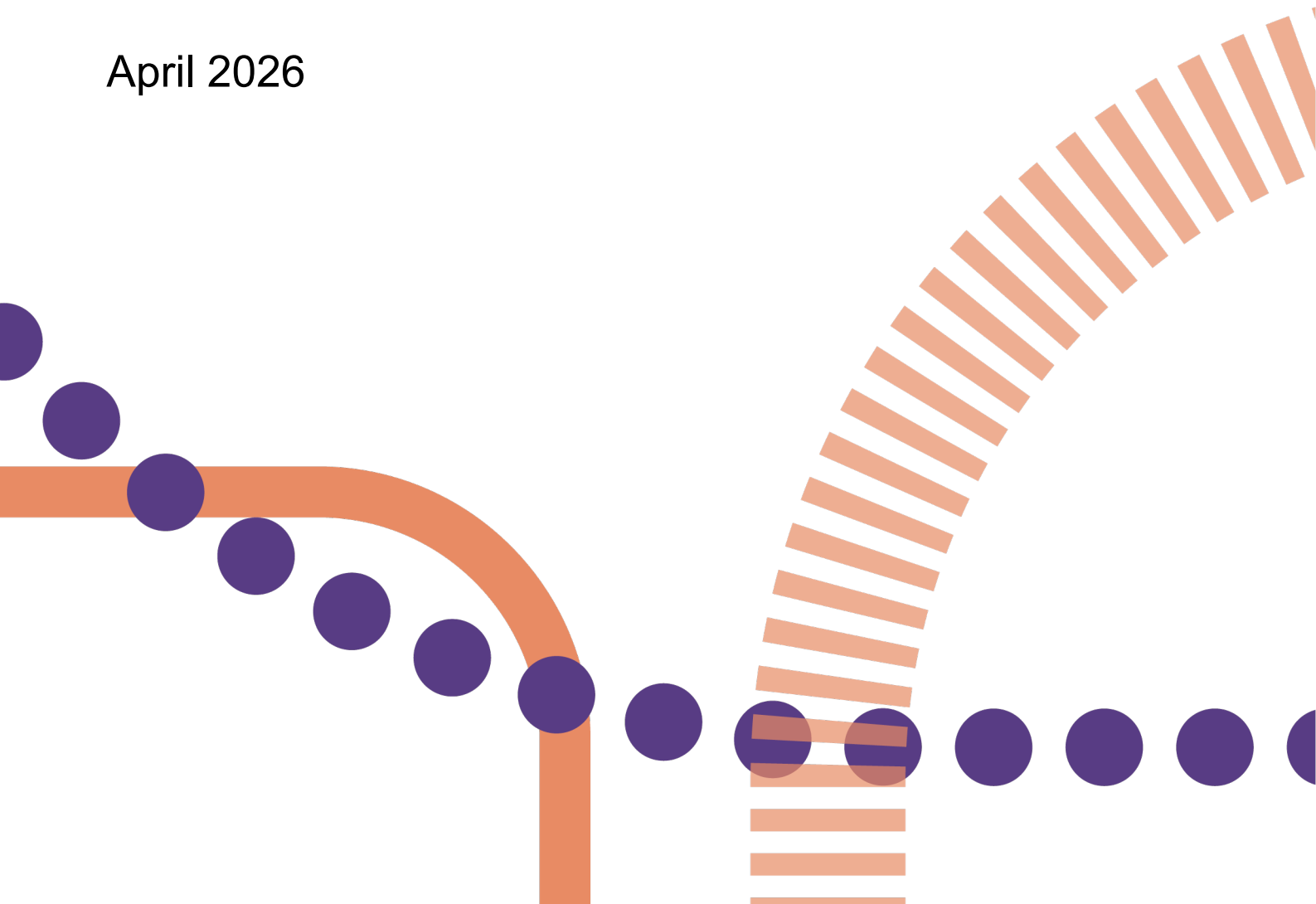


# Child neglect

Seeing the bigger picture: responding to cumulative harm

April 2026



## Introduction

The Child Safeguarding Practice Review Panel published a thematic report in Spring 2026 examining multi-agency responses to child neglect in serious child safeguarding incidents. A critical theme emerging from this review is the pivotal role of Multi-Agency Safeguarding Hubs (MASHs) in identifying and responding to child neglect. While MASHs are designed to facilitate early, coordinated intervention through multi-agency collaboration, the evidence reveals significant barriers at this interface. Referrals for neglect often fail to meet unclear and inconsistently applied thresholds, with a focus on isolated incidents rather than cumulative harm.

## Who is this document for?

Multi-agency practitioners and managers working in universal services such as schools, health services, police and early years settings, and practitioners in specialist safeguarding and child protection roles (including fostering and adoption).

## How to use this resource

Multi-agency practitioners should use this resource as a practical guide to strengthen their approach to identifying and responding to neglect. It is designed to support reflection and action by helping practitioners move beyond isolated incidents and recognise patterns of cumulative harm. The briefing provides evidence-based insights, key facts and hallmarks of good practice, alongside reflective questions that can be used in team discussions, supervision, and strategy discussions. By engaging with this resource, practitioners can develop a shared understanding across agencies that prioritises the child's lived experience and prevents escalation of harm.

## Why is it important for children and young people?

This resource will help professionals move beyond focusing on isolated incidents towards recognising patterns of cumulative harm caused by neglect. By promoting a shared, multi-agency understanding and encouraging coordinated responses, the resource aims to prevent escalation of harm and ensure that children's lived experiences are prioritised.

## What is the evidence base?

The Panel's thematic review included:

- Analysis of one hundred reviews and thirty-four related LCSPRs relating to neglect received by the Panel between 2019 and 2023.
- Five rapid reviews were selected for in-depth fieldwork involving practitioners, experts, and families with lived experience. Group interviews were conducted at each of the five sites, involving thirty-seven frontline practitioners who had worked directly with the children and families.

- Meetings were held with sixty senior managers from strategic groups, including education and third-sector organisations.
- Roundtable discussions brought together forty experts and leaders from health, police, education, and children’s social care/ early help.
- A webinar was convened with twenty-five independent reviewers of LCSPRs and scrutineers from various safeguarding partnerships, focusing on barriers and enablers to effective practice.
- To ensure the inclusion of children and families, the review team conducted interviews with two children and one parent and held two meetings with ten parents from family advocacy groups. These discussions explored their experiences with services, what they found helpful, what they wished had been done differently, and their suggestions for improving practice.
- Policy conversations with the relevant government departments.

## Key facts and figures

- In the UK, the best available evidence suggests that one in thirteen children aged 11 to 17 has experienced neglect, with one in ten reporting severe neglect during their lifetime (Radford et al., 2011).
- As of 31 March 2025, neglect was the primary concern for just over half of the 49,400 children in England subject to child protection plans (DfE, 2025).
- Neglect is a common factor in incidents involving death or serious harm. The Panel’s data shows that 60% of rapid reviews included neglect as part of the broader context of children’s lives (CSPRP Annual Report 24/25).

## Common issues

- Both the Panel’s literature review and the incidents reviewed as part of the analysis highlighted that neglect is often normalised and sporadically assessed leading to missed opportunities and under-identification. The impact of this is cumulative, affecting children’s development, mental health, relationships, and life outcomes.
- Recognising the cumulative nature of neglect—regardless of persistence or visible harm—is essential to more effective safeguarding amongst multi-agency practitioners.
- The interface between universal services and the MASH is an area of concern. In discussion, multi-agency practitioners spoke of a lack of clarity and consistency in how referrals for neglect were managed. Many referrals were rejected for not meeting the threshold for statutory intervention, even when there was evidence of cumulative harm to the child.

- Practice challenges exist that prevent effective responses to child neglect. Such issues are across the identification, assessment, intervention, and multi-agency response including inconsistent and siloed responses that do not capture cumulative harm.
- A key challenge is the ‘normalisation’ of neglect. When referrals do not meet intervention thresholds, they often result in no action which can lead to a lack of response and risk assessment to the cumulative harm caused by neglect. This issue was highlighted by educational professionals during the review.
- The absence of a shared, cross-agency understanding contributes to fragmented and delayed responses, undermining the effectiveness of safeguarding efforts.

## Hallmarks of good practice

- Chronologies are essential for understanding cumulative harm. Putting systems in place to help to capture a shared, multi-agency chronology would lead to patterns of neglect being noticed and identified allowing for interventions to not only focus on isolated incidents but on the broader context of what is going on in the child’s life.
- Having safeguarding frameworks that help to create a landscape where children’s needs are seen and met through responding to the cumulative nature of neglect and its interplay with poverty.
- Safeguarding frameworks that are inclusive and child-centred to support timely and consistent safeguarding practice.
- Having measures in place that prevent a delayed or reactive response if persistence or serious impairment is not yet evident. This would help to prevent an escalation of harm to the child.
- Exploring and implementing innovative local practices—such as daily multi-agency meetings or shared chronologies. For example, in Norfolk, combined agency chronologies were used to analyse and reflect on children’s needs and the effectiveness of interventions. This approach enabled professionals to see patterns over time and across services, supporting more accurate identification of neglect and more targeted responses.
- Exploring the use of neglect toolkits may help professionals structure their thinking and build a shared understanding as well as helping to engage parents in constructive conversations.

## Reflective questions and discussion points

- How are you, as an individual or as a team, recognising the cumulative nature of neglect, rather than focusing only on isolated incidents?
- Has consideration been given to whether any ongoing concerns about a child or family may have been normalised over a period, leading to missed opportunities for intervention? (This includes seeing inside where the child lives)
- What changes have you noticed over time in a child's development, behaviour, presentation, or relationships that might indicate cumulative harm and impact?
- If a referral did not meet the threshold for statutory intervention, have you ensured that the cumulative concerns have not been dismissed or lost?
- Are you confident that there are systems in place that allow all agencies to share information about a child or family to build a multi-agency chronology?
- How do you consider the interplay between neglect and poverty without normalising “concerning” care or missing signs of harm?
- Have you taken time to understand the child's lived experience and what services have (or haven't) been helpful so far?
- Are you acting early enough or is there a delayed or reactive response because severe or persistent harm is not yet evident?

## Reflective questions for leaders

- How does our safeguarding strategy ensure that cumulative harm (and not just isolated harm) is recognised and addressed across all agencies?
- Are our referral thresholds clear and consistently applied, or do they risk dismissing cumulative concerns?
- Have we created a culture that challenges the normalisation of neglect, and how do we monitor this across teams?
- Do we have robust systems in place for building and maintaining multi-agency chronologies, and how do we hold partners accountable for contributing to them?
- Are our safeguarding frameworks proactive enough to prevent delayed responses to neglect?
- How do we guide practitioners to consider poverty without normalising harmful care or overlooking neglect?
- Are we modelling and promoting professional curiosity to challenge assumptions and identify cumulative harm?

- Do we have a multiagency neglect training programme? How might this help us?
- How do we ensure that safeguarding assessments concerning neglect considers a family's intersecting factors such as poverty, race and socioeconomic context, so that assumptions or biases about families from marginalised communities do not shape the way their parenting is framed?

## Case study

Two children in a family were known to multiple agencies over many years due to chronic neglect, periods of physical abuse and complex dynamics within the household. Both parents were known to have learning needs which affected their ability to provide consistent and safe care.

One child's severe obesity was attributed to neglect, alongside repeated safeguarding episodes. The other child's behavioural presentation often diverted multi-agency professional focus. Despite various interventions, the cumulative harm experienced by both children escalated over time. The children were eventually removed from the home for their safety and wellbeing.

### Learning points:

- IT issues hindered practitioners' views of historic harm
- Neglect assessments did not take place to understand the impact on each child
- The child's voice was overshadowed by sibling behaviour and parental needs
- Child protection processes were missing paediatric input and information of missed appointments was not shared by GP
- Parental capacity and learning needs were not adequately addressed
- School professionals experienced pushback when submitting referrals about concerns - this led to schools not raising concerns as they were told thresholds were not met

## Where can I find out more?

Find more information on the Panel's new learning hub:

[www.childsafeguarding.independent-panel.uk](http://www.childsafeguarding.independent-panel.uk), where you can access videos, webinars, podcasts and other content, including the full report.

Other useful resources include:

- NSPCC: [Too little, too late: The multi-agency response to identifying and tackling neglect](#) (pages 6 to 7 apply)