Swindon Safeguarding Partnership Children's Neglect Framework and Practice Guidance

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Document Author:	Swindon Safeguarding Partnership
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Introduction

Neglect is 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. This can be due to failure to give due care, attention or time to a child or through disregard or carelessness. Neglect may involve a parent or caregiver failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or failing to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs. In addition neglect may occur during pregnancy as a result of maternal substance misuse.

Neglect differs from other forms of abuse because it is:

- ✓ Frequently passive
- ✓ Not always intentional
- ✓ More likely to be a chronic condition rather than crisis led and therefore impacts on how we respond as agencies
- ✓ Combined often with other forms of maltreatment
- ✓ Often a revolving door syndrome where families require long-term support
- ✓ Often not clear-cut and may lack agreement between professionals on the threshold for intervention
- ✓ Can often fluctuate with periods of improvement following intervention and then declining when support is reduced

The way in which we understand and define neglect can determine how we respond to it.

As part of the Safeguarding Partnership strategy for neglect in Swindon professionals should use this Practice Guidance when working with families where there are concerns about neglect. The Neglect Framework is designed to assist in the identification of child neglect and identify when there is a concern that the quality of care a child is receiving is leading to their developmental needs being neglected. Swindon Safeguarding Partnership have adopted the Graded Care Profile 2 (GCP2) assessment tool to assess neglect. The GCP2 assessment and this framework can also be used to support referrals and in reflective supervision meetings.

The framework provides a series of questions around the 5 key areas of:

1. Persistence & Change
2. Child Development Areas
3. Impact of neglect on the child and their lived experience
4. Causal factors
5. Acts of Omission or Commission

Accompanying documents to the Neglect Framework include a 7 minute briefing for Neglect.

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6.1 Omission or Commission

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Chronology of Neglect

A good chronology of events can identify patterns of behaviour and show where risks may lie. A chronology can identify; themes, patterns, risks, strengths, capacity to change. If no chronology exists then one should be started. Good practice guidance on chronologies can be found on the SSP Website here

Supervision

The framework provides guidance to help reflection in supervision. Supervisors should support and encourage practitioners to reflect on the impact on themselves as individual workers and how working with this family has made them feel. Practitioners should be encouraged to reflect on how these feelings may have impacted on their assessment.

Identification of Neglect

The following chart defines the areas of neglect referred to in this Neglect Framework

Areas of Neglect	Professional Consideration
Persistence & Change Neglect with constitutes 'significant harm' is that which is; Persistent; Cumulative; Chronic or acute; Resistant to intervention. The behaviour of seriously neglectful parents/carers is frequently characterised by care which lacks consistency and continuity. There may be brief intervals when care is marginally improved. This may raise the hopes of those providing services, but improvement may not be long term change creating a sense of hopelessness for those supporting the family.	Parental/Carer Motivation to; • Make consistent changes in their life • Recognise the cumulative impact of harm • Understand the Child's Experience

Child's developmental areas	
The impact of neglect on the child's biological, psychological and emotional development.	• Physical care received • Emotional Care received • Health & Medical care needs met • Appropriate Supervision & Guidance • Appropriate Stimulation & Education • Adolescent needs met
Impact of neglect on child's lived experience	
The knowledge about the child's world gained through direct, first-hand involvement of their everyday life.	• The child's experience • Exposure to other abuse • External influences on child and parent/carer
Causal Factors	
Causal factors are additional factors which may impact upon a parent/carer's ability to care for a child.	• Parental Mental and Physical Health • Parental Substance Misuse • Domestic Abuse • Parental Learning Disability • Poverty, discrimination, & Social Isolation • Parental criminal behaviour
Acts of Omission and Commission	
Acts of commission are deliberate and intentional. Acts of omission are the failure to provide for a child's basic physical, emotional, or educational, learning and developmental needs or to protect a child from harm or potential harm.	• Carer ignorance of neglect or deliberate harm/abuse

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Agencies Roles and Responsibilities

There is an expectation that when there is a concern that a child is experiencing neglect the Neglect Framework will be used by professionals to make an early proactive assessment of the impact on the child along with the Neglect Screening Tool.

Within Swindon, the Graded Care Profile 2 (GCP2) assessment tool will be completed by staff trained in GCP2. This helps measure the quality of care a child is receiving and so identify neglect and spot anything that is putting that child at risk of harm. Once identified professionals will assess what pre-disposing factors of neglect are potentially there and what action they need to take. Multi-agency planning should occur to prevent deterioration and to coordinate and plan the support services to families.

Further information regarding the Graded Care Profile 2 Principles for use and Frequently Asked Questions can be found here

Swindon Children's Social Care have also implemented The Family Safeguarding Model. The model looks to keep more families together, work in partnership with parents through motivational interviewing, and achieve change for families not monitoring compliance and approach child protection by working as a partnership. Multi-disciplinary teams work together with a range of skills to help and support parents.

1. Responsibility of all agencies

All of these agencies have a responsibility to contribute to the safeguarding of children. Roles and responsibilities are clearly defined in both the statutory guidance and Swindon Safeguarding Partnership Child Protection Procedures.

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2. Responsibility of Health

All health professionals must be alert to the signs of neglect in children and young people.

Health professionals from a variety of health settings e.g. G.Ps, health visitors, school nurses, hospital professionals, CAMHS, dentists, opticians, physiotherapists etc. are involved with children and families at various stages in a child's life. They play an important part in recognising and referring signs of neglect. The nature of neglect is insidious so it is essential that all health professionals maintain accurate, detailed and contemporaneous records. When a health professional identifies concerns regarding neglect in a family they should refer to MASH or liaise with their safeguarding lead in their own agency.

3. Responsibility of Children's Services

Early Help

If early intervention services are being provided to the family in cases of neglect a neglect screening tool or GCP2 assessment should be completed.

Children's Social Care.

The neglect screening tool or GCP2 assessment should be considered in all cases of neglect where it is identified that a statutory assessment should be undertaken.

Where a child is at continuing risk of significant harm Children's Services is responsible for coordinating an inter-agency plan to safeguard the child via a child protection conference and core group.

In cases where the child's name has been made the subject of a child protection plan, the child protection conference chair should identify responsibility for the completion of the GCP2 assessment and identify timescales in line with the Child Protection Plan

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4. Responsibility of Police

The Police have a duty to protect all members of the community and to bring offenders to justice. The welfare of children is a priority for the service, and all officers are responsible for identifying and referring children who are at risk or in need. Any Officer can utilise emergency powers to ensure immediate protection of children believed to be at immediate risk of suffering significant harm.

In cases of neglect, initially it may be unclear whether any offence has been committed. A search of relevant premises, medical examinations and interviews with suspects, children and witnesses should all be considered to determine the circumstances in which a child is cared for and whether any neglect was wilful and would support a criminal prosecution. (Authorised Professional Practice)

5. Responsibility of Early Years

All Early Years providers play an important role in the prevention of abuse and neglect. They provide a healthy, safe and secure environment where the individual needs of each child are met. All staff has a responsibility to be alert to the signs of abuse and neglect and to make a referral to Children's services when it is deemed necessary to do so. Early Years staff may be asked to contribute to assessments and should complete the neglect_screening_tool where there neglect is being identified.

6. Responsibility of Education

All educational settings play an important role in the prevention of abuse and neglect. Educational settings provide a safe environment for children and teach about staying safe from harm. Educational settings provide an essential educative environment for the next generation of parents.

All education staff have a crucial role in noticing indicators of neglect including educational neglect and in referring concerns to Children's Services. Education staff need to have an awareness of the educational development of each child, how these needs are being met so that appropriate educational progress can be made. The neglect_screening_tool can be used to support in the identification of neglect.

7. Responsibility of Housing

The Housing Department may have important information about families, identifying cases of neglect or contributing information to assessments. The Housing Department has a critical role to play in cases of poor home conditions, social isolation, and domestic abuse. Staff have an important role to play in reporting concerns where they believe that a child may be in need of protection.

8. Responsibility of Probation Services

In discharging its statutory responsibility the Probation Service, through its work with offenders and their families, may become aware of children who are at risk through neglect. All Probation staff have a responsibility to be aware of the signs of child neglect and to refer appropriate cases to Children's Services. Probation staff will work in collaboration with other agencies in contributing to assessments and will follow all relevant child protection policies, procedures and protocols.

9. Responsibility of Youth Justice Service

The Youth Justice Service (YJS) aims to prevent offending and re-offending of children aged 10-17. All YJS staff receive safeguarding awareness training and have a responsibility to be alert to safeguarding issues in their work with children and their families. Any concerns are brought to the attention of a line manager and appropriate cases will be referred social care. YJS staff will comply with its own safeguarding policy which clearly states that staff will work in collaboration with all relevant agencies and in accordance with Children Services policies and procedure in respect of safeguarding children.

10. Responsibility of the Voluntary Sector

The voluntary sector should be able to assist in contributions to assessment in cases of neglect. In addition, through the provision of a range of services focusing on quality parenting and family support, the voluntary sector will be able to offer children and parents / carer's positive opportunities and experiences. The voluntary sector has a duty to refer appropriate cases of neglect to Children's Services.

11. Responsibility across the agencies

All agencies within Swindon, whether in the statutory or voluntary sector, have a duty to share information about children who are suspected to be at risk of harm from neglect and to make a contribution to the assessment process and attend multi-agency meetings.

Where a referral about possible/potential neglect is being made to Children's Social Care at level 3 (of the threshold document) or to Early Help at level 2 (of the threshold document). A completed GCP2 assessment tool should accompany the referral or be underway. In urgent cases a referral should not be delayed to complete a GCP2, however the referrer may undertake or contribute to the GCP2 following referral.

Some professionals may not be in a position to complete a full GCP2 assessment but may be able to complete one or more of the 4 areas of care (Physical, Safety, Emotional and Developmental). In those circumstances where no GCP2 assessment can be completed, a neglect_screening_tool is available to assist in evidencing neglect concerns.

Good Practice: Key Principles

Focus on the impact of the circumstances on the child

- Voice of the child and their lived experience (refer to section 3.1).
- Look at the whole picture – not only what has happened to the child, but also the child's health and development, and the wider family and environmental context.
- Be aware of the many factors that may affect a parent's ability to care for a child, and that these can have an impact on children in many ways.
- Build on families' strengths, while addressing difficulties.
- Guard against over optimism, adopt a balanced approach, and beware of overemphasising positives at the expense of negatives especially in situations where the standard of care fluctuates. Professionals must always show professional curiosity.
- Make full use of existing sources of information, e.g. own agency files and computer databases, others who know the child, the child protection plan, the family themselves.
- Be creative in how you work with the family. Use a range of resources and techniques in communicating and working with them.
- Be specific in relation to the changes you expect and clear about the timescales in which you expect the changes to be achieved.

Common Problems

1. Subjectivity about what are good enough standards of care
2. Professionals do not use the work ‘neglect’
3. The plan are not SMART, are not working and there still concerns for the child’s safety.
4. The family know what good parenting is but don’t do it consistently.
5. Lack of professional curiosity
6. Multi-agency communication
7. Parenting capacity and the use of the Mental Capacity Act/advocacy
8. Inconsistency in Core Group and Child in Need plan reviews.
9. The family have significant financial difficulties and this makes it difficult to consistently meet the child’s needs.

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1. Persistence and Change

1.1 Parental Motivation to Change
Q. Is the carer concerned about the child's welfare and wants to meet their physical, social, and emotional needs to the extent the carer understands them?
Q. Is the carer determined to act in the best interests of the child and has realistic confidence that they can overcome problems?
Q. Is the carer willing to ask for help when needed and is prepared to make sacrifices for children?
Q. Does the carer have the right 'priorities' when it comes to child care and may take an indifferent attitude?
Q. Does the carer believe that there is something about the child that deserves ill treatment and hostile parenting?
Q. Does the carer seek to give up the responsibility for the child?
1.2 Cumulative Harm
Q. What evidence is there of persistence of neglect? (I.e. has the neglect been present over a significant period of time; what efforts been made to intervene to minimise or prevent neglect; has this had any significant impact in the past?) Assessment should include whether every time a new referral/ report is made whether a number of low-level risk factors is demonstrating significant cumulative harm? Look at: o Case History o Case conferences o Worker handover o Risk Assessments
1.3 Parents Experience
Q. What is the parent's experience of being parented? o Lack of caregivers o Poor early experiences o Poverty o Lack of Skills and Knowledge

- Social Isolation
- Domestic Abuse
- Parental Learning Disability
- Parental Substance Misuse
- Parental Mental Health issues
- Parental Separation & Divorce

2. Child's Developmental Needs

2.1 Physical Care - Growth, Diet & Nourishment
Q. Is the child's growth appropriate for age?
Q. If growth is not appropriate is there is an organic reason for this?
Q. Does the child have nutritionally balanced meals?
Q. Is there food in the cupboards?
Q. If the child has dietary advice for low weight or obesity does the carer follow dietetic advice?
2.1 Physical Care - Hygiene
Q. Is the child clean and is either given a bath/washed daily or encouraged to do so if appropriate to age?
Q. Is nappy rash treated consistently?
Q. Does the carer take an interest in the child's appearance?
2.1 Physical Care - Safe Sleeping (for babies)
Q. Does the carer have information on safe sleeping and follows the guidelines?
Q. Is there suitable bedding and carer has an awareness of the importance of the room temperature, sleeping position of the baby and the carer does not smoke in household? (Be aware this raises risk of cot death)?

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Q. Is the carer aware of guidance around safe co-sleeping, recognises and observes the importance of the impact of alcohol and drugs on safe co-sleeping?
Q. Is the carer concerned about the impact on the child or risks associated with co sleeping, such as witnessing adult sexual behaviour?
Q. Are there are adequate sleeping arrangements for children?
Q. Is the carer indifferent or hostile when given safe sleeping guidance? Sees it as interference and does not take account?
2.1 Physical Care - Clothing
Q. Does the child have clothing which is clean and fits?
Q. Is the child dressed for the weather?
Q. Does the carer aware of the importance of suitable clothes for the child in an age appropriate way?
Q. Is the carer hostile when given advice about the need for suitable clothes for the wellbeing of the child?
2.1 Physical Care - Animals if Present
Q. Are animals are well cared for and do not present a danger to children or adults?
Q. Are children are encouraged to behave properly towards animals?
Q. Is there a presence of faeces or urine from animals and animals are not well trained?
2.2 Emotional Care - Carer's attitude to the child
Q. Does the carer talk consistently warmly about the child and is able to praise and give emotional reward?
Q. Does the carer value the child's cultural identity and seeks to ensure the child develops a positive sense of self?

Q. Is the carer ridiculing of the child when others praise?
Q. Is the carer hostile when given advice about the importance of praise and reward to the child?
2.2 Emotional Care - Warmth & Care
Q. Does the carer respond to the child's needs for physical care and positive interaction?
Q. Is the emotional response of the carer is one of warmth?
Q. Is the child listened to?
Q. Is the child happy to seek physical contact and care?
Q. Does the carer respond with concern if child distressed or hurt?
Q. Does the carer understand the importance of consistent demonstrations of love and care?
2.2 Emotional Care - Responses to baby
Q. Does the carer respond to the baby's needs and is careful whilst handling and laying the baby down, frequently checks if unattended?
Q. Does the carer spend time with baby, cooing and smiling, holding and behaving warmly?
Q. Is the carer hostile to advice to pick the baby up, and provide comfort and attention?
Q. Does the carer recognise the importance of interaction with the baby?
2.2 Emotional Care - Positive Values
Q. Does the carer encourage the child to have positive values, to understand right from wrong, be respectful to others and show kindness and helpfulness?
Q. Does the carer understand the importance of the child's development to include an

awareness of smoking, underage drinking and substance misuse as well as early sexual relationships?
Q. Does the carer give clear advice and support?
Q. Does the carer ensure the child does not watch inappropriate films/TV or play with computer games which are unsuitable for the child's age and stage of development?
2.3 Medical Needs - Advice in relation to health
Q. Does the carer seek advice from professionals/ experienced adults on matters of concern about child health?
Q. For adolescents, does the carer ensure that sexual health needs are met including advice on contraception and sexually transmitted infections?
Q. Are medical appointments made and attended?
Q. Is preventative care carried out such as dental/optical and all immunisations up to date?
Q. Carer ensures child completes any agreed programme of medication or treatment?
Q. Does the carer attend to childhood illnesses or are illnesses allowed to deteriorate before advice/care is sought?
Q. Is the carer hostile when given advice from others (professionals and family members) to seek medical advice?
2.3 Medical Needs - Disability
Q. Does the carer comply with needs relating to child's disability?
Q. Is the carer is proactive in seeking appointments and advice and advocating for the child's wellbeing?
Q. Does the carer accept advice and support i.e. follows advice from physio and occupational therapists?

Q. Does the carer always value child and not allow issues of disability to impact on feelings towards the child?
2.4 Supervision & Guidance - Supervision
Q. Is supervision provided in line with age and stage of development?
Q. Does the carer recognise the importance of supervision to child's wellbeing?
Q. Is there consistent supervision provided both indoors and outdoors, and the carer does intervene where there is imminent danger?
Q. Does the carer always know where child is and has inconsistent awareness of safety issues when child away from home?
Q. Is the carer hostile when given advice from others regarding supervision and does not recognise the potential impact on children's wellbeing?
Q. Is there a risk that the adult carer is being groomed for criminal or other exploitative purposes i.e. particularly parents who have learning difficulties or misuse substance?
2.4 Supervision & Guidance - Care by other adults and children
Q. When the child is left in the care of someone over the age of 16 yrs., are they a suitable carer?
Q. Is the carer consistent in raising the importance of a child keeping themselves safe from others and provides some advice and support?
Q. Are there occasions where a young person is left alone at home or in the care of another child, young person or unsuitable adult?
Q. Does the parent risk assess the circumstances to ensure the child is safe?
2.4 Supervision & Guidance - Boundaries
Q. Do the carers provide consistent boundaries and ensure the child understands how to behave and to understand the importance of set limits?

Q. Is the child disciplined with the intention of teaching proactively?
Q. Does the carer and treat the child harshly and cruelly, when responding to their behaviour?
Q. Is the carer hostile when given advice about appropriate methods of disciplining?
2.5 Stimulation & Education – Stimulation
Q. Is stimulation provided? Does the carer understand the importance of it for the child?
Q. Does the child have suitable toys to play with?
Q. Does the child have the opportunity to go on outings? To child centred places?
Q. Does the child have the opportunity and space to play outside the house?
2.5 Stimulation & Education – Education
Q. Does the carer take an active interest in the child's schooling and gives support at home, e.g. for homework?
Q. Does the carer engage well with the school/ nursery and does not sanction missed days unless necessary?
Q. Does the carer encourage the child to see school as important, have regular attendance and encourage the child to engage well at school?

3. Adolescent Neglect

The signs of neglect of older children may be more difficult to identify than signs of neglect in younger children, and older children may present with different risks. For example, older children may want to spend more time away from a neglectful home, and, given their experience of neglect, they may be more vulnerable to risks such as going missing, offending behaviour or exploitation.

When older children who have experienced neglect come to the attention of agencies, the most obvious risks of, for example, exploitation or offending behaviour may elicit an appropriate response from professionals initially. But, without understanding and addressing the underlying impact of neglect, the effectiveness of any work to support these children will be limited.

Professionals and parents can sometimes view the presenting issues older children face as the problem: this is often an unconscious assumption. When a child’s presenting issues become the sole problem, professionals do not always consider their behaviour in the context of the impact of neglect on the child and they can fail to take action with parents regarding any ongoing neglect.

The impact of neglect on older children can be significant and, in some cases, life-threatening. Neglect can lead to problems in adolescence and adulthood including, but not limited to:

- Poor mental and physical health
- Difficulties with interpersonal relationships
- offending behaviour
- Substance misuse
- A high propensity for risk-taking behaviour
- Suicide.

Older children who suffer neglect may have been neglected for many years and can carry the legacy and impact of neglect at a younger age with them into adolescence. This means they are often not well equipped to cope with the many challenges that older childhood brings and may not get the support from parents to manage this transition.

Neglect of older children may look very different to that of a young child or baby. Older children may also be skilled at hiding the impact of neglect by seeking support from places other than the family or by spending more time away from home, which in itself may put the child at more risk. They may appear 'resilient' and to be making choices about their lives, when in fact they are adopting behaviours and coping mechanisms that are unsafe. For example, they may look for support from inappropriate and dangerous adults or use alcohol and drugs as a form of escape.

Children themselves are not always sure that they are being neglected or abused. Research shows that children are least likely to recognise neglectful parenting compared with other forms of abuse. When older children discuss their emotional abuse or neglect on online forums, it is common for them to question whether they are experiencing neglect (as a form of abuse) or not.

What older children require from their parents is also different to what younger children need. Older children face risks outside of the home in ways that younger children do not. Parents may not always be equipped to help their older children deal with increased risks outside the home. Alternatively, because their parents are neglecting them at home, older children may spend more time away from the home, which increases their risk of exposure to child sexual exploitation, criminal exploitation, gang-related activity or violence. These, then, are the problems that professionals first see when they encounter a neglected child and these may well be the issues they respond to.

Unless all agencies work together to address the underlying neglect of older children who are experiencing multi-layered problems and risks, the experiences of these children are unlikely to improve. Dealing with the most immediate presenting risks first may be the correct response initially, for example by protecting the child from sexual exploitation. However, supporting and protecting older children is about addressing the risks both inside and outside the home. In cases where parents are neglecting their children's needs, agencies must address this too.

The experiences of older children who are suffering neglect, therefore, may be very different to those of younger children and not fit neatly into definitions of neglect. Research in this area acknowledges that defining neglect in a way that captures the experiences of all children living with it is difficult. There are so many lenses through which we could look at older children's experiences. Sometimes, the last one we look through is neglect.

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While agencies robustly work together to tackle knife crime and gang activity, they must also address the underlying vulnerabilities of the young people that expose them to grooming by gangs/dangerous adults. The way in which we, as a society, view older children and their behaviour is not always in the context of their lived experiences. And where older children do become involved with gang-related activity, criminal behaviour or violence (such as knife crime), we need to get better at understanding those behaviours in the context of the potential risks they may be exposed to in their local areas and/or the neglect or abuse they may be suffering at home. That is not to say that we must excuse the behaviours themselves, nor that they are always the result of neglect, but research shows that by understanding where behaviours may be coming from, we can work better with children to prevent them from experiencing and/or perpetrating more harm.

Adolescent_neglect_briefing_for_professionals (The Children's Society and Luton LSCB) is aimed at improving knowledge, understanding and confidence around identifying and responding to adolescent neglect. It is for anyone whose work brings them into contact with young people or with adults who are parents or carers.

Where young people are seen to be making choices that are seen to be neglectful and detrimental to their wellbeing consideration should be given to the use of the Mental Capacity Act, Gillick competences and Fraser Guidelines, see Appendix 1

Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. Traditional approaches to protecting children/young people from harm have focussed on the risk of violence and abuse from inside the home, usually from a parent/carer or other trusted adult and don't always address the time that children/young people spend outside the home and the influence of peers on young people's development and safety. Contextual Safeguarding recognises the impact of the public/social context on young people's lives, and consequently their safety. It seeks to identify and respond to harm and abuse posed to young people outside their home, either from adults or other young people. It's an approach that looks at how interventions can change the processes and environments, to make them safer for all young people, as opposed to focussing on an individual. For further information visit the Contextual Safeguarding Website - https://csnetwork.org.uk/ or view the contextual safeguarding video clip. https://www.youtube.com/watch?v=V0IE-XENewM.

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3.1 Responding to adolescent neglect
Q. Are the adolescent's needs fully considered with consistent adult care?
Q. Does the carer recognise that the adolescent is still in need of guidance with protection from risky behaviour i.e. an awareness of the adolescent's whereabouts for long periods of time (missing or absent)?
Q. Has the parent/carer reported the episode missing (if relevant)?
Q. Does the carer encourage the child to see education as important, and supports regular attendance at school?
Q. Does the carer either address directly or seek support to address risky and challenging behaviour?
Q. Does the carer have the capacity to be alert to and monitor the adolescent moods for example recognising depression which could lead to self-harm?
Q. Does the carer have the capacity to be alert to and monitor relationships (including online relationships) which may be risky or exploitative?
Q. Is the carer aware of any risks associated to online activities particularly; grooming in relation to sexual and/or criminal exploitation or radicalisation?
Q. Is the carer aware of any risks outside the family particularly; grooming in relation to sexual and/or criminal exploitation or radicalisation?
Q. Does the carer encourage positive peer relationships?
Q. Does the carer take an active interest in the child's day-to-day life and activities?

3.2 Practice questions for when working with young people
responses: never, hardly ever, sometimes, often, always

Q. In the last year how often did your parents, or the adults you live with…

…show an interest in what you were doing at school? **…attend parents' evenings at school?** **…keep track of how you were doing at school – by doing things like reading reports?** …take an interest in your hobbies or activities? …ask about what you want to do in the future? …help you to learn things outside school?	EDUCATIONAL SUPPORT
…help you when you had problems? **…support you if you were upset?** **…tell you when they thought you had done something well?** …praise you? …tell you they loved you? …help you to do your best?	EMOTIONAL SUPPORT
…make sure you saw a doctor if you needed one? **…take care of you if you felt ill?** **…support you to look after your teeth and go to the dentist?** …make sure you ate healthy food? …keep the house clean? …make sure you brushed your teeth? …make sure you washed or showered regularly?	PHYSICAL CARE
…ask you where you were going when you went out? **…like to know where you were after school?** **…expect you to call or text to let them know if you were going to be home late?** …know where you were going when you went out at night? …ask about the plans you had with your friends? …leave you at home alone overnight? …leave you with adults you don't know very well? ...make sure you went to school?	SUPERVISION

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4. The Impact of Neglect and the Child's Lived Experience

4.1 The Child's Experience - Stimulation
Q. If you put yourself in the child's shoes, what is life like?
Q. Can you describe a day in the life of this child using the child's voice?
Q. What is it like for this child living in this house?
4.2 Other Abuse - Other Abuse
Q. Is the poor quality care causing any other kinds of abuse? ○ Sexual Abuse/Sexual Exploitation ○ Physical Abuse ○ Emotional Abuse

5. Casual Factors

5.1 Mental Health
Q. Does the carer have a history of depression or is currently experiencing depression?
Q. Does the carer talk about feelings of depression/low mood in front of the children?
Q. Are the child's needs understood and the carer is aware of the impact of talking about their mental health issues in front of the children?
Q. Does the carer hold the child responsible for feelings of depression and is open with the child and/or others about this?
Q. Is the carer is hostile when given advice focussed on stopping this behaviour and carer does not recognise the impact on the child?

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5.2 Domestic Abuse
Q. Is the carer currently experiencing domestic abuse?
Q. What is the family norm of domestic abuse?
Q. Does the carer does argue aggressively and/or is physically abusive in front of the children?
Q. Does the carer understand the impact of arguments and anger on children and is sensitive to this?
5.3 Substance Misuse
Q. What is the carer's frequency of substance misuse and what substances are they using?
Q. Does the carer believe it is normal for children to be exposed to regular alcohol and substance use?
Q. Does the carer understands the importance of hygiene, emotional and physical care of their child and arranges for additional support when unable to fully provide for the child?
Q. Are finances are affected by parental substance misuse?
Q. Is the mood of the carer can be irritable or distant at times?
Q. Are alcohol and drugs secured safely?
Q. Is the carer aware of the impact of substances misuse on the child (including unborn child)?
Q. Does the carer hold the child responsible for their use and blames their continual use on the child?
5.4 Learning Disability
Q. Is it apparent that the carer has any learning disability?

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Q. What is the level of understanding of the carer?
Q. Does the carer understand written advice and/or instruction?
Q. If learning disability is not apparent, the parent may still have limited comprehension that needs to be assessed. Is there any evidence of barriers to level of understanding or ability to implement advice?
5.5 Poverty & Social Isolation
Q. Are the family currently in debt?
Q. What is the family's source of income and how do they chose to spend their money?
Q. How do those choices impact on the child?
Q. Does the carer have a consistent support network within the family or community?

6. Acts of Omission or Commission

6.1 Omission or Commission
Q. Does the neglectful behaviour occur as a result of carer ignorance or competing carer priorities? (Omission)
Q. Is there a general lack of action regarding the child's needs?
Q. Lack of parent/carer reporting child missing
Q. Does the neglectful behaviour occur due to a deliberate intention to harm? (Commission)
Q. What do the caregivers say about what causes the difficulties they are experiencing with care giving?

Q. Does the parent blame the child for their inability to care for them?
Q. What do you consider to be primary factors causing poor quality parenting?

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Appendix 1

The Mental Capacity Act for 16 and 17 year olds

The following definitions apply in the MCA and the Code of Practice:

• An “Adult” is a person aged 18 years or over.

• A “Young Person” is a person aged 16 or 17 years old.

• A “Child” is a person under the age of 16 years old.

• This differs from the Children Act 1989 and the law more generally where the term “child” is used to refer to people aged under 18.

The Mental Capacity Act, (2005), which was enacted in 2007, applies to all people over the age of 16 years who live in England and Wales and who may lack the capacity (within section 2(1)) to make all or some decisions for themselves

Where the MCA does not apply to young people aged 16-17. There are certain parts of the MCA that do not apply to young people aged 16-17 years. These are:

• Only people aged 18 and over can make a Lasting Power of Attorney, (LPA);

• Only people aged 18 and over can make an advanced decision to refuse medical treatment;

• Making a will. The law generally does not allow people under 18 to make a will and the MCA confirms that the Court of Protection has no power to make a statutory will on behalf of anyone under 18.

Where the MCA Applies to Children under the age of 16

• In most situations, the care and welfare of children under 16 will continue to be dealt with under the Children Act 1989. There are, however, two parts of the MCA that apply to children under 16:

• The Court of Protection can make decisions about a child’s property or finances, (of can appoint a deputy to make these decisions), if the child lacks capacity to make to make such decisions within section 2(1) of the Act and is likely to still lack capacity to make financial decisions when they reach the age of 18.

• The criminal offence of ill treatment or wilful neglect of a person who lacks capacity applies to children under 16 as no lower age limit is specified for the person caused harm/victim.

Parental Responsibility and the MCA

• Parental Responsibility, (PR), refers to the "rights, duties, powers, responsibilities and authority which by law a parent has in relation to a child", (Children Act 1989). Parental Responsibility lasts until the young person, ("child" under Children Act 1989), is 18.

• People with PR for a young person may make decisions on behalf of that young person. The decisions that a person with PR can make are those decisions that are seen to sit within the scope (previously referred to zone of parental control) of parental control. This is a legal concept describing which decisions a parent should be able to take concerning their child's welfare.

There is no codified statement of which decisions come into the zone of parental control. However, the MHA Code of Practice, (36.10), notes two points that should be borne in mind when considering whether a decision comes within the zone of parental control:

• Is the decision one that a parent would be expected to make?

• Are there any indications that the parent might not act in the young person's best interests?

We should also consider:

• Is the young person resisting?

• The nature/invasiveness of what is proposed.

Consent to treatment

- Under the Family Law Reform Act 1969, all people over the age of 16 are presumed to have the capacity to consent to surgical, medical or dental treatment and to associated procedures, such as investigations, anaesthesia and nursing care.
- However, this presumption does not mean that a young person is able to make the relevant decision and decision makers should assess the young person's capacity to consent to the proposed care/treatment. If the young person lacks capacity to consent, then the MCA will apply in the same way as it does to adults.
- However, the Code of Practice says that if a young person lacks the capacity to make a specific care/treatment decision, the healthcare staff providing treatment, or the care staff providing care, can carry out treatment/care with protection from liability whether or not a person with PR consents.

- They must follow the Act's principles, consider all the factors in the checklist and ensure that the acts they carry out are in the young person's best interests. They must take into account the views of everyone interested in the young person's welfare, including those with PR.

Capacity at 16 years

• The moment that a young person wakes up on the morning of their 16th birthday, they are presumed to have the capacity to make their own decisions under the MCA.

• All those involved in supporting a young person are obliged to have regard to the MCA in all that they do in relation to that young person. If you work with young people who lack capacity and you are a professional and/or you are paid for the work you do, you have a legal duty to have regard to the MCA Code of Practice.

The Five Principles

• Principle 1 - Assume Capacity a young person must be assumed to have capacity until proved otherwise

• Principle 2: All Practicable Support a person must not be treated as unable to make a decision/without capacity unless all practicable steps to help them to do so have been taken without success

• Principle 3: Unwise Decisions a person must not be treated as unable to make a decision merely because they have made an unwise one.

• Principle 4: Best Interests If an act is done, or a decision taken, on behalf of a person who lacks capacity it must be done, or made, in their best interests.

• Principle 5: Least Restrictive Any act done, or a decision made, in a person's best interests, must be the least restrictive of the person's rights and freedom of action.

Gillick competency and Fraser guidelines

Gillick competency and Fraser guidelines help people who work with children to balance the need to listen to children's wishes with the responsibility to keep them safe.

When practitioners are trying to decide whether a child is mature enough to make decisions about things that affect them, they often talk about whether the child is 'Gillick competent' or whether they meet the 'Fraser guidelines'. Although the two terms are frequently used together and originate from the same legal case, there are distinct differences between them.

Both Gillick competency and Fraser guidelines refer to a legal case from the 1980s which looked at whether doctors should be able to give contraceptive advice or treatment to young people under 16-years-old without parental consent.

Applying Gillick competence and Fraser guidelines

The Fraser guidelines still apply to advice and treatment relating to contraception and sexual health. But Gillick competency is often used in a wider context to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

You should always encourage a child to tell their parents or carers about the decisions they are making. If they don't want to do this, you should explore why and, if appropriate, discuss ways you could help them inform their parents or carers. For example, you could talk to the young person's parents or carers on their behalf.

If the young person still wants to go ahead without their parents' or carers' knowledge or consent, you should consider the Gillick and Fraser guidelines. The following information looks at how this can be applied in practice.

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Gillick competency

Gillick competency applies mainly to medical advice but it is also used by practitioners in other settings. For example, if a child or young person:

- would like to have therapeutic support but doesn't want their parents or carers to know about it
- is seeking confidential support for substance misuse
- Has strong wishes about their future living arrangements which may conflict with their parents' or carers' views.

Medical professionals need to consider Gillick competency if a young person under the age of 16 wishes to receive treatment without their parents' or carers' consent or, in some cases, knowledge.

If the young person has informed their parents of the treatment they wish to receive but their parents do not agree with their decision, treatment can still proceed if the child has been assessed as Gillick competent.

Assessing Gillick competence

There is no set of defined questions to assess Gillick competency. Professionals need to consider several things when assessing a child's capacity to consent, including:

- the child's age, maturity and mental capacity
- their understanding of the issue and what it involves - including advantages, disadvantages and potential long-term impact
- their understanding of the risks, implications and consequences that may arise from their decision
- how well they understand any advice or information they have been given
- their understanding of any alternative options, if available
- Their ability to explain a rationale around their reasoning and decision making.

Remember that consent is not valid if a young person is being pressured or influenced by someone else.

Children's capacity to consent may be affected by different factors, for example stress, mental health conditions and the complexities of the decision they are making. The same child may be considered Gillick competent to make one decision but not competent to make a different decision.

If you don't think a child is Gillick competent or there are inconsistencies in their understanding, you should seek consent from their parents or carers before proceeding.

Refusal of medical treatment

Gillick competency can be used when young people wish to refuse medical treatment. However, if a young person refuses treatment which may lead to their death or severe permanent harm, their decision can be overruled.

Fraser guidelines

The Fraser guidelines apply specifically to advice and treatment about contraception and sexual health. They may be used by a range of healthcare professionals working with under 16-year-olds, including doctors and nurse practitioners.

Following a legal ruling in 2006, Fraser guidelines can also be applied to advice and treatment for sexually transmitted infections and the termination of pregnancy (Axton v The Secretary of State for Health, 2006).

Using the Fraser guidelines

Practitioners using the Fraser guidelines should be satisfied of the following:

- the young person cannot be persuaded to inform their parents or carers that they are seeking this advice or treatment (or to allow the practitioner to inform their parents or carers)
- The young person understands the advice being given.
- The young person's physical or mental health or both are likely to suffer unless they receive the advice or treatment.
- It is in the young person's best interests to receive the advice, treatment or both without their parents' or carers' consent.
- The young person is very likely to continue having sex with or without contraceptive treatment.
  (Gillick v West Norfolk, 1985)

https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-guidelines

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Appendix 2

Safeguarding unborn babies and under 2's

Case reviews, together with other research findings, show that children under one year of age and in particular, very young babies, are extremely vulnerable to being seriously injured or to dying as a result of abuse or neglect.

"Babies under 12 months old continue to be the most prevalent group notified, and there were a high proportion of cases involving non-accidental injury and sudden unexpected infant death. In these cases, parental and family stressors were the most significant factor in escalating risk." (CSPR Panel Annual Report 2020).

Resources to support practitioners in understanding vulnerability and protective factors for parents

Professionals are encouraged to use the **vulnerability and protective factors in pregnancy to early parenthood** practical resource to increase their awareness of the breadth of factors that may impact on the development of unborn children and infants.

This ensures families receive the support they need to give children in Swindon the best start in life. It includes a summary page with information on application in practice, which can be used as a standalone resource.