CHILD NEGLECT TOOLKIT

Greenwich Safeguarding Children Board- Health Work Group.

February 2017

Contents

1. Introduction:

The Neglect tool kit (Graded Care Profile) can be used by a wide range of professionals, in different settings for the identification and assessment of neglect and to support a consistent, effective and integrated early response to neglected children and young people. The tools have been developed to identify strengths as well as difficulties across three assessment framework domains, the **child developmental needs, parenting capacity to meet the needs of the child or young person and family and environmental factors**. Focussing on strengths assists the assessor to realistically assess the potential for sustained change and improvement within the family.

2. 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); or
- ensure access to appropriate medical care or treatment

It may also include neglect of, or unresponsiveness to a child's basic emotional needs. (Working Together 2015)

3. 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.

4. 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.

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. 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.

5. 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.

6. What is the Child Neglect Toolkit?

The Child Neglect Toolkit is designed to assist you in identifying and assessing children who are at risk of neglect. It is to be used when you are concerned that the quality of care of a child you are working with suggests that their needs are being neglected. It will help you to reflect on the child's circumstances and will help you put your concerns into context and identify strengths and resources.

The Child Neglect Toolkit can be used to inform decision-making, assessments and planning. It can also be used in one to one's with managers or in supervision. It is a **tool** that can be used by professionals in different settings and does not replace Early Help assessment or Children's Social Care assessments.

If you suspect abuse or harm or a criminal offence to a child you must immediately discuss this with your Named/Designated safeguarding leads in your service and make a referral to the **Multiagency Safeguarding Hub on 0208 921 3172**

7. Guidance for using the neglect toolkit

When there are concerns about a child's needs or their needs are unclear, a referral should be considered in line with the Greenwich Threshold document. The Child Neglect Toolkit should be used when there are concerns about whether the child's physical and emotional needs are being neglected. It will assist with the early identification of neglect or in coordinating support for families in need of additional help. The checklist can also be used to track improvements, deterioration or 'drift'.

The toolkit focuses on **six key areas** of need and considers the extent to which children's needs are being neglected and/or the needs of their parents/carers are taking precedence. The toolkit details indicators and possible impact on the child with **four** specific ratings 1 is **child focused care giving** and 4 is **child's needs not considered.**

The six key areas of need are:

- **Physical care**
- **Health**
- **Safety and supervision**
- **Love and care**
- **Stimulation and education.**
- **Parental Motivation to change**

Scoring and Actions
By working through the toolkit and scoring individual sections you will be able to identify strengths as well as areas of concern.

Scores 1 - across all areas) No current concerns on use of Toolkit

Scores 2 - in any area (but no 3s and 4s)– Professional to consider referral for Early Help
Scores 3 and 4 in any area - significant cause for concern and child/ young person should be discussed with your Named/Designated Safeguarding Lead as soon as possible and escalated urgently to children's social care if required

NOTE: This toolkit is to be used as an adjunct to Service Safeguarding Policies and Procedures. The child or young person should be fully assessed and managed in terms of all aspects of Safeguarding risks

8. Child Neglect Toolkit Checklist

Child's name: _____ Dob:_____

Practitioner: _____ Date:_____

Agency: _____

Is there a MASH referral or statutory assessment for this child? YES/NO

Development Need	Score				Examples/evidence of impact child/young person
AREA 1: PHYSICAL CARE	**1**	**2**	**3**	**4**	
Food					
Quality of housing					
Stability of housing					
Child's clothing					
Animals					
Hygiene					
AREA 2:HEALTH					
Safe sleeping arrangements and co-sleeping for babies					
Seeking advice and intervention					
Disability and illness					
Attendance of appointments					
Compliance with Medical care (e.g immunisations, health checks					
AREA 3: SAFETY and SUPERVISION					
Safety awareness and features					
Supervision of the child					
Handling of baby/response to baby					
Care by other adults					
Responding to adolescents' needs					
Traffic awareness and in car safety					
AREA 4: LOVE and CARE					
Parent/carer's attitude to child, warmth and care					
Boundaries					
Adult arguments and violence					
Young carer					
Positive values					
Adult behaviour					
Substance misuse					
AREA 5: STIMULATION and EDUCATION					
Unborn					
0-18years					
School					
Sport and Leisure					

Friendships					
Addressing bullying					
Area 6: PARENTAL MOTIVATION / CAPACITY FOR CHANGE					

What actions are to be taken as a result of completing this checklist?

9. PHYSICAL CARE:

9.1. Food

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Child is provided with appropriate quality of food and drink, which is appropriate to their age and stage of development. Meals are organised and there is a routine which includes the family sometimes eating together Children's special dietary requirements are always met Carer understands importance of foods	Child is provided with reasonable quality of food and drink and seems to receive an adequate quantity for their needs, but there is a lack of consistency in preparation and routine. Children's special dietary requirements are inconsistently met. Carer understands the importance of appropriate food and routine but sometimes their personal circumstances impact on ability to provide.	Child receives low quality food and drink, which is often not appropriate to their age and stage of development and there is a lack of preparation or routine. Child appears hungry Children's special dietary requirements are rarely met. The carer is indifferent to the importance of appropriate food for the child.	Child does not receive an adequate quantity of food and is observed to be hungry. The food provided is of a consistently low quality with a predominance of sugar, sweets, crisps and chips etc. Children's special dietary requirements are never met and there is a lack of routine in preparation and times when food is available. Carer hostile to advice about appropriate food and drink and the need for a routine.

9.2. Quality of Housing

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
The accommodation has all essential amenities such as heating, shower, cooking facilities, adequate beds and bedding and a toilet and is in a reasonable state of repair and decoration. Carer understands the importance of the home conditions to child's well-being.	The accommodation has some essential amenities, but is in need of decoration and requires repair. Carers are aware of this, and have taken steps to address these issues. The accommodation is reasonably clean, but may be damp, but the carer addresses this. Carer recognises the importance of the home conditions to the child's sense of well-being, but is hampered by personal circumstances.	The accommodation is in a state of disrepair, carers are unmotivated to address this and the child has suffered accidents and potentially poor health as a result. The look is bare and possibly dirty/smelly and there are inadequate amenities such as beds and bedding, a dirty toilet, lack of clean washing facilities and the whole environment is dirty and chaotic. The accommodation smells of damp and there is evidence of mould.	The accommodation is in a dangerous state of disrepair and this has caused a number of accidental injuries and poor health for the child. The look is dirty and squalid and there is a lack of essential amenities such as a working toilet, showering/bathing facilities inappropriate and dirty bed and bedding and poor facilities for the preparation of food. Faeces or other harmful substances are visible, and house smells. The accommodation smells strongly of damp and there is extensive mould which is untreated and the carer is hostile to advice about the impact of the home circumstances on child's well being.

9.3. Stability of Housing

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Child has stable home environment without too many moves (unless necessary). Carer understands the importance of stability for child.	Child has a reasonably stable home environment, but has experienced house moves/ new adults in the family home. Carer recognises that this could impact on child, but the carer's personal circumstances occasionally impact on this.	Child does not have a stable home environment, and has either experienced lots of moves and/or lots of adults coming in and out of the home for periods of time. Carer does not accept the importance of stability for child.	Child experiences lots of moves, staying with relatives or friends at short notice (often in circumstances of overcrowding leading to children sleeping in unsuitable circumstances). The home has a number of adults coming and going. Child does not always know these adults who stay over. Carer is hostile about being told about the impact on child of instability

9.4. Child's clothing

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Child has clothing which is clean and fits appropriately. Child is dressed appropriately for the weather and carers are aware of the importance of appropriate clothes for the child in an age appropriate way.	Child has clothes which are appropriate, but are sometimes poorly fitting, unclean and crumpled. The carer gives consideration to the appropriateness of clothes to meet the needs of the child in an age appropriate way, but their own personal circumstances can get in the way.	Child has clothing which is dirty and crumpled, in a poor state of repair and not well fitting. The child lacks appropriate clothes for the weather and does not have sufficient clothing to allow for regular washing. Carer(s) are indifferent to the importance of appropriate clothes for the child in an age appropriate way.	Child has clothes which are filthy, ill-fitting and smelly. The clothes are usually unsuitable for the weather. Child may sleep in day clothes and is not provided with clean clothes when they are soiled. The carer is hostile to advice about the need for appropriate clothes for the wellbeing of the child.

9.5. Animals

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Animals are well cared for and do not present a danger to children or adults. Children are encouraged to behave appropriately towards animals.	Animals look reasonably well cared for, but contribute to a sense of chaos in the house. Animals present no dangers to children or adults and any mistreating of animals is addressed.	Animals not always well cared for or ailments treated. Presence of faeces or urine from animals not treated appropriately and animals not well trained. The mistreatment of animals by adults or children is not addressed.	Animals not well cared for and presence of faeces and urine in living areas. Animals dangerous and chaotically looked after. Carers do not address the ill treatment of animals by adults or children.

9.6. Hygiene

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
The child is clean and is either given a bath/washed daily or encouraged to do so in an age appropriate way. The child is encouraged to brush their teeth and head lice, skin complaints etc are treated appropriately. Nappy rash is treated appropriately. Carers take an interest in the child's appearance	The child is reasonably clean, but the carer does not bath/wash the child regularly and/or the child is not consistently encouraged to do so in an age appropriate way. The child does not always clean their teeth, and head lice and skin conditions etc are treated in an inconsistent way. Nappy rash is a problem, but parent treats if given encouragement and advice.	The child looks unclean and is only occasionally bathed/ washed or encouraged to do so in an age appropriate way. There is evidence that the child does not brush their teeth, and that head lice and skin conditions etc are not treated appropriately. Carer does not address concerns about nappy rash and is indifferent to concerns expressed by others. Carers do not take an interest in child's appearance and do not acknowledge the importance of hygiene to the child's wellbeing	The child looks dirty, and is not bathed or washed or encouraged to do so. The child does not brush teeth. Head lice and skin conditions are not treated and become chronic. Carer does not address concerns about nappy rash and is hostile to concerns expressed by others. The carer is hostile to concerns expressed by others about the child's lack of hygiene.

10. HEALTH:

10.1. Safe sleeping arrangements and co-sleeping for babies

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer has information on safe sleeping and follows the guidelines. There is suitable bedding and carers having an awareness of the importance of the room temperature, sleeping position of the baby and carer does not smoke in household. Carer aware of guidance around safe co-sleeping and recognises the importance of the impact of alcohol and drugs on safe co-sleeping. There are appropriate sleeping arrangements for children.	Carer has information on safe sleeping, but does not always follow guidelines, so bedding, temperature or smoking may be a little chaotic and carer may not be aware of sleeping position of the baby. (Be aware this raises risk of cot death). Carer aware of the dangers of co-sleeping and recognises the dangers of drugs and alcohol by the carer on safe co-sleeping, but this is sometimes inconsistently observed. Sleeping arrangements for children can be a little chaotic.	Carer unaware of safe sleeping guidelines, even if they have been provided. Carer ignores advice about beds and bedding, room temperature, sleeping position of the baby and smoking. (Be aware this raises risk of cot death). Carer does not recognise the importance of safe co-sleeping or the impact of carer's alcohol /drug use on safety. Sleeping arrangements for children are not suitable and carer is indifferent to advice regarding this. Carer not concerned about impact on child.	Carer indifferent or hostile about safe sleeping guidance. Sees it as interference and does not take account of beds and bedding, room temperature, sleeping position of the baby and adults smoke in the household. (Be aware this raises risk of cot death). Carer hostile to advice about safe sleeping and the impact of carer's drug and alcohol on safe co-sleeping for the baby. Sleeping arrangements for children are not suitable and carer is hostile to advice regarding this. Carer not concerned about impact on child or risks associated with this, such as witnessing adult sexual behaviour.

10.2. Seeking advice and intervention

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Advice sought from professionals/ experienced adults on matters of concern about child's health. Appointments are made and consistently attended. Preventative care is carried out such as dental/optical and all immunisations are up to date. Carer ensures child completes any agreed programme of medication or treatment.	Advice is sought about illnesses, but this is occasionally delayed or poorly managed as a result of carer difficulties. Carer understands the importance of routine care such as optical/dental but is not always consistent in keeping routine appointments. Immunisations are delayed, but eventually completed. Carer is inconsistent about ensuring that the child completes any agreed programme of medication or treatment, but does recognise the importance to the child, but personal circumstances can get in the way.	The carer does not routinely seek advice about childhood illnesses but does when concerns are serious or when prompted by others. Dental care and optical care are not routinely attended to. Immunisations are not up to date, but carer will allow access to children if home visits are carried out. Carer does not ensure the child completes any agreed programme of medication or treatment and is indifferent to the impact on child's wellbeing.	Carer does not attend to childhood illnesses, unless severe or in an emergency. Childhood illnesses allowed to deteriorate before advice/care is sought. Carer hostile to advice from other (professionals and family members) to seek medical advice. Routine appointments such as dental and optical not attended to, immunisations not up to date, even if a home appointment is offered. Carer does not ensure that the child completes any agreed programme of medication or treatment and is hostile to advice about this from others, and does not recognise likely impact on child.

10.3. Disability and illness

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer positive about child's identity and values him/her. Carer complies with needs relating to child's disability. Carer is proactive in seeking appointments and advice and advocating for the child's well-being.	Carer does not always value child and allows issues of disability to impact on feelings towards the child. Carer is inconsistent in their compliance with needs relating to child's disability, but does recognise the importance to the child, but personal circumstances get in the way. Care giver accepts advice and support but is not proactive in seeking advice and support around the child's needs.	Carer shows anger and frustration at child's disability. Often blaming the child and not recognising identity. Carer does not ensure compliance with needs relating to child's disability, and there is significant minimisation of child's health needs. The carer does not seek or accept advice and support around the child's needs, and is indifferent to the impact on the child.	Carer does not recognise child's identity and is negative about child as a result of the disability. Carer does not ensure compliance with needs relating to child's disability, which leads to deterioration of the child's well-being. Carer hostile when instructed to seek help for the child, and is actively hostile to any advice or support around child's disability

11. SAFETY & SUPERVISION:

11.1. Safety awareness and features

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer aware of safety issues and there is evidence of safety equipment use and maintenance	Carer is aware of safety issues, but is inconsistent in use and maintenance of safety equipment, and allows personal circumstances to get in the way of consistency.	The carer does not recognise dangers to child and there is a lack of safety equipment, and evidence of daily dangers to the child. Carer indifferent to advice about this and does not recognise or acknowledge the impact on the child.	Carer does not recognise dangers to the child's safety and hostile to advice regarding this, does not recognise the importance to the child, and can hold child responsible for accidents and injuries.

11.2. Supervision of the child

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Appropriate supervision is provided in line with age and stage of development. Carer recognises the importance of appropriate supervision to child's well-being.	Variable supervision is provided both indoors and outdoors, but carer does intervene where there is imminent danger. Carer does not always know where child is and inconsistent awareness of safety issues when child away from home. Shows concern about when child should be home. Carer aware of the importance of supervision, but does allow personal circumstances too impact on consistency.	There is very little supervision indoors or outdoors and carer does not always respond after accidents. There is a lack of concern about where child is or who they are with and the carer is inconsistently concerned about lack of return home or late nights. Carer indifferent to importance of supervision and to advice regarding this from others.	Complete lack of supervision. Young children contained in car seats/pushchairs for long periods of time. The carers are indifferent to whereabouts of child, and often do not know where child is or who they are with, and are oblivious to any dangers. There are no boundaries about when to come home or late nights. Carer hostile about advice from others regarding appropriate supervision and does not recognise the potential impact on

			children's wellbeing.

11.3. Handling of baby / response to baby

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer responds appropriately to the baby's needs and is careful whilst handling and laying the baby down, frequently checks if unattended. Carer spends time with baby, cooing and smiling, holding and behaving warmly.	The carer is not always consistent in their responses to the baby's needs, because their own circumstances get in the way. Carer is a bit precarious in handling and is inconsistent in supervision. Carer spends some time with the baby, cooing and smiling, but is led by baby's moods, and so responds negatively if baby unresponsive.	Carer does not recognise the importance of responding consistently to the needs of the baby. Handling is precarious and baby is left unattended (bottle left in the mouth). Carer does not spend time with baby, cooing or smiling, and does not recognise importance of comforting baby when distressed.	Carer does not respond to the needs of the baby and only addresses issues when carer chooses to do so. There is dangerous handling and the baby is left dangerously unattended. The baby is strapped into a car seat or some other piece of equipment for long periods and lacks adult attention and contact. Carer hostile to advice to pick baby up, and provide comfort and attention. Carer does not recognise importance to baby.

11.4. Care by other adults

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Child is left in care of a vetted adult. Never in sole care of an under 16. Parent/child always aware of each other's whereabouts. Out of necessity a	Child 0-9 year old is sometimes left with a child age 10-13 or a person known to be unsuitable. Parents unsure of child's whereabouts. Carer inconsistent in	Child 0-7 year old is left with an 8-10 year old or an unsuitable person. Child found wandering and/or locked out. Carer does not raise awareness of the	Child 0-7 year old is left alone or in the company young child or an unsuitable person. Child often found wandering and/or locked out.

child aged 1-12 is left with a young person under 14 who is familiar and has no significant problem for no longer than necessary as an isolated incident.	raising the importance of a child keeping themselves safe from others and provides some advice and support. Carer aware of the importance of safe care, but sometimes is inconsistent because of own personal circumstances.	importance of child keeping themselves safe from others and provides no advice and support. Carer is indifferent to the importance of safe care of the child and leaves the child with unsuitable or potentially harmful adults and does not recognise the potential risks to the child.	Carer does not provide any advice about keeping safe, and may put adult dangers in the way of the child. Carer hostile to advice or professional challenge about giving safe care and impact of children being left with unsuitable and/or unsuitable or dangerous adults.

11.5. Responding to adolescent's needs

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
The adolescent's needs are fully considered with appropriate adult care. Where risky behaviour occurs it is identified and responded to appropriately by the carer.	The carer is aware of the adolescent's needs but is inconsistent in responding to them. The carer is aware that the adolescent needs appropriate care but is inconsistent in providing it. Where risky behaviour occurs the carer responds inconsistently to it.	The carer does not consistently respond to the adolescent's needs and recognises risky behaviour but does not always respond appropriately.	The adolescent's needs are not considered and there is not enough appropriate adult care. The carer does not recognise that the adolescent is still in need of guidance with protection from risky behaviour i.e. lack of awareness of the adolescent's whereabouts for long periods of time or seeking to address either directly or by seeking support of risky and challenging behaviour. The carer does not have the capacity to be alert to and monitor the adolescent moods for

			example recognising depression which could lead to self harm.

11.6. Traffic awareness & in-car safety

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Baby/Infant is well secured in pram/pushchair. Where a toddler is walking their hand is held safely. 3 – 5 yrs old are allowed to walk without holding hands, but are close and in vision. 5- 8 yr olds are allowed to cross with 13+ year old. Child taught traffic skills as per developmental needs.	Baby/infant not always secured in pushchair and 3- 5 yr old not fully supervised. 7yrs onwards are allowed to cross with another young child alone and 8 yrs old crosses regardless of suitability. Child given some guidance about traffic skills.	Baby/infant not secured in pushchair and 3- 5 yr old dragged along with annoyance or left to follow behind alone, with supervision. Under 7s onwards are allowed to cross road alone. Child not taught traffic skills.	Babies/infants are unsecured in pram/pushchair and carer is careless with pram. There is a lack of supervision around traffic and an unconcerned attitude. Lacks understanding of why teaching traffic skills might be important for the child.

12. LOVE AND CARE:

12.1. Parent/carer's attitude to child, warmth and care

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer talks warmly about the child and is able to praise and give appropriate emotional reward. The carer values the child's cultural identity and seeks to ensure child develops a positive sense of self. Carer responds appropriately to child's needs for physical care and positive interaction. Child is listened to and carer responds appropriately. Child is happy to seek physical contact and care. Carer responds appropriately if child distressed or hurt. Carer understands the importance of consistent demonstrations of love and care.	Carer talks kindly about the child and is positive about achievements most of the time but allows their own difficulties to impact. Carer recognises that praise and reward are important but is inconsistent in this. Carer recognises child's cultural identity and is aware of the importance of ensuring child develops and allows personal circumstances to impact on this. Child is main initiator of physical interaction with carer who responds inconsistently or passively to these overtures. Child not always listened to and carer angry if child seeks comfort. Does not always respond appropriately if child distressed or hurt. Carer understands the importance of demonstrations of love and care, but circumstances and difficulties sometimes get in the way.	Carer does not speak warmly about the child and is indifferent to the child's achievements. Carer does not provide praise or reward and is dismissive of praise from others. Carer does not recognise the child's cultural identity and is indifferent to the importance of ensuring that the child develops a positive sense of self Carer seldom initiates interactions with the child and carer is indifferent if child attempts to engage for pleasure, or seek physical closeness. Emotional response is sometimes brisk or flat and lacks warmth. Can respond aggressively or dismissively if child distressed or hurt. Carer indifferent to advice about the importance of love and care to the child.	Carer speaks coldly and harshly about child and does not provide any reward or praise. Carer is hostile to advice about the importance of praise to the child. Carer hostile to the child's cultural identity and to the importance of ensuring that the child develops a positive sense of self. Carer does not show any warmth or physical affection to the child and responds negatively. Responds aggressively or dismissively if child distressed or hurt. Carers will respond to incidents of harm if they consider themselves to be at risk of involvement with the authorities. Carer hostile to advice about the importance of responding appropriately to the child.

12.2. Boundaries

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer provides consistent boundaries and ensures child understands how to behave and to understand the importance of set limits. Child is disciplined appropriately with the intention of teaching proactively.	Carer provides inconsistent boundaries and uses mild physical and moderate sanctions. The carer recognises the importance of setting boundaries for the child, but is inconsistent because of own personal circumstances or difficulties.	Carer provides few boundaries, and is harsh and critical when responding to the child's behaviour and uses physical sanctions and severe sanctions. Carer can hold child responsible for their behaviour. Carer indifferent to advice about the need for more appropriate methods of disciplining.	Carer provides no boundaries for the child and treats the child harshly and cruelly, when responding to their behaviour. Carer uses physical chastisement and harsh other methods of discipline. Carer hostile to advice about appropriate methods of disciplining

12.3. Adult arguments and violence

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carers do not argue aggressively and are not physically abusive in front of the children. Carer has a good understanding of the impact of arguments and anger on children and is sensitive to this.	Carers sometimes argue aggressively in front of children, but there is no physical abuse of either party. Carer recognises the impact of severe arguments on the child's wellbeing but personal circumstances sometimes get in the way.	Carers frequently argue aggressively in front of children and this leads to violence. There is a lack of awareness and understanding of the impact of the violence on children and carers are indifferent to advice regarding this.	Carers argue aggressively frequently in front of the children and this leads to frequent physical violence. There is indifference to the impact of the violence on children and carers are hostile to advice about the impact on children

12.4. Young carer

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Child contributes to households tasks as would be expected for age and stage of development. Does not take on additional caring responsibilities. Carer recognises the importance of appropriateness regarding caring responsibilities.	Child has some additional responsibilities within household, but these are manageable for age and stage of development and do not interfere with child's education and interfere minimally with leisure/sporting activities. Carer recognises that the child should not be engaged in inappropriate caring responsibilities but is inconsistent in their response.	Child has onerous caring responsibilities that interfere with education and leisure activities. Carer indifferent to impact on child.	Child has caring responsibilities which are inappropriate and interfere directly with child's education/leisure opportunities. This may include age inappropriate tasks, and/ or intimate care. The impact on the child's well being is not understood or acknowledged. Carer is hostile to advice about the inappropriateness of caring responsibilities.

12.5. Positive values

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer encourages child to have positive values, to understand right from wrong, be respectful to others and show kindness and helpfulness. Carer understands importance to child's development. This includes an awareness of smoking, underage drinking and drug misuse as well as early sexual	Carer inconsistent in helping child to have positive values, to understand right from wrong, be respectful to others and show kindness and helpfulness. Carer aware of importance to child's development, but not always able to impose framework. Carer has variable awareness of smoking, underage drinking and drug	Carer does not teach child positive values. Is indifferent to issues of right and wrong, kindness and respect to others. Carer does not understand importance to child's development. Carer gives little advice about smoking, underage drinking and drug misuse as well as early sexual relationships. Carer does not	Carer actively encourages negative values in child and has at times condoned anti-social behaviour. Carer indifferent to the impact on child's development. Carer indifferent to smoking, underage drinking and drug misuse, and early sexual relationships. No advice given and may at times have encouraged some of these activities. Carer(s) allows

relationships. Carer gives clear advice and support. Carer ensures child does not watch inappropriate films/TV or play with computer games which are inappropriate for child's age and stage of development.	misuse as well as early sexual relationships. Carer gives some advice and support. Carer aware of need to monitor child watching inappropriate material and playing inappropriate computer games , but is inconsistent in monitoring because of own personal difficulties and circumstances.	monitor the watching of inappropriate materials or playing inappropriate games and is indifferent about the impact on the child.	child(ren) to watch inappropriate TV /film material and inappropriate computer games. Is hostile to advice about inappropriateness and to the impact on child (s) wellbeing.

12.6. Adult behaviour

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer does not talk about feelings of depression /low mood in front of the children and is aware of potential impact. Carer does not misuse drugs or alcohol.	Carer does discuss feelings of depression and low mood, but does not discuss suicide and is aware of the impact of parental mood on children, but their own mood or circumstances means there is inconsistency in awareness of this. Carer uses drugs and alcohol, but ensures that this does not impact on child.	Carer talks about depression and suicide in front of child and is unaware of potential impact on child. Carer indifferent to advice about the importance of not talking about this issue. Carer misuses drugs and/or alcohol, and is not aware of impact on child.	Care giver has attempted suicide in front of child. Carer can hold the child responsible for feelings of depression and is open with the child and/or others about this. Carer is hostile to advice focussed on stopping this behaviour and carer does not recognise the impact on the child. Carer misuses drugs and alcohol and does not ensure that this does not impact on the child and this impacts on safety and wellbeing. Carer hostile to advice about this.

12.7. Substance misuse

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Alcohol and drugs are stored safely, if in the home. The carer models low consumption or does not drink or use in front of the child. The carer's use does not impact on the child. The carer is able to respond to emergency situations should they arise appropriately. The carer talks appropriately about substances to the child, being aware of the child's development, age and understanding. The carer is aware of the impacts of substances on an unborn child and follows recommendations. Appropriate antenatal care is sought. Alcohol and substances do not impact on the family finances. The child's needs are fully met and a wide network of family and supportive others are involved.	The carer believes it is normal for children to be exposed to regular alcohol and substance use. The carer maintains boundaries and routines but these are changed and/or adapted to accommodate use at times. The carer understands the importance of hygiene, emotional and physical care of their child and arranges for additional support when unable to fully provide for the child. Finances are affected but the child's needs are generally met. The mood of the carer can be irritable or distant at times. The carer is aware of the impact of substances on an unborn child but inconsistently follows recommendations regarding the child's wellbeing.	The carer lacks awareness of the impact their substance use has on their child and is inconsistent in their engagement with specialist agencies. The carer's use leads to an inconsistency in caring and the child takes on inappropriate responsibilities at home. The carer needs support in order to manage their use during pregnancy and lacks awareness on the impact this may have on their baby in terms of immediate and medium to long term future. Substances can be accessed by the child. The child's access to appropriate medical or dental care is delayed and education is disrupted. The finances are affected and the carer's mood is unpredictable.	The carer holds the child responsible for their use & blames their continual use on the child. The carer significantly minimises and is hostile to advice around their use or refuses to acknowledge concerns. The carer involves the child in their using behaviour (i.e. asking the child to get the substances or prepare the substances). The carer refuses antenatal care or does not attend care offered. The carer cannot respond to the child's needs or shows little awareness of the child's wellbeing (i.e. attending school) There is an absence of supportive family members or a social network. The child is exposed to abusive or frightening behaviour of either the carer or other adults (i.e. delusions/hallucinations). The carer does not recognise and respond to the child's concerns and worries about the carer's circumstances.

13. STIMULATION & EDUCATION:

13.1. Unborn

	1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Unborn	The mother acknowledges the pregnancy and seeks care as soon as the pregnancy is confirmed. The mother attends all her antenatal appointments and seeks medical advice if there is a perceived problem. She prepares for the birth of the baby and has the appropriate clothing, equipment and cot in time.	The mother attends antenatal clinic and prepares for the birth of her baby, but she is acutely aware of her mental health or substance misuse problems which could negatively impact on her unborn baby.	The mother is unaware of the impact her mental health and/or substance misuse problems on the unborn child.	The mother does not attend any antenatal clinic appointments; she ignores medical advice during the pregnancy. She has nothing prepared for the birth of her baby. She engages in activities that could hinder the development, safety and welfare of the unborn.

13.2. 0-18 years

	1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
0-18 Years	The child is well stimulated and the carer is aware of the importance of this.	There is inadequate stimulation and the baby is left alone at times because of carer's personal circumstances and this leads to inconsistent interaction. Carer is aware of the importance of stimulation, but is inconsistent in response.	The carer provides the baby with little stimulation and the baby is left alone unless making serious and noisy demands.	The carer does not provide stimulation and the baby's mobility is restricted (confined in chair/pram). Carer gets angry at the demands made by the baby. Carer hostile to advice about the importance of

				stimulation and paying attention to the baby's needs for attention and physical care.
0-18 years	The child receives appropriate stimulation such as carer talking to the child in an interactive way, as well as reading stories and the carer playing with the child. Carer provides all toys that are necessary. Finds a way even if things are unaffordable (uniform, sports equipment, books etc). Outings: Carer takes child to child centred places locally such as park, or encourages child in an age appropriate way to make use of local resources.	The carer provides adequate stimulation. Carer's own circumstances sometimes get in the way because there are many other demands made on the carer's time and there is a struggle to prioritise. However, the carer does understand the importance of stimulation for the child's well-being. The child has essential toys and the carer makes an effort to ensure appropriate access to toys even if things are unaffordable, but sometimes struggles. Outings: Child accompanies carer wherever carer decides, usually child friendly places, but sometimes child time taken up with adult outings because of carers needs.	The carer provides little stimulation and does not see the importance of this for the child. The child lacks essential toys, and this is not because of financial issues, but a lack of interest or recognition of the need. Carer allows presents for the child but the child is not encouraged to care for toys. Child may go on adult oriented trips, but these are not child centred or child left to make their own arrangements to plays outdoors in neighbourhood. Child has responsibilities in the house that prevents opportunities for outings.	No stimulation is provided and carer hostile to child's needs or advice from others about the importance of stimulation. The child has no toys and carer may believe that child does not deserve presents. No toys, unless provided by other sources, gifts or grants and these are not well kept. No outings for the child, may play in the street but carer goes out locally e.g. to pub with friends. Child prevented from going on outings with friends or school.

13.3. School

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer takes an active interest in schooling and support at home, attendance is regular. Carer engages well with school or nursery and does not sanction missed days unless necessary. Carer encourages child to see school as important. Interested in school and support for homework.	Carer maintains schooling but there is not always support at home. Carer struggles to link with school, and their own difficulties and circumstances can get in the way. Can sanction days off where not necessary. Carer understands the importance of school, but is inconsistent with this and there is also inconsistency in support for homework.	Carer makes little effort to maintain schooling. There is a lack of engagement with school. No interest in school or homework. Carer does not recognise child's need for education and is collusive about child not seeing it as important.	Carer hostile about education, and provides no support and does not encourage child to see any aspect positively. Total lack of engagement and no support for any aspect of school such as homework, outings etc.

13.4. Sport and leisure

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer encourages child to engage in sports and leisure, if affordable. Equipment provided where affordable, or negotiated with agencies/school on behalf of child. Carer understands the importance of this for child's wellbeing. Recognises when child good at something and ensures they are able to pursue it.	Carer understands that after school activities and engaging in sports or child's interests is important, but is inconsistent in supporting this, because own circumstances get in the way. Does recognise what child is good at, but is inconsistent in promoting a positive approach.	Child makes use of sport through own effort, carer not motivated and not interested in ensuring child has equipment where affordable. Does not recognise the value of this to the child and is indifferent to wishes of child or advice from others about the importance of sports/leisure activities, even if child is good at it.	Carer does not encourage child to take part in activities, and may be active in preventing this. Does not prevent child from being engaged in unsafe/unhealthy pursuits. Carer hostile to child's desire to take part or advice from others about the importance of sports/leisure activities, even if child is good at it.

13.5. Friendships

1) Child focused care giving.	2) Care is not child focused.	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
This is supported and carer is aware of who child is friends with. Aware of safety issues and concerns. Fully aware of the importance of friendships for the child.	Carer aware of need for friends, does not always promote, but ensures friends are maintained and supported through opportunities for play etc. Aware of importance to child.	Child finds own friendships, no help from carer unless reported to be bullied. Does not understand importance of friendships.	Carer hostile to friendships and shows no interest or support. Does not understand importance to child.

13.6. Addressing bullying

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer alert to child being bullied and addresses immediately.	Carer aware of likelihood of bullying and does intervene when child asks.	Carer unaware of child being bullied and does not intervene.	Carer indifferent to child being bullied.

14. PARENTAL MOTIVATION / CAPACITY FOR CHANGE:

1) Child focused care giving.	2) Care is not child focused	3) Child's Needs are secondary to adults.	4) Child's needs are not considered.
Carer is concerned about children's welfare; wants to meet their physical, social, and emotional needs to the extent he/she understands them. Carer is determined to act in best interests of children. Has realistic	Carer seems concerned about children's welfare and claims he/she wants to meet their needs, but has problems with own pressing circumstances and needs. Professed concern is often not translated into effective action,	Carer is not concerned enough about children's needs to change or address competing demands on their time and money. This leads to some of the children's needs not being met. Carer does not have the right 'priorities'	Carer rejects the parental role and takes a hostile attitude toward child care responsibilities. Carer does not see that they have a responsibility to the child, and can often see the child as totally responsible for themselves or believe

confidence that he/she can overcome problems and is willing to ask for help when needed. Is prepared to make sacrifices for children.	but carer expresses regrets about own difficulties dominating. Would like to change, but finds it hard. May be disorganised, does not take enough time, or pays insufficient attention; may misread 'signals' from children; may exercise poor judgement.	when it comes to child care; may take an indifferent attitude. There is lack of interest in the children and in their welfare and development.	that any harm that befalls the child is the child's own fault and that there is something about the child that deserves ill treatment and hostile parenting. May seek to give up the responsibility for children.

Appendix 1: A Day in the Life of a Child

What Is the Child's Daily Routine?

Waking
Do they use a clock to get up? Does someone get them up?
What time does this happen? Do they have to get anyone else up? Does anyone else get up with them? Does the same thing happen every day?

Breakfast
Do they have breakfast? What sort of food do they have? Do they have a choice? Who makes breakfast?

Dressing
Do they dress themselves? Do they help anyone else get dressed? Do they wash and clean their teeth before getting dressed? Who makes sure they're doing this? Is there hot water and clean clothes to use?

Getting to School
Does someone take them? Do they have to take anyone else? Do they cross busy roads? Who helps them do this? Do they get to school on time?

In School
What do they like about school? What don't they like about school? Do they have friends? What do they do with their friends? Are they being bullied? What do they do break times? What do they eat at lunchtimes? Do they have favourite teachers or subjects?

School holidays/weekends
Do they look after anyone? Do they have chores/jobs to? If so, what are they and who are they for? How else do they spend their time? Do they see friends? Who looks after them when not in school? Who supervises mealtimes?

After school

Does someone collect them from school? Is this person on time? Are they part of any after school clubs? How do they get home from school? Do they look after anyone else after school? Do they meet with friends? Do they have something to eat when they get home? What do they have? Who makes it for them? Do they prepare food for anyone else?

Evenings
Do they have an evening meal? What time is this? Who prepares the meal? What is their favourite food? Do they have this often? Do they eat together with their family/ carers? If not, where do they eat? Who do they tell if they are hungry and what happens about this? Do they watch TV? If so, what do they watch? Do they use the internet / social networking sites? Is this supervised? Who do they communicate with online? What do they talk about? Do they go out? If so, where, who with and what do they do? Do they like toys and games? Do they have any? What do their parents/carers do in the evening? What do they think about what they do? Do they spend time with parents/carers in the evening? If so, what do they do? Are they put in charge of anyone else in the evening?

Bedtime
Do they have a set time to go to bed? Who decides it is time for bed? Where do they sleep? Do you like where you sleep? Is it clean and warm? Do they change for bed? Do they wash and brush their teeth at bedtime? Do they sleep without being disturbed? Who else is in the house at night? Are they put in charge of anyone else at bedtime?

Appendix 2: Long term consequences of neglect

The results and long term consequences of poor standards of home hygiene

Result	Long term effects on child
Persistent dirty carpets, bedding, chairs, clothing. Child smells. Infestation. Itching and scratching. Infected bites, skin infections.	Itching and scratching leads to loss of sleep. Irritable and crying. Raises family stress levels. Skin lesions become infected. Spread of infection, may need repeated antibiotics over a long periods of time. Others reluctant to interact with child. Affects social, emotional and development progress
Persistent inhalation of polluted air in the home accumulated dust, cigarette smoke, animal hair. Damp atmosphere, moulds and fungus growing on walls etc. Stagnant air through lack of ventilation	Repeated chest infections, asthma attacks, inhalation of second hand cigarette smoke, chronic lung disease. Repeated chest infections debilitating. Babies may require frequent hospital admission.
Eating food from the floor which is contaminated with dirt and/or animal faeces. Food left on the floor that becomes mouldy. Eating food that is past sell by date. Keeping food at incorrect temperature (bacterial growth). Using dirty/contaminated crockery and utensils. Inadequate cleaning	Toxoplasmosis and Toxicara widespread damage to all tissues can result in impaired vision. Recurrent gastro-enteritis. Salmonella, Botullism. Frequent gastro-enteritis can cause damage to gastro-intestinal tract reducing

particularly of feeding bottles and other equipment.	effectiveness of function.

The results and long-term consequences of failure to obtain appropriate health care

Result	Long term effects on child
Failure to obtain vaccinations, risk of contracting potentially serious childhood illnesses, Measles, Mumps, Rubella, Meningitis, Polio, Whooping Cough.	Death. Irreversible brain damage. Damage to major organs. Chronic lung conditions. Reproductive prospects. Source of infection in the community.
Failure or delay in obtaining medical treatment when the child is ill. Illness suffering prolonged unnecessary illness, condition more difficult to treat increased risk of having more, potentially toxic medication, hospitalisation, source of infection in the community	Death. Chronic ill health, impairment of major organs, dependent on infection/condition. Prolonged medical intervention. Repeated hospital clinic attendance.
Failure to enable child to access developmental/health promotion opportunities delayed or failure to detect treatable conditions, squints, hearing loss, congenital dislocation of the hips, undescended testicles, heart abnormalities, delayed development.	Visual and hearing impairment, impairment of mobility, delay in providing appropriate resources to maximise potential learning disabilities, poor academic achievement, chronic heart and lung conditions, low self-worth/esteem.

The result and long-term consequences of failure to provide personal hygiene for the child

Result	Long term effects on child
Persistent failure to adequately wash/change nappy. Nappy area in babies quickly becomes red and sore leading to pain and discomfort. Area becomes infected, septic spots and/or fungal infection, ammonia, dramatis, has appearance of 2nd degree burns. Poor toilet, hygiene, soreness around anus, may develop fissure, reluctance to open bowels, constipation. In females spread of infection to genitalia can cause urinary tract infection. Skin folds become moist, ideal for bacterial growth, infection.	Pain and discomfort cause irritable and crying baby recognised source of increased stress levels. Infection may be difficult to clear and require local systematic treatment. Pain associated with constipation may cause behaviour difficulties in toddlers and children and may have dietary problems. Particular consideration needs to be the implications for disabled, incontinent child/young people. Social contact may be reduced. People reluctant to interact as baby/child smells. Impacts on self-esteem and social interactive skills.
Hands and nails, babies put hands in mouth. Source of transmission or threadworms. Handling contaminated food on floor or animal faeces if home hygiene poor. Gastroenteritis ,toxoplasmosis, toxocariasis Sharpe broken nails cause damage to skin, nails tear causing pain/infection.	Toxoplamosis, toxocariais can be major health hazard in young children, causing wide spread damage to all tissues and damage to retina of eye.
Hair, daily grooming essential for detection of head lice. Washing hair would be part of grooming. Head lice leads to excessive scratching, skin is broken, becomes infected/infectious. Hair tangled and knotted, smells, gives general unkempt appearance.	As child grows, they become more aware of their personal appearance and its impact on others and can be victimised by both children and adults. They become marginalised within their communities and may face academic and social exclusion. They may not have developed skills to care for themselves which may impact on future relationships and role as parents. The effects of exclusion may be far reaching.

The result and consequence of failure to provide adequate nutrition

Result		Long term effects on child
Insufficient food intake for growth needs	Deficiencies of essential nutritional elements. If severe in under 2 years impaired brain growth. Poor growth, thin older female reduced energy levels. Miserable and lethargic.	Anaemia, poor bone growth (rickets/severe) poor absorption of essential vitamins, learning difficulties, development delay, poor concentration, delayed neurological development. Psychological effects of being small and thin. Poor

		participation in social activities social isolation. Poor academic achievement
Restricted/ rigged diets/foods	Imbalanced diet too much, fats, protein, vitamins, minerals and carbohydrates dependent type of diet. Poor growth, mineral and vitamin deficiencies	
Early introduction of inappropriate solid foods to babies	Imbalanced diet, insufficient levels of nutrition for growth. Immature digestive system cannot cope, constipation kidneys overload	
Low nutritional value food	High carbohydrates and fats. Poor growth but maybe very overweight. Need to differentiates between a well-nourished child/baby overweight or child/baby through fat carbohydrates e.g. snacks	

The result and consequence of failure to supervise and provide a safe environment

Results	Long term effects on child
Examples: Inside/outside home Falls Scalds/burns Ingestion of poisons and toxic substances Fires in the home House fire Suffocation (plastic bags, baby left alone propped on cushions) Road traffic accidents Abduction Abuse by risky adults	Death Permanent brain damage One or damage to vital organs permanent scarring Loss of function of limbs Repeated surgical interventions Chronic lung damage Accumulative effects of long-term medication Loss of family and home Chronic illness/disability, permanent residential care, poor school attendance impact on academic achievement, inability to participate in childhood pursuits, social exclusion, poor self-esteem and worth. Repeated hospitalisation, stigmatism. Reduced opportunities in adulthood.

	Risk of mental health problems.
Unsupervised meal times/prop feed Unsupervised bathing, baby left in bath	Death through suffocation, choking, nutritional intake may be inadequate. Death through drowning, hypothermia, burns/scalds. Near drowning incidents. Weight loss. Irreversible brain and lung damage.
Left with unsuitable or dangerous cares Left alone with young children. Exposure to pornographic images Exposure to domestic violence.	Significant harm through all forms of abuse. Acute life threatening neglect, Sibling abuse/bullying. Obvious dangers of being left alone, including emotional trauma Death/abduction. Emotional and sexual abuse. Consequences of self-evidence.

Acknowledgements

Greenwich has adapted this toolkit from Islington LSCB but the original concept came from work undertaken by Dr Leon Polnay and Dr O P Srivastava at Bedfordshire and Luton Community NHS Trust and Luton Borough Council.

GSCB Health Work Group. February 2017