October 2016

Working with Neglect

Inter-agency Practice Guidance

Nottinghamshire SAFEGUARDING CHILDREN Board

NOTTINGHAM CITY Safeguarding Children BOARD

Contents

1. Introduction

The most common category for a child being made subject to a child protection plan is neglect, both regionally and nationally. Willful neglect is a criminal offence and can be life-threatening: in the NSPCC's review of Serious Case Reviews 2009-2011, it was identified as the dominant factor in 60% of the reviews examined.

In March 2014, Ofsted published a report entitled "In the child's time, professional responses to neglect", which includes reference to the considerable body of research identifying the potential emotional and physical damage which can be caused to children due to neglect.

> All aspects of children's development can be, and are, adversely affected by neglect, including physical and cognitive development, emotional and social well-being and children's mental health and behaviour. For some children the consequences of neglect are fatal." Ofsted 2014

This practice guidance is issued as supplementary guidance and does not replace the Nottingham City and Nottinghamshire Interagency Safeguarding Children Procedures. http://nottinghamshirescb.proceduresonline.com/ It is for the use of all those who work with children, young people and families across all agencies and settings. Its aim is to support practitioners in their assessments to form professional judgments and to promote the best outcomes for children and young people. It seeks to highlight the importance of working in a *think family* way across adult and children's services; specific guidance for professionals working with adults who are also parents is included in Chapter 7. When working with families where neglect has been identified as a concern, professionals should be aware of the need to consider the impact of adults' problematic behaviours (such as substance misuse, domestic abuse and mental ill-health) on the children in their care: **think child, think parent, think family.**

1.1 The effects of neglect

Neglect can be far-reaching in its consequences for a child. Not only will the experience of it make a child's life miserable but it can affect all aspects of their development. It is also likely to influence the relationships they make with others in both early and later life and have an impact on how they parent their own children. Early recognition and prompt intervention are therefore crucial.

The main areas of impact on a child will depend on how early the neglect occurs, but neglect can have lifelong effects, potentially leading to the following:

1.2 Health and physical effects

- early brain development being affected in ways which influence how a child reacts to stress and other stimulating situations in their early and later life;
- a child being underweight (or grossly overweight), having persistent infections, being late in developing abilities such as walking, being tired and listless and having toileting problems;
- cognitive difficulties such as language delay, poor intellectual ability and inability to concentrate or express feelings;
- physical injuries as a result of accidents, due to lack of care or supervision.

1.3 Emotional effects

- the bonding between child and care-giver potentially being affected and leading to insecure attachment problems;
- low self-esteem and self-regard, anxiety and depression, over-compliance or anger/hostility;
- difficulties in seeking emotional support from adults.

1.4 Social effects

- social isolation due to difficulties in forming and keeping friendships, being bullied or being ignored by peers;
- social exclusion leading to becoming involved with groups of children who display anti-social behaviour or who may bully others.
- behaviour difficulties which can make managing the school environment hard
- poor school attendance and attainment which means the child does not reach their potential.

1.5 Later effects: adolescence and adulthood

- becoming involved in risky behaviours such as substance misuse, criminal activity and sexually exploitative relationships;
- self-harm and suicide attempts;
- difficulties in forming relationships, becoming involved with violent partners and adopting parenting styles which may pass on similar problems to their own children.

The impact on the child/young people

- Not all children exposed to similar experiences of abuse and neglect are affected in the same way.
- A range of other life experiences and family circumstances, both positive and negative, impact on a child's vulnerability or resilience in the face of maltreatment. It is important to recognise that neglected children are also likely to be exposed to other adversities such as the effects of poverty, poor housing, isolation from sources of support, parental mental ill-health etc.
- The interaction of multiple adversities, including abuse and neglect impact negatively overall on childhood development. When assessing neglect, the child's age, stage of development and specific needs (e.g. those relating to disability) should be a focus.

2. Definitions of Neglect

Working Together to Safeguard Children 2015 defines neglect as the *persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:*

- *provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
- *protect a child from physical and emotional harm or danger;*
- *ensure adequate supervision (including the use of inadequate care-givers); or*
- *ensure access to appropriate medical care or treatment.*

The 2009 **National Institute for Health and Clinical Excellence guidance** 'When to suspect child maltreatment' states that:

- *Professionals should consider neglect if parents or carers repeatedly fail to attend essential follow-up appointments that are necessary for their child's health and wellbeing.*

Horwath (2007) 6 types of neglect:

Medical neglect: This involves carers minimising or ignoring children's illness or health (including oral health) needs, and failing to seek medical attention or administering medication and treatments. This is equally relevant to expectant mothers who fail to prepare appropriately for the child's birth, fail to seek ante-natal care, and/or engage in behaviours that place the baby at risk through, for example, substance misuse;

Nutritional neglect: Typically this involves a failure to provide a child with the necessary food and calories to ensure normal growth. Conversely, an un-regulated, unhealthy diet and a lack of exercise resulting in obesity can also be viewed as neglect;

Emotional neglect: This involves a carer being unresponsive to a child's basic emotional needs for affection and emotional warmth and a failure to develop the child's self-esteem and identity. The difference here between neglect and emotional abuse is best understood by assessing the carer's motivation. Emotional abuse is more likely when linked to an act of commission when the carer deliberately, wilfully and calculatingly targets the child in order to cause emotional distress;

Educational neglect: This involves the carer failing to provide stimulation for the child, showing an interest in their educational development, supporting their learning or responding to special needs;

Physical neglect: This involves a carer failing to provide appropriate clothing, food, cleanliness and living conditions. This is sometimes difficult to assess due to the need to consider socio-economic deprivation and because such judgements are subjective in nature. Where poverty appears to be a contributing factor it is vital that the assessment thoroughly explores access to benefits, money management and help that is available to improve the environment of the child;

Supervision and guidance: This involves a failure by the carer to provide adequate levels of guidance and supervision that ensure the child is physically safe and protected. This can affect children and young people of all ages. It is important here to remember that the age of a child should not blur the fact that they are children. Leaving a child to cope alone in a situation for which they are not equipped to manage or a failure to provide appropriate boundaries or appropriate carers should all be considered as neglect.

Dubowitz (1999) in his paper entitled 'neglect of children's health care' stated that in order to determine whether a child is being neglected, professionals need to consider:

- Severity – the actual or estimated potential harm as well as the degree of harm involved
- Likelihood of harm - both the potential medical and psychological ramifications should be considered
- Frequency – measuring the frequency or chronicity of a problem.

These are helpful definitions for practitioners to consider when working with neglect. Being clear about the type and features of the neglect is critical when working with families to improve the children's experience. It is important to remember that a child can present as clean, adequately dressed and well groomed, and still be suffering from a form of neglect. In the case of medical neglect, the impact could be life threatening.

3. Risk Factors

The assessment of risks, strengths and safety factors in parenting requires a holistic, multi-agency assessment using professional judgement. Any assessment needs to consider the impact of patterns of care over time on the child along with the nature of the neglect (types, frequency and chronicity). The table below indicates some of the risk and protective factors to support such professional judgement. Where neglect is suspected the list can be used as a tool to help assess whether or not the child is exposed to an elevated level of risk. This list is neither exhaustive nor listed in order of importance.

Elevating risk factors	Strengths & Safety Factors
Basic needs of the child not adequately met	Support network/extended family meets child's needs; parent or carer works meaningfully and in partnership to address shortfalls in parenting capacity
Age of the child	Child is of age where risks are reduced
Interruptions in early attachment e.g. Birth difficulties/prematurity Early complex medical needs /separation	Good health, history of adequate development. Personality factors- easy temperament, positive disposition Secure attachment; positive and warm parent-child relationship
Child with a disability/learning difficulty/complex needs	Secure attachment; positive and warm parent-child relationship Supportive family environment. Parent/ care has good coping skills
Family structure - single parent with lack of support, high number of children in household and poor support networks	Supportive family environment, Extended family support and involvement, including caregiving help
Substance misuse by parent or carer	Substance misuse is 'controlled'; presence of another 'good enough' carer
Dysfunctional parent-child relationship Lack of affection to the child Lack of attention and stimulation to the child Early parenthood	Good attachment. Parent-child relationship is strong. Family expectations of pro-social behaviour. Stable relationship with parents. Supportive adults outside of family who serve as role models/mentors to child
Social isolation/ lack of social support, ambivalence/hostility to helping organisations	Supportive family environment, Access to health care and social services, Supportive adults outside of family who serve as role models/mentors to child
Mental health difficulties of the parent/ carer Parent/ carer has learning difficulties, parent/ carer has chronic ill health.	Capacity and motivation for change; capacity to sustain change. Support available to minimise risks. Presence of another 'good enough' parent or carer
Father's criminal convictions	Household rules/structure; parental monitoring of child, family expectations of pro-social behaviour
Low maternal self esteem	Mother has positive view of self. Capacity and motivation for change
Existence of domestic abuse in the household	Recognition and change in previous patterns of domestic abuse
Early parenthood	Support for parent/ carer in parenting task. Parent/ carer co-operation with provision of support services; maturity of parent/ carer

Elevating risk factors	Strengths & Safety Factors
Economic disadvantage/long term unemployment, homelessness, multiple house moves, exposure to racism/discrimination	Access to health care and social services. Consistent parental employment Adequate housing
Negative, adverse or abusive childhood experiences of parent/ carer	Positive childhood. Understanding of own history of childhood adversity; motivation to parent more positively
History of abusive parenting Dangerous, damaging expectations on the child Child left home	Abuse addressed in treatment Appropriate awareness of a child's needs. Age appropriate activities and responsibilities provided.
Failure to seek appropriate medical attention	Evidence of parent engaging positively with agency network (health) to meet the needs of the child

4. Recognising/Identifying Neglect

The tool to be found at **appendix 1** outlines the signs and symptoms of neglect; it is designed as an aid to all practitioners working with families to assist in the identification of neglect. It can also be used to evidence neglect, to support referrals to specialist services. During assessment it can be used to assess the nature of the neglect and identify key areas of focus for improvement. It supports child centred thinking and should assist to describe exactly what the concerns are, and what remains unknown, requiring further enquiry.

5. Assessing Neglect

5.1 Guiding principles for assessing Neglect

When completing assessments, practitioners should always follow the assessment process or framework appropriate to their service area, and the level of presenting need. The following chapter sets out the key principles for assessing neglect that have generic application

Assessments of neglect must:

- **Be comprehensive, include multi-agency information**
- **Establish a clear understanding of the family circumstances**
- **Avoid looking at incidents in isolation**
- **Consider and understand parental behaviours, attributes and motivation to change**
- **Be informed by observations of the parent-child interactions**
- **Build a chronology of events, and analysis of impacts**
- **Seek to understand parental history**
- **Engage in clear, open communications with parent/carers**
- **In cases of medical neglect request a medical chronology, consider commissioning a medication review, use safe discharge planning procedure**
- **Be supported by the effective use of appropriate tools**

Be comprehensive

- Like all good quality assessments; assessments of neglect must be conducted in a multi-agency framework. They should consider needs, risks, and strengths, and the relationship between them.

Understand the family's circumstances

- A clear understanding of the family's background and previous involvement with services is required at the start of assessments and this can be gained by completing a Genogram (family tree), social history and starting a chronology.

Isolated incidents of neglect are rare

- It is likely that there will be several, possibly fairly minor incidences of neglect, which over time begin to identify patterns of parenting and heighten concerns. It is important to identify and analyse any patterns of neglectful behaviour within the family context and therefore the usefulness of compiling chronologies cannot be over stated.

5.2 Building a chronology of events

- Any new or re-assessment of a family must take into account the family's history in order to make sense of the present, a chronology is a key part of any assessment and assists the process of care planning and reviewing.
- It is used to record significant events to help professionals from a range of disciplines understand what is happening in the life of a child or young person providing a better understanding of the immediate and cumulative impact of events.
- Developing and analysing chronologies is essential to help identify patterns of behaviour/ risk or concerns that may be preventing a child from achieving positive outcomes. Patterns in social history and behaviour can be detected and something which might appear insignificant in isolation can be identified as a key warning sign in context.
- Recording a family's past history, patterns of behaviour and agency interventions help guard against 'start again' syndrome which involves a succession of assessments at crisis points which do not take into account the findings of previous assessments (Brandon et al, 2009). The parents own history should be part of any chronology. This includes any experiences of child abuse and neglect which may impact on their parenting capacity (Jones, 2010).
- Further guidance on the completion of Chronologies can be found at: http://www.proceduresonline.com/nottinghamshire/scb/user_controlled_lcms_area/uploaded_files/guide_pract_chronol_geno.pdf

5.3 Talking with parents about the neglect

It is often difficult to raise issues with about neglect because it requires practitioners to question their own value base and to communicate with parents on matters which are personal and difficult to raise, for example, smells, dirt or hazards in the house.

As part of the assessment process practitioners need to ensure that their specific concerns are clearly and explicitly understood by parents who can then be informed about what needs to change in the care of their children, why and in what timescales. It is important to be honest, clear and sensitive, not to use jargon and check that parents have understood what has been said to them.

The whole family is key to the process of assessment, they need to know what the assessment is going to involve, why it is happening, what their role is within it and possibilities in terms of outcomes.

At the end of the assessment where it is identified that there are on-going needs or risks workers should use the assessment to write danger/worry statements and safety/wellbeing goals. For further information about safety goals see **appendix 2**.

5.4 Assessing motivation to change

An essential part of any assessment process is evaluating parents'/carers' ability and motivation to change. This is characterised by parents accepting responsibility for their own actions; sustaining changes over time; and taking up offers of support and resources from services.

Practitioners should note evidence of changes and improvements made as a result of previous interventions and the impact of this for the child. Capacity to change should be considered at an early point.

Practitioners should guard against being overly optimistic about the potential for parents to effect lasting change and provide consistently good parenting. Change is not always possible and even when positive change occurs, practitioners need to be mindful if it is so minor that it does not really improve the child's experience of harm. Furthermore practitioners also need to monitor that positive changes are sustained over time.

Families may co-operate with plans although their motivation in doing may be related to a wish to be seen to be compliant to remove the safeguarding work rather than any understanding or acceptance of the need for change to meet their child's needs. Such motivation is less likely to lead to sustained change and therefore outcomes for the child remain unaltered.

The model below taken from Horwath and Morrison (1999) of parental motivation to change provides a framework to help with the identification of compliance and whether it is genuine commitment, tokenism, avoidance or externally motivated compliance which seeks approval from others.

GENUINE COMMITMENT

Talk the talk & walk the walk

Parent recognises the need to change and makes real efforts to bring about these changes

TOKENISM

Talk the talk

Parent will agree with the professionals regarding the required changes but will put little effort into making change work

While some changes may occur they will not have required any effort from the parent. Change occurs despite, not because of, parental actions

COMPLIANCE/APPROVAL SEEKING

Walk the walk: disguised compliance

Parents will do what is expected of them because they have been told to "do it"

Change may occur but has not been internalised because the parents are doing it without having gone through the process of thinking and responding emotionally to the need for change

DISSENT/AVOIDANCE

Walk away

Dissent can range from proactively sabotaging efforts to bring about change to passively disengaging from the process

The most difficult parents are those who do not admit their lack of commitment to change but work subversively to undermine the process (i.e. perpetrators of sexual abuse or fictitious illness)

5.5 Observe the parent-child interactions

Observations can inform assessments of attachment and offer insight into the relationships between parents and child, and child and other siblings. Unrealistic expectations or skewed interpretations of a child's behaviour are often a feature of neglectful parenting, for example, a child who cries a lot being described by the parents as 'nasty' – as though the child's crying is a deliberate action designed to irritate the parent.

5.6 Assess each child within the family unit as a unique individual

Not all children in a family will be treated the same or have the same roles or significance within a family. For example there may be a child who is perceived to be different, perhaps due to an association by the parent/s with a difficult birth, the loss of a partner, the child's age or needs, an unplanned child or a stepchild or a change in life circumstance. Negative feelings may be projected onto one child but not others in the family.

5.7 Involve fathers, father-figures and the wider family

Fathers, father figures and the wider family need to be engaged in the assessment in order to understand the role they have in the child's life. Care of children is likely to be more effective where there is positive support from fathers and most children want and benefit from this contact.

Where fathers may pose a risk to the child, it is imperative that they are engaged with the assessment process so that risks are identified, understood and managed.

5.8 Assessing Medical Neglect

In cases of medical neglect learning from local reviews has highlighted that it is essential practitioners:

a) Gather information from other professionals involved with the child or young person. Specific information should be sought around:
   - attendance at planned and unplanned healthcare appointments
   - treatments provided, prescribed, dispensed and administrated
   - response to interventions
   - impact on the child/young person (for example on school attendance)
   - the impact of providing care to the child/young person on their carer and family
   - any factors for the family which may impact on ability to provide/deliver medical care to the child/young person
   - any risk factors which increase the risk of medical neglect.

b) Assessments of a child's medical presentation and behaviours should not be based solely on parental reporting. Information should be sought from other professionals in contact with the child and family, to seek their views and to verify the parent's explanation.

c) Construct a medical chronology of key pieces of information held in different parts of the health services.

d) Seek to understand the lived experience of the child or young and specifically to understand the impact of their medical condition on their lives and wellbeing

e) Establish, if possible through consultation with colleagues in the multi-disciplinary medical team or named medical professionals, the:
   I. Risk(s) to the child or young person and the dangers of not receiving interventions or treatment
   II. Signs of safety – understand the risk and resilience factors present and make an overall assessment of the child/young person's safety
   III. What needs to change to ensure the risk of significant harm is minimised

f) Follow NCSCB/NSCB guidance for safe discharge planning which can be found at: http://nottinghamcitychildcare.proceduresonline.com/chapters/p_hosp_discharge_plan.html

5.9 Additional Assessment Resource;

Using Genograms to Understand Family Patterns

One of the best and most graphic ways to explore family patterns from generation to generation is through the use of a genogram. The genogram is a way of taking the family tree and converting it to a relationship road map; it is an organised and systematic diagram of family membership over time.

The genogram provides an;

- Overview of family structure and make-up over time. It traces back family chronology and patterns for three or four generations.
- Relationships - the genogram charts biological connections and relationships through marriage. It clearly helps to identify who is related to whom and how, and can help determine potential placement resources.
- Roots - looking at a genogram can give a real sense of a person's origin and beginnings. It helps to trace and understand the process of being connected over time.
- Graphic - the genogram provides a visual tool for tracing patterns.
- Family Life - looking at the genogram enables you to get a sense of the different life cycle stages that many of the family members could be experiencing

6. Working with Neglect

Guiding principles when working effectively with neglect

- Maintain focus on the child
- Use effective planning and review processes to avoid drift
- Avoid becoming immune
- Address parental needs

6.1 Maintain a focus on the child

In complex situations such as working with neglect, it is easy to lose sight of the child whose needs can be over-shadowed by the needs of the parents or where parents are reluctant for professionals to have access to the child. The significance of seeing and observing the child cannot be overstated in such complex and chaotic circumstances. Guidelines for keeping the child in focus include:

- Children should be seen in their family unit and in other settings, i.e. school, nursery, respite care, to observe any differences in their demeanour and behaviour. They should be seen on their own. The child's views should be sought in relation to where they would be comfortable to meet with you.
- It is important to use age and interest appropriate tools, games and other methods to communicate with children. These are relevant to begin to engage with the child and get to know them as a person so that there is an understanding about what life is like for the child every day in their home. Remember that neglect is less about an event or an incident but about the daily lived experience of a child who doesn't get their needs met. Workers should seek to understand what the child's experience of being parented feels like, and the impact this may have.
- It is essential that workers enable parents to understand the reasons for any changes requested. To help them understand that it is driven by the positive impact on the child's wellbeing. Successfully sustained change will not be achieved if parents are making changes without understanding why, or purely to comply with the aim of services withdrawing.

6.2 Effective Planning – Avoiding drift

It is important to have a clear plan for interventions and have clear time-scales for achieving targets and reviewing progress. Remember that before, during and after undertaking formal assessments, the safeguarding interventions and service delivery still needs to be inputted as required to protect/support the child.

Practitioners should include all professionals involved with the family in the review process and should be alert to the dangers of becoming over optimistic about small changers.

6.3 Guard against becoming 'immune' to neglect

Professionals who work regularly with families where there is neglectful parenting can become de-sensitised and can tend to minimise or 'normalise' situations which in other contexts would be viewed as unacceptable.

Sound supervision, which involves reflective discussion and evaluation, is vital to prevent workers becoming desensitised. It is also valuable for workers from different agencies to meet, e.g. in professionals meetings or case consultation forums to discuss issues, share concerns and keep neglect issues in focus.

6.4 Addressing Parental needs

Parents are likely to have many needs of their own; examples of these could include substance misuse, learning disability, mental health difficulties, domestic violence and abuse, all of these requiring high levels of support. It is important to offer support and services to parents and carers who will ultimately enhance their care of the children, however this must never be allowed to compromise keeping a clear focus on the needs of the child.

7. Adult Services

Safeguarding is everybody's business and all professionals working with adults should engage and work with their clients to improve the health, safety and wellbeing of those clients and their families. Children, young people and adults do not live in isolation and services provided should take into account the client's family circumstances.

Consideration should be given to the involvement of children and young people in care provision and carer support. 'Keeping the Family in Mind' (Barnardo's 2007) suggests that potentially up to 17,000 children or young people may be caring for a parent with a mental health problem (Aldridge and Becker 2003).

All staff who work with service users are obliged to consider the potential effects that the client/patient's illness/behaviour may have on children. The following points may impact negatively upon their ability to meet the needs of children who they may care for or have significant contact with:

- Problematic and chaotic substance/alcohol misuse;
- Complex mental health needs including poor compliance with treatments, unstable mental health, symptomology, effects of prescribed medication;
- Parental learning disability;
- Aggression/violence (especially domestic violence);
- Self-neglect/poor motivation;
- Dangerous persons/adults who may pose a risk to children.

It is the responsibility of all professionals to recognise and respond to parenting concerns when they arise. Professionals should 'Think Family' at all times taking a social history from the adult they are working with and identifying any children who may be at risk. When considering Think Family, staff should take into account the context of the family structure in which the child lives.

It is recognised that family structures are dynamic and varied far beyond those defined by blood relationships or partners. Family is often constituted by the individuals themselves and is unique to their diverse and individual needs, including class, culture, race, ethnicity, religion and sexuality. Whilst the nature of 'Family' will change, the importance of understanding how it impacts on the person and the interdependence of individual support and wellbeing remains vital. (This understanding is not constrained by a legal definition of 'family'.)

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Staff should have open and honest discussions with clients regarding any concerns that they may have arising from their illness or problematic substance/alcohol misuse. Specific consideration should be given to the level of insight shown by the client regarding the actual or potential impact that their illness/difficulties may have upon the child. Referrals to other agencies should be discussed with parents and carers prior to the referral being made, unless to do so would increase the risk of harm to children or another adult (see NCSCB/NSCB Interagency Safeguarding Children Procedures).

Identifying risk

The level of risk to a child should always be assessed and action taken to address any identified concerns. Professionals should also consider the wider impact of parental failure to engage with treatment or support on their ability to care for their child; and this failure to engage should be shared with other agencies working with the family. Children not being brought to medical appointments and disengagement from treatment can have a fundamental effect on the quality of care provided to a child. Furthermore, parental/carer failure to bring a child to a medical appointment (Was Not Brought) can have serious consequences to a child's health needs.

Professionals should endeavour to identify early risk of harm and ensure appropriate early help and intervention is provided through co-ordinated thinking and delivery of services. This can be initiated by making contact with the child's health visitor (for a child aged 0-5 years) or the child's school nurse (for a child aged 5-18 years). Professionals should work together to build on the family's strengths and recognise and promote resilience within the family unit to try and prevent an escalation of the concerns and address the issues. Where this cannot be achieved and a child is at risk of or suffering significant harm, a referral to children's social care should be made.

When completing safeguarding children risk assessment screening tools, it is essential that staff give consideration to the following points:

- Actual/potential risk posed by the client either as part of or as a consequence of mental and/or physical ill health;
- Diagnosis, symptoms and relapse indicators;
- Age and developmental stage of the child being cared for or with whom the patient has contact - children aged under 5 and especially infants are particularly vulnerable;
- Impact of the situation on child's emotional wellbeing;

- Whether the child's needs are being neglected (unresponsiveness to both physical and emotional needs);
- Contact with children in the family and wider community, either presently or in the future;
- Strengths and weaknesses of the family, including access to formal or informal support networks;
- Any risk of injury, aggression or dangerous behaviour (including domestic abuse).

Staff should consider whether, based on their assessment, a referral to children's social care and/or other agency is indicated and the referral processes as highlighted by the Interagency Safeguarding Children Procedures should be followed.

Assessed risks, whether to a child or other adults, should be clearly recorded in the client's professional records and shared with partner agencies as appropriate. Any safeguarding risk assessment screening tools should be considered as a 'live' document that should be amended should the client's condition improve or deteriorate. Staff should ensure that details regarding the care arrangements for children are an integral part of emergency and contingency planning. This information should be clearly recorded within the client's professional records and communicated to relevant agencies and professionals.

Children's social care must be informed if an arrangement is made where a child or young person lives with someone who is not a close relative. This may constitute a private fostering arrangement. If the arrangements are in response to an emergency, e.g. Mental Health Act Assessment, notification should occur within 48 hours.

If the child leaves a private fostering arrangement, staff must ensure that children's social care have been informed within 48 hours, giving the name and address of the person who has taken over the care of the child, even if this is the parent upon discharge from adult services.

Discharge planning for adult service users

Discharge plans must consider the impact on children and young people within the household, family and wider community, in particular any specific needs and/or support required by the family. Discharge plans must evidence these discussions.

Discharge planning meetings for an adult mental health patient should routinely include a representative from children's social care where they are or will be involved in supporting the

family. It is also good practice to invite the health visitor (for children aged under 5) or community child health nurse (for school aged children).
Consideration should also be given as to whether the child's school may also need to be informed about the discharge of a child's parent/carer. Discharge letters should be copied, with the client's knowledge, to the relevant professionals involved with the family. If concerns arise regarding the discharge arrangements and the negative impact on a child, consideration should be given as to whether the discharge should be delayed pending a multi-agency discussion and provision of appropriate support.

Transferring or closing a case

Following non-attendance, (in the case of children not being brought) and No Access Visits (NAV) the responsibility for any assessment of the situation rests with the practitioner to whom the child has been referred in conjunction with the referrer (Laming 2003). The relevant staff must consider the impact on a child (born or unborn) or young person if a parent/carer or close relative does not engage with services and whether there is any intervention required in order to secure the child's welfare.

Where relevant, partner agencies and other professionals involved with the family should be contacted prior to transfer/closure of the case, to ascertain if any concerns regarding the welfare of a child exist.

Prior to the transfer of a case to another worker/service, staff must ensure that the relevant documentation has been completed, the demographic information is accurate and any safeguarding risk assessment screening tools have been adequately completed. Concerns regarding a child's welfare should be clearly documented and communicated to new workers. Providing a chronology of events and a verbal handover is considered good practice.

Before the case is closed staff are encouraged to consider, in conjunction with the family, whether they have any additional needs and what support may be available.
If a decision is made to close a case, relevant professionals should be informed in writing, with the client's knowledge, highlighting any concerns and ensuring they are clear that the service is no longer involved with the family. In the case of children who are subject to child protection plans or local authority intervention, discussions with the allocated worker should occur prior to closure/transfer.

Needs assessment

If a client has significant contact with a young person under the age of 18, staff should discuss with the client whether the child or young person is carrying out any caring responsibilities for the client or other relatives. Staff should discuss the impact that the caring role may have upon the child or young person's physical, emotional, educational or social development, with both the patient and the young person. Children under 16 with carer responsibilities are entitled to a 'Child in Need' referral to local authority children's services. Young people over the age of 16 are entitled to a carer's assessment. Staff should discuss referral to 'Young Carers' networks and groups for support. Consideration should also be given as to whether the young person would benefit from a CAMHS referral.

Outpatient arrangements for patients with children

Staff should consider the childcare arrangements of clients when arranging outpatient appointments. Staff should be aware in advance of whether a client may need to bring a child or young person with them to an appointment and have arrangements in place as to how to deal with the situation that are agreed and understood by all relevant staff. It may be necessary to rearrange the appointment if the environment or context of the visit is deemed to be unsuitable. Clear expectations should be provided to parents/carers regarding the level of supervision required for the child or young person and appropriate behaviour during the appointment. All wards and departments should provide a clear explanation to parents/carers via verbal and written communication.

APPENDIX 1 – Recognising / identifying neglect N.B. Throughout the tool the generic term carer is used, to include parent / mother / father/ guardian / person with caring responsibility for the child / young person.

CHILDREN DEVELOPMENTAL NEEDS			
Signs & Symptoms	**Applies**	**Not known at this time**	**Describe what has happened/or what your concerns are & the impact on the child**
Health			
Medical attention not sought in a timely manner			
Child not taken to key health appointments			
Childhood illnesses allowed to deteriorate before advice/care sought			
Child frequently attends the emergency department at hospital			
Child is not registered with a GP			
Child does not have all the appropriate immunisations			
Child has a poorly managed skin condition or head lice			
Child is not taken to all appointments regarding, hearing, vision, speech and language problems			
The child has not had all their developmental checks (0-5 years)			
Carer does not ensure needs			

relating to a child's disability are met			
Carer does not address concerns about nappy rash			
Carer does not support/ensure that the child cleans their teeth			
The child has tooth decay			
Education / Development			
The child's general development is not what you would expect for a child of a similar age			
The child is not speaking as expected for a child of their age and development			
The child has poor/erratic/late attendance at school or nursery			
The child is not consistently met on time from school or nursery			
The child is not reaching their academic potential (5-16 years)			
Emotional & Behavioural Development			
The child is fractious and difficult to settle (0-5)			
There is evidence of offending behaviour (5-16)			
The child runs away from home (5-16)			
Child attempting to starts fights			
Child has made suicide attempts or self-harms			
Child is being bullied or bullying others			
Engaging in sexual activity			

Involved in or at risk of Child Sexual Exploitation			
Suffering from depression, anxiety or low self esteem			
Family & Social Relationships			
The child has poor/limited relationships with peers & limited support networks			
Child does not respond to or seek mother's attention			
Child does not respond to or seek father's attention			
Social Presentation			
Evidence of attention seeking behaviour or short attention span			
Evidence of behaviour problems or destructive behaviour			
Displaying inability to control emotions or impulses			
Presents as quiet or submissive			
Self-care skills			
The child misuses substances (5-16 years)			
Acting highly independent, completing self-care skills inconsistent with age.			
Summary			
Analyse risks & needs identified along with strengths and safety factors within the family, and what this means for the child/ young person.			

PARENTAL CAPACITY			
Signs & Symptoms	**Applies**	**Not known at this time**	**Describe what has happened/or what your concerns are & the impact on the child**
Basic Care			
The child's growth is not appropriate for their age and there is no organic reason for this			
The child appears under nourished and is observed to be hungry			
Child's special dietary requirements are not met			
The child's height and weight are out of proportion with expectations			
There is evidence that the child is taking or hoarding food			
The child is not provided with an adequate diet			
The child is not dressed in clothes suitable for the weather			
The child wears poorly fitting clothes and shoes			
The child presents with poor personal hygiene (i.e. dirty, unkempt, smelly)			
There is little or no food in the cupboards			
The child has no bed and/or bedding			
Nappies are not changed			

regularly and there is persistent/recurrent nappy rash			
Ensuring Safety			
The child is exposed to a smoky environment			
Carer does not recognise dangers to child's safety			
There are no clear or clean areas for the child to play			
There is evidence of hazards to the child (e.g. fire risks, sharp objects or needles)			
The child's home is in a poor state of repair			
Faeces or other harmful substances are visible and the house smells			
The child is left home alone inappropriately			
Inappropriate carers/baby sitters used			
There is evidence of bruising on babies/children who are not mobile [1]			
There is evidence of unexplained injuries			
The child is exposed to inappropriate behaviours (e.g.			

[1] Workers should refer to the NCSCB Practice Guidance Bruising in Babies / May 2016 http://nottinghamshirescb.proceduresonline.com/p_bruising_babies.html and make appropriate safeguarding referrals

drug/alcohol misuse, domestic abuse, criminal activity) [2]			
There is a lack of supervision around traffic			
Babies/infants are unsecured in pram/pushchair and carer is careless with pram			
Child often found wandering unsupervised and/or locked out			
There is unsafe handing of the baby			
The baby/infant is inappropriately left unattended			
Carer indifferent to child's whereabouts and often does not know where they are or who they are with.			
Child strapped in car seats/pushchairs/other types of chair for long periods of time			
Safe sleeping arrangements are not in place (e.g. co-sleeps with baby)			
Animals are not well cared for and there are faeces & urine in living areas			
Animals are dangerous and chaotically looked after, risk not recognised/managed			
Carers do not address the ill treatment of animals by adults or children			

[2] If there are unexplained injuries that are of concern workers should always make a referral to Children's Social Care

Emotional Warmth			
Carer shows inappropriate response to child's emotional/physical needs			
Carers shows anger or a lack of attention towards the child			
Carer has unrealistic expectations for the child			
The carers emotional response is harsh, critical and lacks warmth			
Carer responds aggressively or dismissively if child distressed or hurt			
Carer does not show any warmth or physical affection to the child and responds negatively to the child seeking warmth and care			
Carer speaks coldly and harshly about child and does not provide any reward or praise and is ridiculing of child when others praise			
Stimulation			
Child is lacking in stimulation/no access to toys/activities			
Carers shows disinterest in their child			
Guidance & Boundaries			
The child has little, no or inconsistent routine			
The child has few/no or inconsistent boundaries			

The child is exposed to inappropriate films/materials and behaviour			
There are no boundaries set appropriate to age about when to come home or late nights			
Stability			
The home life is unsettled with unknown adults or young people in the home			
Child has experienced lots of moves, staying with relatives or friends at short notice (Often in circumstances of overcrowding leading to child sleeping in unsuitable circumstances)			
Summary			
Analyse risks & needs identified along with strengths and safety factors within the family, and what this means for the child/young person.			

Family and Environmental Factors			
Signs & Symptoms	**Applies**	**Not known at this time**	**Describe what has happened/or what your concerns are & the impact on the child**
Community Resources			

The family are unable or do not access community resources			
The family are inappropriately accessing community resources			
Family & Social Integration			
The family is involved in on-going neighbourhood disputes			
Income			
The family is financially unstable (e.g. significant debts unable to meet basic care needs)			
The family are at risk of becoming homeless			
The family are not able to pay their utility bills			
Wider Family & Friends			
The family has little or no support from wider family or friends			
Family History & Functioning			
Carer Physical health is poor			
Carer mental health is a concern			
The carers have problems with drug or alcohol misuse			
There are current concerns around domestic abuse			
There is a history of frequent house moves			
Summary			

Analyse risks & needs identified along with strengths and safety factors within the family, and what this means for the child/young person.
Full Assessment Analysis
What is the assessment telling you about the family situation and the impact on the child? Consider what outcomes are needed and what the situation would look like if these were achieved.

APPENDIX 2 – Using Danger Statements

Danger/Worry Statements and Safety/Wellbeing goals.

A danger/worry statement sets out the reasons why agencies are working with the child and family, in clear terms that the family understands. They clarify the risks/worries/danger. Danger/worry statements state;

- Who is worried?
- What they're worried about?
- What people are worried will happen if nothing changes?
- Whilst all the time thinking about the impact on the child.

If there is more than one concern you will need to write a separate danger/worry statement and safety/wellbeing goal for each concern that needs to be addressed.

Example of Danger/worry Statement: Neglect and Substance Misuse

Danny the Social Worker, his manager Jane, Mark Germaine's teacher, Beth the Police officer, Mark Kestie's nursery worker and Steve Sharon's drug worker are all worried that Sharon will feel sad and alone and keep using drugs and drinking so much she will lose focus on Kestie and Germaine and keep doing drug things like sleeping late into the day or partying late at night like she did on July 5th when the police found the children out on the street at night. If these things keep happening everyone is worried that Kestie and Germaine will get very scared and even hurt when they are unsupervised and alone and that they won't get looked after, get to school and nursery like they should and rather than just being kids they'll end up worrying all the time about Sharon.

Safety/wellbeing goals

Safety/wellbeing goals describe what the child's life will be like and how the family will be behaving so that people are no longer worried about the child. When developing a safety/wellbeing goal workers need to consider;

- What will the parent be doing different?
- What will the child be experiencing?
- What will professionals see that tells them that things are good enough, that the child is safe, their needs are being met and will continue to have their needs meet and continue to be safe

Example of a Safety/wellbeing Goal: Neglect and Substance Misuse

Danny the Social Worker, his manager Jane, Mark Germaine's teacher, Beth the Police officer, Mark Kestie's nursery worker and Steve Sharon's drug worker know how much Sharon loves Kestie and Germaine and how much they want to be with her and want them to be able to live with Sharon. For this to happen they need:

- Sharon to work with Danny and one or two people who are close to her to create a simple and honest explanation for Kestie and Germaine about Sharon's problems with drugs and alcohol and feeling alone and why they can't live with Sharon right now.
- Sharon to discuss and create a honest, detailed plan made with her family and friends that shows everyone that when Sharon does get overwhelmed and sad what she will do to get herself back on track for the kids. If Sharon can't do this the plan will spell out who in Germaine and Kestie's safety network will help with the children so Kestie and Germaine always get attention, get played with, talked to, cuddled like they need however sad or overwhelmed Sharon feels.
- Sharon to discuss and create a detailed plan with her family and friends that shows everyone she won't use drugs or drink or if Sharon does drink or use everyone knows what the plan is to make sure Kestie and Germaine are with someone that is drug/alcohol free until Sharon is sober and clean