**Practice Guidance**

**Neglect**

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| **Title:** | **Practice Guidance – Neglect** |
| **Effective From:** | **27th September 2013** |
| **Practice Note:** | Guidance on Neglect.  Practitioner responsibilities when neglect is suspected and guidance relating to responses to housing conditions, where housing standards do not meet requirements. |
| **Authorised by:** | **Senior Leadership Team**  **Children’s Services, Dudley Council** |
| **Review date:** | **27th September 2015** |

**Purpose of the guidance**

The purpose of this document is to provide clear guidance to all practitioners working with children and families in Dudley where neglect is a feature of the child/ren’s care, ensuring:

* practitioners understand neglect and the domains it encompasses. Enabling early identification, robust assessment and targeted intervention
* practitioners and the families with whom they work have clear goals to work towards to improve circumstances for the child/ren

Dudley has a comprehensive Neglect Strategy for 2022-2024, it is recommended that this is read in conjunction with this practice guidance and can be found here: <https://dudleysafeguarding.org.uk/children/wp-content/uploads/sites/2/2022/11/DSPP-Child-Neglect-Strategy-2022-2024.pdf>

**What is Neglect?**

Neglect is the persistent failure to meet a child's basic needs, likely to result in the serious impairment of the child’s health or development. Neglect is the most common form of child abuse in the UK. Currently in Dudley, of the 220 active Child Protection plans, neglect is recorded as the primary need in 38% of plans. (Information obtained in May 2023)

Children of all ages can experience neglect, including the prenatal period and adolescences. Research indicates that neglect co-exists with other forms of abuse/adversity and can be just as damaging in adolescence, as neglect in earlier years.

Neglect is difficult to define and varies by type, severity and persistence. Neglect is further complicated by practitioner subjectivity and threshold application, often leading to optimism in relation to ‘good enough care’. Dudley has adopted the Graded Care Profile 2 assessment framework, to challenge subjectivity and standardise the assessment response where neglect is identified.

It is important that neglect is identified, assessed and responded to for children, as its effects are often long lasting and harmful to the child. Broadly, neglect affects four development areas, as below:

* **Health and Physical Development** - Inadequate growth and failure to thrive
* **Cognitive and Intellectual Development** - Impact on brain development which effects functioning across life course.
* **Emotional and Psychological** - Negative impact on attachment behaviours, emotional dysregulation, increased risk of developing mental health illness.
* **Social and Behavioural** – Risk taking behaviour, difficulty forming healthy relationships

There are six sub-categories of neglect (Horwath 2007), supporting practitioners to identify where a child’s needs are being neglected, these include:

* **Medical neglect –** this involves carers minimising or denying children’s illness or health needs, and failing to seek appropriate medical attention or administer

medication and treatments.

* **Nutritional neglect –** this typically involves a child being provided with inadequate calories for normal growth. This form of neglect is sometimes associated with ‘failure to thrive’, in which a child fails to develop physically as well as psychologically. More recently, childhood obesity resulting from an unhealthy diet and lack of exercise has been considered as a form of neglect, given its serious long-term health consequences.
* **Emotional neglect –** this involves a carer being unresponsive to a child’s basic emotional needs, including failing to interact or provide affection, and failing to develop a child’s self-esteem and sense of identity. It can be distinguished from emotional abuse by the intention of the parent.
* **Educational neglect –** this involves a carer failing to provide a stimulating environment, show an interest in the child’s education at school, support their learning, or respond to any special needs, as well as failing to comply with national requirements regarding school attendance.
* **Physical neglect –** this involves not providing appropriate clothing, food, cleanliness and living conditions. It can be difficult to assess due to the need to distinguish neglect from deprivation, and because of individual judgements about what constitutes standards of appropriate physical care.
* **Lack of supervision and guidance –** failure to keep a child safe, including leaving a child alone; leaving a child with inappropriate carers; failure to provide appropriate boundaries.

**How we respond to neglect?**

Where neglect is suspected practitioners should complete the **Graded Care Profile 2** to inform robust assessments.

**What is the Graded Care Profile?**

Graded Care Profile 2 (GCP2) is an evidence-based assessment tool for measuring the quality of care provided by a parent or carer in meeting their child’s needs, where neglect is suspected. The tool seeks to manage subjectivity, allowing practitioners to make reasoned and explicit judgements, over a specific time period. Graded Care Profile 2 (GCP2) is a licenced tool and training for its use is mandatory. All frontline social care staff are required to attend this one day training course to enable practitioners to effectively use the tool. (Dates for this training can be found on the CPP website <https://cpp.event-booking.org.uk/events-list> ).

Restorative Practice encourages workers to work in collaboration ‘with’ families, not ‘to’ or ‘for’ families. The GCP2 tool is designed to be completed with families and should not be completed in isolation.

The GCP2 seeks to explore “what is it like for the child” not “why is it happening”. The tool looks at four key aspects of parenting: Physical Care, Care of Safety, Emotional Care and Developmental Care. These categories are further divided into subcategories, the practitioner grades each category to reflect the quality of care as defined in the grade descriptors. Grades provided are 1-5, which supports to define the care; highlighting both strengths and weaknesses. The GCP2 supports to identify specific needs so interventions can be targeted.

In addition to the GCP2, practitioners should complete an impact chronology, where neglect is suspected. Chronologies inform assessments, analysis and decision making and are vital for understanding family history, significant events and emerging patterns, when neglect is suspected.

**Family Safeguarding**

For those children and young people that we are working with under the Family Safeguarding Model, the GCP2 tool should be completed as part of the workbook. Modules 5 and 6 focus on Parenting Capacity, and it is within these areas of the programme that the GCP2 can be used to identify strengths and areas for change. For example, under Guidance and Boundaries (as noted in the workbook guidance):

Use the graded care profile to assess the levels of care provided and the grades to identify where the parent/s think they are on the scale.

Use the graded care profile to look at:

* How they communicate with the child, warmly, harshly etc.
* Do they have routines?
* How do they set boundaries?
* How do they ensure the safety and supervision of the child(ren)?
* How do they offer praise/reprimand/discipline their child(ren), are they consistent?

**How we respond to pre & post-natal Neglect**

Children can experience neglect in utero; the impact of neglect at this stage of development can be profound and have long term health and wellbeing implications. GCP2A aims to identify evidence of neglect at an early stage, allowing for targeted intervention and mitigation of neglectful care.

GCP2A seeks to identify what is happening but not why it is happening, the tool should therefore be used in conjunction with other assessments/chronologies. The GCP2A is split into three Sections. Section 1 has 7 questions and is completed when vulnerabilities or concerns are identified. This supports the practitioner in identifying if Section 2 needs to be completed. Section 3 is for the immediate post birth period (first 3 months of a baby’s life) and is more akin to the full GCP2.

Practitioners must be trained to complete the licensed tool. In the Dudley Borough, Section 1 of the GCP2A should be completed at all antenatal 1st booking appointments by the Midwife. Section 1 of the GCP2A should then be revisited and updated at every care contact by the midwife (documented on Sunrise).

GCP2A section 2 should only be completed if section 1 identifies indicators of neglectful care.

**Who completes section 2?**

* If the mother/family are only known to universal services, the Midwife would complete section 2 of the GCP2A.
* If the family are known to Early Help, a practitioner in Family Solutions would complete section 2, if a new concern arose whilst they were working with a family, discussions with the Midwife would inform the assessment tool.
* Families known to respective agencies such as Family Nurse Partnership or Perinatal Mental Health would have section 2 completed by their allocated practitioner.
* Families known to Social Care for statutory assessment and planning, would have section 2 completed by the allocated Social Worker to inform pre-birth planning and assessment.
* Any family already the subject of GCP2 assessment would require a GCP2A if a pregnancy was identified.
* Agencies are to discuss with the allocated Midwife if members of their team are not GCP2A qualified.

Section 3 of the GCP2A is completed post birth in the timeframe of 7days to 28days. Section 3 is undertaken by the agency who completed section 2, in liaison with the Health Visitor who will transition into using GCP2 after 28 days if neglect is identified and continues to impact the child.

**Managing mould/damp**

Sometimes the conditions of a home can be outside of the control of the occupier, for example, in instances where mould and/or damp are present. Mould and damp present serious challenges for respiratory health. As recently as 2020, an inquest ruled that a child of 2years had died from a respiratory condition caused by exposure to mould at his home. Mould and damp need to be taken seriously and the risks to health acknowledged, so what can we do as practitioners to support families?

**Council accommodation**

* All tenants have a duty to report their repairs. This can be either via the call centre, Dudley Council App or to any council employee- who must report the issue via the channels above.
* If responses are not satisfactory, the complaints procedure must be utilised.

**Housing Association**

* Practitioners, in the first instance, need to support the tenant to make a formal complaint to the housing association, exhausting their full complaints procedure.
* If responses are not satisfactory and housing conditions remain of concern, practitioners should support the tenant to write to the Housing Ombudsman Service (HOS) who regulate Housing Associations. The Ombudsman will investigate the compliant and the housing associate’s response and make findings on the matter.

**Privately rented accommodation**

* Support and encourage the tenant to raise concerns in writing to their landlord, explicitly stating the problem and the impact it is having on the home and health of the occupants.
* If no resolution is reached the Private Housing Repairs team can be contacted at Dudley Council, for further assistance. The tenant should be supported to contact the Private

Housing Repair team, information should be provided in writing outlining the housing concern, action already taken, and why discussions with the landlord have not ended with resolution. The Private Housing Repair Team have a number of powers to ensure that homes meet the minimum statutory housing standard.

**References & further reading**

* Howarth J: Child Neglect Identification and Assessment: MacMillan 2007
* <https://www.dudley.gov.uk/residents/housing/repairs-and-maintenance/protecting-your-home/damp-condensation-and-mould-growth/>
* <https://learning.nspcc.org.uk/services-children-families/scale-up/graded-care-profile-2-gcp2>
* <https://www.dudleycpp.org.uk/restorativepractice>

**APPENDIX 1 – CARRYING OUT A GRADED CARE PROFILE 2 ASSESSMENT**

**Initial home visit – indicators of neglect are identified.**

Social Worker to explore the indicators of neglect with the parents / carers.

*What do we know about the neglect? What indicators are present? Are circumstances consistent/usual for the family? Are there any aggravating factors / influential factors which may impact upon quality of care offered, such as mental health issues, emotional wellbeing, domestic abuse, disabilities, substance misuse etc.*

Social Worker to explore with the children their day to day experiences at home, their wishes and feelings, their routines, and the impact of neglect.

*Is there a child who requires more care because of a disability/care need? Are there a range of ages within sibling groups? If so, consider individual GCP2 Assessments.*

**Completing the GCP2 Assessment.**

Complete the GCP2 Assessment, contextualising the scoring with wider factors within the family which may impact upon parenting in the analysis, such as poor mental health, domestic abuse, substance misuse, disabilities etc; then identify clear actions to support the family to improve the level of care. These actions will feed in to the Early Help / Child in Need / Child Protection Plan and Reviews.

**Repeat**

The progress of actions and impact of support needs to be monitored through regular review meetings. The GCP2 should be completed again within a three-month timeframe to capture any fluctuations of care.

**Decision to complete GCP2 Assessment.**

Social Worker to discuss findings with the Team Manager, and plan the GCP2 Assessment.

Visit the family, explain the purpose of the assessment and how it will be carried out. Schedule assessment sessions in using a blend of announced and unannounced visits to the home.

Remember the GCP2 should be completed over a short period of time, and then repeated at a later stage to capture any fluctuations of care.