Swindon Safeguarding Partnership Response to Childhood Obesity in the Context of Neglect: Policy and Practice Guidance.

Date:	December 2024
Review Date:	December 2026
Document Author:	Charlotte Hinder, SBC Named Nurse for Safeguarding 0-19.
Document Owner:	Swindon Safeguarding Partnership

Please note: If a child appears ill or seriously injured, seek emergency treatment immediately and notify children's social care of your concerns.

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Introduction

The World Health Organisation (WHO) considers that childhood obesity is reaching alarming proportions in many countries and poses an urgent and serious challenge. Locally we are seeing rising obesity rates among year six students, significantly exceeding regional averages. Data shows us that the prevalence of obesity among children and young people in Swindon increases with age and that around 80% of adolescents with obesity will continue to be so in adulthood. Whilst it is common that children are an unhealthy weight it is rare that it is linked to a safeguarding concern.
Children with obesity alone are not a child protection concern nor is failure to reduce weight but rather a consistent failure to change and engage with support or if it is identified as part of wider concerns around neglect or emotional abuse.
The 2010 Russell Viner et al, framework helps identify safeguarding concerns

Children with obesity 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 National Health Service (NHS) more than £5 billion every year.

The burden of childhood obesity is being felt the hardest in the more deprived areas with children growing up in low-income households and living in the most deprived areas in England more than twice as likely to be living with obesity compared to those living in the least deprived areas. Those children living with severe obesity are 3-4 times more likely to be living with severe obesity compared to those living in the least deprived areas. Children from Black and minority ethnic families are also more likely than children from white British families to be overweight or obese but are also more likely to experience deprivation 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, social isolation, low self-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 patterns and trends in child obesity in England 22/23

The fundamental cause of obesity is an energy imbalance between calories consumed and calories expended. However, the reasons underpinning the development of obesity in individuals are complex and challenging and the condition remains very difficult to treat. The National Institute for Health and Care Excellence (NICE) published Guidance for assessing, identifying and managing Obesity in 2014 (updated 2022).

Weight management is a complex and emotive issue for both families and practitioners, 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 foods 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. Obesity can affect a child's academic achievement and emotional well-being, as well as their physical health, and in a minority of cases obesity can be life threatening. It is therefore

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.

Professionals working with children with obesity / young people should also be mindful of the possible role of abuse or neglect in contributing to obesity. When assessing such children, a comprehensive picture of the child's functioning from a health, psychological, and educational perspective is necessary and older children and adolescents should be offered the chance to talk apart from their parents to explore their understanding of their weight issues – as for any clinical condition which is having a significant impact on the health and well-being of a child.

1. When Does Obesity Become a Safeguarding Issue?

In isolation, Obesity, or failure to lose weight, is not necessarily a safeguarding concern. However, consistent failure to change lifestyle and engage with outside support can indicate neglect, especially in younger children and obesity may be part of wider concerns about neglect or emotional abuse. We may need to take into consideration:

- Availability of services locally
- Lack of parental resources
- Parental physical and mental health issues
- Obesity may be part of wider concerns about neglect or emotional abuse.

Parental behaviours of concern would include:

- Consistent failure to present the child for health appointments
- Refusal to engage with practitioners or dedicated health plans.

These behaviours are of particular concern if a child with obesity is at imminent risk of co morbidities – for example, obstructive sleep apnoea / hypopnea syndrome, hypertension, type 2 diabetes or reduced mobility.

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's General Practitioner or education services. This approach requires multi-agency collaborative assessment, including psychological or other mental health assessment.

Assessment should include family and environmental factors. Assessment of parental capacity to respond to a particular child's needs is central to this, such as parental learning difficulties, or parents / carers struggling to control their own weight and eating, but these 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 from their 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 it does indicate the potential for the child to be able to lose or avoid gaining weight.

The 2010 Russell Viner et al, framework helps identify safeguarding concerns

2. The 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 certain ethnic minorities.
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 systems, 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. It is essential to assess the individual there is no straightforward relationship between obesity and ethnicity, with a complex interplay of factors affecting health in minority ethnic communities in the UK. Practitioners should be mindful of making sweeping generalisations for 'Black ethnicity' as an example, when practices and diets in Black Caribbean and Black African communities may vary greatly.

Disabilities, learning difficulties and Neurodiversity

Consideration too must be given to any disabilities, including learning difficulties or neurodiversity, affecting family members, which may influence the support required to enable them to successfully implement changes to improve health outcomes for the child.
When working with children with a pre-existing physical disability consideration is needed regarding equipment weight limits. This is of particular importance for young people who use walking aids and other equipment. Obesity can mean a young person loses their independence and becomes reliant on wheelchair mobility.

Health Implications

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 can experience significant emotional and psychological distress. Bullying 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. Children with obesity are more often ill, experience more day-to-day health issues (e.g. breathlessness, discomfort, fatigue, etc.), have greater school absence, health care 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 as part of a complex health problem

Obesity may be part of a more complex health problem, which further jeopardises a child's wellbeing. Examples include but are not exclusive to:

- 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 can restrict mobility.
- Obesity related to steroids or other treatments known to increase the 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.

3. Autism / Neurodiversity and Eating Challenges

For non-autistic people, issues with weight, body image, trauma and mental health often contribute to the development of disordered eating. For autistic people, the reasons can be different and may include:

- Sensory differences related to food (including not recognising hunger or fullness, known as interoception)
- A need for control and familiarity (such as restricted eating)
- Using food to manage difficult emotions – made harder if you have alexithymia (difficulty recognising and understanding emotions).
- Sensory sensitivity. In the context of eating this means being more or less sensitive to how foods: look, smell, taste and feel.
- Cognitive factors. Cognitive rigidity and the 'desire for sameness' may result in adherence to particular foods, routines or rituals.

The pattern of food refusal is usually present by age 2 and by school age, typical number of foods eaten frequently reduces to as few as 5-10. These tend to be foods from categories that are perceptually similar, for example, 'beige carbohydrates' or foods with manageable textures 'smooth yoghurts no bits'. www.autism.org.uk

4. 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 that of obesity or obesity related issues, as well as evidence that the care giver/s 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's 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's Act.

Case management should be regularly reviewed to ensure that the risks to the child's health and well-being are monitored carefully to ensure appropriate and timely actions are taken under the legal framework.

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'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 rate of increase does not slow.

Unwilling to engage

- Not attending health 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 their weight continues to increase.
- Actively not supporting or engaging with efforts of professionals or child to reduce weight gain.
- Oppositional behaviour: parents/carers unable/unwilling to set and maintain boundaries with child to maintain lifestyle changes and allow further weight gain.

Disguised Compliance

Indicators of disguised compliance can 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 change.
- 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 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/carers and other practitioners working with the child / family.

6. 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 identified as obese.
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 disorder (or diseases), whether related to obesity or not (see appendix 2 for obesity related co-morbidities).
- Continuous and persistent weight gain after obesity diagnosed.
- Unable to access equipment for independent mobility.
- Unkempt appearance.
- Depression.
- Low self-esteem.
- Self-harm
- Poor school attendance or non-attendance.
- Socially isolated
- Parents/carers not engaging with 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 Professionals

Professionals 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 focussed, co-ordinated, and shared appropriately.

Medical Practitioners (Which include Paediatricians and GP's)

In the same way that obesity, or failure to lose weight, is not necessarily a child protection concern in isolation, it is important to note that obesity in itself is not cause for a referral for secondary care / treatment. It is important not to over-medicalise obesity. Paediatricians will only become involved where there are concerns regarding medical complications, which require specialist management.

It is important that a child is holistically assessed, this will include assessing the child's health needs, and where possible, the assessment of any environmental / socio economic factors that are having a negative impact on their weight gain or loss. This information facilitates an assessment of the parent / carers ability to support the child to maintain a healthy weight and active lifestyle. It is important that paediatricians involved in the child's care are part of a coordinated package of care and that relevant information is shared with all relevant professionals involved.

Good communication between primary and secondary care practitioners is essential in order to facilitate a clear plan of care.

Other Health professionals / services

All health professionals who are involved in caring for a child including School Nurses, Health Visitors and Paramedics, 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 a professional recognises that their interventions alone are not having an impact on the weight management and the health risks are escalating, they need to ensure that concerns are shared with the wider children's workforce, including consideration of a referral to a paediatrician / GP.

Mental Health

There is an association between obesity in children and an increased risk of mental health issues such as anxiety, and low self-esteem. It is important that any mental health needs are considered, and appropriate support offered / referrals made. The proportion of young people with obesity with emotional difficulties such as depression and anxiety, is around twice that observed for young people with a health Body Mass Index (BMI) (19% vs 10%).

Kokka I, Mourikis I, Bacopoulou F. (2023) Psychiatric Disorders and Obesity in Childhood and Adolescence - A systematic Review of Cross-Sectional Studies. Children (Basel)

Education

Schools (including early years settings) who have concerns about a child's weight must establish that the child's health is being managed and with parent's consent, confirm with health colleagues that an appropriate weight management programme is in place, signpost for support or gain consent to refer to an appropriate service. If consent is not gained seek advice from your Designated Safeguarding Lead who will then review and advise on what further steps should be taken.

The school or early years setting educate children about the importance of healthy eating and regular physical exercise and are therefore in a good position to monitor the day-to-day impact of persistent weight gain and the parent / carers' ability to manage the child's weight. They could provide examples of healthy snacks and lunchboxes, invite the child to attend extra curricula sports and physical activities. If the weight continues to cause concerns and the indicators above are identified, a referral to Children's Social Care should be made.

Oral Health

Professionals working within the scope of oral health need to consider the link between dental caries and obesity as two of the most prevalent health conditions affecting children. Consumption of free sugars is a risk factor both for dental caries and obesity. Poor oral health can affect children's ability to sleep, eat, speak, play and socialise with other children. Other impacts include pain, infections, and impaired nutrition. Practitioners should consider these factors alongside the safeguarding trigger points.

Public Health England (2015) The relationship between dental caries and obesity in children; an evidence summary

8. 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

Concerns should be raised with Contact Swindon with the parent/ carers consent (unless there are significant safeguarding concerns – see legal framework above). Any professional considering referring a child where the safeguarding concerns are linked to obesity should consider the contents of this policy, including the Neglect Screening Tool and refer to The Right Help at the Right Time Guidance before making the referral, specifically the safeguarding indicators and triggers.

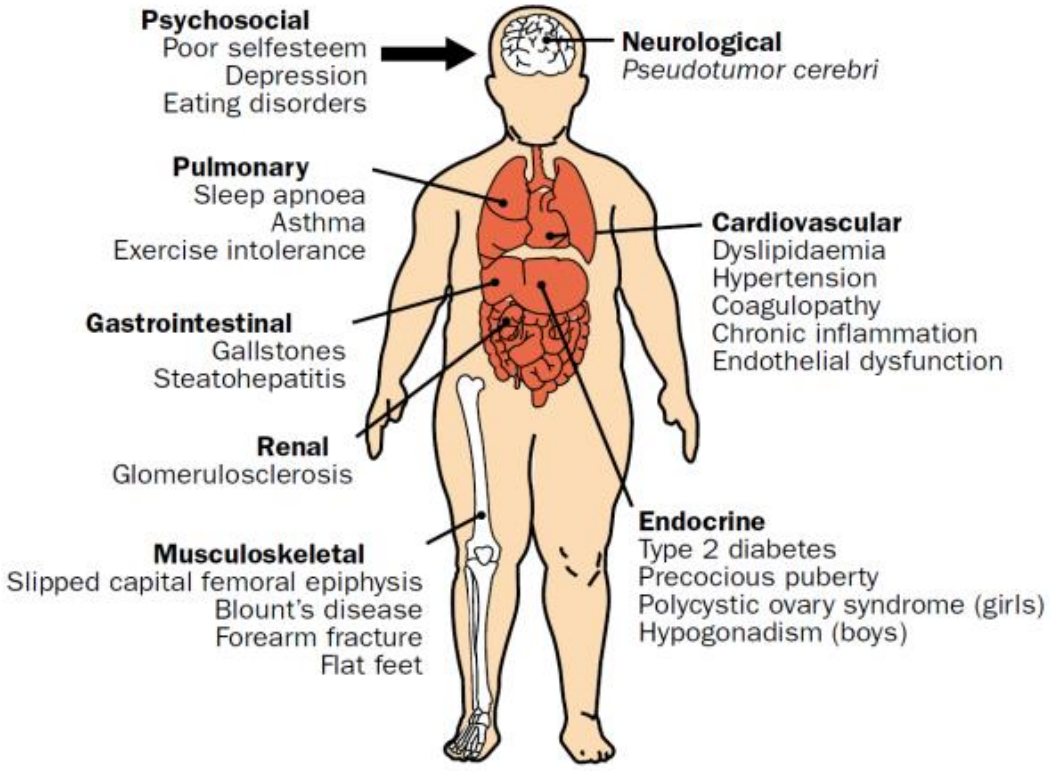
Contact Swindon

Telephone: 01793 464646

Email: Contactchildrenandfamilies@swindon.gov.uk

Referrals by professionals are made using a request for help and support form.

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: Neglect screening tool

Person completing this form			
Name, Agency & Role		**Date Completed**	
Have you discussed your concerns with parent/carer?		**Yes**	**No**

Child's Details			
Child's Name		**Address**	
DOB or EDD		**Details of any siblings/step siblings living in the home**	
Mother's Name		**Mother's Contact Details**	
Father's Name		**Father's Contact Details**	

Carer's Name and Contact Details (if not living with parents)	

Category: **Emotional and behaviour**	Very concerned	Sometimes concerned	Not concerned	Not Known
Relationships with peers/support networks are poor				
Child feels or is excluded by family				
Evidence of emotional withdrawal				
Attachment disorder: anxious, avoidant, socially unresponsive				
High criticism, low warmth from parent/ carer				
Non-biological partner appears to resent the child				
Child seeks inappropriate Physical comfort from a stranger/professional *(please specify which)*				
Under-stimulation evident				
Exposed to inappropriate films, websites, games or materials				

Shows reluctance to go home				
Self-harm				
Episodes of missing or running away				
Child has Inappropriate carer responsibilities for other family members				
Emotional and Behaviour Issues Noted? Please Provide Details:	**Yes**	**No**	**Not Sure**	
Any additional comments/analysis:				
Category: Environmental factors	**Very concerned**	**Sometimes concerned**	**Not concerned**	**Not Known**
Human and animal excrement				
Unsafe unhygienic home environment				
Little or no bedding/furniture				
Rural isolation/Poverty				
Animals pose a level of risk				
Poor housing				
Unidentified adults or young people in the home				
Inadequate supervision in and outside of the home				

Environmental Factors Issues Noted? Please Provide Details:	Yes	No	Not Sure	
Any additional comments/analysis:				
Category: Health/Physical Care	**Very concerned**	**Sometimes concerned**	**Not concerned**	**Not Known**
Frequent attendance at Emergency Department and/or hospital admission				
Delay in seeking medical care & attention				
Failure to Thrive, *e.g. poor weight gain* / Faltering Growth *e.g. nutrition*				
Dietary concerns including obesity				
Untreated or persistent head lice or other infestation				
Refusing help/services				
Poor personal hygiene of child				
Substance abuse of child/adult/household member				
Continuously failing appointments, not addressing health needs/treatments				

Inappropriately dressed for time of year clothes are not clean and do not fit.				
Not Registered with a G.P				
Dental hygiene poor/not registered with a dentist				
Health/Physical Care Issues Noted? Please Provide Details:	**Yes**	**No**	**Not Sure**	
Any additional comments/analysis:				
Category: Parenting	**Very concerned**	**Sometimes concerned**	**Not concerned**	**Not Known**
Poor inappropriate family support				
Inappropriate language/poor boundaries for own behaviour				
Fails to give child appropriate boundaries for behaviour				
Lack of supervision by carer				
Substance misuse				
Parental learning disability impacting on parenting				
Disguised compliance - involves a parent or carer giving the appearance of co-operating with agencies to				

avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention				
Aggressive or threatening behaviour towards professionals				
Leaving children with inappropriate carers/babysitters				
Unsure of child's whereabouts				
Lives from day to day *(e.g. lack of forward planning)*				
Unrealistic expectations of child				
Parenting Issues Noted? Please Provide Details:	**Yes**	**No**	**Not Sure**	
Any additional comments/analysis:				

Category: Education	**Very concerned**	**Sometimes concerned**	**Not concerned**	**Not Known**
Non-attendance at school/nursery/college				
Developmental delay				
Inadequately prepared for nursery/school/college				

Lack of parental/carer engagement with nursery/school/college				
Withdrawn/lethargic				
Unexplained extremes of behaviour				
Educational Needs Issues Noted? Please Provide Details :	**Yes**	**No**	**Not Sure**	
Any additional comments/analysis:				

Category: Feeding and eating	**Very concerned**	**Sometimes concerned**	**Not concerned**	**Not known**
Little or no food in cupboards				
Stealing/scavenging food				
Presents at nursery/school/college as hungry				
Does not have a breakfast				
Excessively hungry				

Inadequate / Inappropriate diet				
Excessive weight gain/weight loss				
Inadequate area to prepare food				
Food and Eating Habits Issues Noted? Please provide details:	**Yes**	**No**	**Not Sure**	
Any additional comments/analysis:				

Have you identified an immediate safeguarding concern?	**Yes**	**No**
Date RF1 sent to MASH:		
Have you identified an unmet need within the family?	**Yes**	**No**
If you answered 'Yes' is your service able to provide the appropriate support?	**Yes**	**No**
If you answered 'No' what are your next steps? Please provide details:		

If your concerns need referring to Contact Swindon, please attach this screening tool to the Request for Help and Support Form when making the request.
Please note this tool should always be sent with a referral form and not in isolation.
For further information, please refer to the SSP webpage Request for help and support guidelines and contact information - Swindon Safeguarding Partnership

Appendix 3: Chronology

The purpose of a chronology is to record significant events that have had, or continue to have a significant impact (positive or otherwise) on the child.

Further guidance on completion can be found in SSP chronology guidance - Swindon Safeguarding Partnership

Name of Child or Young Person:
Date of Birth:

Date or period of significant event	**Significant Event** *Information recorded should be a brief description, concise, clear, factual, accurate and evidence based to support good decision making*	**Source of the event -** *i.e. who and what service/agency provided the information***.**	**Impact on the child** *(either positive or negative. If unknown please specify) this may change/ become clearer over time.*	**Action Taken to mitigate adverse impact on child.** *Include if single practitioner/service/agency response and multi-agency responses. If no action taken, please specify why.*	**Date of Entry** *(when recorded on system – highlight if this is a retrospective entry)*