Safeguarding Response to Obesity when Neglect is an Issue

1. Introduction

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

This policy should be read with reference to the **relevant Threshold document**, **Neglect strategy** and consideration of the **Perplexing Presentations & Fabricated and Induced Illness/Disorders in Children**.

The management of obesity is complex and challenging. Obesity in childhood is a significant public health issue. 22.7% of children/young people measured at year 6 were either overweight or obese in England in 2022/2023 **PHE data**. Obesity is the greatest risk factor for **Type 2 diabetes** and the rates for Type 2 diabetes have risen significantly over the last decade. Obesity is also a risk factor for cardiovascular disease and cancer **Childhood obesity foundation**.

The World Health Organisation and American Medical Association recognise obesity as a disease. The root causes of obesity are complex, and obesity remains difficult for practitioners to treat once established. Obesity is caused generally by a long-term positive energy balance related to changes to modern diets and a reduction in the level of activity. The National Institute for Health and Care Excellence (NICE) produced guidance in 2014 (updated in 2023) **NICE guidance Obesity** and an updated population-level approach to prevention in 2015 **NICE Prevention**.

Weight management is an emotive issue, and many families struggle to maintain a healthy diet and take the recommended amount of physical activity. This is on a background of a modern lifestyle with diets high in processed food and sugar, availability of sugary drinks, food advertising and sedentary activities resulting in reduced 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/young person's outcomes in several 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.

However, practitioners working with obese children/young people should be mindful of the possible role of abuse or neglect in contributing to obesity. When assessing such children/young people, a comprehensive picture of the child/young person's functioning from a health, psychological, and educational perspective is necessary and older children/young people and adolescents should be offered the chance to talk apart from their parents to explore their understanding of their weight issues (**Framework for practice**). This should be as for any clinical condition which is having a significant impact on health and wellbeing of a child/young person.

2. The Child/Young Person and their Family

Obesity is the most common nutritional disorder affecting children/young people and is much more common in families living in poverty and those from some ethnic minorities (**National obesity observatory**).

Consideration must be given to cultural and ethnic influences when considering obesity as a potential harm in safeguarding children/young people. 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.

In addition to the physical consequences of obesity, children/young people experience significant emotional and psychological distress. Teasing and discrimination is not uncommon, with resultant low self-esteem anxiety and depression.

Obese children/young people 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 is often the harbinger of adult obesity. 79% of adolescents who are obese are likely to remain obese as adults. Being overweight or obese in childhood has both short-term and longer-term consequences for health, with greatly increased risks of disability, chronic ill-health and premature death. Moreover, once severe, obesity is very difficult to treat effectively. Obesity can be a result of an eating disorder that requires management through child and adolescent mental health services.

Morbid obesity may have serious health implications for the child/young person **Complications of obesity** (see Appendix 1 below). The health risks increase with duration and severity of obesity and in rare instances may have a fatal outcome.

Obesity may be part of a more complex health problem, which further jeopardises a child/young person's wellbeing.

Examples include obesity:

- In a child/young person with a genetic condition, such as **Prader-Willi Syndrome**.
- In a child/young person 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.

Some families and even practitioners working with the family will use the attendant health issues to justify, explain or excuse the child/young person's obesity and whilst a medical condition may be an additional challenge it should be considered in the context of the parent's

engagement. The dual diagnosis of obesity and another health condition may place additional strains on a family's ability to cope and amplifies the risks to the individual child/young person. It is this group of children/young people in whom obesity most commonly becomes a safeguarding concern. It is important to consider these cases under Management of Complex Health Issues Management of Complex Health Issues and Appendix-Care Pathway

. It is imperative to use professional judgement when considering each case.

3. Legal Framework, 1989 Children Act

Where there is clear medical advice that the child/young person is likely to suffer or is suffering significant harm because of 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/young person, then the case requires action under Section 47 of the Children's Act.

Where there is medical evidence that the child/young person 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's Act.

Case management should be regularly reviewed to ensure that the risks to the child/young person's health and wellbeing are monitored carefully to ensure appropriate and timely actions are taken under the legal framework.

4. When does obesity become a safeguarding issue?

Childhood obesity can become a child protection concern if parents fail to provide their child adequate treatment or when parents behave in a way that actively promotes treatment failure, as with any chronic illness in a child/young person. **Russell Viner in an article published in the British Medical Journal (21.8.10, Volume 341)** proposed a framework for practice.

Parental behaviours of concern include:

- Consistently failing to attend appointments.
- Refusing to engage with various practitioners or with weight management initiatives; or
- Actively not follow weight management initiatives.

These behaviours are of particular concern if an obese child/young person 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 therefore it is essential to evaluate other aspects of the child/young person's health and wellbeing and determine if concerns are shared by other practitioners such as the family GP or education services. This will require a multi-agency collaborative assessment, including psychology or

other mental health assessment. If concerns are expressed, a multi-agency meeting is appropriate.

Assessment of parental capacity to respond to that particular child/young person'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. Admission to hospital or another controlled environment may be useful because it allows a more detailed assessment of behaviours and parent-child interactions. However, admission removes a child/young person from his or her wider familiar environment as well as from parents so weight loss in a controlled environment needs to be evaluated carefully and although on its own is not evidence of neglect or abuse does indicate the potential for the child/young person to be able to avoid gaining weight.

5. 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/young person's overall health, safety and wellbeing.

Lack of capacity to engage

- Parents/carers unable to effectively provide for their 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
- Transient or intermittent engagement
- 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
- Actively frustrating efforts of practitioners or child/young person to reduce weight gain
- Oppositional behaviour: parents/carers unable/unwilling to set and maintain boundaries with their child to manage lifestyle changes and allow further weight gain.

Parental Agreement

- Parents/carers appear to follow advice, but are not making any changes to lifestyle which would make a significant difference to their child's wellbeing
- Parents/carers unwilling/unable to model appropriate behaviour to facilitate lifestyle changes
- Parents/carers playing one practitioner off against another
- Agencies need to be aware of how parents/carers can distract practitioners both within one agency and across agencies from focusing on their child by favouring one agency/practitioner 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 practitioners
    - 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. Practitioners need to be cognisant of the child's needs and prepared to challenge both parents and other practitioners working with the child/young person/family.

6. Identifying Children/Young People where there are Safeguarding Concerns

There are number of warning signs and indicators that will support practitioners working with children/young people to **identify safeguarding concerns for those who are visibly overweight**. The following list should be considered in the context of the child/young person'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 co-morbidities)
- 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.

7. The role of the Local Safeguarding Children Partnership (LSCP) & Individual Organisations where there are safeguarding concerns identified

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

must be alert to these children/young people, 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.

8. Paediatricians

It is important that the child/young person'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/young person to maintain a healthy weight and active lifestyle. It is important that the paediatrician ensures health provision is well co-ordinated and there is good communication between those involved.

Where an obese child/young person 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. In order to do this the local clinical obesity pathway should be consulted or there should be a referral to the GP for clinical assessment.
- If a paediatrician is allocated the paediatrician or a representative should aim to 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. There should be reflection upon the child's weight and the impact on not only their current but future health. This should be explicit within the child protection plan.
- In identified safeguarding cases, consideration should be given to appointing the paediatrician as medical lead for all the child/young person's presenting conditions particularly where there are co-morbidity concerns There should be regular communication with the child/young person's GP to assess whether any other arising health concerns are considered. This principle should be applied for any health practitioners responsible for primary care, such as school nurses or health visitors, to ensure that the paediatrician maintains a holistic overview of the risks.

9. Other Health Practitioners

All other health practitioners who are involved in caring for a child/young person should be mindful of the differences 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 a health practitioner recognises 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.

10. Education

Schools who have concerns about a child/young person's weight must establish that their 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/young person 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/young person's weight and **should not rely solely on the health professionals' interventions**. If the child/young person'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/young person 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/young person gives them regarding their eating patterns so that they can report on whether parents are being compliant with the CP Plan. Consideration should be given to the impact of obesity on the child/young person'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/young person 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.

11. Social Care

Social workers – including frontline staff, their managers, and conference chairs – with caseloads of children/young people 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 CP 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/young person'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/young people (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/young person in their care makes appropriate progress.

12. 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/young person is considered likely to suffer significant harm (Section 47 of the Children/young people 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/young person would ordinarily be considered under Section 1(1) of the Children/young people 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 must 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/young person and information sharing will be crucial to any action taken by police.

Whilst not prescriptive, the below should be considered as the threshold to police involvement.

1. The child/young person 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/young person's health **AND**
5. The child/young person is likely to be caused unnecessary suffering or injury to health.

It will be 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 (e.g. **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.

13. 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/young person is the priority, and it is everyone's responsibility to act on their concerns. It is likely that practitioners will have attempted to engage families over a period of time.

Concerns should be raised with the **relevant MASH/IFD/Hub**, with the parents'/carers consent unless there are significant safeguarding concerns (see Legal Framework above). Any practitioner considering referring a child where the safeguarding concerns are linked to obesity should consider the contents of this guidance and refer to the **relevant Threshold Guide** before making the referral, specifically safeguarding indicators and triggers.

To aid practitioners in making this decision an analysis tool has been developed and is attached:

- **Appendix 2: for health practitioners/clinicians**
- **Appendix 3: for all other children's workforce staff**
- **Appendix 4: An intervention scale to assist the decision makers in agreeing actions.**

See also:

Appendix 1: Childhood overweight and obesity is a critical risk factor for a range of health and social consequences summarised.

A Serious Case Review was undertaken in Manchester (2018) in relation to obesity **https://safeguarding.network/content/wpcontent/uploads/2019/09/2018ManchesterChildF1Overview.pdf**