

NEGLECT TOOLKIT

Guidance for Practitioners

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1.0 Introduction

Awareness of child neglect and its consequences on the future well-being and development of children has increased during the last two decades. It is notoriously difficult to define and varies by type, severity and chronicity. Research shows that it often co-exists with other forms of abuse and adversity. To make the management of neglect even more complex, numerous reviews have commented on the dynamics of professional uncertainty regarding thresholds and criteria and what constitutes significant harm. Thus neglect can lead to a difference of opinion and professional optimism in relation to 'good enough care'.

Neglect is the most common reason for child protection plans in the United Kingdom. Analysis of Serious Case Reviews has made the link between neglect and childhood fatalities. Apart from being potentially fatal, neglect causes great distress to children and leads to poor outcomes in the short and long-term. As with all areas of abuse including neglect consequences can include an array of physical and mental health problems, difficulties in forming attachments and relationships, lower educational achievements, an increased risk of substance misuse and higher risk of experiencing abuse, as well as difficulties in assuming parenting responsibilities later on in life. The degree to which children are affected during their childhood and later in adulthood depends on the type, severity and frequency of the maltreatment and on what support mechanisms and coping strategies were available to the child.

Neglect is a priority for the Northamptonshire Safeguarding Children Board (NSCB) and a number of initiatives are underway to improve awareness, recognition and interventions for children and families affected.

This guidance is designed for multi-agency Managers and Practitioners from all agencies working with children and their families, whether their principal focus is upon a child or an adult within the home. It is only by working together and co-ordinating our activities that we can be effective in addressing concerns about neglect.

This document has been produced to support professionals in their understanding, identification, assessment and interventions in childhood neglect. Thus this toolkit is intended to assist in decision making and planning so that children about whom there are concerns about neglect are effectively safeguarded.

2.0 Definitions and Types of Neglect

"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.

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)
- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to a child's basic emotional needs."

HM Government 'Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children' 2015.

This is the official Government definition of neglect and is important as it supports a consistent understanding of neglect amongst multi-agency professionals. It provides a guide and a threshold in the identification, assessment and decision making process of neglect and is the criteria for determining whether a child's name is to be placed on a Child Protection Plan.

However the definition can only be useful if there is a clear and shared understanding of neglect – and its impact upon a child's health and development - in its broadest sense.

Neglect, (in contrast to other forms of abuse where specific and critical incidents can highlight significant harm) often presents us with less tangible and more diverse indicators which make it harder to identify. Further, differences of opinion about what constitutes *persistent failure*, *serious impairment* of health or development and *adequate* make this definition, as with others, more open to interpretation, resulting in confusion and a lack of consensus amongst childcare professionals about what neglect actually involves.

An additional difficulty that professionals may have in identifying neglect relates to concerns about imposing their own standards and values on other people and a reluctance to be judgemental. Yet professionals are tasked to make professional judgements, based on the best evidence available and within a co-ordinated multi-agency response. The definitions of neglect, an understanding of the impact upon the child's health and development and effective working together can help professionals to distinguish between being judgemental and articulating a defensible professional judgement.

In seeking to clarify neglect further, some areas to consider are:

- a. **Persistence:** Neglect is usually (but not always) something that is persistent, cumulative and occurs over time. It can continue without a critical event, or incidents may be widely spaced, but its effects are corrosive to children's development. Its presentation as a chronic condition requires the collation and analysis of sometimes small and seemingly insignificant events that only provide evidence that neglect is an issue of concern when viewed together.

Gardener (2008) warns of the danger of viewing neglect as a chronic phenomenon as this involves waiting for a time when chronic issues are deemed to be present which delays professional response to children's safeguarding needs.

Neglect can also occur as a one-off event e.g. where there is a family crisis or a parent is under the influence of drink/drugs. It is possible that one-off incidents are part of a wider background of the neglect of the child, thus any incident based reports need to be assessed to identify whether there are patterns, however widely spaced.

- b. **Acts of Omission and Acts of Commission:** Neglect is often (but not always) a passive form of abuse and the definition from *Working Together, 2015*, refers to failures to undertake important parenting tasks, which are often referred to as *acts of omission*. It is not always easy to distinguish between acts of omission and acts of commission however and both can occur simultaneously. For example, a parent leaving a child in the supervision of an unsuitable person involves both an omission to provide appropriate supervision and commission, in leaving the child with someone unsuitable. The issue for those identifying and assessing neglect is less about understanding intent and more about assessing which of the child's needs are not being met. Neglect may be passive, but it is nevertheless harmful.
- c. **Neglect often co-exists with other forms of abuse:** Certainly emotional abuse is a fundamental aspect of children's experiences of neglect. However other forms of harm such as physical abuse, sexual abuse, harm from exposure to domestic abuse and child sexual exploitation can and do co-exist with neglect. The existence of neglect should alert practitioners to exploring whether children are being exposed to other forms of abuse.
- d. **Parents and carers with complex and multiple needs:** A wide range of circumstances and stressors exist for parents whose children are neglected including poor housing, poverty and lack of capacity or knowledge about children's needs, disability, learning impairment, asylum or refugee status and other circumstances which might weaken parental capacity. Brandon (2012) in a review of serious cases involving child deaths collectively called parental substance and/or alcohol misuse, domestic abuse and mental health difficulties the *Toxic Trio*.

There is a complex interaction between the three areas which significantly increases risk for children. Parents need support to address their complex circumstances and needs so that they can parent their children effectively. Professionals may feel great empathy for parents and develop a tolerance for actions or inactions which are detrimental to the child. This type of a parent-centred approach invokes a risk that the focus on the child, the actual or potential harm they experience and the impact on the child's development, becomes marginalised. Keeping a focus on the child has to be a priority.

Types of Neglect:

Howarth (2007) identified five types of neglect and this breakdown is helpful for practitioners to begin considering where the child's needs may be being neglected. A thorough and methodical way of addressing failure to meet need will assist in identifying and planning interventions in neglect.

Medical – minimising or denying illness or health needs of children; failure to seek medical attention or administer treatments.

Nutritional – not providing adequate calories for normal growth (possibly leading to failure to thrive); not providing sufficient food of reasonable quality; recently there have been discussions about whether obesity should be considered a form of neglect.

Emotional – failure to respond to a child's basic emotional needs; to interact or provide affection; failure to develop child's self esteem or sense of identity.

Educational – failure to provide a stimulating environment; failure to show interest in education or support learning; failure to respond to any special needs related to learning; failure to comply with statutory requirements regarding attendance.

Physical – failure to provide appropriate clothing, food, cleanliness, living conditions.

Lack of supervision and guidance – failure to provide for a child's safety, including leaving a child alone; leaving a child with inappropriate carers; failure to provide appropriate boundaries.

3.0 Recognising Signs and Indicators of Neglect

Neglect can impact on children in numerous ways and children can show signs of neglect in a variety of ways – dependent on their age, the severity, frequency and duration of the harm, their resilience, the availability of alternative sources of care and support. Children may exhibit many, some or none of these indicators of neglect.

By themselves, many of these signs do not necessarily prove the existence of neglect but they do indicate that all is not well for the child, illustrating a need for further exploration and assessment into the child's circumstances. Being inquisitive, talking with and listening to children, observing them and their interactions with their parents and seeking a multi-agency perspective are key to gaining a wider understanding of what may be happening in the child's life. Recognition and a prompt response to indicators of neglect are crucial if the neglected child is to be safeguarded. The longer a child is exposed to neglect, the more difficult it will be to reverse the adverse effects.

It is important to recognise that many neglected children may also 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 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.

The National Institute for Health and Care Excellence (NICE) has produced guidance *When to Suspect Child Maltreatment* which has sections on *Neglect; Emotional, Behavioural, Interpersonal and Social Functioning; and Parent - or Carer - Child Interactions*; including indicators of harm. The link to this guidance can be found at <https://www.nice.org.uk/guidance>

Disabilities:

Disabled children are 3-4 times more likely to be the victims of abuse and neglect (Sullivan & Knutson, 2000). Of course disabled children are not an homogenous group and careful assessment of their unique circumstances is required. However some of the increased risk factors for disabled children are:

- They have a prolonged and heightened dependence upon their carers which may make them more susceptible to neglect and a range of other issues, for example, isolation.
- The caring responsibilities for parents may increase stress levels and lower their capacity to parent effectively.
- Disabled children may be less likely to be able to protect themselves or be less able to speak out about their experience of being parented.
- Professionals may relate the signs and indicators of distress or harm to the disability and not necessarily to the possibility of maltreatment.
- Professionals can accept a different or lower standard of parenting for a disabled child than for a non-disabled child (Brandon et al, 2012).

Culture:

There are many differences in patterns and methods of parenting across cultures. However there are no cultures that accept abuse and neglect of children.

Parents may explain their approach to parenting in terms of cultural factors and it is important to explore and seek to understand their perspective. However caution is required in placing too much emphasis on cultural factors – the main focus has to be about the impact on the child's health and development.

4.0 Risk and Protective Factors Associated with Child Neglect

Risk factors raise concern that the care given by parents and carers may be compromised. Risk factors do not inevitably mean that parenting capacity is reduced but do need to be assessed: if care given to the child is deemed to be good, then concerns about risk factors may be dispelled. However, some risk factors may still affect care adversely in the future if the severity worsens or if the care required becomes more demanding, for example when the child is unwell. Some risk factors (e.g. substance abuse, mental illness) may mean that the care the child receives is inconsistent or unpredictable, such that their health and development are affected. The priority and focus when assessing risk factors is that the safety and well-being needs of the child are ensured.

Factors which indicate strengths in parenting capacity are also important to acknowledge and build upon. As noted above when relating to risks however, strengths in parenting do not always relate to good care being provided to the child in a consistent and predictable way.

Research (from reviews into serious cases) suggests that certain family and environmental factors may be seen as predisposing risk factors in child neglect. These include:

Factors in Parents/Carers:

- History of physical and/or sexual abuse or neglect in own childhood; history of care
- Multiple losses
- Multiple pregnancies, with many losses
- Economic disadvantage/long term unemployment
- Parents with a mental health difficulty, including (post natal) depression
- Parents with a learning difficulty/disability
- Parents with chronic ill health
- Domestic abuse in the household
- Parents with substance (drugs and alcohol) misuse
- Early parenthood
- Families headed by a lone parent or where there are transient partners
- Criminal convictions
- Strong ambivalence/hostility to helping organisations

Factors in the child:

- Birth difficulties/prematurity
- Children with a disability/learning difficulty/complex needs
- Children living in large family with poor networks of support
- Children in larger families with siblings close in age

Environmental Factors:

- Families experience of racism/discrimination
- Family isolated/in dispute with neighbours
- Social disadvantage
- Multiple house moves/homelessness

The assessment of risks and strengths in parenting requires a holistic, multi-agency assessment using professional judgement. 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 not exhaustive nor listed in order of importance:

Risk Factors	Strengths (protective factors)
Basic needs of the child are 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 see section on Age of the Child (page 10) for consideration of adolescent neglect.
Substance misuse by parent or carer	Substance misuse is controlled; presence of another 'good enough' carer.
Dysfunctional parent – child relationship Lack of affection to child Lack of attention and stimulation to child	Good attachment. Parent-child relationship is strong.
Mental health difficulties for parent / carer Parent / carer learning difficulties	Capacity and motivation for change; capacity to sustain change. Support available to minimise risks. Presence of another 'good enough' parent or carer.
Low maternal self esteem	Mother has positive view of self. Capacity and motivation for change.
Existence of Domestic Abuse	Recognition and change in previous patterns of domestic abuse.
Age of parent or carer	Support for parent / carer in parenting task. Parent / carer co-operation with provision of support services; maturity of parent / carer.
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	Abuse addressed in treatment .
Dangerous / damaging expectations upon children Child left home alone	Appropriate awareness of a child's needs. Age appropriate activities and responsibilities provided.
Failure to see appropriate medical attention	Evidence of parent engaging positively with agency network (health) to meet the needs of the child.

Poverty:

Professionals should guard against the risk of excusing or minimising neglect because a family is in poverty. Neglect is about a child's needs being unmet through a parent or carers action or inaction to such a degree that there is impairment of a child's health and development. This can occur in families that are in poverty or in those who could be considered as well-off. It should be noted that many parents are able to bring up their children happily and effectively in spite of limited financial resources – the parenting task is invariably more difficult, but these parents are able to maintain a focus on meeting their child's needs.

Substance Misuse:

If parents or carers misuse either drugs or alcohol and this use is chaotic, there is a strong likelihood that the needs of the child will be compromised. Any concerns of substance misuse need to be assessed thoroughly and the household carefully checked for dangers and risk of immediate harm.

Parental addiction to substances including alcohol can alter capacity to prioritise the child's needs over their own and in some cases alters parenting behaviour so that child experiences inconsistent care, hostility or has their needs ignored.

It is essential that there is a collaborative and joined up approach between those working with adults involved in substance misuse and the Safeguarding Children Professionals so that there is a clear understanding regarding:

- The level and type of substance misuse, prognosis for change, commitment to reduce or control substance use.
- Whether the findings of any assessments are based on self-reporting or have been verified. It is essential that self-reports of reduction or cessation of substance misuse are verified before safeguarding activities are reduced. It is not effective safeguarding practice to take self-reports about substance addiction at face value.
- The impact that parental substance misuse is likely to have on parenting capacity, and the likelihood of the child receiving consistently good care under these circumstances.

The key message contained in *Hidden Harm - Responding to the Needs of Children of Problem Drug Users (2003)* was that parental problem drug use can and does cause serious harm to children of every age. The report states that reducing the harm to children should be the main objective of drug policy and practice and concludes that:

- Effective treatment of the parent can have major benefits to the child.
- By working together, services can take practical steps to protect and improve the health and well-being of affected children.
- The number of affected children is only likely to decrease when the number of problem drug users decreases.
- Whenever substance misuse is identified as a concern, a thorough assessment of the impact upon parenting and potential implications for the child must be completed.

Mental Health Difficulties:

It is known that mental health problems in parents and carers can significantly impact upon parenting capacity. Type of mental illness and individual circumstances are factors that need to be taken into account in any assessments. The following may be possible contributory factors when assessing neglect:

- Severe depression or psychotic illness impacting upon the ability to interact with or stimulate a young child and/or provide consistent parenting.
- Delusional beliefs about a child, or being shared with the child, to the extent that the child's development and/or health are compromised.

Specialist advice about the impact of mental health difficulties on parenting capacity must always be sought from an appropriate mental health practitioner in these cases. It is essential that there is a collaborative and joined up approach between those working with adults who have mental health difficulties and the safeguarding children professionals so that there is a clear understanding between both sets of staff about:

- The degree and manifestation of the mental health difficulty, treatment plan and prognosis.
- The implications for parenting capacity and good care being offered to the child consistently in relation to the mental health difficulty.

The NHFT's *Adult Mental Health Pathway* leaflet can be found [here](#) which will help you as a practitioner understand the services available and how you might access them.

Learning Disabilities:

Many parents and carers with a learning disability have an instinct to parent their child well, whilst others may not. However, even with a good caring instinct, parents and carers with a learning disability may have difficulty in acquiring the skills to care (e.g. feeding, bathing, cleaning and stimulating) or being able to adapt to their child's developing needs. The degree of the learning disability as well as their commitment and capacity to undertake the parenting task are key areas to assess.

It is a priority that the child's health and development needs are met both now and as those needs change in the future; and that the child is not exposed to harm as a result of parenting which deprives them of having their physical and emotional needs met. Thus any interventions will also need to consider the level and length of time that support for parents will be required to assist them to parent adequately, and to ensure that plans made in this regard are viable and robust.

Specialist advice about the nature and severity of the learning difficulty is required as well as the impact of the difficulties on parenting capacity. It is essential that there is a collaborative and joined up approach between those working with adults who have learning difficulties and the safeguarding children professionals so that there is a clear understanding between both sets of staff regarding:

- The degree and manifestation of the learning difficulty, support and services available and prognosis.
- The implications for parenting capacity and good care being offered to the child consistently in relation to the learning difficulty.

Domestic Abuse:

Growing up in a violent and threatening environment can significantly impair the health and development of children, as well as exposing them to an ongoing risk of physical harm. Chronic, unresolved disputes between adults, whether these involve violence or not, have an adverse impact on the child's emotional wellbeing and hence emotional neglect is a relevant concern. Professionals need to remain alert to the indicators of neglect whenever domestic abuse is raised as an issue and equally consider whether the child is exposed to domestic abuse when working with cases of neglect.

Age of the Child:

Babies and toddlers depend almost exclusively on their parents or carers to meet their basic physical and emotional needs. Babies who are not fed cannot compensate by eating at school and babies who are not cleaned do not have the capacity to do this themselves. Generally speaking, the younger the child, the greater the vulnerability and the more serious the potential risk in terms of either their immediate health or the longer-term emotional or physical consequences.

The neglect of adolescents is an area that has received less attention, both in practice and research terms, but it is essential that the health and development needs of adolescents are considered by professionals.

Adolescence may well be a time when young people experience abandonment by their parents or carers or where they are forced to leave home (acts of commission). This is particularly worrying as it may be likely that these young people have experienced long term physical and emotional deprivation (persistent neglect) such that their resilience and ability to fend for themselves is impaired (although it may be over-estimated by young people themselves as well as their parents and professionals). It also leaves young people potentially exposed to harm such as sexual abuse, sexual exploitation and the risks to their health and development as a result of homelessness, lack of education etc.

The table below provides some points for consideration and also some of the issues around defining and working with adolescent neglect.

Themes from Research Review	Issues for Practitioners
Neglect is usually seen as an act of omission	For adolescents in particular, some acts of commission should be seen as neglect, or contribute to young people being neglected e.g. being abandoned by parents, being forced to leave home, being exposed to others who may exploit the young person.
Neglect from different viewpoints	There may be different viewpoints, for example between the views of Social Workers, other professionals, parents and young people themselves. Awareness of these different viewpoints and what may contribute to them (e.g. culture, parents' own experiences of being parented, beliefs, values and so on) is a starting point for establishing a working consensus.
Young people may underestimate neglect	This may be related to young people's acceptance of their parents' behaviour, young people's sense of privacy, or their loyalty to families.
Neglect is often seen as a persistent state	It is necessary to look at patterns of neglect over time and recognise the impact both acute and chronic neglect.
There is a difficulty in making a distinction between emotional abuse and neglect	These are inevitably associated, especially when neglect is seen as an omission of care. What matters is not the label but the consequences for the young person's health and development.
Neglectful behaviour and experience of neglect	Defining neglect should consider both the maltreatment itself, as well as how the young person experiences neglect i.e. the consequences for them.

5.0 Effects of Neglect

Practitioners and Academics are agreed that all forms of abuse including chronic and serious neglect can have disastrous effects upon childhood and child development. The persistent nature of neglect is corrosive and cumulative and can result in irreversible harm (Hildyard and Woolfe, 2002; Davies and Ward, 2011). Research clearly identifies that if babies and young children are exposed to neglectful care giving and poor stimulation in the first 3 years of life, the neural pathways requiring stimulation are likely to wither and children may never achieve their full potential (Perry, 2004).

The impact of neglect upon a child's development is uniquely experienced by each child depending upon their individual circumstances, the nature of the neglect and their degree of resilience.

Amongst the challenges that may be encountered by children who are exposed to neglect are:

- Development delay and failure to thrive.
- Hunger and thirst.
- Low weight.
- Being overweight, obesity.
- Lack of appropriate medical care, missed medical appointments and pain caused by untreated condition(s).
- Inadequate protection from emotional, physical or sexual harm.
- Pain/embarrassment caused by ill fitting or inappropriate clothes.
- Difficulties concentrating and making friends at school.
- Lack of opportunities for socialisation.
- Elevated likelihood of poor mental health and low self-esteem.
- Feelings of isolation and rejection.
- Additional challenges are faced by children living in neglectful circumstances where parental alcohol or substance misuse are a feature (see *Hidden Harm*, 2003).
- Addiction to substances at birth.
- Anxiety about the wellbeing of carers/parents.
- Exposure to dangerous adults and frightening or inconsistent adult behaviour.
- Exposure to dangerous substances.
- Expectation to keep secrets.
- A feeling of isolation from within the family home and wider community.
- Involvement in the supply of substances.
- Early involvement in use of substances.

Neglect can have a significant impact on a child's emotional and physical development, the effects of which can last into adulthood. It impacts on all aspects of a child's health and development including their learning, self-esteem, ability to form attachments and social skills.

The Impact of Failure of Poor Standards in Home Hygiene:

Presentation	Immediate impact on the child	Possible long term impact on the child
<ul style="list-style-type: none"> Persistent dirty carpets, bedding, chairs, clothing. 	<ul style="list-style-type: none"> Child smells. Itching and scratching leads to loss of sleep. Irritability and crying. Skin lesions which may become infected. 	<ul style="list-style-type: none"> Others reluctant to interact with the child – affects social, emotional and development progress. Family stress levels raised. Spread of infection, may need repeated antibiotics over a long period of time.
<ul style="list-style-type: none"> Polluted air in the home – accumulated dust, cigarette smoke, animal hair. Curtains permanently/ frequently drawn. Windows permanently/ frequently closed. 	<ul style="list-style-type: none"> Repeated inhalation of second hand cigarette smoke, dust, animal hair. 	<ul style="list-style-type: none"> Repeat chest infections, bronchiolitis, asthma attacks (can be life threatening), chronic lung disease. Babies may require frequent hospital admissions.
<ul style="list-style-type: none"> Food left on the floor/counter tops that become mouldy. Food that is a long way past its sell by date. Keeping food at incorrect temperature. Inadequate cleaning of/dirty utensils, crockery, feeding bottles. Floor/counter tops contaminated with dirt and/or animal faeces/urine. 	<ul style="list-style-type: none"> Stomach upsets, Salmonella, Botulism. Toxoplasmosis and Toxicara 	<ul style="list-style-type: none"> Frequent gastroenteritis causing damage to intestinal tract reducing effectiveness of function. Widespread damage to tissues can result in impaired vision.

The Impact of Failure to Provide an Appropriate Diet for Children:

Presentation	Immediate impact on the child	Possible long term impact on the child
<ul style="list-style-type: none"> Insufficient food intake for growth needs. 	<ul style="list-style-type: none"> Deficiencies of essential nutritional elements. Reduced energy levels. Miserable and lethargic. Poor concentration. 	<ul style="list-style-type: none"> Impaired brain development (if severe in under 2 years old). Learning difficulties, development delay, delayed neurological development. Anaemia, poor bone growth, poor absorption of essential vitamins. Poor participation in social activities. Social isolation. Poor academic achievement.
<ul style="list-style-type: none"> Restricted/rigid diets/foods. 	<ul style="list-style-type: none"> Imbalanced diet – for example, excessive levels of fats /carbohydrates, insufficient vitamins or too little variety. Mineral and vitamin deficiencies. 	<ul style="list-style-type: none"> Poor growth. Dental decay.

<ul style="list-style-type: none"> • Early introduction of inappropriate solid foods to babies. 	<ul style="list-style-type: none"> • Inbalanced diet. • Insufficient levels of nutrition for growth. 	<ul style="list-style-type: none"> • Immature digestive system cannot cope; constipation, kidneys overload leading to failure.
<ul style="list-style-type: none"> • Low nutritional value food. 	<ul style="list-style-type: none"> • High carbohydrates and fats. 	<ul style="list-style-type: none"> • Poor growth but may be very overweight. • Dental decay. • Poor participation in social activities. • Breathing difficulties. • Low self esteem.

The Impact of Failure to Supervise, or Provide a Safe Environment:

Presentation	Immediate impact on the child	Possible long term impact on the child
<ul style="list-style-type: none"> • Household cleaners accessible. • Plastic bags accessible. • Baby left alone propped on cushions. • Matches/lighters accessible. • Levels of supervision inside and outside the home are inappropriate for the age of the child. 	<ul style="list-style-type: none"> • Ingestion of poisons/toxic substances. • Suffocation. • Potential for fire in the home which could accelerate rapidly. • Road traffic accidents. • Abduction. • Exposure to adults/children /young people who pose a potential risk. 	<ul style="list-style-type: none"> • Death. • Damage to vital organs. • Permanent brain damage impacting development. • Serious injury. • Lung damage caused by smoke inhalation. • Loss of home/possessions. • Inability to trust adults. • Mental health issues. • Low self esteem. • Self harm. • Poor school attendance.
<ul style="list-style-type: none"> • Unsupervised meal times/ proper feeding. 	<ul style="list-style-type: none"> • Choking. • Nutritional intake inadequate. • Burns/scalds. 	<ul style="list-style-type: none"> • Death. • Irreversible brain damage. • Weight loss.
<ul style="list-style-type: none"> • Unsupervised bathing. • Unsupervised exposure to unprotected areas of water e.g. garden pond. 	<ul style="list-style-type: none"> • Drowning or near drowning incidents. • Hypothermia. • Burns/scalds. 	<ul style="list-style-type: none"> • Death. • Irreversible brain and lung damage. • Frequent hospital visits/ operations
<ul style="list-style-type: none"> • Left home alone or with unsuitable children/ young people that cannot provide appropriate supervision. • Exposure to violent/ pornographic images/films/ games/media. • Exposure to domestic violence and abuse. 	<ul style="list-style-type: none"> • Sibling abuse/bullying. • Emotional trauma. • Emotional and sexual abuse. • Physical injury. 	<ul style="list-style-type: none"> • Acute life threatening neglect. • Developmental delays. • Emotional trauma. • Mental health difficulties. • Sexually inappropriate or problematic behaviour.

The Impact of Failure to Obtain Appropriate Health Care:

Presentation	Immediate impact on the child	Possible long term impact on the child
<ul style="list-style-type: none"> Failure to obtain vaccinations. 	<ul style="list-style-type: none"> Risk of contracting potentially serious childhood illnesses: Measles, Mumps, Rubella, Meningitis, Polio, Whooping Cough. 	<ul style="list-style-type: none"> Death. Irreversible brain damage. Damage to major organs. Chronic lung conditions. Repeat absences from school. Frequent hospital visits/stays.
<ul style="list-style-type: none"> Failure or delay in obtaining medical treatment when the child is ill. 	<ul style="list-style-type: none"> Risk of poisoning from inappropriate medication. Hospitalisation. 	<ul style="list-style-type: none"> Death. Prolonged suffering. Chronic ill health. Prolonged medical intervention. Frequent absences from school.
<ul style="list-style-type: none"> Failure to enable child to access developmental/health promotion opportunities. 	<ul style="list-style-type: none"> Delayed/failure to detect treatable conditions. 	<ul style="list-style-type: none"> Squints. Hearing loss. Congenital hip dislocation. Undescended testicles. Heart abnormalities. Delayed development/growth. Low self esteem. Visual/hearing impairments. Impairment of mobility. Dental decay. Delay in providing appropriate resources to maximise potential learning. Frequent absences from school. Poor academic achievement.

The Impact of Failure to Provide Personal Hygiene for the Child:

Presentation	Immediate impact on the child	Possible long term impact on the child
<ul style="list-style-type: none"> Persistent failure to adequately wash/ change nappy. No/poor potty or toilet training and hygiene. 	<ul style="list-style-type: none"> Pain and discomfort cause Irritability and crying baby. Nappy area becomes red and sore. Soreness around anus. Constipation/reluctance to open bowels. Skin folds become moist. 	<ul style="list-style-type: none"> Increased stress levels. Future inattention to bodily functions. Pain and discomfort. Infection, septic spots, fungal infection, appearance of 2nd degree burns (dramatis), fissures. Urinary tract infection in females. Pain associated with constipation may cause behaviour difficulties in toddlers and children. Dietary problems. Isolation/poor social skills. Low self esteem. Bacterial growth, infection which may be difficult to clear and require local systematic treatment.

<ul style="list-style-type: none"> • Persistent failure to ensure hands and nails are clean and nails are cut. 	<ul style="list-style-type: none"> • Transmission of threadworms. • Sharp broken nails cause damage to the skin. • Nail tears. 	<ul style="list-style-type: none"> • Infection. • Gastroenteritis, toxoplasmosis, toxocariasis. • Widespread damage to retina or eye. • Pain, infection.
<ul style="list-style-type: none"> • Persistent failure to ensure hair is regularly clean/brushed/combed. 	<ul style="list-style-type: none"> • Head lice, excessive scratching, broken skin. • Hair knotted/tangled/smells. 	<ul style="list-style-type: none"> • Infections. • Social isolation/stigma. • Victim of bullying. • Low self esteem. • Poor academic achievement. • Poor self care skills that do not develop as they grow.

The Impact of Failure to Provide Personal and/or Environmental Warmth:

Presentation	Immediate impact on the child	Possible long term impact on the child
<ul style="list-style-type: none"> • Poorly heated environment. 	<ul style="list-style-type: none"> • Hypothermia. • Chest infections / Pneumonia. • Premature babies may have difficulty in retaining their body heat. • Cold injury – swollen hands and feet, • Babies reluctant to feed. 	<ul style="list-style-type: none"> • Death. • Repeated chest infections requiring frequent trips to a health setting. • Loss of function of limbs. • Dehydration and weight loss. • Malnutrition.
<ul style="list-style-type: none"> • Clothing inadequate for weather conditions. 	<ul style="list-style-type: none"> • May 'stand out' from their peers. • Children may present with pallor and blueness of extremities. 	<ul style="list-style-type: none"> • Victim of bullying. • Social isolation. • Low self esteem • Lethargic • Low academic achievement

Learning from Serious Case Reviews (SCR):

In Northamptonshire, neglect has been identified as an issue in a number of SCR's including that of Child R and Family R published in April 2016. The overview report can be found [here](#) and offers further insight into the issues identified in this review.

A number of reviews and analyses of Serious Case Reviews nationally have taken place seeking to summarise the learning from these cases. A summary of this guidance is listed below for practitioners' reference (the References section at the end of this document offers suggestions for further reading):

- a. A large percentage of children who were subject of Serious Case Reviews involving serious incidents and death were known to agencies in relation to long-term neglect. This indicates the severe extent of the harm that neglect can do. It should be mentioned that whilst there are particular characteristics of children that make them more vulnerable to harm, children of all ages and spectrums of ability have been represented in Serious Case Reviews.
- b. Reviews found that there had been insufficient challenge by professionals to parents and carers whose comments or explanations for injuries had been accepted at face value, even where those explanations seemed unrealistic. Often, there was a focus on the adult parent or carer in relation to their complex needs, allied with a desire to support them and to be optimistic about their parenting of their child. Many reviews have described the *rule of optimism* which is a tendency by professionals towards rationalisation and under-responsiveness in certain situations. In these conditions, workers focus on adults strengths, rationalise evidence to the contrary and interpret data in the light of this optimistic view. They confuse parental participation with meaningful engagement by parents.
- c. The *rule of optimism* is at the cost of maintaining focus on the child who risked becoming invisible in their own safeguarding interventions. Reviews described professionals having a poor understanding of what life was like for the child now, or what life would be like for the child in the future if nothing changed. Steps were not taken to establish the wishes and feelings of children or young people or for their voice to be sufficiently heard.
- d. Most of the Serious Case Reviews identified sources of information that could have contributed to a better understanding of the child and their family. This included information about or from fathers and extended family, historical knowledge, information from other agencies, the cultural background and research findings.
- e. Many reviews commented on the issue of fathers or father-figures who either absented themselves or were not known to safeguarding professionals, but who had a significant influence in the family and on the welfare of the child. In a number of reviews, these male figures were not known or not engaged with by professionals and the risk they posed in the home was either not understood or misunderstood thus jeopardising safeguarding activities.
- f. Most of the reviews noted difficulties in inter-agency information sharing and multi-agency working together. Some reviews noted 'silo' working whereby professionals did not look at the needs of the child beyond their own specific brief. There were also concerns that poor co-operation and information sharing meant that professionals assumed – incorrectly – that someone else was undertaking an important aspect of information sharing such as reporting a concern.
- g. A number of reviews explored concerns about the 'start-again' syndrome or 'assessment paralysis', whereby assessment was viewed as a child protection intervention in itself rather than as a process by which the most appropriate intervention can be identified.

- h. Recording – or rather the absence of clear records which can then inform planning and decision making – has regularly been a feature of learning from Serious Case Reviews. This includes chronologies which help in the management of neglect which involves harm experienced by the child over a prolonged time. It is imperative that chronic harm is not viewed as a series of single incidents or episodes but rather that a longer-term developmental perspective is taken.
- i. Many reviews have highlighted short-comings in supervision and the lack of opportunities for practitioners to participate in reflective supervision and critical thinking in child protection cases. Such supervision can provide opportunities to question underlying assumptions – or fixed ideas – about the circumstances in the family; offer support from multi-agency working, guide the work with families presenting with complex difficulties, ensure holistic assessments and that the child's views are obtained and that they influence future decision making.

6.0 Assessment of Neglect

An assessment must address the most important aspects of the child's needs and the capacity of the parents or carers to respond to those needs within the wider family and community context. These are the three domains of the Assessment Framework, shown below. An important principle of the Assessment Framework is that assessments are based on inter-agency collaboration and contribution and are not the sole responsibility of one agency. The assessment should be informed by a variety of relevant sources, develop a critique and an analysis, draw conclusions about risks and protective factors and create plans for a way forward. These plans need to be implemented, monitored and reviewed.



The Framework for the Assessment of Children in Need and their Families, DH, 2000.

Key areas to consider when undertaking an assessment:

- **Understand the family's circumstances:**
A clear understanding of the family's background and previous involvement with services is required at the start of assessment 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 incidences of neglect, which over time begin to identify patterns of parenting and heightened 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 overstated.
- **Talking with parents about the neglect:**
It is often difficult to raise issues with parents 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.

- **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.
- **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 requiring high levels of support. It is important to offer support and services to parents and carers who will ultimately enhance the care of their children, however this must never be allowed to compromise the clear focus on the needs of the child.
- **Avoid drift and lack of focus:**
It is important to plan the assessment and have clear time-scales for finalising written assessments. Remember that before, during and after undertaking formal assessments, the safeguarding interventions and service delivery still need to be inputted as required to protect the child. These services and interventions can inform the assessment process.
- **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 Learning Meetings to discuss issues, share concerns and keep neglect issues in focus.
- **Use assessment tools as a means of focussing and reviewing:**
Assessment tools can be used as a means of evidencing concerns and will give clarity and a transparent basis to any planning of interventions or legal proceedings if they become necessary. Assessment tools can highlight where more in-depth work needs to be undertaken or joint working with specialist services. It is important to remember that assessment tools should not be used as a tick-box but will require an application to the child and family's unique circumstances and will always warrant use of professional judgement.
- **Consider at an early point the likelihood of the parents capacity for change:**
Practitioners involved with child neglect should guard against being overly optimistic about the potential for parents to effect lasting change and consistently provide well enough parenting. Change is not always possible and even when positive change occurs, practitioners need to be mindful of the degree of improvement experienced by the child, which may be relatively minor, and to monitor to ensure that positive changes are sustained over time.

Families may co-operate with plans although their motivation in doing so 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 assessment of positive change needs to be made on the basis of timely outcomes for the child. The *rule of optimism* can come into play, whereby practitioners are reluctant to consider possible signs of abuse or minimise the significance of what children say, because the parents are perceived to be making improvements. Practitioners should also be careful not to implement 'start again syndrome' with families and (re)commence assessment work at points such as change in worker or an incident in the family, without taking into account previous understanding of the family dynamics. 'Start again syndrome' can cause delay and undermine the effectiveness of an assessment or plan.

Appendix 1 contains further information and tools to support practitioners to assess parental motivation to change.

- **Assess sources of resilience as well as risk:**
Assessments should not overlook the importance of sources of resilience and opportunities for building upon areas of a child's life that reduce the risk. Resilience has been described as *"qualities which cushion a vulnerable child from the worst effects of adversity, in whatever form it takes, and which may help a child or young person to cope, survive and even thrive"* (Gilligan, 1997). There are many aspects of resilience, the key area is secure attachment with one other person and other areas include a sense of self-esteem, a safe friendship group, problem solving skills, social skills, abilities, talents, or interests and hobbies. Assessing resilience in a child needs to be done with care as some children may present as being able to cope or minimise their sense of vulnerability.
- **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.
- **Address the child's basic needs:**
The assessment process should continue to consider the child's basic needs and routinely check aspects of care e.g. food in the cupboards and fridge, sleeping arrangements, hazards in the home, toilet and bathing facilities. Practitioners will need to look into rooms and cupboards to observe these aspects rather than take what parents say at face value. Gaining agreement to do this is important and relates to discussions held with the parents at the engagement stage of the work.
- **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, a stepchild or a change in life circumstance. Negative feelings may be projected onto one child but not others in the family.
- **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 safeguarding professionals.
 - It is important to use age and interest appropriate tools, games and other methods to communicate with children. These can help to begin the process of engaging 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 everyday 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.
 - Speak with the child in their first language or using the communication methods with which they are comfortable. This may require you to use interpreters or to seek specialist advice.
 - Children value being treated with respect, honesty and care. This involves listening to them and showing that you have heard, remembered and have taken into account what they have expressed. It also involves making sure that they are not let down e.g. missing appointments with them or making last minute changes to plans that have been agreed with them. These behaviours can impair any relationship that they want to form with you and reinforce any negative feelings about themselves.
 - Children should be spoken to and observed to determine the quality of attachment they have to their parents and siblings and other members of the family.

- Consideration should be given to each child within the family. How are they different or similar, e.g. in appearance and personality? Are any of the children in the family more resilient than others to the care they are receiving? What can be discovered about their health and development (using the dimensions of the Assessment Framework)? Theories of child development should be used as a benchmark by which to measure concerns about a child's presentation and welfare.
- Give children age appropriate explanations about why you are involved and what information you will discuss with their parents.

- **Be confident about the assessment:**

A good assessment that practitioners can be confident in is one that includes:

- All relevant information (and comments on any gaps).
- An evidence base, including tools, guidance, research.
- Analysis and evaluation of the information. Analysis is key to any assessment and involves interpreting and attaching meaning and significance to the information that has been gained and to observations that have been made. If the information that has been gathered is a description of 'what' has happened, the analysis should reflect on 'so what' does that mean for the individual child now and in the future.
- Reasoned conclusions and professional judgements.
- Plans for the logical next steps and timeframes, i.e. the 'now what'. It is imperative that those next steps are implemented and their effectiveness monitored and measured.
- Update and revision (assessments have to be an ongoing process not a single event) in the light of new and emerging information

- **Specialist assessments:**

These can be useful but should only be commissioned in specific, agreed circumstances where there are additional complexities. Examples of such situations may include:

- Children born to parents with additional needs such as chronic mental ill-health difficulties, parents with a disability or long term illness who may face particular challenges which may impact on their parenting capacity. Joint working between professionals working with adult and children's services should occur.
- Children born to mothers who use drugs during pregnancy may suffer from withdrawal and exhibit distressed or restless behaviour which parents find difficult to manage. Parents may lack motivation because of drug use and may find meeting the needs of their children difficult. A pre-birth assessment may be required in these cases to inform planning. Joint working between professionals working with adult and children's services should occur.
- Babies born prematurely or with low birth weight may mean that parents find coping with the high dependency needs of the baby to be very stressful and this may have a negative effect on the ability of the carer to form attachments to the baby. These children are more likely to have feeding difficulties, chronic illness, and neurological, behavioural and cognitive disabilities than other children.
- Children with disabilities are more vulnerable to abuse and neglect but are unrepresented in child protection figures. Research indicates that children with disabilities are 3.4 times more likely to be abused than non-disabled children and 3.8 times more likely to be neglected (Sullivan and Knutson, 2000). Reasons for this are varied and complex, they may be less able to communicate their needs and concerns, or to be able to access help outside of their families; the stresses of caring for a disabled child may mean the child becomes the outlet for the parents' frustration.

7.0 Assessment Tools to be used in Northamptonshire

7.1 Graded Care Profile (GCP):

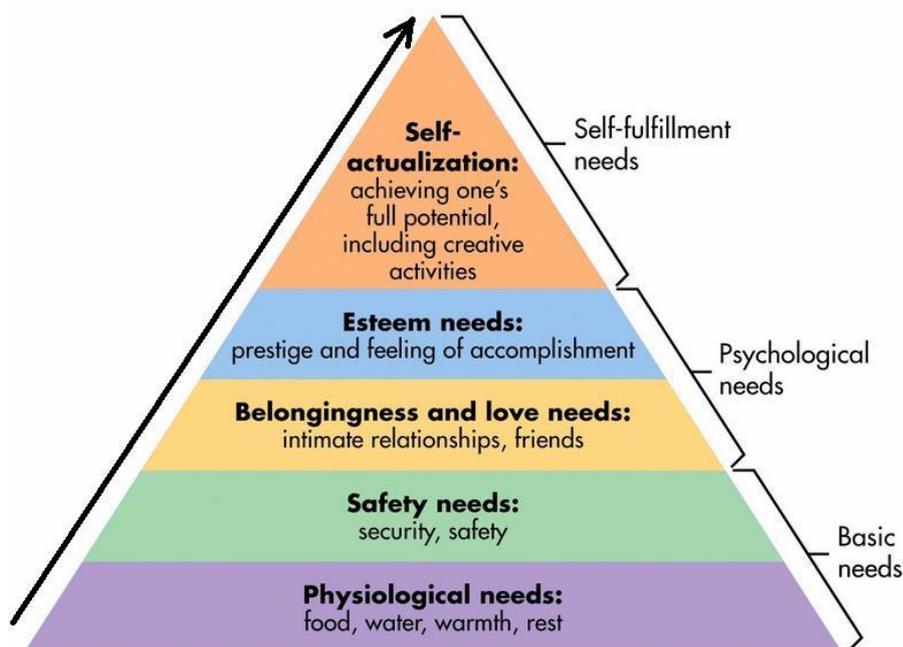
As we have seen, effective assessment of neglect is a key to improving outcomes for children. The Graded Care Profile (GCP), developed by Drs Srivastava and Polnay, is a practice tool which helps practitioners identify neglect and assess the care that is given to children.

The GCP is a tool that gives an objective and graded measure of the quality of care provided to children across four areas of need: Physical, Safety, Love and Esteem. The GCP displays both the strengths and weaknesses in different grades (1-5, with 1 being the best care and 5 being the poorest care) so that it defines the quality of care giving. It helps to target areas of work and can support the understanding of changes after interventions have been made. It is important from the point of view of objectivity because the ill effect of bad care in one area may be offset by good care in another area. It can enable engagement with families because areas of strength as well as weaknesses are highlighted.

The benefits of using the Graded Care Profile are:

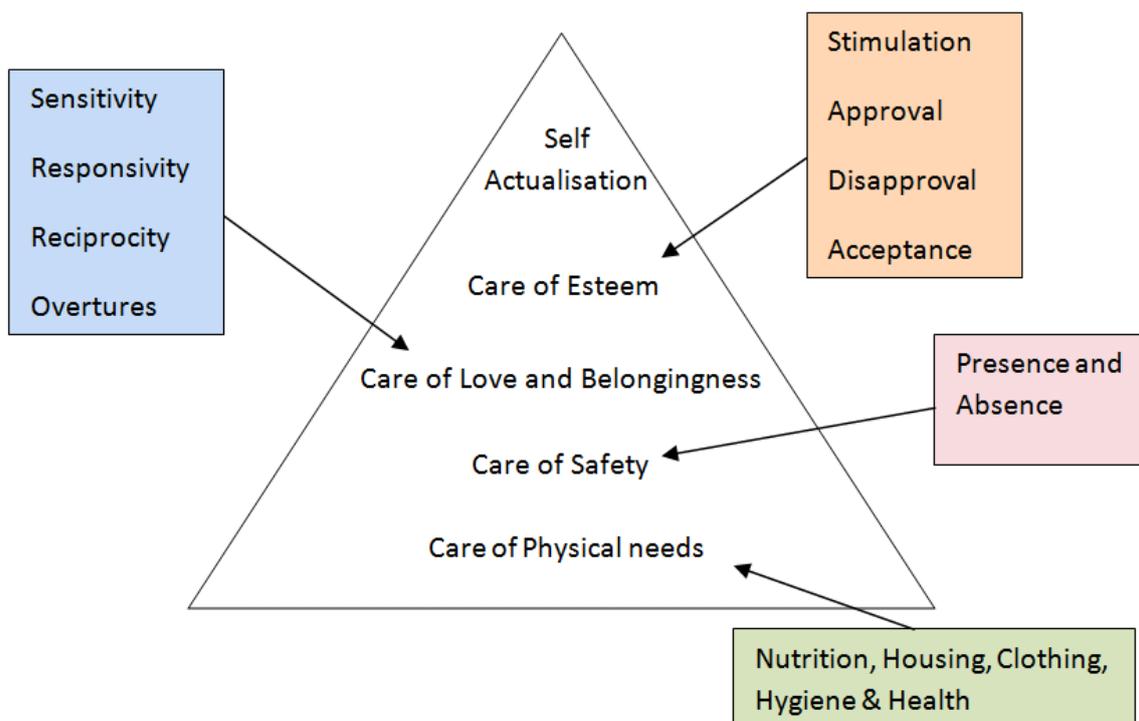
- The early recognition of neglect through the clear identification of environmental risk factors or concerns.
- The categorising of the level of neglect as severe, intermediate or low.
- The early referral of severe neglect and focused intervention in intermediate cases to prevent deterioration.
- The SMART management of neglect.
- The timely referral to Children's Social Services where early intervention has demonstrably failed.
- The immediate referral to Children's Social Work Services where the GCP score grading is in the severe category, thereby minimising length of exposure to the neglect.
- The post-referral use of the GCP scores to complement other statutory assessments.
- Assessing the impact of intervention in measurable steps and the timely initiation of legal proceedings where intervention has demonstrably failed.

The GCP is based on Maslow's *Hierarchy of Needs* represented below:



The GCP develops the Maslow hierarchy by creating sub-sections for the first four levels, which in turn have been translated into a set of descriptive behaviours that can be measured as in the model below:

1. **Physical** - nutrition, housing, clothing, hygiene and health.
2. **Safety** - present and absent.
3. **Love** - sensitivity, responsivity, reciprocity, overtures.
4. **Esteem** - stimulation, approval, disapproval, acceptance.



This gives us 13 sub-sections. Underneath each subsection are a set of factors that need to be observed in terms of the parent-child interaction as follows:

Areas of Need	Sub-Sections	Descriptive Factors			
Physical	Nutritional	Quality	Quantity	Preparation	Organisation
	Housing	Maintenance	Decor	Facilities	
	Clothing	Insulation	Fitting	Look	
	Hygiene				
	Health	Opinion sought	Follow up	Surveillance	Disability
Safety	In presence	Awareness	Practice	Traffic	Safety Features
	In absence				
Love	Carer	Sensitivity	Response Synchronisation	Reciprocation	
	Mutual Engagement	Overtures	Quality		
Esteem	Stimulation				
	Approval				
	Disapproval				
	Acceptance				

The grading table is below and helps to identify how well the child’s needs are met in relation to each of the descriptive factors previously noted.

	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
1	All child’s needs met	Essential needs fully met	Some essential needs unmet	Most essential needs unmet	Essential needs entirely unmet/ hostile
2	Child first	Child priority	Child / carer at par	Child second	Child not considered
3	Best	Adequate	Equivocal	Poor	Worst

1 = level of care; 2 = commitment to care; 3 = quality of care

You will find the full GCP tool in **Appendix 2** of this guidance (with acknowledgments to Salford and Luton LSCBs) and offers detailed instructions about completing the assessment and scoring the observations.

7.2 Neglect Screening Tool:

The Graded Care Profile (GCP) is the preferred tool for practitioners when assessing neglect in Northamptonshire however it is noted that some practitioners may only come into contact with children, young people and their families for a short period of time so may be unable to complete the GCP; this would include A&E Staff, Ambulance Crews, Police Emergency Staff and many more.

In order to ensure these professionals still have the ability to assess neglect in a timely manner the NSCB have developed a Screening Tool that will determine whether a full assessment using the Graded Care Profile (GCP) is needed and assist with concluding whether or not a referral into MASH is required.

If upon completion of the Screening Tool you still have concerns about the family regarding neglect you should use the screening tool to as evidence in a referral. You may also take a number of steps, including requesting that an appropriate person – usually a designated professional - within your organisation undertakes a full assessment using the GCP with the family. You will need to consult your own agency’s procedures for further guidance on how to do this. If as a result of using the Screening Tool you decide on referring to the MASH please see the following section on *How to Make a Referral and Next Steps*. You will also need to be clear on why you feel further assessment using the GCP would be of benefit to the child, young person and family and include a copy of your completed Screening Tool as evidence to support your referral.

A copy of the Screening Tool can be found at **Appendix 3**.

8.0 Chronologies

Chronologies are imperative for a true picture of family history. A chronology seeks to provide a clear account of all significant events in a child's life to date. This brief and summarised account of events provides accumulative evidence of patterns of concern as well as emerging need and risks and can be used to inform decisions on support and safeguarding services required to promote a child's welfare. Chronologies are particularly important when working with neglect where there may be fewer critical incidents, but where children live in families where they are exposed to chronic and long term harm. Chronologies can help identify these patterns of harm.

Chronologies do not replace routine case recording, but offer a summary view of events and interventions in a child's life in date order and over time. These could be, for example, changes in the family composition, address, educational establishment, in the child or young person's legal status, any injuries, offences, periods of hospitalisation, changes to health, interventions by services. The changes that are noted could be positive or negative events in the child's life.

The chronology should be used by practitioners as an analytical tool to help them to understand the impact, both immediate and cumulative, of events and changes in the child or young person's developmental progress.

Chronologies are undertaken for these reasons:

- Done effectively it helps to place children at the centre of everything we do.
- An effective chronology can help identify risks, patterns and issues in a child's life. It can help in getting a better understanding of the immediate or cumulative impact of events.
- It helps to make links between the past and the present, helping to understand the importance of historic information upon what is happening in a child's life now.
- Good chronologies enable new workers to become familiar with the case.
- Importantly, a good case chronology can, at a later stage, help children, young people and families make sense of their past.
- A good chronology can draw attention to seemingly unrelated events or information.
- Using chronologies in practice can promote better engagement with children and families.
- Accurate chronologies can assist the process of assessment, care planning and review.
- When carried out consistently across agencies, good chronologies can improve the sharing, and understanding of the impact of information about a child's life.

Compiling a chronology:

The way that a chronology is compiled and how it is used and referred to will have a significant impact on the future outcomes for the child. When undertaking a new chronology:

- Commence chronologies at the start of your involvement in a case.
- Enter relevant information as it occurs, including the date of the event and the source of the information.
- Include only factual information – analysis and professional opinion on events should be recorded within the case records or assessment documentation.
- Enter information throughout your involvement in the case, an out of date chronology cannot provide full information for further analysis and planning.
- Be brief in chronologies, normally one line.

Make reference to where in the case records more detailed information can be found.

If chronologies are to help with ongoing analysis of the case, they must be reviewed and used as a 'live' document in the following ways:

- When adding information to case chronologies consider its relationship and relevance to previous information. (For example, numbers of missed appointments, A&E appointments, Police call outs to a home, numbers of injuries over time etc). Ask yourself after making a new entry "what is the impact of the known information on this child and what else do I need to do?"
- Build in regular reviews of the chronology to assist in the case planning and evaluation progress, for example, in preparation for reviews and discussion in supervision.
- Share the information being placed in chronologies with children, young people and families as appropriate. This can be to (a) check for accuracy of information (b) check children and family's views and perceptions of the information/events.

9.0 Working with Resistance

Resistance is used here as a catch all phrase to indicate a range of parental behaviours which serve to keep professionals at bay and from identifying, assessing and intervening in neglect. Working with resistant families is very challenging indeed, and good multi-agency working and effective supervision is essential to support practitioners and help maintain the focus on the needs of the child. The quality of supervision available is one of the most direct and significant determinants of the practitioner's ability to develop and maintain a critical mindset, and work in a reflective way. This is pivotal when practitioners are working with resistant families. Resisting behaviours by family members can seriously hamper professional practice and leave already vulnerable children subject to significant harm. In terms of prevalence, a 2005-2007 analysis of Serious Case Reviews found that 75% of families were characterised as uncooperative (Brandon 2008).

The existence of resistance may be identified when parents:

- Only consider low priority areas for discussion.
- Miss appointments.
- Are overly co-operative with professionals.
- Are aggressive or threatening.
- Minimise or deny events or responsibility or the effects on the child.

Parents and carers resist in numerous ways and their reasons for doing so vary. At one end of the continuum, parents may genuinely not understand the problem or the way it has been defined and feel they are unfairly caught up in a process which is not their responsibility. At the other end, some parents understand they are harming their children and wish to continue to behave in this way without interference. In the middle are parents who fear authorities, have previously had poor experiences of authority, lack confidence and feel anxious about change. They may struggle to work with individual practitioners. Research indicates that families want to be treated with respect and in a non-judgemental way, be kept fully involved in processes and receive services which meet their needs in a timely manner.

When considering whether resistance is a dynamic in the family, it is helpful to clarify the identifying behaviour and possible alternative reasons for it. This is because sometimes what appears to be resistance is rather a family's frustration regarding the type and quality of service they are receiving, which is not meeting their needs; rather than an attempt to divert attention from the safeguarding concerns in their family.

Resistance can be grouped into four types:

- Ambivalent
- Denial/avoidance
- Violent/aggressive/intimidating
- Unresponsive to intervention/disguised compliance

Ambivalent:

Parents may have mixed, conflicting feelings towards the agency, the individual worker or the safeguarding issue. Most parents who are involved in safeguarding interventions will experience mixed feelings but some, in extreme situations may remain stuck in their ambivalence. Behaviours related to ambivalence include avoidance of people, meetings or of certain topics; procrastination, lateness for appointments or superficially undertaking the tasks required. Ambivalence occurs when families are not sure of the need to change or are stuck at a certain point.

Denial/Avoidance:

This could manifest as a result of feelings of passive hopelessness and involve tearfulness and despair about change. It may also be about parents wishing to hide something relevant or being resentful of outside interference. Indicators include an unwillingness to acknowledge the neglect; purposely avoiding practitioners; avoiding appointments or cutting visits short due to other apparently important activities.

Violence, Aggression and Intimidation:

Parents who actively display violence or anger or make threats which could either be obvious, covert or implied e.g. discussion of harming someone else; use threatening behaviour e.g. deliberate use of silence, bombarding professionals with e-mails and phone calls or entering personal space; use intimidating or derogatory language or swearing, shouting and throwing.

Unresponsive to intervention/disguised compliance:

Disguised compliance is identified by Fauth et al (2010) as *"families where interventions are not providing timely, improved outcomes for children"*. Reder et al (1993) state that it is where a parent gives the appearance of co-operation to avoid raising suspicions, to allay professional concerns and diffuse professional intervention. Indicators of disguised compliance include:

- No significant change at reviews despite significant input.
- Parents agreeing about the change is needed but making little effort.
- Change occurring, but only as a result of external agencies' efforts.
- Change in one area of function not matching change in other areas.
- Parents engaging with certain, preferred, aspects of a plan, and aligning themselves with certain professionals.
- A child's report of matters conflicting with that of the parents.

This can be classified as passive-aggressive resistance because co-operation is noticeable but is superficial and the compliance covers up hostility, antagonism and anger. Disguised compliance occurs when parents want to draw the professional's attention away from allegations of harm and by giving the appearance of co-operating to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention.

It is a significant concern because the apparent compliance can affect the professional's engagement with families and children and can prevent or delay understanding of the severity of harm to the child. Examples of disguised compliance include a sudden increase in school attendance, attending a run of appointments, engaging with professionals such as Health Workers for a limited period of time, or cleaning the house before a visit from a professional. Disguised compliance has been reported to be a dynamic in many Serious Case Reviews and the learning from these indicates that the following practice is helpful:

- Focus on the child, see and speak to the child, listen and take account of what they say.
- Cross check what parents say, question the accounts they give, get additional opinions and remain curious. Above all, don't take at face value explanations that parents give for significant events or incidents.
- Address the safeguarding aspects for children who are living in chronic neglect.
- Don't be overly optimistic without sufficient evidence. Be curious about what is happening to the child.
- In supervision and within the multi-agency network consider which strategies to employ when families are hostile and keep professionals at arm's length.
- Share information with other professionals and other agencies, check your assumptions with your colleagues, and explore with each other the parent's accounts of events.

Appendix 1 discusses further assessment of parental motivation to change and shows a model to help with the identification of compliance and whether it is genuine commitment, tokenism, avoidance or externally motivated compliance which seeks approval from others. Practitioners are referred to **Appendix 1** for further details - the model (with additional detail) is as follows:

<p style="text-align: center;">GENUINE COMMITMENT Talk the talk & walk the walk</p> <p>Parent recognises the need to change and makes a real effort to bring about these changes.</p>	<p style="text-align: center;">TOKENISM Talk the talk</p> <p>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. Changes occur in spite of, not because of, parental actions.</p>
<p style="text-align: center;">COMPLAINE / APPROVAL SEEKING Walk the walk: disguised compliance</p> <p>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</p>	<p style="text-align: center;">DISSENT / AVOIDANCE Walk away</p> <p>Dissent can range from proactively sabotaging efforts to bring about change to passively disengaging from the process.</p> <p>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).</p>

Howarth and Morrison (1999)

10.0 Planning, Reviewing and use of Supervision

Multi-agency plans should be in place for children who are considered to be in need or vulnerable as a result of neglect. A plan should be in place whatever level of service or intervention is being offered, and whether it is a single or a multi-agency intervention. The plan should be drawn up with the family, including the child wherever possible, together with any other agencies involved.

The plan should detail the outcomes sought, the services that will be offered to the family and the clear timescales for effective changes to be demonstrated. The plan should be SMART:

- Specific
- Measurable
- Achievable
- Realistic
- Timely

Children who are neglected are often isolated within the community, by their peers and sometimes within their own families. Plans for children should consider ways in which children could become involved in activities to reduce the experience of isolation. In order to reduce risks, plans for children who have been neglected need to address the process of building resilience. Building resilience might include:

- Linking a child with leisure or community services.
- Linking a child with school based activities.
- Linking the child with a safe adult or friend who might be willing to spend time doing activities with the child.

The plan should be reviewed on a regular basis. A review can be held if there is a change of circumstances or an event that suggests the plan needs to be changed in any way. Parents and the child (where appropriate), should always be encouraged to attend and take part in the review.

Where children are subject to a Child Protection Plan as a result of concerns about neglect, the plan will be reviewed in accordance with the timeframe set out in the NSCB Child Protection Procedures.

Other considerations that may be important in planning and reviewing services include:

- Think creatively from a needs-led perspective that draws on informal as well as formal avenues of support and assistance.
- Whenever possible try to express outcomes in terms of behaviours and include how the anticipated changes will help the children thrive, develop and reach their potential within the plan.
- Think about the learning needs/styles of the parents and ensure that what is being offered to them is suitable.
- Consider whether the service you are proposing/providing is empowering a family, or whether it is contributing to feelings of dependency.
- Think specifically about how each child is included in the plan – does the child need help and support to improve their self-esteem, build resilience or cope with some aspect of their lives?
- Consider any parental needs that remain un-met and whether this will undermine their capacity for change. There may be a need to involve adult orientated services if this is the case.
- Try to ensure that the plans are co-ordinated and agreed across services so that the family experiences clarity and consistency about the required changes.

In complex cases where practitioners have been involved for 6 months and no progress appears to have been made, it might be helpful for the review to be chaired by someone independent of the line management of the case.

It may be that further assessments will be needed if there are new or ongoing concerns about a child.

The Purpose of Supervision:

Good supervision is central to the management and oversight of work with families where there are concerns about child neglect. The supervision process should ensure:

- The worker is clear about their roles and responsibilities.
- The workers meet their agency's objectives.
- A quality service is provided to children and parents.
- A suitable climate for practice is developed.
- The worker is supported in accessing appropriate pathways for professional development.
- The worker is supported in managing stress.

Professionals will always need to refer to their employing agency's policy in relation to staff supervision.

In working with neglectful families, there are further specific considerations:

- Serious neglect poses worrying problems for practice. It raises anxiety but also can create a kind of numbed despair. Working with chaotic families can equally be reflected in a sense of hopelessness. Part of the supervisory process should identify these feelings and work on ways of minimizing the effects.
- A lack of direction and drift have been characteristics in a number of cases where neglect has resulted in tragic deaths. Therefore, a key component of effective supervision should be to give focus and purpose to the work.
- Supervision must always review the state of the children at that time and consider risk in a holistic sense, for example the implications of missed medical appointments etc.
- It is unhelpful to assume that case closure in cases of serious neglect is realistic within ordinary time scales. Supervision should involve a dialogue about outcomes sought for the child.
- Since inter-agency and inter-professional working is essential for these cases, supervision in the conventional sense can usefully be widened, and can on occasion (for example) involve managers and workers from other agencies in a case discussion.
- Supervision should support practitioners in being open and honest with parents about the ways in which their care falls short of meeting their children's needs, and what should be done, not only about immediate safety, but about the conditions for their child's healthy development.
- Supervision should identify clearly where attempts at partnership are failing.
- Furthermore, it may be that agency involvement needs to be long term. This needs clarity of purpose and a shared belief in the capacity of the parents to provide good enough care, albeit with supplementary support. **Supervisors may also have a number of lessons to learn about such cases. Their experience in turn, may influence others in the agency.**
- Supervision should identify issues which workers need to take forward through training and professional development.
- Supervision should always encourage honest and meaningful reflection - *"Reflective practice is something more than thoughtful practice. It is that form of practice that seeks to problematise many situations of professional performance so that they can become potential learning situations and so the practitioners can continue to learn, grow and develop in and through practice"* (Jarvis, 1992:180 in McLure, no date).

11.0 The Role of Early Help in Cases of Neglect

The impact of neglect on children is often cumulative, advancing gradually and imperceptibly and therefore there is a risk that agencies do not intervene early enough to prevent harm. It is important that all agencies, Health, Schools/Education, Children's Centres, Police, Probation, Housing, Voluntary and Community Organisations identify emerging problems and potentially unmet needs and seek to address them as early as possible. It is equally important that practitioners are alert to the danger of drift and 'start again' syndrome.

The Ofsted thematic inspection on joint working between Children's Services and Adult Mental Health Services highlighted the lack of signposting to early help by Adult Services and particular delays in considering the impact of paternal mental ill health on children.

Working Together (2015) requires local agencies to have in place effective assessments of the needs of children who may benefit from Early Help Services. In Northamptonshire, partners should effectively utilise the Early Help Assessment (EHA) to assess unmet needs and co-ordinate appropriate support. The delivery of an effective Early Help offer is not the responsibility of a single agency - it requires a Whole-Family approach owned by all stakeholders working with children, young people and families.

In order to address neglect in Northamptonshire it is important that all agencies work together in an integrated way, using the EHA and co-ordinating work through the Team Around the Child or Family to assess and plan services for children and families.

The Early Help Menu of Services supports practitioners to access services to support this work www.northamptonshire.gov.uk/earlyhelp. It is similarly important to ensure that when specialist services are stepping down there is continued longer term co-ordinated support, to enable parents to sustain the improvements in care that have been achieved.

12.0 How to Make a Referral and Next Steps

Once concerns about neglect are identified practitioners need to make judgments about the level of intervention that is required and what should happen next. The practitioner or agency that has identified the concerns must evaluate the seriousness of their concerns and decide what the appropriate response should be using the [Northamptonshire Thresholds & Pathways Document](#) and/or having a conversation with an Early Help Advisor in the Northamptonshire Multi Agency Safeguarding Hub (MASH).

Making judgments about referrals can cause some anxiety for practitioners as well as creating tension between agencies. Building good working relationships between agencies, developing an understanding of respective agency roles and capacity as well as a shared understanding around thresholds can assist with this. Being able to articulate concerns clearly by drawing on signs and indicators, risk factors and knowledge of the impact of neglect will also be helpful.

Decisions following the identification of neglect may include:

- Talking about your concerns with the family and continuing to support and monitor the situation as a single agency.
- Gaining consent from the family to start an Early Help Assessment (EHA).
- Referring for additional support e.g. from Preventative Services / Early Help Services.
- Referral (via MASH) to Children's Social Care as Child in Need (S.17) or;
- Referral (via MASH) to Children's Social Care as Child Protection (S.47).

If a decision is made not to refer to MASH, the agencies that are already involved should discuss with the family whether the EHA process would be appropriate. Making a decision not to refer may be a suitable response if there is potential to effect positive change and if the risks to the child are felt to be manageable. Within these situations it is also important that the parents have a level of understanding and acceptance of the practitioner concerns and the motivation to work with others to improve things. It is important to clearly record reasons for not making a referral, consider the use of the EHA process and keep these decisions under review.

Where a family or child is receiving targeted or universal support services as a result of concerns about neglect, it is particularly important that the support is planned, monitored and reviewed regularly and that there is a good system for interagency liaison and coordination. It may be a good idea for a Team Around the Family meeting (TAF) to be held to clarify this.

If the decision is taken to offer support without a referral to Social Care it is always good practice to review this decision at regular intervals with your supervisor or line manager with the following considerations:

- Is the plan working and is this making a difference for the child?
- In view of the signs, indicators and risk factors that originally caused concern, has there been any change?
- Is it appropriate to make a Child in Need referral to Children's Social Care via MASH?
- Is there an indication that the child is at risk of significant harm and may be in need of protection? If so, refer the matter urgently to Children's Social Care via MASH.

Serious concerns in regards to a child's welfare or development will always need to be referred to MASH in order that a multi-agency assessment can be undertaken to determine whether the child is a Child in Need and what services may be required.

As well as the factual information about the child, their family members, and the reasons for the referral, MASH will require the following information:

- What evidence is there of an impact on the health and safety of the children? (draw upon facts and observations rather than feelings and assumptions)
- Any completed versions of the Graded Care Profile or Neglect Screening Tool.
- What changes have occurred in the family circumstances to require a referral?

- Why you think this has come about?
- What has already been done to try and improve the situation?
- Does the parent know they are being referred and what sort of help do they want or expect?
- How will you remain involved with the family?
- What would you like Children's Social Care to do?

Professionals who make referrals to Children's Social Care via MASH should address the questions above when completing the MASH Referral form which can be accessed [here](#).

Making a referral to children's social care via MASH - seeking parental consent:

Practitioners who refer their concerns to MASH need to decide whether the consent of the person with parental responsibility is required. However if there is evidence that by seeking consent the child or young person may be at risk of, or at further risk of significant harm, then consent may not be necessary. However, these concerns should be discussed with MASH at the point of referral.

If there is uncertainty about the level of concerns, referral must not be delayed. It may be useful to discuss any referral dilemmas with:

- A line manager/supervisor.
- The agency lead person for safeguarding.
- MASH.

Response by Children's Social Care/MASH to referral:

When a child is referred to Children's Social Care via MASH an initial decision will be made within 24 hours as to the actions required, and whether a Single Assessment will be undertaken. If the referral progresses to a Single Assessment, this will entail a full consideration of the circumstances of the child and their family. It aims to identify needs and whether services are necessary to promote the child's welfare.

The outcome of a Single Assessment may be that:

- Children's Social Care will not offer any further service but that Universal Services should continue to work with the family.
- The EHA process should be used.
- A Child in Need plan co-ordinated by Social Care is appropriate.
- A Strategy Discussion is required.

Children in Need or Children who are in Need of Protection:

Children in Need of Protection are children who are suffering or are likely to suffer significant harm, including those children whose lives are in danger or who are at risk of serious harm. The children may already be known to Children's Social Care or another professional who is concerned about maltreatment of the child. However, this may also be the first time the concern has come to the attention of a professional.

Once the local authority has reasonable cause to suspect that a child is suffering or is likely to suffer significant harm it is under a duty to make enquiries, or cause enquiries to be made. These enquiries are made under Section 47 of the Children Act 1989 in accordance with the NSCB Child Protection Procedures

Parental Neglect which is likely to constitute 'significant harm' is that which is:

- severe
- persistent
- cumulative
- chronic or acute
- resistant to intervention

There will need to be a clear sense of how the neglectful acts fail to meet a child's needs and in turn how this links to the harm that is being caused. Immediate health, well-being and safety will be a consideration as well as the developmental harm that will affect the child into the future. The key issue is that long term neglect can cause more developmental delay and impairment than any other form of abuse.

Whilst this is by no means exhaustive or prescriptive, the types of factors that may indicate that a strategy discussion and further assessment is necessary include the below that should be evidenced by using the Graded Care Profile or the Neglect Screening Tool:

- Evidence that the children's basic needs for food, warmth, shelter, safety etc. are not being met and that this is causing persistent harm or immediate danger e.g. children left unsupervised in potentially dangerous circumstances; very young babysitters; children asking neighbours for food or stealing food/money on a regular basis
- Dirty unhygienic environment e.g. house over-run with pets, faeces not cleaned up, etc
- Primary school age children frequently left alone or unsupervised in the house for periods of several hours
- History of unexplained injuries to children, or a series of injuries with unconnected/inconsistent explanations, particularly those involving non-mobile babies, children or young people.
- Previous concerns about the care of other children in that family, or in another household where these adults have lived before
- Parents with severe mental ill-health, chronic ill-health, physical disability, and/or learning disability who are struggling to care adequately for their children
- Children whose non-attendance for medical treatment causes serious concern
- Repeat episodes of being homeless or frequent house moves
- Long term non school attendance or not being registered for education where this is causing serious concerns for the child's safety or development

13.0 Case Studies

The case studies below provide some practical examples of how the Graded Care Profile has been used to assess cases of neglect including the impact the assessment has had on Children, Young People and Families.

13.1 Case Study 1 - NCC Early Help for Disabled Children

Background / Story:

At point of referral there were five children in the family with ages ranging from one to ten. The mother lives with the father of the younger three children and the two older children, who do not have contact with their biological fathers, view their mother's partner as their father. The case was referred to Early Help after an unsuccessful referral to Social Care for neglect. The children had been previously referred into Social Care due to allegations of neglect and physical abuse on several occasions and there had been a Child Protection Plan in 2013.

The lead child (A) is the second eldest child. He has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) and is on the Autistic Spectrum (ASD). At the point of referral A was being home-schooled following exclusion from a complementary education setting. He has previously attended three mainstream primary schools. He had been aggressive to other pupils and staff. In addition he had self harmed in school. At point of referral, the family had never received support from additional agencies with Child A's ADHD or ASD.

Historically, prior to the diagnosis of ADHD and ASD, some professionals had suggested that child A's poor behaviour was a result of neglect and poor attachment with his mother. The parents do not experience behavioural difficulties with any of the other children although there have been concerns about the children's physical appearance and conditions in the home. Schools have previously reported Child A to present as a 'scared and damaged child'. In addition there have been concerns regarding his presentation and personal hygiene. The Early Help Assessment (EHA) had identified that the parents struggle to bathe him. In addition they report finding it hard to ensure he wears fresh clothes every day.

As part of the EHA, all the other children were seen individually. The elder children have good school attendance and were progressing in their academic studies. All children were up to date with their immunisations and were reported to be in good health by both the GP and Health Visitor. All of the children reported their love for each other and suggested that they were comfortable and felt safe in their home.

Intervention:

Completion of the Graded Care Profile and direct feedback to parents was undertaken to consider the quality of care in the family and to look for evidence of neglect through conversations, with parent, the impact of Child A's disabilities and lack of appropriate provision became apparent. These difficulties were having a direct impact on the care parents were able to provide to all the children.

The situation regarding the parents' ongoing decoration of a new home was explored. The house was lacking carpets and the decor needed updating. To assist parents in purchasing the required items Early Help for Disabled Children funded new bed sheets and winter duvets for all of the children.

Parents were helped to apply for an appropriate specialist provision for Child A. Parents were initially informed they could not have their preferred placement due to transport. This required liaison with the Education, Health and Care Plan Coordinator and area SEN officer to obtain transport.

As a result of liaison with CAMHS in regards to Child A's medication a number of medication changes were made through the course of the intervention and the impact of this was recognisable in both Child A's behaviour and sleeping pattern. This had a direct impact on the presentation of the other children.

Liaison with the new secondary school, for the eldest child (B), ensured a suitable transition programme was in place in light of his previous attendance issues.

A School Mentor was put in place in regards to Child B. This was set up to encourage Child B to have regular attendance following occasions where he left the school site and also reported incidents of bullying.

Protective Behaviour work undertaken with the older girls of the family, particularly one of the daughters who was reported to have begun her periods at the age of 7.

Key Features:

Historically a number of referrals had been made to Social Care regarding unexplained injuries. A number of injuries were received by Child D, through the course of the intervention. Timely liaison with parents and professionals enabled the practitioner to identify that these were indeed accidental injuries, mainly caused through Child A's behaviour. The Graded Care Profile identified that Child A's safety was often compromised due to his own lack of self awareness.

Parents had received a number of parenting interventions including Family Intervention Project. Use of the Graded Care Profile, in respect of Child A, established that the lack of appropriate resources in place to meet the needs arising from his disability was having a direct impact on the parents' ability to succeed through these interventions.

As part of completing the Graded Care Profile, observations were made of parents' interactions with each of the children. Observations and additional 1:1 sessions with the children determined that they were happy in their home environment and that they felt love and warmth from their parents.

Consistent monitoring and observations of the family over a 6 month period allowed for a pattern in deteriorating home conditions to be recognised. During the course of the intervention it became apparent that during low periods and significant events in the family, the home conditions deteriorated. This included Mother's low emotional wellbeing. Completion of the Graded Care Profile during a relatively steady period identified that home conditions can meet to an adequate standard.

Reports had previously been made in regards to the children's access to food. The Graded Care Profile highlighted concerns in regard to the infrequent preparation of meals. 1:1 work with all the children established that appropriate foods were available to the children including fresh home cooked meals. Unannounced visits at meal times also enabled the practitioner to observe that healthy and freshly prepared meals were provided by the mother.

Impact on Outcomes:

Child A continues to successfully attend his specialist provision. A 1:1 Key Worker is provided with whom he has built a good relationship. This has contributed to his improved behaviour in the home.

Child A is now on suitable medication for his needs. It has taken some time to establish the best program for his needs but the regular input from CAMHS has ensured that changes have been made when required. This has resulted in improved behaviour and has also had a positive impact on Child B's ability to sleep whilst sharing a room with Child A.

The Protective Behaviour work completed with the older girls and sessions with the nurse have offered reassurance that the girls can keep themselves safe by liaising with school staff and their parents.

All children's school attendance, other than the eldest Child B, has significantly improved. This was a direct result of Child A being in specialist provision and no longer home-schooled. Appropriate routines are in place for all children.

Now it has been established there are no specific causes for concern in regards to Child B's wellbeing, a parenting contract is in place and a managed move to the child's school of choice is being considered.

Attendance at the local children's centre was encouraged. Two Year Old funding was available, for the youngest child.

Toward the end of the intervention the home was observed to be nearly fully decorated. Bedding was provided and in place for all the children. Beds were observed to be appropriately covered over a number of visits.

Feedback from the primary schools is now that they have no concerns in regards to the children's general appearances and personal hygiene.

13.2 Case Study 2 – Children's Social Care

Background/ Story:

In this case, a previous neglect based referral had been made, resulting in No Further Action to Children's Social Care in the MASH. School attendance was 80% and mother failed to collect Child A on two occasions. Mother's behaviour was noted to be erratic and the home conditions were reported by school staff to be cluttered and foul smelling, with unsafe items including a guillotine, cutting tools and other items within easy reach. A family dog was observed as being caged beneath the stairs. At this stage an EHA was advised.

The referral raised contained concerns about the levels of care afforded to Child A following intervention from the Early Help Team which included parental disguised compliance. Child A's mother had not been able to make identified and required positive changes to address the concerns raised in the referral regarding neglectful parenting - including the flat being dirty, limited food within the home and Child A not attending school regularly / on time.

Child A's mother's engagement with services was identified as sporadic and she avoided professional contact, including contacts with Mental Health Workers. Child A's mother did not engage with the Initial Assessment and, as such, a Core Assessment was required to explore the mother's ability to meet her daughter's needs on a consistent basis.

Intervention:

The Core Assessment was completed in September 2015 and, as a result, a Child in Need Plan was implemented, with regular CIN meetings held. Child A had a place in the school's Nurture Group to promote her continued emotional development and also attended extra-curricular activities at school to promote her emotional and social development including a Breakfast Club to ensure she had eaten before school and to encourage punctual attendance.

Commissioned Family Support has been put in place to support Child A's mother to develop positive routines, monitor home conditions and promote mother's independence. The Graded Care Profile was used as the tool to undertake this task. In addition to this, a Parenting Assessment is on-going to compliment the use of Graded Care Profile Assessment.

Key features:

Child A's mother understands the concerns that have been raised and there is no doubt that she wants to be a good mother to her daughter. However services involved continue to find her difficult to engage with, and the positive changes made are rarely fully sustained over a period of time.

Child A has said to professionals that she likes 'Writing' and Maths and that she has lots of friends at school and near her Grandma's house. She also said that she has hot dinners at school and she enjoys these, she especially likes chicken dippers. Child A said that when she is not at school, she likes to do puzzles and enjoys playing outside with her friends on her bike. She is proud that she can ride her bike without stabilisers and said that she goes down the hill 'really fast'. She also said that she can do cart-wheels, hand-stands and roly-polys. Child A has also spoken about never feeling sad and that she feels happy when she sees her cousin as she enjoys playing with him. She also advised that her Uncle keeps her safe because 'he got rid of a spider'.

Impact on outcomes:

Child A's attendance at school has improved and she has benefitted from the time spent in Nurture Group. Commissioned Family Support continue to work with Child A's mother to improve home conditions, impose positive routines, ensure that there is sufficient nutritious food in the home and work with mother to promote her independence. The Graded Care Profile is completed regularly and key actions identified to improve outcomes for Child A based on this.

Child A now spends more time at home, rather than at her Grandmother's house. Her mother's lack of engagement with professionals has been addressed, along with an issue of collusion from her maternal Grandmother. These controlling behaviours from her maternal Grandmother have been addressed by a number of pieces of work undertaken. There are now positive routines and stability for Child A helping her reach her potential and achieve in school and at home.

14.0 References, Further Reading and Resources

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Howarth, J (2007) *Child Neglect: Identification and Assessment*, Palgrave MacMillan, Hampshire

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Reder, P, Duncan, S & Gray, M (1993) *Beyond Blame: Child Abuse Tragedies Revisited* Routledge, London

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Resources:

Department for Education:

This link takes you to the safeguarding children pages of the website where there are numerous articles, reviews and research papers related to child neglect as well as wider safeguarding concerns.

<https://www.gov.uk/childrens-services/safeguarding-children>

NSPCC:

The website provides access to an information service to help to locate practice, policy and research on particular topics. CASPER provides free email updates about safeguarding matters and Inform which includes full and summary research documents.

<http://www.nspcc.org.uk/>

Ofsted:

This site contains several publications including findings from Serious Case Reviews and good practice guides.

<http://www.ofsted.gov.uk>

Research in Practice (RIP):

RIP supports practitioners and agencies to ensure evidence informed practice to achieve the best outcomes for children. The site contains a wide range of resources and research and policy updates as well as access to learning events. <https://www.rip.org.uk/>

Northamptonshire Safeguarding Children Board (NSCB):

Our Board's website has the link to multi-agency procedures for identifying and responding to safeguarding concerns. The website also contains numerous articles, links and resources that can support practitioners and managers including training available to support practitioners and managers.

<http://www.northamptonshirescb.org.uk/> - Website

<http://northamptonshirescb.proceduresonline.com/> - NSCB Procedures Manual

Northamptonshire Thresholds & Pathways Document:

This link takes you to the Northamptonshire Thresholds and Pathways Document. Here you will be able to download the document as well as access further guidance on what to do as a professional with concerns about a child or young person in Northamptonshire.

<http://www.northamptonshire.gov.uk/thresholdsandpathways>

Northamptonshire Children's Services Procedures Manual:

This link takes you to the Northamptonshire Children's Services Procedures Manual which provides staff working in Children's Services with all the procedures and practice guidance they need for working with children and young people in Northamptonshire.

<http://northamptonshirechildcare.proceduresonline.com/index.htm>

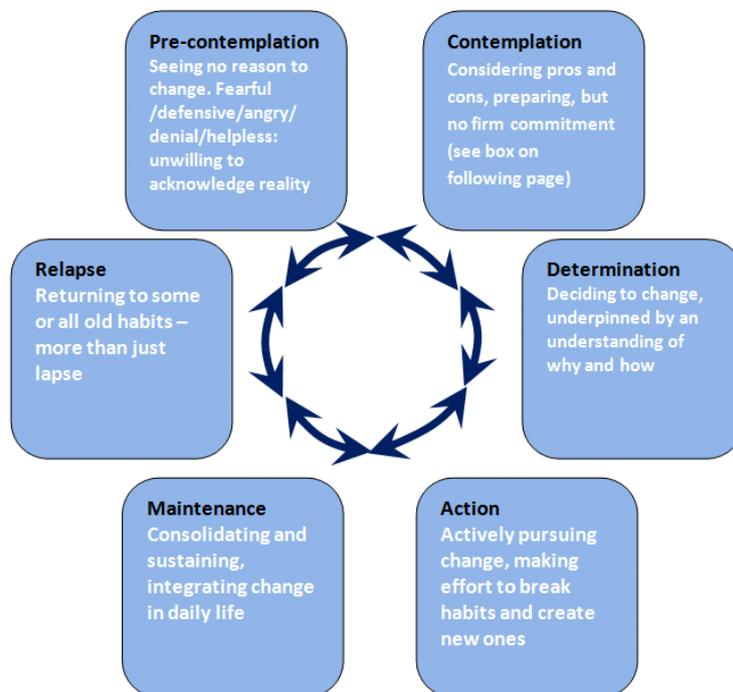
Appendix 1

Assessment of Parental Motivation to Change

This is based on "Assessment of Parental motivation to change" by Jan Horwath and Tony Morrison in: Jan Horwath (ed) (2001): The Child's World. London: Jessica Kingsley.

The Assessment Framework guides professionals to assess the child's developmental needs, as well as the parent's capacity to meet these needs. If an assessment suggests that a child's health and development are impaired or likely to be impaired, the assessment needs to identify the changes needed, both in terms of parenting and support services. If the change needed is in the parenting, this should lead to an assessment of the parents' capacity to change. This is in order to assess their willingness to work to achieve and sustain the changes required of them. Change must be assessed over time.

Capacity to change is made up of motivation and ability, and the authors suggest that if either of these is missing, the parent in question will lack the ability to change. They suggest that the use of DiClementi's *Model of Change* (1991) might be helpful:



Stages of Change incorporating Seven Steps of Contemplation (based on Prochaska and DiClemente, 1982 and Morrison, 2010)

Assessments often focus on information gathering but often fail to consider and understand motivation and change and to engage parents in that process. This model can be used with parents, especially when their engagement with professionals is involuntary.

The basis premises are:

- Change is a matter of balance. If the motivational forces are greater than the status quo forces, change will be likely to happen.
- For the process to work, professionals need to assess and work with parents in terms of their readiness to accept or deny the need for change.

The blocks to change in terms of the model above are pre-contemplation and relapse.

Pre-contemplation:

Most families are at this stage at the start of contact with the agencies. They may have a vague notion of *wanting* change, but not that they *need* to change. Parents at this stage are unable to make a full psychological commitment, as they have not yet come to terms with the need to change. The implications for this are that early contracts need to be reviewed as (if) the parents move into the change cycle.

Contemplation:

At this stage, the parents consider that there is a problem, and can explore how to tackle it. Effective intervention will depend on whether external motivation can be transformed into internal motivation. This means that workers need to be able to combine external sanctions with engagement with parents in order to effect change.

Parents may need time to:

- Look at themselves and come to terms with what they see.
- Appreciate the child's needs.
- Count the cost of change.
- Identify the benefit of change.
- Identify goals which are meaningful to them.

The professional task is to assess sources of motivation:

- Recognise the parents' ambivalence, compliance, genuine commitment and capacity to change.
- Recognise that each parent may be at a different stage of the change process.
- Recognise that different changes may be required from each parent.
- Assess the motivational/status-quo sources in the extended family.

The authors identify seven stages of contemplation as follows:

- i. Accept that there is a problem.
- ii. Accept some responsibility for the problem.
- iii. Have some discomfort about the problem.
- iv. Believe things must change.
- v. See yourself as part of the problem.
- vi. Make a choice to change.
- vii. See the next steps towards change.

Determination:

At this stage, parents should be able to express:

- Real problems and their effect on the child.
- Changes they wish to/should make.
- Specific goals to achieve.
- How parents and professionals will co-operate to achieve the goals.
- The rewards of meeting the goals.
- Consequences if change is not achieved.

Professionals need to be clear about agreed plans, which should be detailed and specific. Plans should be for incremental change, as motivation to change is more likely if there is early support and clear expectations.

Action:

This is the point of change, where parents use themselves and services. There can be a danger of confusion and parents feeling overwhelmed (and consequently disengaging) at this stage, so clarity of aims and objectives is essential. Any agreement which was made at the pre-contemplation stage needs to be reviewed to see if it is still valid.

Maintenance:

This stage is about consolidating changes made, rehearsal and testing of new skills and coping strategies over time and in different conditions.

Professionals need to pay attention to prevent relapse, essentially work to anticipating stresses and triggers which might arise.

This can be the stage where one parent may be able to change, and the other not thus causing stress in the relationship. If this is due to professionals concentrating their efforts on one parent, this sets up failure, so including both parents is important. The assessment task is to ascertain if parents are able to internalise changes if external motivators are relaxed.

Lapse and relapse:

Change is cyclical, and most of us do not succeed the first time. Change comes from repeated efforts, re-evaluation, renewal of commitments and incremental successes. A lapse can usually be dealt with, but a relapse, such as a return of their abusive behaviour is not so easy to deal with.

Overall, the task for professionals is to increase the weight of the factors which promote change, whilst decreasing the forces for the status quo. Motivation is interactional, so look to the wider network (partners / professionals / family / friends and community) for sources of motivation, stresses and weaknesses.

Managing ambivalence:

Ambivalence is an ordinary response to change, so the assessment of parent's real commitment is important. The response to change model is useful. It identifies four possible types of response to change, depending on effort and commitment to change:

- Dissent and/or avoidance.
- Tokenism.
- Genuine commitment.
- Compliance.

		EFFORT	
		High	Low
COMMITMENT	High	Genuine commitment	Tokenism
	Low	Compliance; Imitation; Approval seeking	Dissent; Avoidance

The professional task is to be aware of ambivalence, and assess how parents manage ambivalence.

Main messages:

- Assess both parents.
- Be child centred, especially on the timing of change, can children wait?
- Being forced to engage heightens parents' sense of failure and uncertainty.
- If parents are unsure, they are likely to respond negatively.

The Salford Graded Care Profile

**Adapted by Salford LSCB from
The Graded Care Profile**

**Designed by
Dr Leon Polnay and Dr O P Srivastava,
(Bedfordshire and Luton Community NHS Trust
and Luton Borough Council).**

With Acknowledgements to Salford LSCB

1.0 Introduction

The Graded Care Profile (GCP) was developed as a practical tool to give an objective measure of the care of children across all areas of need by Drs. Polnay and Srivastava. The profile was developed to provide an indication of care on a graded scale. It is important from the point of view of objectivity because the ill effect of bad care in one area may be offset by good care in another area. This Profile was adapted by Salford LSCB.

It is a descriptive scale. The grades indicate quality of care and are recorded using the same 1 – 5 scale in all areas. Instead of giving a diagnosis of neglect it defines the care showing both strengths and weaknesses as the case may be. It provides a unique reference point. Changes after intervention can demonstrably be monitored in both positive and negative directions.

It can be used to improve understanding about the level of concern and to target areas for work as it highlights areas of greater risk of poorer outcomes. It should be used in all cases where neglect is identified as an issue. The profile can be used with the family by individual workers, or groups of workers, to inform Family Action meetings and child protection Core Group meetings.

Finally it should be remembered that it provides a measure of care as it is actually delivered irrespective of other interacting factors. In some situations where conduct and personality of one of the parents is of grave concern, a good care profile on its own should not be used to dismiss that fact. At present it brings the issue of care to the fore for consideration in the context of overall assessment.

Grades:

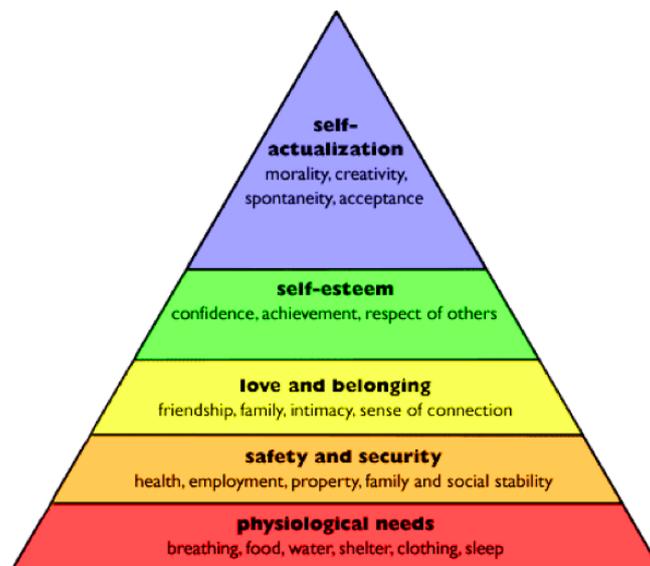
In this scale there are five grades based on levels of commitment to care. Parallel with the level of commitment is the degree to which a child's needs are met and which also can be observed. The basis of separation of different grades is outlined in table 1 below.

Table 1

	Grade 1	Grade 2	Grade 3	Grade 4	Grade 5
1	All child's needs met	Essentially needs fully met	Some essential needs unmet	Most essential needs unmet	Essentially needs entirely unmet / hostile
2	Child first	Child priority	Child / carer at par	Child second	Child not considered
3	Best	Adequate	Equivocal	Poor	Worst

1 = level of care; 2 = commitment to care; 3 = quality of care

These grades are then applied to each of the four areas of need based on Maslow's *Hierarchy of Needs* – physiological, safety, love and belongingness and esteem. This model was adopted not so much for its hierarchical nature but for its comprehensiveness. Each area is broken down into sub-areas, and some sub-areas to items, for ease of observation. An explanatory table shows all the areas and sub-areas with the five grades alongside.



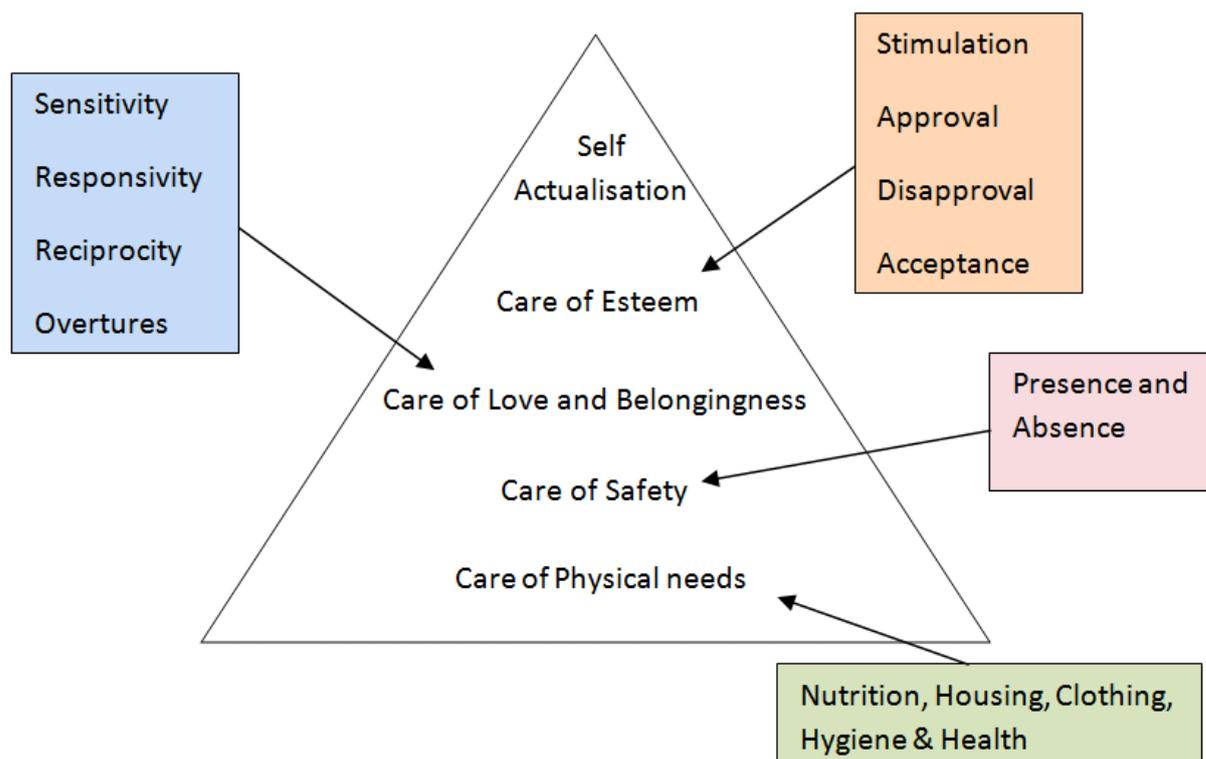
To obtain a score, follow the instructions in this manual. The explanatory table gives brief examples of care in all sub-areas/items for all the five grades. From these, scores for the areas are decided.

Instructions:

The Graded Care Profile (GCP) gives an objective measure of care of a child by a carer. It gives a qualitative grading for actual care delivered to a child taking account of commitment and effort shown by the carer. Personal attributes of the carer, social environment or attributes of the child are not accounted for unless actual care is observed to be affected by them. Thus, if a child is provided with good food, good clothes and a safe house the GCP will score better irrespective of the financial situation.

The grades are on a 1 – 5 scale (see table 1). Grade one is the best and five the worst. This grading is based on how carer(s) respond to the child’s needs. This is applied in four areas of need – physical, safety, love and esteem. Each area is made up of different sub-areas and some sub-areas are further broken down into different items of care. The score for each area is made up of scores obtained for its items. An explanatory table is prepared giving brief examples of levels of care for the five grades against each item or sub-area of care. Scores are obtained by matching information elicited in a given case with those in the explanatory table. This is taken advantage of in designing the follow-up and targeting intervention.

Methods are described below in detail. It can be scored by the carers/s themselves if need be or if this is practicable.



How the profile is organised:

There are three main components, which are described below.

1. The explanatory table:

The explanatory table, which starts at page 55, is laid out in areas, sub areas and items. There are four 'areas' – physical, safety, love and esteem which are labelled as – A, B, C and D respectively. Each area has its own 'sub-areas', which are labelled numerically – 1, 2, 3, 4 and 5. Some of the 'sub-areas' are made up of different 'items' which are labelled as – a, b, c, d. Thus the unit for scoring is an 'item' (or a 'sub-area' where there are no items). See table 2 which shows Area A (physical), sub-area 1 (nutrition) and item a (quality).

Table 2

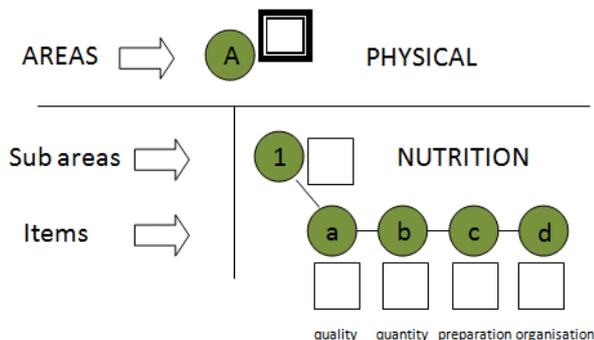
Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
1 Nutrition					
a. Quality	Aware and thinks ahead; provides excellent quality food and drink.	Aware and manages to provide reasonable quality food and drink.	Provision of reasonable quality food, inconsistent through lack of awareness or effort.	Provision of poor quality food through lack of effort; only occasionally of reasonable quality if pressurised.	Quality not a consideration at all or lies about quality.

For some of the sub-areas or items there are **age bands** written in bold italics. *Stimulation*, a sub-area of the area *esteem*, is made up of sub-items for age bands 0 – 2, 2 – 5 & above 5 years. Clearly, only one will apply in any case.

2. The scoring sheet:

There is a scoring sheet, which accommodates the entire system down to the items. It gives an overview of all scores and should be completed as the scores are decided from the explanatory table. See **Table 3**.

Table 3



3. The Summary Sheet:

This is printed on an A4 sheet. At the top there is room to make note of personal details, date and to note who the main carer about whom the scoring is done. Areas and sub-areas are in a column vertically on the left hand side and scores (1 to 5) in a row of boxes horizontally against each sub-area. Next to this is a rectangular box for noting the overall score for the area, which is worked from the scores in sub-areas (described later). Next to the area score, there is another box to accommodate any comments relating to that area. See **Table 4**. At the bottom there is a separate table designed to target sub-area(s) or item(s) where care is particularly deficient and to follow them up.

Table 4

Area	Sub-Area	Scores					Area Score	Comments
A Physical	1. NUTRITION	1	2	3	4	5		
	2. HOUSING	1	2	3	4	5		
	3. CLOTHING	1	2	3	4	5		
	4. HYGIENE	1	2	3	4	5		
	5. HEALTH	1	2	3	4	5		

Workers who have used this say that although it looks complicated at first, it gets easier once they are familiar with the tool

How to Use:

1. Discuss your wish to complete a GCP with them with the parent or carer. Once you are sure they have understood, ask them to sign the consent form on the summary sheet. Fill in the relevant details at the top of the record sheet. Keep the form for your records and note that consent has been given in your case recording system.
2. The Main Carer: is the main carer present when you do the graded care profile. It can be either or both parents, or another main carer. Note who is involved in the top right corner of the record sheet.

3. **Methods:** It is necessary to do a home visit to make observations. You need to be familiar with the area headings to be sure everything is covered during one or more visits. This document can be shared with the family during the visit, or you can fill it in afterwards. Carers using it themselves can simply go through the explanatory table.
4. **Situations:**
 - a) As far as possible, use the *usual state* of the home environment, don't worry about any short term, smaller upsets e.g. no sleep the night before.
 - b) Don't take into account any *external factors* on the environment (e.g. house refurbished by welfare agency) unless carers have positively contributed in some way by keeping it clean, adding their own bits in the interest of the child like a safe garden, outdoor or indoor play equipment or safety features etc.
 - c) Allowances should be made for background factors, e.g. bereavement, recent loss of job, illness in parents. It may be necessary to revisit and score at another time.
 - d) If the carer is trying to mislead deliberately by giving the wrong impression or information in order to make one believe otherwise- score as indicated in the explanatory table. (e.g. misleading explanations- for PHYSICAL Health/follow up would score 5. and any warmth/guilt not genuine for LOVE Carer/reciprocation would score 5).
5. Once completed, share a copy with the parents with whom you have completed it and ask them to sign to say they have seen the completed profile. Send them a copy as soon as possible.

Obtaining Information on Different Items or Sub-Areas:

A) PHYSICAL

1. Nutritional: (a) Quality (b) Quantity (c) Preparation and (d) Organisation:

Take a history about the meals provided including nutritional contents (milk, fruits etc.), preparation, set meal times, routine and organisation. Also note carer's knowledge about nutrition, note carer's reaction to suggestions made regarding nutrition (whether keen and accepting or dismissive). Observe for evidence of provision, kitchen appliances and utensils, dining furniture and its use without being intrusive. It is important not to lead as far as possible but to observe the responses carefully for honesty. Observation at a meal time in the natural setting (without special preparation) is particularly useful. Score on amount offered and the carer's intention to feed younger children rather than actual amount consumed as some children may have eating/feeding problems.

2. Housing (a) Maintenance (b) Décor (c) Facilities:

Observe If lacking, ask to see if effort has been made to improve, ask yourself if the carer is capable of doing them him/herself. It is not counted if repair or decoration is done by welfare agencies or landlord.

3. Clothing (a) Insulation (b) Fitting (c) Look:

Observe See if effort has been made towards repairing, cleaning and ironing. Refer to the age band in the explanatory table.

4. Hygiene:

Child's appearance (hair, skin, behind ears and face, nails, rashes due to long term neglect of cleanliness, teeth). Ask about daily routines. Refer to age band in explanatory table.

5. Health (a) Opinion sought (b) Follow-up (c) Health checks and immunisation (d) Disability/Chronic illness:

Ask who is consulted on matters of health, and who decides when health care is needed. Check about immunisation uptake, reasons for non-attendance if any, see if reasons are valid. Check with relevant professionals. Distinguish genuine difference of opinion between carer and professional from non-genuine misleading reasons. Beware of being over sympathetic with carer if the child has a disability or chronic illness. Remain objective.

B) SAFETY

1. In Presence (a) Awareness (b) Practice (c) Traffic (d) Safety features:

This means how safely the home environment is organised. It includes safety features and carer's behaviour regarding safety (e.g. lit cigarettes, drugs or medication left lying in the vicinity of child) in every day activity. Awareness may be assumed from the presence and appropriate use of safety fixtures and equipment in and around the house or in the car (child safety seat etc.) by observing carers handling of young babies and supervision of toddlers. Also observe how carer instinctively reacts to the child being exposed to danger. If observation not possible, then ask about the awareness. Observe or ask about child being allowed to cross the road, play outdoors etc. along the lines in this manual. If possible check answers out with other sources. Refer to the age band where indicated.

2. In Absence:

This covers child care arrangements where the carer is away, taking account of reasons and period of absence and age of the minder. This itself could be a matter for concern in some cases. Check answers out with other sources.

C) LOVE

1. Carer (a) Sensitivity (b) Timing of response (c) Reciprocation (quality of response):

This mainly relates to the carer's relationship with the child. Sensitivity refers to the degree of awareness of the child's signals displayed by the carer. Carer may become aware yet respond a little later in certain circumstances. Note the timing of the carer's response in the form of appropriate action in relation to the signal from the child. Reciprocation means the emotional quality of the response.

2. Mutual Engagement (a) Beginning interactions (b) Quality:

Observing what goes on between the carer and child during feeding, playing and other activities gives you a sense of whether both are actively engaged. Observe what happens when the carer and the child talk, touch, seek each other out for comfort and play, babies reaching out to touch while feeding or stop feeding to look and smile at the carer. Skip this part if child is known to have behavioural problems as it may become unreliable.

Contact between carer and child that is unplanned is the best opportunity to observe these items. See if carer spontaneously talks to the child or responds when the child talks or makes noises. Note who gets pleasure from this, the carer and the child, either or neither. Note if it is play or functional (e.g. feeding etc.).

D) ESTEEM

1. Stimulation:

Observe or enquire how the child is encouraged to learn. Talking and making noises, interactive play, nursery rhymes or joint story reading, learning social rules, providing fun play equipment are such examples with infants (0 – 2 years). If lacking, try to note if it was due to carer being occupied by other essential chores. Follow the explanatory table for appropriate age band. The four elements (i, ii, iii and iv) in age band 2-5 years and 5- years provide a comprehensive picture. Score in one of the items is enough. If more items are scored, score for which ever column describes the case best. In the event of a tie choose the higher score (also described in the explanatory table).

2. Approval:

Find out how child's achievement is rewarded or neglected. It can be assessed by asking how the child is doing or simply by praising the child and noting the carer's response (agrees with delight or child's successes rejected or put down)

3. Disapproval:

If opportunity presents, observe how the child is told off, otherwise enquire carefully (Does the child throw tantrums? How do you deal with it if it happens when you are tired yourself?) Beware of any difference between what is said and what is done. Any observation is better in such situations than the carer's description e.g. child being ridiculed or shouted at. Try and ask more if carer is consistent.

4. Acceptance:

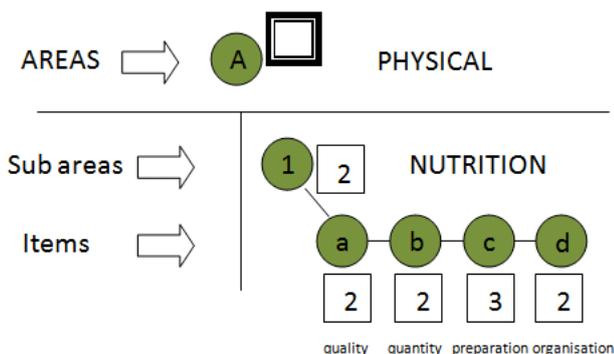
Observe or ask how carer generally feels after she/he has told the child off, or when the child has been told off by others (e.g. teacher), when child is not doing well, or feeling sad for various reasons. See if the child is rejected (put down) or accepted at these times with warm and supportive behaviour.

SCORING ON THE EXPLANATORY TABLE

Make sure your information is factual as far as possible. Go through explanatory table – (Sub-Areas and Items). Find the description which matches best, read one grade on either side to make sure, then place a tick on that description (photocopy the score sheet to use each time). The number at the top of the column will be the score for that item or sub-area. Where more than one item represents a sub-area, use the method described below to obtain the score for the sub-area.

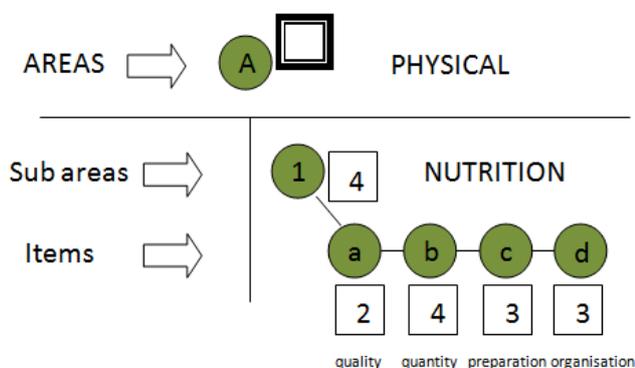
Obtaining a score for a sub-area from its items' scores. Transfer the scores from the explanatory table to the scoring sheet for the items (and sub areas without items i.e. hygiene). Read the score for all the items of a particular sub-area: if there is a clearly repeated number but none of the ticks are beyond 3, score that number for that particular sub-area. To record it on the scoring sheet enter the number in the box for that sub-area.

Example: the scores for the items average 2 so the sub area score is 2.



If there is even a single score of 4 or 5, score that point regardless of other scores. *

Example: the scores for the items average 3, but there is a score of 4, so the sub area score is 4.



Obtaining a score for an area:

Follow the same principle for getting an overall score for an area by taking an average of the sub-area scores. Again, if there is even a single score of 4 or 5, score that point regardless of other scores. *

**This method helps identify the problem even if it is one sub-area or item. Its primary aim is to safeguard child's welfare while being objective. The average score is not used as it will not show up the high scores which are the areas of concern.*

Transferring the scores to the summary sheet:

Transfer all scores in double boxes from the scoring sheet to the summary sheet. This will be the sub area and area scores.

Comments:

This column in the summary sheet can be used for flagging up issues, which are not detected by the profile but may be relevant in a particular case. For example, a child whose behaviour is difficult or a parent whose over protectiveness gives rise to concern. Comments noted may then lead to additional support.

Targeting:

If a particular sub-area scores highly, it can be noted in the table at the bottom of the summary sheet. A better score can be aimed at after a period of work. Aiming for one grade better will place less demand on the carer than by aiming for the ideal in one leap.

EXPLANATORY TABLES

A AREA OF PHYSICAL CARE:

Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
1 Nutrition					
a. Quality	Aware and thinks ahead; provides excellent quality food and drink.	Aware and manages to provide reasonable quality food and drink.	Provision of reasonable quality food, inconsistent through lack of awareness or effort.	Provision of poor quality food through lack of effort; only occasionally of reasonable quality if pressurised.	Quality not a consideration at all or lies about quality.
b. Quantity	Ample	Adequate.	Adequate to Variable.	Variable to Low.	Mostly low or starved.
c. Preparation	Painstakingly cooked/prepared for the child.	Well prepared for the family always thinking of the child's needs.	Preparation infrequent and mainly for the adults, child sometimes thought about.	More often no preparation. If there is, child's need or taste not thought about.	Hardly ever any preparation. Child lives on snacks, cereals or takeaways.
d. Organisation	Meals carefully organised – seating, timing, manners	Well organised- often seating, regular timing.	Poorly organised- irregular timing, improper seating.	Ill organised- no clear meal time.	Chaotic – eat when and what one can.

Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
2 Housing					
a. Maintenance	Additional features benefiting child- safe, warm and clean (also referred to B-safety area/1/d)	No additional features but well maintained.	State of repair adequate.	In disrepair- but could be repaired easily	Dangerous disrepair- but could be repaired easily (exposed nails, live wires).
b. Décor	Excellent, child's taste specially considered.	Good, child's taste considered (practical constraints prevent a score of 1).	In need of decoration but reasonably clean.	Dirty.	Long term engrained dirt. (bad odour).
c. Facilities	Essential and additional fixtures and fittings- good heating, shower and bath, play and learning facilities.	All essential fixtures and fittings; effort to consider the child. If lacking, due to practical constraints (child first).	Essential to bare- no effort to consider the child.	Adults needs for safety, warmth and entertainment come first	Child dangerously exposed or not provided for.
NOTE: Discount any direct external influences like repair done by other agency but count if the carer has spent a loan or a grant on the house or had made any other personal effort towards house improvement.					

Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
3 Clothing					
a. Insulation	Well protected with high quality clothes.	Well protected, even if with cheaper clothes.	Adequate to variable weather protection.	Inadequate weather protection.	Dangerously exposed.
b. Fitting	Excellent fitting and design.	Proper fitting even if handed down.	Clothes a little too large or too small.	Clothes clearly too large or too small.	Grossly improper fitting.
c. Look – age 0 – 5	Newish, clean, ironed.	Effort to restore any wear. Clean and ironed.	Repair lacking, usually not quite clean or ironed.	Worn, somewhat dirty and crumpled.	Dirty, badly worn and crumpled, odour.
d. Look age 6+	As above	As above, odour if bed wetter, not otherwise.	Worse than above unless child does own washing. If younger (under 7) gets relatively better clothes.	Same as above unless child does own washing. Even under 7 same as above.	Child unable to help him/herself therefore same as above.

Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
4 Hygiene					
Age 0 to 4	Cleaned, bathed and hair brushed more than once a day.	Regular, almost daily.	No routine. Sometimes bathed and hair brushed.	Occasionally bathed but seldom hair brushed.	Seldom bathed or clean. Hair never brushed.
Age 5 to 7	Some independence at above tasks but always helped and supervised.	Reminded and products provided for regularly. Watched and helped if needed.	Irregularly reminded and products provided. Sometimes watched.	Reminded only now and then, minimum supervision.	Not bothered.
Age 7+	Reminded, followed, helped regularly.	Reminded regularly and encouraged if lapses.	Irregularly reminded, Products not provided consistently.	Left to their own initiatives. Provision minimum and inconsistent.	Not bothered

Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
5 Health					
a. Opinion sought	Not only on illnesses but also other genuine health matters thought about in advance and with sincerity.	From professionals/ experienced adults on matters of genuine and immediate concern about child health.	On illness of any severity. Or frequent unnecessary consultation and/ or medication.	Only when illness becomes moderately severe (delayed consultation).	When illness becomes critical (emergencies) or even that ignored.
b. Follow up	All appointments kept. Rearranges if problems.	Fails one in two appointments due to doubt about their usefulness or due to pressing practical constraints.	Fails one in two appointments even if of clear benefit for reasons of personal inconvenience.	Attends third time after reminder. Doubts its usefulness even if it is of clear benefit to the child.	Fails a needed follow up a third time despite reminders. Misleading explanations for not attending.
c. Health checks and immunisations	Visits in addition to the scheduled health checks, up to date with immunisation unless genuine reservations.	Up to date with scheduled health checks and immunisation unless exceptional or practical problems. Plans in place to address this.	Omission for reasons of personal inconvenience, takes up if persuaded.	Omissions because of carelessness, accepts if accessed at home.	Clear disregard of child's welfare. Blocks home visits.
d. Disability/ chronic illness (3 months after diagnosis)/ illness	Compliance excellent, (any lack is due to difference of opinion). Compassion for child's needs.	Any lack of compliance is due to pressing practical reason. Compassion for child's needs.	Compliance is lacking from time to time for no pressing reason (excuses). Shows some compassion for child's needs.	Compliance frequently lacking for trivial reasons, very little affection, if at all. Shows little compassion for child's needs.	Serious compliance failure (medication not given for no reason), can lie, (inexplicable deterioration). Shows no compassion for child's needs.
Compliance = accepting professional advice at any venue and carrying out advice given.					

B AREA OF CARE OF SAFETY:

Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
1 In Presence					
a. Awareness	Good awareness of safety issues how ever remote the risk.	Aware of important safety issues.	Poor awareness and perception except for immediate danger.	Oblivious to safety risks.	Not bothered.
NOTE: Please refer to the item 'd (Safety Features)' and the note below it.					
b. Practice					
Pre-mobility age	Very cautious with handling and laying down. Seldom unattended.	Cautious whilst handling and laying down, Frequent checks if unattended.	Handling careless. Frequently unattended when laid within the house.	Handling unsafe. Unattended even during care chores (bottle left in the mouth).	Dangerous handling, left dangerously unattended during care chores like bath.
Acquisition of mobility	Constant attention to safety and effective measures against any perceived dangers when up and about.	Effective measures against any danger about to happen.	Measures taken against danger about to happen of doubtful use.	Ineffective measures if at all. Improvement from mishaps soon lapse.	Inadvertently exposes to dangers (dangerously hot iron near by).
Infant school	Close supervision indoors and outdoors.	Supervision indoors. No direct supervision outdoors if known to be at a safe place.	Little supervision indoors or outdoors. Acts if in noticeable danger.	No supervision, Intervenes after mishaps which soon lapses again.	Minor mishaps ignored or the child is blamed; intervenes casually after major mishaps.
Junior and Senior School	Allows out in known safe surroundings within appointed time. Checks if goes beyond set boundaries.	Can allow out in unfamiliar surroundings if thought to be safe and in knowledge. Reasonable time limit. Checks if worried.	Not always aware of whereabouts outdoors believing it is safe as long as returns in time.	Not bothered about daytime outings, concerned about late nights in case of child younger than 13.	Not bothered despite knowledge of dangers outdoors- railway lines, ponds, unsafe building, or staying away until late evening / nights.

c. Traffic					
Age 0 – 4	Well secured in the pram, harnesses, or when walking, hand clutched. Walks at child's pace.	3-4 year old allowed to walk but close by, always in vision, hand clutched if necessary i.e. crowd.	Infants not secured in pram. 3-4 year old expected to catch up with adult when walking, glances back now and then if left behind.	Babies not secured,	3-4 year olds left far behind when walking or dragged with irritation.
5 and above	5-10 year old escorted by adult crossing a busy road, walking close together.	5-8 year old allowed to cross road with a 13+ child: 8-9 allowed to cross alone if they reliably can.	5-7 year olds allowed to cross with an older child, (but below 13) and simply watched: 8-9 crosses alone.	5-7 year old allowed to cross a busy road alone in belief that they can.	A child, 7, crosses a busy road alone without any concern or thought.
d. Safety Features	Abundant features- gate, guards, drug lockers, electrical safety devices, intercom to listen to the baby, safety with garden pond and pool etc.	Essential features- secure doors, windows and any heavy furniture item. Safe gas and electrical appliances, drugs and toxic chemicals out of reach, smoke alarm. Improvisation and DIY if can't afford.	Lacking in essential features, very little improvisation or DIY (done too casually to be effective).	No safety features. Some possible hazard due to disrepair (tripping hazard due to uneven floor, unsteady heavy fixtures, unsafe appliances).	Definite hazard for disrepair- exposed electric wires and sockets, unsafe windows (broken glass), dangerous chemicals carelessly lying around.
Note: This item along with other safety provisions which are not a fixture like a bicycle helmet, safety car seats, sports safety wear etc. can be used to score for item 'a' (Awareness of safety).					

Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
2 In Absence					
Safety in Absence	Child is left in care of a vetted adult. Never in sole care of an under 16.	Out of necessity a child aged 1-12 is left with a young person over 13 who is familiar and has no significant problem, for no longer than necessary. Above arrangement applies to a baby only in an urgent situation.	For recreational reason leaves a 0-9 year old with a child aged 10-13 or a person known to be unsuitable.	For recreational reason a 0-7 year old is left with an 8-10 year old or an unsuitable person.	For recreational reason a 0-7 year old is left alone or in the company of a relatively older but less than 8 year old child or an unsuitable person.

C AREA OF CARE OF LOVE

Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
1 Carer					
a. Sensitivity	Looks for or picks up very subtle signals- verbal or nonverbal expression or mood.	Understands clear signals – distinct verbal or clear nonverbal expression.	Not sensitive enough – messages and signals have to be intense to make an impact e.g. crying.	Quite insensitive – needs repeated or prolonged intense signals.	Insensitive to even sustained intense signals or dislikes child.
b. Timing of response	Responds at time of signals or even before in anticipation	Responds mostly at time of signals except when occupied by essential chores.	Does not respond at time of signals if during own leisure activity. Responds at time of signals if fully unoccupied or child in distress.	Even when child in distress responses delayed.	No responses unless a clear mishap for fear of being accused.
c. Reciprocation (quality)	Responses fit with the signal from the child, both emotionally (warmth) and materially (food, nappy change). Can get over stressed by distress signals from child. Warm.	Material responses (treats etc.) lacking, but emotional responses warm and reassuring.	Emotions warm towards child if in good mood (not burdened by strictly personal problem), otherwise flat.	Emotional response brisk and flat. Annoyance if child in moderate distress but attentive if in severe distress.	Disliking and blaming even if child in distress, acts after a serious mishap mainly to avoid being accused, any warmth/guilt not genuine.

Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
2 Mutual Engagement					
a. Beginning interactions	Carer starts interactions with child. Child starts interactions with carer. Carer does this more often.	Carer starts interactions with child. Child starts interactions with carer. Equal frequency. Positive attempt by carer even if child is defiant.	Child mainly starts interactions. Sometimes the carer. Carer negative if child's behaviour is defiant.	Child mainly starts interactions. Not very often the carer.	Child does not attempt to start interaction with carer. Carer does not start interactions with child. Child appears resigned or apprehensive.
b. Quality	Frequent pleasure of engagement, both enjoy it, carer may seem to enjoy a bit more.	Quite often and both enjoy equally.	Less often engaged for pleasure, child enjoys more. Carer passively joins in getting some enjoyment at times.	Engagement mainly for a practical purpose. Indifferent when child attempts to engage for pleasure. Child can get some pleasure (attempts to sits on knees, tries to show a toy).	Dislikes it when child tries to enjoy interactions, if any. Child resigned or plays on own. Carer's engagement for practical reasons only (dressing, feeding).

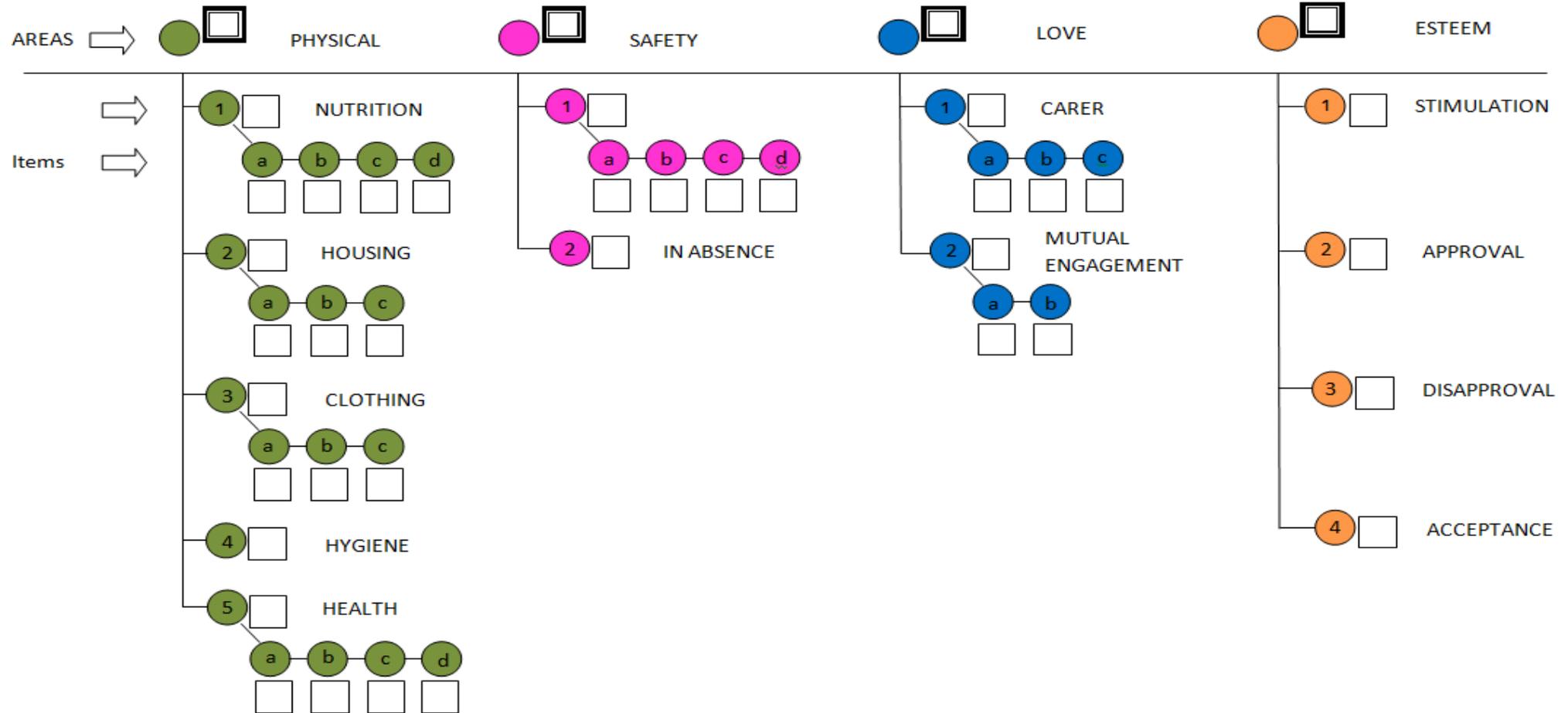
CAUTION: If child has temperamental/behavioural problems, scoring in this sub-area (mainly quality item) can be affected unjustifiably. Scoring should be done on the basis of score in area of 'carer' (C/1) alone and problem noted as comments.

C AREA OF CARE OF ESTEEM

Sub-areas	1 Child priority	2 Child first	3 Child and carer equal	4 Child second	5 Child not considered
1 Stimulation					
Age 0 – 2 years	Plenty of appropriate stimulation (talking, touching, looking). Plenty of equipment	Enough and appropriate intuitive stimulation (See below), less showy toys, gadgets, outings and celebrations	Inadequate and inappropriate- baby left alone while carer pursues own amusements; sometimes interacts with baby.	Baby left alone while adult gets on with pursuing own amusements unless strongly sought out by the baby.	Absent- even mobility restricted (confined in chair/pram) for carer’s convenience. Cross if baby demands attention.
Age 2 – 5 years	<ul style="list-style-type: none"> i <i>Interactive stimulation</i> (talking to, playing with, reading stories and topics) plenty and good quality. ii <i>Toys and gadgets</i> (items of uniform, sports equipment, books etc.) – Plenty and good quality iii <i>Outings</i> (taking the child out for recreational purposes) – frequent visits to child centred places locally and away. iv <i>Celebrations</i> – both seasonal and personal, child made to feel special 	<ul style="list-style-type: none"> i Sufficient and of satisfactory quality. ii Provides all that is necessary and tries for more, make do if unaffordable. iii Enough visits to child centred places locally (e.g. parks) occasionally away (e.g. Legoland, zoos). iv Equally keen and eager but less showy. 	<ul style="list-style-type: none"> i Variable-adequate if usually doing own thing. ii Essentials only. No effort to make do if unaffordable. iii Child accompanies carer wherever carer decides, usually child friendly places. iv Mainly seasonal (Christmas) low key personal (birthdays). 	<ul style="list-style-type: none"> i Scarce- even if doing nothing else. ii Lacking on essentials. iii Child simply accompanies – holidays or locally (e.g. shopping), plays out doors in neighbourhood. iv Only seasonal- low key to keep up with the rest. 	<ul style="list-style-type: none"> i Nil. ii Nil, unless provided by other sources- gifts or grants. iii No outings for the child, may play in the street but carer goes out locally e.g. to pub with friends. iv Even seasonal festivities absent or dampened.
Age 5+	<ul style="list-style-type: none"> i <i>Education</i> – active interest in schooling and support at home. ii <i>Sports and leisure</i> – well organised outside school hours e.g. swimming, clubs. etc. iii <i>Friendships</i> – encouraged and checked out iv <i>Provision</i> – stylish e.g. sports gear, computers. 	<ul style="list-style-type: none"> i Active interest in schooling, support at home when can. ii All affordable support. iii Carer offers some help. iv Well provided and tries to provide more if could. 	<ul style="list-style-type: none"> i Maintains schooling but little support at home even if has spare time. ii little effort in finding out but takes up opportunities at doorstep. iii Accepts if a friend is from a supportive family with carer. iv Poorly provided. 	<ul style="list-style-type: none"> i Little effort to maintain schooling or mainly for other reasons like free meals etc. ii Child makes all the effort, carer not bothered. iii Child finds own friends, no help from carer unless reported to be bullied. iv Under provided. 	<ul style="list-style-type: none"> i Not bothered or can even be discouraging. ii Not bothered even if child is doing unsafe/unhealthy activity. iii Not bothered. iv No provision.
NOTE: Whichever describes the case best should be ticked as the score; in the event of a tie choose the higher score.					

2 Approval					
	Talks about the child with delight/praise without being asked; material and generous emotional reward for any achievement.	Talks fondly about the child when asked, generous praise and emotional reward, less of material reward.	Agrees with other's praise of the child, low key praise and damp emotional reward.	Indifferent if child praised by others, indifferent to child's achievement, which is quietly acknowledged.	If the child is praised by someone else, successes rejected. Achievements not acknowledged, lack of reprimand or ridicule is the only reward if at all.
3 Disapproval					
	Mild verbal and consistent disapproval if any set limit is crossed.	Consistent terse verbal, mild physical, mild sanctions if any set limits are crossed.	Inconsistent boundaries or methods terse/shouts or ignores for own convenience, mild physical and moderate other sanctions.	Inconsistent, shouts/harsh verbal, moderate physical, or severe other sanctions.	Terrorised. Ridicule, severe physical or cruel other sanctions.
4 Acceptance					
	Unconditional acceptance. Always warm and supportive even if child is failing.	Unconditional acceptance, even if temporarily upset by child's behavioural demand but always warm and supportive.	Annoyance at child's failure, behavioural demands less well tolerated.	Unsupportive to rejecting if child is failing or if behavioural demands are high. Accepts if child is not failing.	Indifferent if child is achieving but rejects if makes mistakes or fails. Exaggerates child's mistakes
NOTE: If the style of parenting (over protective, permissive to foster independence, authoritarian) or type of values instilled is of concern, please make a note in the corresponding comment box on the record sheet.					

Scoring Sheet



This is the scheme representing all 'items' (represented by small letters); 'sub areas' (represented by numbers), and 'areas' (represented by capital letters) these are printed in circles.

Scores are to be noted in boxes adjacent to corresponding 'items', 'sub areas' and 'areas'. This represents the entire record as in the explanatory table for full reference.

NORTHAMPTONSHIRE SAFEGUARDING CHILDREN BOARD

Graded Care Profile Summary Sheet

Name (Child) _____ Date of Birth / /

Name Main Carer(s) _____

Carer(s) signature(s) of
Consent to complete
Graded Care Profile (GCP): _____

Scorers Name _____ Date / /

Scorers Signature _____

Area	Sub-Area	Scores					Area Score	Comments
A Physical	1. NUTRITION	1	2	3	4	5		
	2. HOUSING	1	2	3	4	5		
	3. CLOTHING	1	2	3	4	5		
	4. HYGIENE	1	2	3	4	5		
	5. HEALTH	1	2	3	4	5		
B Safety	1. IN CARERS PRESENCE	1	2	3	4	5		
	2. IN CARERS ABSENCE	1	2	3	4	5		
C Love	1. CARER	1	2	3	4	5		
	2. MUTUAL ENGAGEMENT	1	2	3	4	5		
D Esteem	1. STIMULATION	1	2	3	4	5		
	2. APPROVAL	1	2	3	4	5		
	3. DISAPPROVAL	1	2	3	4	5		
	4. ACCEPTANCE	1	2	3	4	5		

NORTHAMPTONSHIRE SAFEGUARDING CHILDREN BOARD

Graded Care Profile

Targeting Particular Item of Care:

Any item with disproportionately high score can be identified by reference to the explanatory table by writing the area, sub area and item i.e. physical/nutrition/quality in the table below.

	Targeted items (area/sub area/item)	Current Score	Period for change	Target Score	Actual Score after first review
1					
2					
3					

I have seen the completed GCP scores for my child:

Parent/carer comments:

Signed _____

Dated

/ /

Appendix 3

NSCB Neglect Screening Tool

Would completion of the Graded Care Profile help you understand the child's lived experience?

Are You Worried About?	Yes	No	Maybe	Evidence / Reasoning
A child's weight (are they under or overweight)				
A child's access to adequate, healthy food				
Conditions in the home (disrepair/clutter/overcrowding)				
A child having nowhere to sleep/co-sleeping				
A lack of age appropriate safety measures (stair gates etc)				
Inappropriate care of pets (waste/feeding/lack of exercise)				
A child not having appropriate clothing for weather conditions				
A child not having clean or adequate clothing (size/condition)				
A child's appearance (cleanliness/lack of hair brushing or teeth cleaning)				
Whether a parent is seeking medical advice appropriately				
Whether a child lacks confidence or has very low self esteem				
A lack of warmth and interaction between parent and child				
A lack of appropriate stimulation or play				
A parent who is not interested in their child's learning/not engaged with nursery or school				
Inappropriate behaviour management /frequent criticism/lack of interest in child's achievements				
Subtotal				

Signed

Date

Print Name

Organisation

If you have 3 or more 'Yes' or 'Maybe' answers (or a combination of both), completion of the Graded Care Profile is recommended to understand the lived experience of a child you are worried about.

In order to carry out the full assessment using the Graded Care Profile you should contact the relevant person or team within your organisation who can conduct this assessment, alternatively you should make a referral to the MASH stating why you believe the child, young person or family would benefit from a assessment using the GCP using this screening tool as the basis for the referral and included as evidence.

Appendix 4

An Accumulative Chronology of Neglect and its Impact:

Date of Referral	Reason for Referral / Issue	Action Taken	Outcome	Risk Level for Specific Referral	Analysis of Impact Accumulative	Accumulative Risk Level

An Accumulative Chronology of Neglect and its Impact

An Example:

Date of Referral	Reason for Referral / Issue	Action Taken	Outcome	Risk Level for Specific Referral	Analysis of Impact Accumulative	Accumulative Risk Level
01.01.2015	Very poor home conditions; kitchen dirty, no food, no clean clothes	Single Assessment completed; parents advised to address the issues (left)	Further visit; home conditions improved. Case closed	Low		
25.03.2015	Poor home conditions Children found wandering around the street	Single Assessment Completed. Child in Gran's care whilst wandering. Home conditions good enough.	Case closed	Low		
04.06.2015	Poor school attendance Child's behaviour deteriorating	Letter to family with community based services EWS informed	Case closed	Low		
05.11.2015	Children hungry, children's poor presentation, poor home conditions	House cluttered, limited food available, food parcel given	Refer to tenancy support. Case closed	Low		
02.01.2015	Concerns regarding parents drinking, parents arguing; home conditions poor	Single Assessment completed, child in need plan in place; work with parents around managing the home	Case closed - 1.08.10	Low		
04.02.2015	Child calls 999, parents arguing	Police attended – no disclosure made	Case closed	Low		
06.06.2015	Domestic Violence incident; parents drunk; poor home conditions	Strategy discussion; S47 investigation; children placed with grandparents; CP conference arranged	CP Plan and CIN plan in place. Case closed – 1.5.12	Medium		
04.06.2015	Domestic disturbance; parents drunk; poor home conditions; child with injury	Strategy discussion; S47 investigation; child placed in foster care	ICO applied for, children remain in care	High		

Appendix 5

Example Genogram:

A genogram is a quick and simple way of capturing family structures, particularly those that are more complex. It can be useful to complete at the start of an assessment or whenever there is a need to gather information about family relationships, gender, ages etc. There are standard symbols, e.g. males are always represented by a square, females by a circle, marriage/civil partnerships represented by a solid line. The example below shows a very basic family structure.

- John was born in 1995
- Sarah was born in 1998
- Their dad was born in 1975, their mum in 1973
- Parents married

