Suffolk Safeguarding Partnership

Safeguarding Response to Obesity when Neglect is an Issue

Multi Agency Guidance
Designated Nurses Safeguarding Children

January 2020

Policy Version History

Version	Date of SSP Approval	Review date	Author/Reviewer
1	January 2020	January 2021	Caroline Holt, Designated Nurse Safeguarding Children NHS West Suffolk CCG, NHS Ipswich and East Suffolk CCG

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Appendices

This is multi-agency guidance to support professionals when working with children and young people when it is considered that a child's obesity may be related to neglect.

Introduction

The World Health Organization (WHO) considers that childhood obesity is reaching alarming proportions in many countries and poses an urgent and serious challenge. Obese children are more likely to be ill, be absent from school due to illness, experience health-related limitations and require more medical care than healthy weight children. Overweight and obese children are also more likely to become obese adults, and have a higher risk of morbidity, disability and premature mortality in adulthood. In England, the health problems associated with being overweight or obese cost the NHS more than £5billion every year.

Childhood obesity is one of the biggest health problems this country faces. Nearly a quarter of children in England are obese or overweight by the time they start primary school aged five, and this rises to one third by the time they leave aged 11. Our childhood obesity rates mean that the UK is now ranked among the worst in Western Europe.

The burden of childhood obesity is being felt the hardest in more deprived areas with children growing up in low income households more than twice as likely to be obese than those in higher income households. Children from black and minority ethnic families are also more likely than children from white families to be overweight or obese and this inequality gap is increasing.

Children who are obese or overweight are increasingly developing type 2 diabetes and liver problems during childhood. They are more likely to experience bullying, low-esteem and a lower quality of life and they are highly likely to go on to become overweight adults at risk of cancer, heart and liver disease.

HM Government Childhood obesity: a plan for action Chapter 2

The National Child Measurement Programme (NCMP) is an annual programme that measures the height and weight of children in Reception (aged 4-5 years) and Year 6 (aged 10-11 years) in England.

Public Health England document National Child Measurement Programme: Operational Guidance 2019

Although the NCMP only covers certain age groups, it includes the majority of children in those year groups. The participation rate in 2016/17 was 95.0%. NHS Digital reported NCMP data for the 2017/18 school year in October 2019.

National Child Measurement Programme, England 2018/19 School Year [NS]

Data from the NCMP is used to track trends in childhood obesity and identify areas with higher need of services aimed at encouraging healthy weight.

According to the ‘State of Suffolk’ Public Health Report published in 2017, data from 2016-17 indicates that Suffolk is broadly in line with the national statistics.

22.1% of Suffolk children aged 4-5 are overweight or obese.

31.7% of Suffolk children aged 10-11 are overweight or obese.

this equates to 3 Suffolk children in every 10 being obese.

Click here for more data on the National Child Measurement Programme (NCMP).

In response to the launch of the Government's childhood obesity strategy, OneLife Suffolk, aim to help local people live healthier lives by working with families, schools, businesses and other vital stakeholders.

1 in 6 children in Suffolk are obese at the point they leave primary school and are at an increased risk of becoming obese adults.

OneLife Suffolk offer a number of child weight management programmes throughout the county, funded by Suffolk County Council. Held in community venues, these programmes follow a whole-family approach involving physical activity, understanding about healthy eating and changing unhealthy behaviours.

https://onelifesuffolk.co.uk/families-and-young-people/

These programmes and the other healthy lifestyle services offered by OneLife Suffolk allow work with Government, schools, workplaces and industry to help improve the health of the Suffolk population. This will enable us to support the actions outlined within the childhood obesity strategy.

For more information about all the services offered by OneLife, see link above.

The financial costs of childhood obesity are likely to be stored up as future costs in treating and managing the arising co-morbidities in adulthood. However, there are examples of more contemporary costs – such as schools needing to purchase specialist classroom and gym equipment to accommodate the needs of obese and overweight children

The physical risks and implications of obesity are well documented (see Appendix 1), but the links to safeguarding are harder to define.

When Does Obesity Become a Safeguarding Issue?

In July 2010, the British Medical Journal published an article by Dr Russell Viner from the UCL Institute of Child Health in London, in which he and a group of child health experts, set out to review existing evidence and propose a framework for practice and is the source that links some obesity cases to safeguarding.

When does childhood obesity become a child protection issue? Dr Russell Viner

In the absence of evidence, Viner suggested the following as a framework to understand child protection concerns with children who are obese.

Childhood obesity alone is a concern, but it is not usually a child protection concern. A consultation with a family with an obese child should not raise child protection concerns if obesity is the only cause for concern. The root causes of obesity are so complex that it is untenable to institute child protection actions relating parental neglect to the cause of their child's obesity. However, professionals working with obese children should be mindful of the possible role of abuse or neglect in contributing to obesity. Older children and adolescents should be offered the chance to talk 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 at best, with the body mass index of some children falling substantially and that of others increasing despite high family commitment. As obesity remains extremely difficult for professionals to treat, it is untenable 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 indicate neglect, particularly in younger children. Parental failure to provide their children with adequate treatment for a chronic illness (asthma, diabetes, epilepsy, etc.) is a well-accepted reason for a child protection registration for neglect.

Childhood obesity only becomes a child protection concern when parents behave in a way that actively promotes treatment failure in a child who is at serious risk from obesity and when the parents or carers understand what is required, and are helped to engage with the treatment programme.

Parental behaviours of concern include consistently failing to attend appointments, refusing to engage with various professionals or approaches/advice re weight management, or actively subverting weight management initiatives. These behaviours are of particular concern if an obese child is at imminent risk of comorbidity - for example, obstructive sleep apnoea, hypertension, type 2 diabetes, or mobility restrictions. Clear 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 in 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 general practitioner or education services. This would typically require a multidisciplinary assessment, including psychology or other mental health assessment. If concerns are expressed, a multiagency meeting is appropriate.

Assessment should include systemic (family and environmental) factors. As with any childhood behaviour, understanding what maintains a problem involves understanding factors within the child and their context. Assessment of parental capacity to respond to that particular child’s needs is central to this, such as parent(s) struggling to control their own weight and eating, but they 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 other controlled environment may be useful because it allows a more detailed assessment of behaviours and parent-child interactions. However, admission removes a child from his or her wider familiar environment as well as from parents so weight loss in a controlled environment is not evidence of neglect or abuse.

It is envisaged that only a very small number of children will reach the safeguarding threshold in relation to obesity linked to neglect.

‘Neglect is characterised by the absence of a relationship of care between the parent/carer and the child and the failure of the parent/carer to prioritise the needs of their child. It can occur at any stage of childhood including the teenage years’ (Working Together 2018)

Determining what constitutes consistent failure to meet a child's needs remains a matter of professional judgement.

This guidance recognises that weight management is an emotive issue and many families struggle to maintain a healthy diet and take the recommended amount of physical activity.

Wherever possible, it is important to work with 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; in a very small minority of cases, obesity can be life threatening.

It is imperative that any parent or carer who is trying to manage their child's weight understands the risks and has access to appropriate support and guidance.

As in all areas of child health, we have a duty to be open to the possibility of child neglect or abuse in any form. When assessing such children, a comprehensive picture of the child's functioning from a health, psychological, and educational perspective is necessary.

This guidance should be read with reference to the Suffolk Safeguarding Partnership's Neglect Guidance.

https://www.suffolksp.org.uk/safeguarding-topics/neglect/

The Child & 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 minorities. For more detail visit the National Obesity Observatory website: **www.noo.org.uk**.

Consideration must be given to cultural and ethnic influences when considering obesity as a potential harm in safeguarding children. In particular 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 in regard to 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.

In the case of severe (morbid) obesity, it may have serious health implications for the child (see Appendix 1). 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, etc.), have greater school absence, healthcare attendances and hospital admissions. Obesity in childhood is often the antecedent of adult obesity, with greatly increased risks of disability, chronic ill-health and premature death.

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.
- Obesity in a child with autism or learning difficulties.
- Obesity associated with other health problems, such as blindness or arthritis which restrict mobility.
- Obesity related to steroids or other treatments known to increase risk of obesity.
- Obesity complicated by asthma, obstructive sleep apnoea, Type 2 Diabetes or other obesity-related illness.

Some families, 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.

Legal Framework, 1989 Children Act

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.

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 requires action under Section 17 of the Children Act.

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.

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.

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.

Disguised Compliance

- 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 Professionals against each other

- 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 sensationalising 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.

Identifying Children where there are Safeguarding Concerns

There are number of warning signs and indicators that will support practitioners working with children and young people to **identify safeguarding concerns for children who are visibly overweight.** 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 2 for obesity related co-morbidities).
- Continuous and persistent weight gain after obesity diagnosed.
- Unkempt appearance.
- Depression.
- Low self-esteem.
- Self-harm.
- Poor school attendance or non-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.

The Role of Professionals

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.
- Health professionals to liaise and nominate an appropriate representative to attend child protection conferences. This representative should collate health information and then disseminate information from the conference back to health professionals (both primary and secondary care).

Other Health Professionals

Health professionals including GPs, school nurses, 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, a safeguarding referral should be considered. Consideration for a multi-agency meeting with family and child may be another way of addressing the issues and alerting the family that health's interventions alone are not having any impact on weight management and that concerns may be shared with the wider children's workforce. It is vital that individual practitioners and agencies work openly and in partnership with parents and carers, and concerns should generally be discussed openly and transparently together in meetings where parents and carers are present and able to contribute.

Education

Schools who 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 MASH should be made. 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 protection conferences and/or core groups, should ensure that they record on a regular basis any information that the child gives them regarding their eating patterns so that they can report on whether or not parents are being compliant with the CP Plan. Consideration should be given to the impact of obesity on the child's emotional wellbeing 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.

Social Care

Social workers – including frontline staff, their managers, and conference chairs – with caseloads of 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 a particular agency/agencies to be identified quickly and challenged. Parents/care givers 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/drinks.
- Independent Reviewing Officers working with Looked After Children (LAC) 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.

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

Referrals and Risk Assessment

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.

Any professional considering a referral for a child where the safeguarding concerns are linked to obesity should consider the contents of this guidance before making the referral, specifically around safeguarding indicators and triggers.

To aid professionals in making this decision an analysis tool has been developed for health professionals/clinicians and is attached to this guidance as Appendix 2. This information should be included on the Multi-Agency Referral Form (MARF) or attached to the referral as an addendum.

mash Suffolk Multi Agency Safeguarding Hub

To discuss a case and seek advice, you can contact the Suffolk MASH Professional Consultation Line, 09:00-16:25 Monday to Thursday on 0345 6061499.

Alternatively, you can use the MASH Webchat service. Webchat enables you to seek professional advice from MASH using your PC/laptop/smartphone. For further information about how to use this service, please click on the link below.

https://www.suffolksp.org.uk/concerned

To Make a Referral:

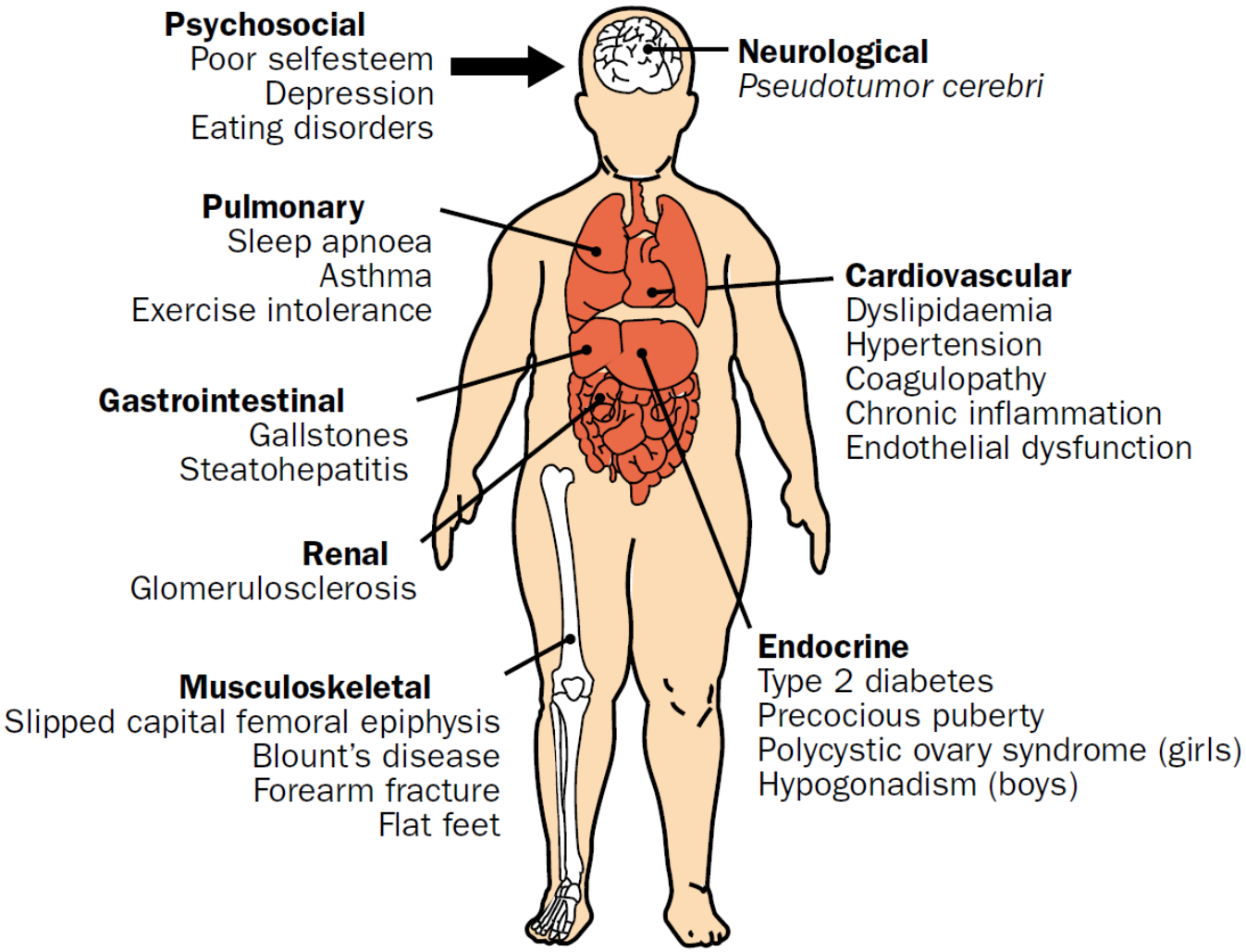
A Multi-Agency Referral Form (MARF) **must** be completed and submitted using the secure Suffolk Children and Young People's Portal. You can access the Portal here:

Access the Secure Suffolk Children and Young People's Portal

The first time you complete a form you will be asked to create a new portal account. It's quick and easy to register for an account. To make sure the information you send to us is secure, you will need to log into this account every time you access the portal.

There are user guides and video guidance available if you need help using the portal.

Appendix 1: Physical Risks and Implications of Childhood Obesity



Ebbeling CB, Pawlak DB, Ludwig DS. Childhood obesity: public-health crisis, common sense cure. Lancet 2002;360:473-82.

Appendix 2: Analysis tool, Impact of obesity on safeguarding (Health Professionals/Clinicians)

Suffolk Safeguarding Partnership

Name of Referrer			
Referrers agency			
Name of Child			
School/Other Education (please specify)			
General	**Response**		
Are the parents / carers aware of this referral?	YES	NO	
Are the parents likely to be receptive to support?	YES	NO	
Identifying Obesity	**Response**		
Has the child been formally diagnosed as Clinically Obese?	Yes	No	Not Known
Are you or your agency actively recording the child's weight and height?	YES	NO	
If not please detail your concerns about the child's obesity?			
Is the child currently engaged with Children's Services?	Yes	No	Not Known
Is the child on a weight management plan?	Yes	No	Not Known
Has the child made any progress on the plan?	Yes	No	Not Known
Are there any other Child Safeguarding Concerns?	Yes	No	Not Known
Co-Morbidity Factors	**Prognosis**		
Are you aware of any co-morbidity factors?			
Asthma			
Sleep apnoea			
Joint problems			
Weight related injuries (Sprains, Breaks etc)			
Incontinence			
Skin conditions			
Diabetes			
Other (Please Specify)			

General Observations on Safeguarding Triggers				**Comments and details**
Parents/carers lack capacity to engage	Y	N	Not Known	
Parents/carers unwilling to engage	Y	N	Not Known	
Concerns about Deceptive Compliance	Y	N	Not Known	
Parents/carers play one professional off against another.	Y	N	Not Known	

Child's outcomes are compromised by weight gain, e.g. social presentation/interaction with peers/educational attainment	Y	N	Not Known	
Concerns escalating over time (Specify time period)	Y	N	Not Known	

Appendix 3: Suffolk OneLife Tier 2 and 3 Access Criteria

TIER 2 (2 – 18 YEARS)

Access Criteria:

- Children and parents/guardians of children aged 2-18 years with a BMI>91st Centile.
- Focus on enabling clients from the 40% most deprived LSOA's to access the service.
- Young people aged 16-18 years are also able to access the adult weight management service if more appropriate – see AWM pathway.
- Enquiry received for weight management support via: School Nurses; Self-referral; GP; Other Health Professional (incl. Midwife, Health Visitor); Social Care (Incl. OT's, Social Workers); Outreach/Community Events.

Exclusion Criteria:

- Children, young people and families who live outside the geographical boundaries of Suffolk.
- Children and young people who are under the 91st BMI centile.
- Children and young people who are not within the age criteria (2-18 years old).
- Individuals with an underlying medical cause for obesity who would benefit from more intensive clinical management than a tier 2 service – see Tier 3 access criteria (page 3).
- Individuals with diabetes treated by Insulin.
- Active Eating Disorder or active Psychosis.
- Active Substance Abuse Disorder (SUD) including Alcohol.
- Individuals who have undergone Bariatric Surgery in the last 12 months.
- Individuals with more complex needs such as learning difficulties and mental health issues should be considered on a case by case basis by multi-disciplinary team.

TIER 3 (5 – 18 YEARS)

Access Criteria:

Children and young people aged between 5 – 18 years who have: BMI>91st centile one of the following:

- Emotional or behavioural issues (e.g. some autism spectrum disorder and attention deficit hyperactivity disorder and/or a documented history of violent behaviour), learning disability, and Prader-Willi syndrome.
- Children and young people who have previously accessed a tier 2 service and subsequently identified as requiring more intensive support, parent/carer has a history of an eating disorder, complex medical history including co-morbidities, complex social history.
- BMI>95th centile without comorbidities or complex needs.

- Focus on enabling clients from the 40% most deprived LSOA's to access the service.
- Enquiry received for weight management support via: School Nurses; GP; Other Health Professional (incl. Midwife, Health Visitor); Social Care (Incl. OT's, Social Workers); and Outreach/Community Events.

Exclusion Criteria

- Children, young people and families who live outside the East and West Suffolk CCG boundaries.
- Children and young people who are under the 91st BMI centile.
- Children and young people who are not within the age criteria of 5 – 18 years old.
- Active Psychosis.
- Active Substance Abuse Disorder (SUD) including Alcohol.