BRIEFING 1

Why children die at their parents' hands, and how to prevent it

Domestic violence, addiction and mental illness lie behind most of the deaths that shock us. All three can be tackled by public health. Removing more children has not been shown to reduce them.

Dr Charlotte Ritchie October 2026 England Reading time 10 minutes

Child Protection: A Public Health Approach · Briefing 1 · October 2026
Based on chapter 2 of *Child Protection – A Public Health Approach: Reducing the Numbers in Care* (2021), updated with 2023–26 evidence.

Key points

- England has no single, reliable count of children who die at their parents' hands. The best estimates suggest the number has changed little in twenty years, while the number of children in care has kept rising.
- Serious case reviews find domestic violence in two thirds of the families where a child died or was seriously harmed, substance misuse in more than half and mental ill health in more than half.
- All three can be reduced by public health policy. Better-off parents already buy the help they need. Poorer parents fear that asking will cost them their children.
- Parents need agency: the ability, like their better-off counterparts, to choose how their problem is resolved without fear of child protection.

66%
of families in serious case reviews where domestic violence was present
Brandon et al. 2008

66%
of parents who killed their children in England and Wales were fathers
Flynn et al. 2013

£8.1bn
long-term cost of perinatal mental illness for each year's births; 72% falls on the child
Bauer et al. 2014

1 What we know about the numbers

England does not have one identifiable way of recording child homicides by a family member. Figures vary depending on how they are measured.

In 2003 the Health Secretary told Parliament that "about 80 children a year die from abuse or neglect".[1] The most careful later estimate, for 2009–10, was around 85 violent and maltreatment-related deaths a year, of which 50 to 55 were directly caused by abuse or neglect.[2] In the year to March 2026, councils notified the Government of 126 child deaths where abuse or neglect was known or suspected, and the Department for Education itself warns that not all such deaths are notified.[3] In December 2024 the Children's Commissioner concluded that the evidence "is not good enough to say whether the trend is up or down".[4]

Over the same years, the number of children in care rose from 60,810 in 2003 to 81,770 in 2025.[5] Repeated attempts to tighten up child protection have not led to any clear improvement in the measure that matters most: the number of children who die.

In terms of risk, a death that social services might be held "responsible" for is what every local authority seeks to avoid. It is not just the individual life; it is the fear that has become synonymous with managing children's services. Much of the edifice of child protection is built around that worst-case scenario. Now is the time to think the unthinkable: to turn the focus from risk and investigation towards open access and universal support, underpinned by a public health strategy that promotes the wellbeing of all children and families.

2 The three triggers

So what lies behind the deaths? A study of serious case reviews, where a child died or was seriously harmed, found:

> "There is evidence that domestic violence is present in two thirds of the cases (66%), substance misuse in 57%, and mental ill health in 55% of families."
>
> Brandon et al. (2008), serious case reviews 2003–2005, p.51

A later review of cases from 2009 to 2011 found much the same.[2] The same three problems are the ones social workers record most often in ordinary assessments: in 2024–25, concerns about a parent's mental health and domestic abuse were each recorded in around one in three assessments in England.[6]

Domestic violence, substance misuse and mental health difficulties are all factors that can be dealt with by public health policy.

3 Mental illness

Depression and psychosis can affect a parent's ability to cope. Most parents manage. For a small percentage, proactive help is needed.

Affluent parents are more likely to get the treatment they need from their doctors, more able to pay for therapy, nannies, au pairs or babysitters, and face fewer of the stresses that trigger a crisis. They can reduce the risk themselves. They have agency. For parents on low incomes, and for care leavers, high-quality mental health support at the point of need is still largely absent, and revealing a need risks intrusion by state agents over whom they have no say.

The risks are not always where we look for them. In a study of every filicide in England and Wales over ten years, two thirds of the parents who killed their children were fathers, and in most cases mental illness was not a feature.[7] Yet antenatal and postnatal services tend to see mothers, not fathers.

For mothers, the year after birth is a time of real danger. Mental health-related causes accounted for 34% of maternal deaths between six weeks and a year after pregnancy in the latest UK confidential enquiry.[8] Getting perinatal mental health care right is also cost effective: perinatal depression, anxiety and psychosis carry a long-term cost of about £8.1 billion for each year's births, and nearly three quarters of that falls on the child.[9] Care is not the answer; universal support is.

Asking the question

We now accept that professionals should ask a depressed person whether they have thought about suicide. Research suggests that GPs, counsellors and mental health workers also need to ask: "Have you had any thoughts about harming the children?"[10] But to expect an honest answer, the parent must feel safe giving it. They must not believe their children will be taken. If necessary, the parent might spend time out of the home while support is put in place at home: something most of us would not only accept, but welcome.

> “Parents describe how they fear losing their children, and the reality of it happening. They feel on trial about their parenting abilities and though they may need help, they fear the consequences of asking for it.”
>
> Department of Health research, as quoted in the book

A PUBLIC HEALTH RESPONSE

- A mother and baby unit within reach of every family, and a right to be admitted when needed.
- Support in the home while a parent is in hospital, and daily support from someone they trust in the weeks after discharge, when the risk is highest.
- Home visiting for every new parent who wants it. The Family Nurse Partnership is still limited to first-time mothers aged up to 24, under local criteria, and several local programmes closed in 2025–26.[11]
- Asking about thoughts of harming a child, in a service parents trust not to remove their children for answering honestly.

4 Drugs and alcohol

What do we say about a parent who reportedly used drugs constantly, and claimed to have snorted his own father’s ashes mixed with cocaine? Or about a father who drinks before lunch and before supper, usually spirits and usually doubles? The first, Keith Richards, was not, as far as is known, ever the subject of child protection investigations, and has by all accounts well-adjusted adult children. The second is my own father; a lovelier man it would be hard to find.

This is not to make light of addiction, but to show that its effect on children can be very much shaped by other things in a child’s life, not least relative affluence. A parent who has to steal to fund a habit, who cannot put enough food on the table, who leaves needles where small children can find them and who has no au pair or nanny, needs practical support.

In 2024–25, almost one in five people starting drug and alcohol treatment in England, 31,821 people, were living with children, and a further 13% were parents not living with their children.[12] Yet councils that could give a figure spent on average just 1.58% of their substance misuse budgets on support for families.[13] In a South London study, 82% of mothers in treatment who were involved in care proceedings had their child placed in care; the researchers concluded that treatment services “are not designed to support mothers in retaining the care of their children”.[14]

A PUBLIC HEALTH RESPONSE

- Residential rehab where parents and children stay together, like Trevi House in Plymouth, in every region.
- Family drug and alcohol courts everywhere: in a national evaluation, 52% of children were reunited with their parent at the end of proceedings, against 12.5% in ordinary proceedings.[15]
- Treatment linked to family support, health visiting and parenting help, offered on the parent's terms. We are suggesting only what middle-class drinkers and drug users already have: choice.

5 Domestic violence

Taking children out of the home is not the answer. Preventing domestic violence, and removing the abuser, is.

Children can be removed from the home with a care order made in the civil Family Court, with no jury and a lower standard of proof than a criminal court. Abusers, by contrast, cannot be permanently removed or kept away. A victim can apply for an occupation order, but it gives no lasting security. If the police respond, a domestic violence protection order can ban the abuser from the home for no more than 28 days.[16] The abused parent and the children are not granted the same consideration, and frequently flee to refuges or lose their children to care.

New domestic abuse protection orders, with no maximum duration, are being piloted in some areas until November 2026, and the Government says it is rolling them out more widely.[17] But a 2026 study of local responses found professionals still putting the expectation on the victim to safeguard her children from the perpetrator, which can increase the risk of harm.[18]

Many women do not leave because they have no money of their own, no financial awareness and nowhere to go. Only 58% of refuges now have a dedicated service for children.[19]

A PUBLIC HEALTH RESPONSE

- The abuser leaves, not the mother and children: fast protection orders, with housing and income support so the non-abusing parent can stay.
- Financial independence: bank accounts in each adult's own name, and teaching every child the real mathematics of money, debt and credit.
- No sole tenancies in a family home unless the tenant is the only person with parental responsibility, so that the victim has an equal right to stay.
- Enough refuge places, and counselling for children of violent parents so the pattern is not repeated.

6 What should change

1. **Count the deaths**
   Publish one consistent annual figure for children who die from abuse or neglect, so we can know whether what we do is working.

2. **Make help safe to ask for**
   Give parents, like their better-off counterparts, the agency to choose how their problem is resolved without fear of child protection.

3. **Perinatal mental health for every family**
   Mother and baby units within reach, support at home during and after a hospital stay, and home visiting for every new parent who wants it.

4. **Treatment that keeps families together**
   Parent-and-child residential rehab and family drug and alcohol courts in every area, with treatment linked to family support.

5. **Remove the abuser, not the child**
   Fast, lasting protection orders, financial independence for victims, and housing that lets the non-abusing parent stay at home.

Questions for discussion

Q1 Is there any evidence that child protection works for children and parents, and what would that evidence look like?

Q2 Why do the Netherlands, Sweden, Denmark and Finland do so much better than the UK on child wellbeing?

Q3 What would a public health approach to domestic violence look like, and how might men be involved?

Q4 What public health initiatives might better support parents who misuse drugs or alcohol, and their children?

Sources

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Photo

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