Safeguarding Response to Childhood Obesity in the Context of Neglect:

Policy and Practice Guidance

October 2021

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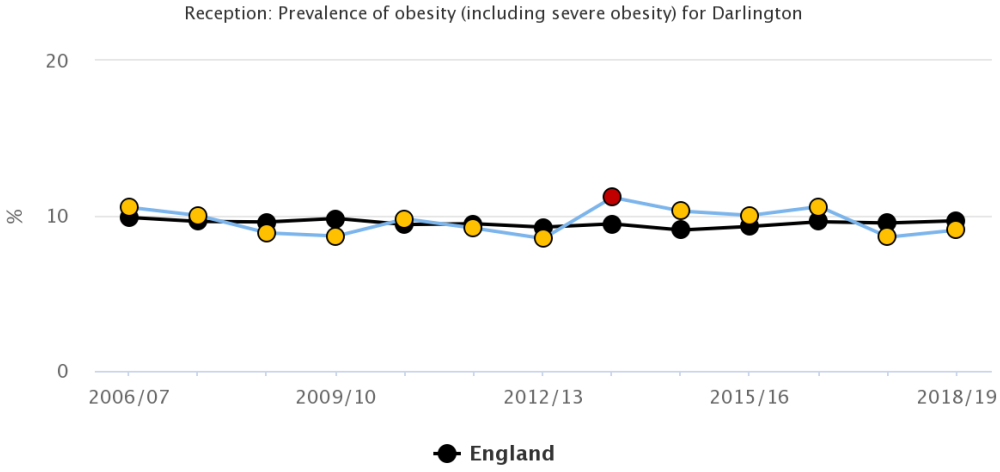
1. Introduction

Childhood Obesity in Darlington. Childhood obesity and excess weight are significant health issues for children. They can have serious implications for the physical and mental health of a child continuing into adulthood as obese children are more likely to become obese adults and have a higher risk of morbidity and premature mortality. Obesity and being overweight are linked to a range of diseases including type 2 diabetes, asthma, hypertension, cancer, heart disease and stroke. The most recent childhood obesity data (2018/19) is shown below. Darlington is similar to the national and regional picture. The percentage of children at year 6 who are categorised as obese in Darlington is 22.5%. This figure is more than double the figure at reception age (9.1%).



Levels of obesity mirror deprivation across the town with areas of deprivation generally experiencing higher levels of obesity. Although the main causes of obesity are poor diet and lack of physical activity, these things cannot be looked at in isolation. The environment that children live, learn and develop in has a significant impact on obesity.

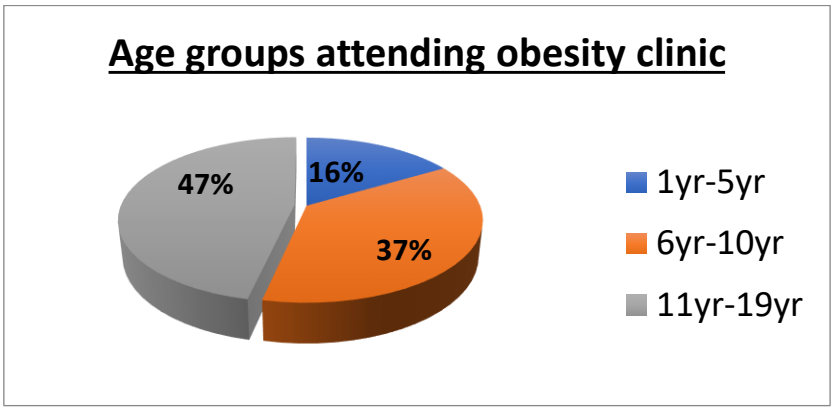
There is a long-term plan setting out the intention to implement a whole system approach to tackling childhood obesity across the town. The scope and vision of the Darlington Childhood Healthy Weight Plan is to ensure that more children leave primary school aged 10-11 years with a healthy weight. This will only be achieved by developing a whole systems approach to tackling childhood obesity recognising the complex relationship between the social, economic and physical environment coupled with individual factors that underpin the development of obesity.

The Covid-19 pandemic has added further emphasis on the need to put plans in place, given there is strong evidence to suggest that living with excess weight places people at much greater risk.

A multi-disciplinary holistic approach is required in working with and assessing child obesity - within universal health and social care services, early intervention and child protection services.

2. Childhood Obesity and Safeguarding/Neglect

This policy and practice guidance relates to all children under the age of 18.



Source-County Durham and Darlington NHS Foundation Trust 2017

Practitioners and the public should be aware that childhood obesity becomes a safeguarding issue when there are wider concerns about neglect and/or emotional abuse. This policy should be read with reference to the Darlington Safeguarding Partnership Multi Agency Practice Guidance on Neglect.

3. When does obesity become a safeguarding issue?

Childhood obesity alone is a concern but not usually a child protection concern. A consultation with the family of an obese child should not raise safeguarding issues if obesity is the only cause for concern. The root causes of obesity are complex, and in many instances, it is not appropriate to institute child protection proceedings in relation to parental neglect as being the cause of the obesity.

However, practitioners working with obese children must be mindful of the possible role of abuse or neglect in contributing to the obesity. Older children and adolescents should be offered the chance to speak apart from their parents to explore their understanding of their weight issues.

Failure to reduce weight alone is not a child protection concern. The outcomes of weight management programmes for childhood obesity are mixed with the body mass index of some children falling substantially but that of others increasing despite high levels of family commitment. Obesity remains extremely difficult to treat and it is not appropriate to criticise parents for failing to address it successfully if they engage adequately with treatment.

Consistent failure to change lifestyle and engage with outside support can be an indicator of neglect, especially in young children. Parental failure to provide children with adequate treatment for a chronic illness is an accepted reason for instigating child protection investigations/proceedings under the category of neglect.

Childhood obesity only becomes a child protection concern when parents/carers behave in a way that actively promotes treatment failure in a child who is at serious risk from obesity where the parent/carer understand what is required and are supported in engaging with the treatment programme. Parental/carer behaviours of concern include:

- consistently failing to attend appointments
- refusing to engage with various practitioners or with weight management initiatives
- actively subverting weight management initiatives.

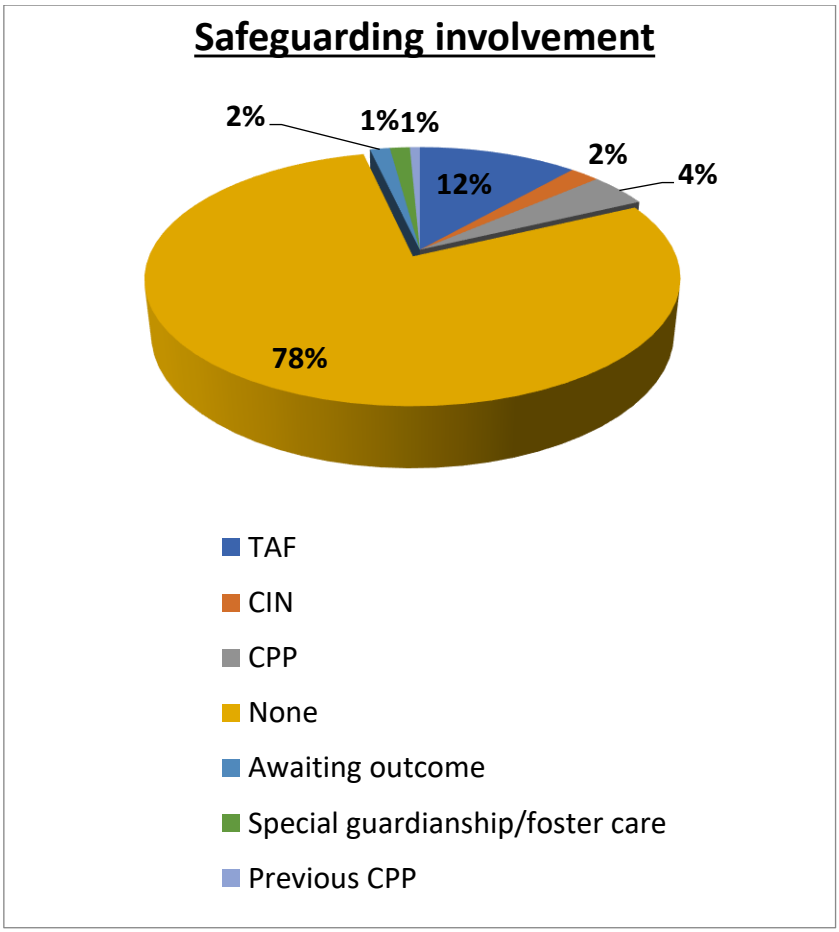
The behaviours are of particular concern if the obese child is at imminent risk of comorbidity, for example obstructive sleep apnoea, hypertension, Type 2 diabetes or mobility restrictions. Clear and objective evidence of this behaviour over a sustained period is required and the treatment offered must have been adequate and evidence based.

Obesity may be part of wider concerns about neglect or emotional abuse. Obesity is likely to be one part of wider concerns about the child's welfare, for example poor school attendance, exposure to or involvement with violence, neglect, poor hygiene, parental mental health problems, emotional and behavioural difficulties or other medical concerns. It is essential to evaluate other aspects of the child's health and wellbeing and determine if concerns are shared by other professionals such as the family GP or education services. This will require a multi-disciplinary assessment including a psychological or other mental health assessment. If concerns are expressed, then a multi-agency meeting should be convened.

Assessment should include systemic (family and environmental) factors. As with all childhood behaviour understanding what maintains a problem involves understanding factors within the child and the context. Assessment of parental capacity to respond to a child's needs is central to this, for example parents/carers struggling to manage their own weight and control their eating, but these are not the only factors. For example, a child who lives in an area where it is unsafe to play outdoors is inevitably at greater risk. Admission to hospital or another closed environment may be useful as it allows a more detailed assessment of behaviours and parent-child interaction. However, admission removes a child from his or her wider familiar environment as well as from parents/carers, so weight loss is in a controlled environment and therefore not evidence of neglect or abuse in the family home environment.

It is envisaged that a small number of children will reach the safeguarding threshold in relation to obesity linked to neglect. Weight management is an emotive issue, and many families struggle to maintain a healthy diet and achieve the recommended levels of daily activity. Wherever possible it is important to families to understand potential risks and signs of safety.

Morbid obesity can affect a child's outcomes in a number of ways, including academic achievement and emotional wellbeing. It is imperative that any parent/carer who is trying to manage their child's weight understands the risks and has access to appropriate support and guidance.



Source-County Durham and Darlington NHS Foundation Trust 2017

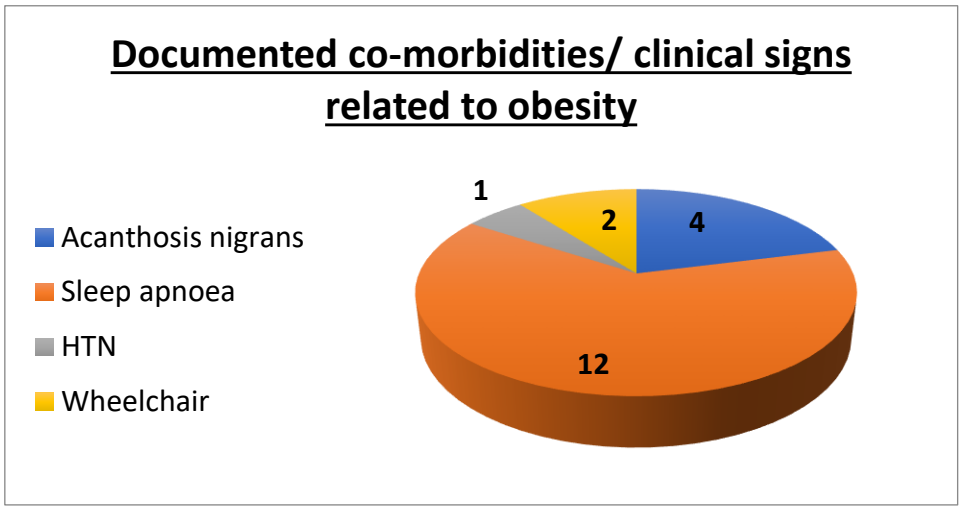
4. The Child and Family

Child and family obesity is the most common nutritional disorder affecting children and is much more common in families living in poverty and those from some ethnic minority groups.

Consideration must be given to cultural and ethnic influences when considering obesity as a potential harm in safeguarding children; an understanding of varying approaches to what constitutes; healthy foods, food preparation, exercise and a healthy weight must be explored in the cultural context of the family. It is important not to make assumptions about or stigmatise certain cultural beliefs regarding weight nor the belief system which sits behind those values. This may require some education and wider consultation to be undertaken by the practitioner when working with culturally diverse groups thus ensuring a parity of approach and assessment of risk.

Being overweight or obese in childhood has both short-term and longer-term consequences for health. Moreover, once severe, obesity is very difficult to treat effectively. In addition to the physical consequences of obesity, children experience significant emotional and psychological distress. Teasing and discrimination is not uncommon, with resultant low self-esteem anxiety and depression.

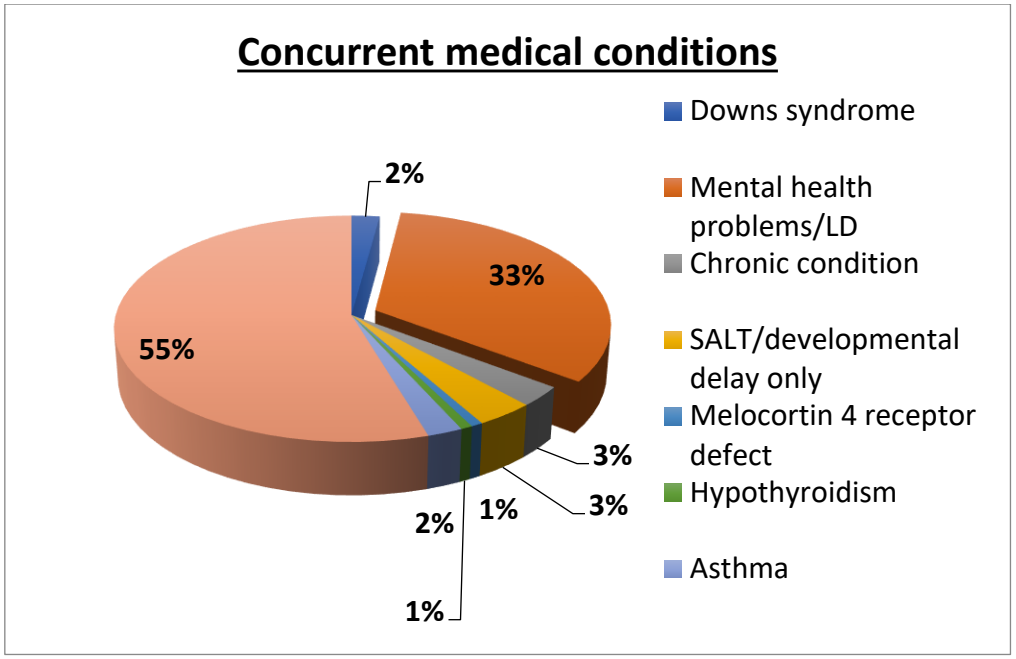
Severe (morbid) obesity may have serious health implications for the child. The health risks increase with duration and severity of obesity and in rare instances may have a fatal outcome. For the most part, childhood obesity is so called “simple obesity”, arising from a chronic imbalance between energy intake and activity. Often this reflects the family environment, and one or both parents is commonly overweight or obese. Obese children are more often ill, experience more day-to-day health issues (e.g. breathlessness, discomfort, fatigue), have greater school absence, healthcare attendances and hospital admissions. Obesity in childhood often leads to obesity in adulthood, with greatly increased risks of disability, chronic ill-health and premature death.



Source-County Durham and Darlington NHS Foundation Trust 2017

Obesity may be part of a more complex health problem, which further jeopardises a child’s wellbeing. Examples include obesity:

- in a child with a genetic condition, such as Prader-Willi Syndrome
- in a child with autism or learning difficulties
- associated with other health problems, such as blindness or arthritis which hamper mobility
- from treatment with steroids or other treatment known to increase risk of obesity
- complicated by asthma, obstructive sleep apnoea, Type 2 Diabetes or other obesity-related illness.



Source-County Durham and Darlington NHS Foundation Trust 2017

Some families and even professionals working with the family will use the attendant health issues to justify, explain or excuse the child's obesity. However, the dual diagnosis of obesity and another health condition strains a family's ability to cope and amplifies the risks to the individual child. It is this group of children in whom obesity most commonly becomes a safeguarding concern.
There are of course exceptions, for example, a child on long term steroids particularly in a high dose will be obese and even the most attentive parent will struggle to address this. It is imperative to use professional judgement when considering each case.

5. Legal Framework-The Children Act 1989

Where there is clear medical advice that the child is likely to suffer or is suffering significant harm from health conditions, specifically obesity and/or obesity related issues, as well as evidence that the care givers are unable or unwilling to engage in a plan that will realistically lead to improvements for that child, then the case requires action under Section 47 of the Children Act 1989.

Where there is medical advice that the child is unlikely to achieve /maintain a reasonable standard of health/wellbeing, but parents are engaging and/or there is no immediate risk of significant harm, then the case may require action under Section 17 of the Children Act 1989 if parental consent is granted.

For the purposes of this document, 'immediate' can be defined as risks escalating significantly within 12 months. Case management should be regularly reviewed to ensure that the risks to the child's health and wellbeing are monitored carefully to ensure appropriate and timely actions are taken under the legal framework.

6. Safeguarding Trigger Points

All trigger points need to be understood in terms of managing lifestyle, including healthy eating, physical activity and behaviour change, linked to the child's overall health, safety and wellbeing.

- lack of capacity to engage
- parents/carers unable to effectively provide for the child's health needs due to additional family factors, such as learning difficulties, socio-economic issues, unmet parental needs
- unable to attend appointments and make necessary changes to lifestyle
- weight continues, or appears to continue, to increase/or not to decrease. Unwilling to engage
- not attending appointments
- unwilling to make any changes to child's lifestyle even with appropriate support and intervention by agencies.
- parent/carer refusing, rejecting or ignoring professional advice regarding ongoing significant health risks to their child if the weight continues to increase.
- transient or intermittent engagement
- actively frustrating efforts of professionals or child to reduce weight gain.
- oppositional behaviour: parents/carers unable/unwilling to set and maintain boundaries with child to manage lifestyle changes and allow further weight gain

7. Disguised Compliance

Indicators of disguised compliance include:

- parents/carers appear to follow advice but are not making any changes to lifestyle which would make a significant difference to the child's wellbeing
- parents/carers unwilling/unable to model appropriate behaviour to facilitate lifestyle changes.
- parents/carers playing one professional off against another
- agencies need to be aware of how parents/carers can distract professionals both within one agency and across agencies from focusing on the child by favouring one agency/professional over another.

Behaviours can include:

- appearing helpless and/or overwhelmed
- being aggressive and/or confrontational
- using media and/or politicians and/or legal advisers to challenge the professionals
- over sensationalise particular comments/issues to detract from the significant harm being experienced by the child/young person.
- parents/carers may use medical diagnoses to justify their inability to adhere to recommended advice.

Professionals need to be cognisant of the child's needs and be prepared to challenge both parents and other practitioners working with the child/family.

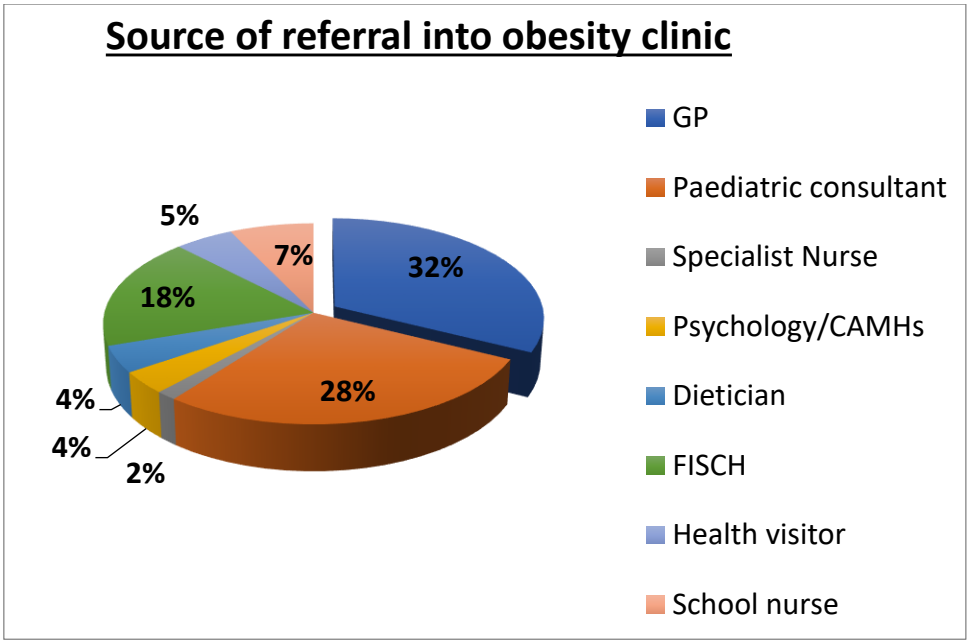
8. Identifying children where there are safeguarding concerns

There are a number of warning signs and indicators that will support practitioners working with children and young people who are obese. The following list should be considered in the context of the child's overall presentation and not in isolation:

- sleep deprived and/or sleep apnoea: effects of inadequate rest affecting day to day functions
- incontinence
- inability/unwillingness to participate in physical activity
- requires medical assessment to manage weight
- avoidance of school weight/height measurements (National Child Measurement Programme)
- A & E attendance with mobility related injuries
- Co-morbidity, i.e. presence of one or more additional disorders (or diseases), whether related to obesity or not (see Appendix 1 for obesity related comorbidities)
- continuous and persistent weight gain after obesity diagnosed
- unkempt appearance
- depression
- low self-esteem
- self-harm
- poor or non-school attendance
- socially isolated
- parents/carers not engaging in weight management programmes
- parents/carers poor mental health
- family identity linked to obesity/intergenerational weight issues
- any other feature of neglect
  The list above is not exhaustive and need to be considered in line with safeguarding trigger points.

9. The role of Darlington Safeguarding Partnership and individual organisations

Working Together 2018 sets out the requirement for organisations, working together, to take a coordinated approach to ensure effective safeguarding arrangements. This is supported by the duty on local authorities under section 10 of the Children Act 2004 to make arrangements to promote cooperation to improve the wellbeing of all children in the authority's area. There is specific guidance on the range of individual organisations and professionals working with children and families, outlining their specific statutory duties to promote the welfare of children and ensure they are protected from harm. The child's welfare is paramount.



Source-County Durham and Darlington NHS Foundation Trust 2017

Practitioners and the public should be aware that obesity becomes a safeguarding issue when there are wider concerns about neglect and/or emotional abuse.

Practitioners must be alert to these children, who may be isolated and/or not accessing universal services and ensure that the risks are recognised and assessed appropriately. Practitioners and the public need to recognise that safeguarding is everybody's responsibility.

However, when dealing with complex issues such as obesity there are specific contributions that can be and should be made by different agencies and these interventions and assessments need to be child focused, co-ordinated and shared appropriately.

A multidisciplinary holistic approach is required in working with and assessing child obesity - within universal health and social care services, early intervention and child protection services if the threshold for safeguarding is reached.

i. Paediatricians

It is important that the child's health needs are properly assessed, including, where possible, assessment of any environmental factors that are having a negative impact on their weight gain or loss. This will enable close monitoring of the parents'/carers' ability to support the child to maintain a healthy weight and active lifestyle.

Where an obese child is on a Child Protection (CP) Plan, there are two key practice points to follow:

- the CP Plan should ensure that a paediatric assessment takes place where obesity is presenting as a safeguarding issue

- the Paediatrician should attend all child protection conference reviews and, where, appropriate core group meetings, so that the effectiveness of the weight management programme can be reviewed in line with ongoing parenting capacity monitoring

In identified safeguarding cases, consideration should be given to appointing the Paediatrician as medical lead for the child's presenting conditions. There should be regular communication with the child's GP to assess whether any other arising health concerns are considered in light of concerns over his/her health. This principle should be applied for any health professionals responsible for primary care, such as School Nurses or Health Visitors, to ensure the Paediatrician maintains a holistic overview of the risks.

ii. General Practitioners

GPs should be mindful of the delineation between obesity as a health issue and a safeguarding concern, using the indicators above. GPs should ensure that information is sought from both parents in assessing the safeguarding risk to the child and the need to share concerns with Health colleagues and/or partner agencies.

iii. Harrogate and District NHS Foundation Trust (HDFT)

The HDFT 5-19 team delivers the NCMP (National Child Measurement Programme) for children in Reception and Year 6, this includes height and weight. Children who are underweight are referred to their GP to be seen by Paediatrics if the GP feels it is necessary. Those that are borderline we review in 3-6 months. The very overweight receive two pro-active phone calls to offer support from the service or they are referred to the Obesity service.

iv. Other Health Practitioners

Other health professionals including Health Visitors and Paramedics, should be mindful of the delineation between obesity as a health issue and a safeguarding concern, using the indicators above. Most cases of obesity will be managed by health, working with parents, however when the lifestyle challenges trigger failure to thrive concerns safeguarding referrals should be considered. When the health professional recognise that their interventions alone are not having any impact on the weight management and the health risks are escalating, they need to ensure that their concerns are shared with the wider children's workforce.

v. Education

Schools which have concerns about a child's weight must establish that the child's health is being managed and, with parents' consent, confirm with health colleagues that an appropriate weight management programme is in place. If consent is not gained, the school should clearly record its concerns and keep a log to monitor the weight, how it is being managed and whether the parents are supporting the child to exercise and eat healthily.

The school is in the strongest position to monitor the day-to-day impact of persistent weight gain and the parents' ability to manage the child's weight and should not rely solely on the health professionals' interventions. If the child's weight continues to increase and the indicators noted above are identified, a referral to children's social care should be made (see Referral and Risk Assessment below). Challenges need to be recorded clearly.

Schools should be prepared to challenge any barriers presented by parents in addressing lifestyle changes such as not allowing the child to participate in physical activities. All concerns should be recorded and where appropriate shared with partners to better assess the risks.

Schools involved in Child in Need Reviews, Child Protection Conferences and/or Core Groups should ensure that they record on a regular basis any information the child gives them regarding their eating patterns so they can report on whether or not parents are working with the child's plan. Consideration should be given to the impact of obesity on the child's emotional well-being and the school should record observations on any signs of emotional harm, such as depression, isolation or bullying. Any activities that the child cannot engage with due to their weight should be noted in terms of the impact of social isolation as well as affecting educational attainment. This should be recorded in the log.

vi. Social Care

Social Workers, including frontline staff, their Managers, and Conference Chairs with cases involving children with obesity related safeguarding concerns should be aware of the safeguarding warning signs and indicators noted above. As safeguarding leads, they should ensure that all aspects of non-compliance with the Child Protection Plan are communicated to all Core Group members as and when this occurs, and not wait until reporting the incidences at the next Core Group. This will enable any patterns to be identified, and where the parent/carer fails to comply with agencies to be identified quickly and challenged. Parents/carers and young people will need to be informed that this will happen and the reasons why.

Non-compliance includes:

- not attending school
- missing medical appointments
- not participating in physical activity unless there is clear medical evidence which is signed off by the Paediatrician overseeing the child's health plan
- parents/carers intervening to prevent their child from participating in physical activity
- parents/carers consistently providing inappropriate lunches/snacks.

Independent Reviewing Officers working with Looked After Children who are obese should challenge any lack of progress to reduce/manage weight within the care plan. Carers need to be supported to understand the risks and ensure that the child in their care makes appropriate progress.

vii. Police

Childhood Obesity per se should be managed primarily by parents and carers with incremental support from Health and Children's Social Care.

The Police may well engage in multi-agency strategy discussions in cases where a child is considered likely to suffer significant harm (Section 47 of the Children Act 1989) where their obesity is cited as a primary factor. However, the role of the Police within the Child Safeguarding partnership is to investigate and prosecute criminal offences. To that end any neglect or ill-treatment of a child would ordinarily be considered under Section 1(1) of the Children and Young Persons Act 1933 which states:

If a person who has attained the age of sixteen years and has responsibility for a child or young person under that age, wilfully assaults, ill-treats, neglects, abandons, or exposes him, or causes or procures him to be assaulted, ill-treated, neglected, abandoned, or exposed, in a manner likely to cause him unnecessary suffering or injury to health (including injury to or loss of sight, hearing, limb, or organ of the body, and any mental derangement), that person is guilty of a misdemeanour Any police involvement must be determined by the facts presented.

There has to be a very distinct line drawn where the potential harm is directly attributable to wilful acts or omissions by the parent or carer.

Police involvement will be very reliant on the combined information of the agencies engaged with the child and information sharing will be crucial to any action taken by Police.

Whilst not prescriptive, the following points should be considered as the threshold to Police involvement:

1. the child is obese, and their weight is continuing overall to increase disproportionately to age OR is not reducing in line with a realistic and achievable health plan AND
2. paediatric examination shows that this is leading to co-morbidity factors (other medical factors as a direct result of the obesity) AND
3. the parents or carers are aware of the risks and have the capacity and capability to engage in their child's treatment AND
4. they are frustrating, or unnecessarily failing to engage in, a coordinated plan to improve the child's health AND
5. the child is likely to be caused unnecessary suffering or injury to health.

It is important to be able to discern cases where the parents or carers require significant support in the management of their child's obesity. Such cases may include genetic conditions (for example Prader Willi Syndrome) or perhaps cases where the parents or carers do not have the ability to properly manage these more complex needs. Except in exceptional circumstances these cases will be managed by health and children's social care.

10. Assessment and Referral Pathway

It can be difficult to discuss obesity with parents who may be hostile, unreceptive or who lack capacity to recognise the safeguarding implications. Regardless, the protection and welfare of the child is the priority, and it is everyone's responsibility to act on their concerns.

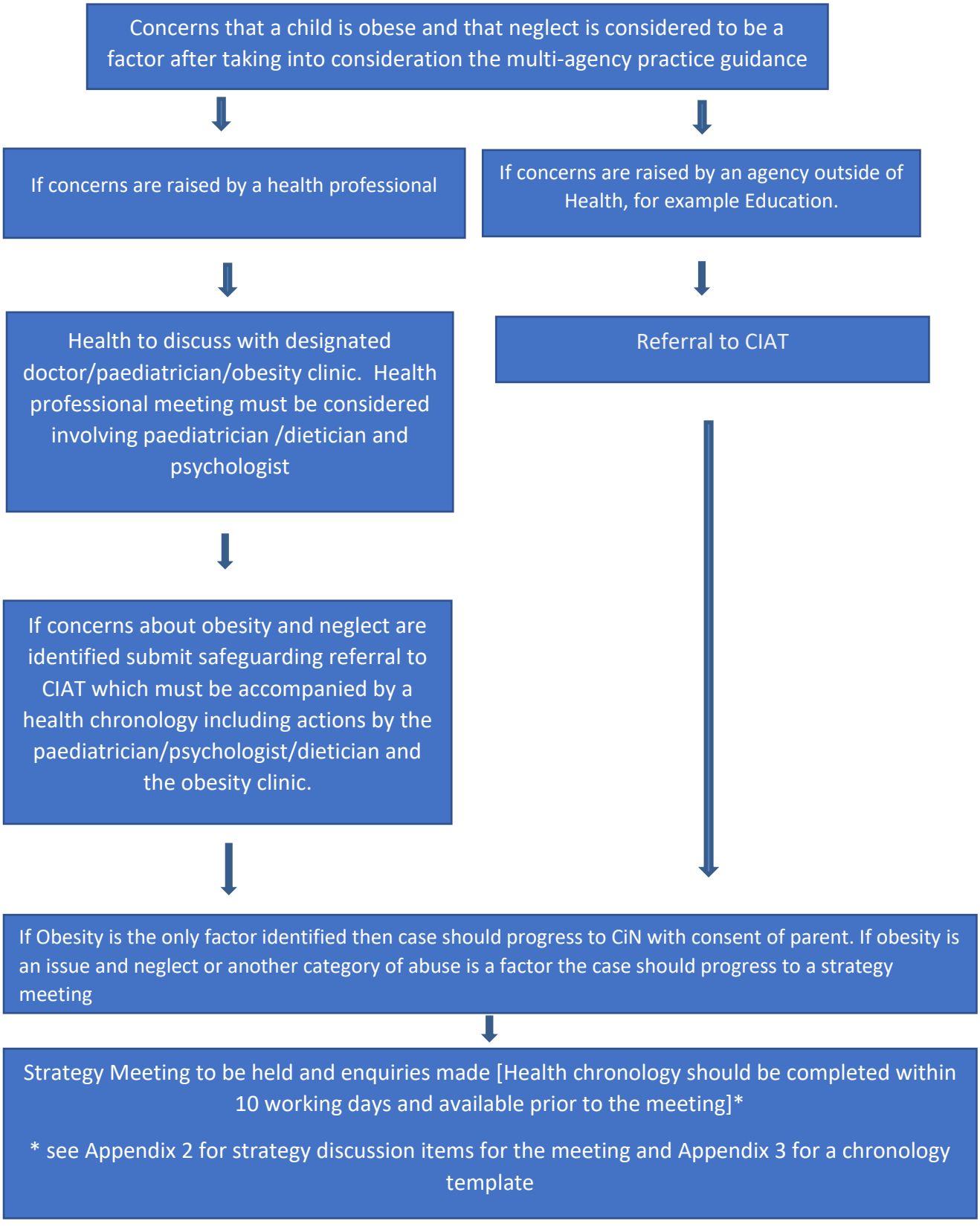
Concerns about a child should be referred to the Children's Initial Advice Team (CIAT) with the parents'/carers consent unless there are safeguarding concerns in which case consent is not required. Any practitioner considering referring a child where the safeguarding concerns are linked to obesity should consider the contents of this policy before making the referral, specifically safeguarding indicators and triggers. A balanced assessment will depend on both the medical and social assessments of the child. Most referrals are likely to come from a single agency viewpoint and each child that meets the threshold should be referred to other relevant agencies for a multi-agency approach to ensure a holistic approach.

If a case is referred by a paediatrician or other health practitioner, the referral to CIAT must include a chronology. The chronology should include the role of the obesity clinic and actions taken by the paediatrician, dietician and psychologist.

If a referral comes from another source, for example Education and obesity is the main concern, there is an expectation that health partners will provide a chronology (as above) within 10 working days as part of the assessment process. The referral pathway is outlined in **Appendix 1.**

APPENDIX 1

CHILDHOOD OBESITY AND NEGLECT FLOWCHART



APPENDIX 2

ADDITIONAL AGENDA ITEMS FOR STRATEGY MEETING

- Chronology from Health which should be submitted with the referral (if referred by Health) or within 10 working days from request by CIAT if referred by another agency.
- Chronology from education
- Chronology from social care
- Chronology from other relevant agencies involved with the family/child(ren)
- Police information
- When does CSC become visible to the family [if not actively involved with the family/child(ren)
- What information is shared with the parents/carers, how and when is this to be done and by whom [this is not the sole responsibility for CSC in all cases]
- Timescales for agreed actions
- Has a crime been committed and is there an immediate safeguarding response required.

APPENDIX 3

Chronology:

Name: DOB:

Address:

Agency: Author:

Date dd/mm/yy	Time 00:00 (24hr)	Significant Event	Agency	Whose Professional/ Agency Records (Source)?	Who was involved?	Decisions/Outcome including any actions taken	Child seen/views sought: Yes/No (record the child's views)	Author Comments

Name:	This is the name of the child
DOB:	This is the child's date of birth
Address:	This is the address of the child
Agency:	This is the agency sharing the information
Author:	This is the name of the author of the chronology
Date:	This is the date the episode event is said to have taken place (not the date of recording)
Time:	This is the time the episode event is said to have taken place (not the time of recording)
Significant Event:	The significant piece of information e.g. police log of reported incidence of domestic violence: report from school that child arrives from home hungry, unkempt and tired: missed medical appointments: allegation of non-accidental injury: anonymous referral regarding child left unsupervised: Section 47 enquiry etc.
Agency:	The record from which the information was obtained, e.g. social work record, health visiting record, school nursing record, police record, probation record, etc.
Whose Professional Records:	Details of whose professional records you are referring to i.e. source of information
Who was involved:	Who was involved in the event, e.g. the names of each individual involved in the episode including professionals, child/ren or parent/s, carer/s other adults
Decisions/Outcomes:	Comments should inform the reader of key decisions taken, any action taken and the outcome in response to the event or episode.
Child Seen/View obtained:	Yes or No. If obtained, statement re the child's views, either expressed or observations of behaviour should be noted.
Author Comments:	To provide details of author comments relating to the episode/significant event.