CHILD NEGLECT TOOLKIT 2018

In-depth version

Quality of Care and CHILD NEGLECT TOOLKIT - Guidance

Introduction

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. 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 to Safeguard Children 2018)

Neglect issues which have been highlighted in recent **Serious Case Reviews and Learning Lessons**, nationally and in the Boroughs of Kingston and Richmond, include poor supervision, children not being brought to medical appointments, numerous moves, lack of attention to children's needs including hygiene and basic needs in children under the age of 5. The follow contributory factors should also be explored: parental mental health problems, parental substance misuse, domestic violence, poor parental functioning, missed medical appointments including not accessing antenatal care, inadequate housing and poverty, and sexual abuse.

Background to the tool.

The Quality of Care, (QoC) tool was created for Hounslow by Jane Wiffin. Hounslow's tool is based on the Graded Care Profile developed by Dr Srivastava, a consultant paediatrician. His aim was to provide practitioners with a method of **assessing** when **inadequate care** might put a child at **risk of harm**.

The Graded Care Profile is based on **Maslow's hierarchy of needs** which identified the varied human needs that must be met for a person to flourish. The QoC tool was introduced to support workers to assess the quality of parental care. In families where concerns about parental care are substantiated the tool supports balanced and considered professional judgement of the extent to which children may be harmed. This clarity in turn assists in developing appropriate and specific plans to assist parents to change.

Bias

Eileen Munro drew attention to the influence of human bias on professional judgement and our tendency to form explanations for a family or individual's circumstances early on. Assessments too often confirm original explanations. Many workers aim to work against this tendency by aiming to be objective and neutral but objectivity is an impossible goal in human interactions. Additionally our tendency to work with our original hypothesis is so strong that we need to do more than aim to be neutral, we need to use processes that actively force us to consider a range of possible ways of understanding a particular set of family circumstances.

Acknowledgements

Kingston and Richmond LSCB have adopted this guidance from Hounslow LSCB, Jane Wiffin 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.

Why do we need a Child Neglect Toolkit in Kingston and Richmond?

We know that concerns about quality of care are regularly present where a Child in Need (CIN) Plan is put in place.

During 2016/17 the number of open cases which include child protection and Children Looked After totalled **745 in Kingston and 836 in Richmond of which 363 and 482** respectively came under the primary category of **'neglect'.** The primary neglect category includes emotional, physical and sexual abuse incidences.

The number of children subject to a Child Protection Plan (CPP) for Kingston in **2016/17** was **142** and Richmond **111** and respectively **51 and 21** of these were categorised as 'neglect'. The trend for **2017/18** is showing a **significant increase** in children with CPPs due to neglect although both boroughs are below the national average.

Research shows that nationally, **neglect** is the most common reason for taking child protection action. It is a factor in 60% of serious case reviews- source NSPCC. Record cruelty & **neglect** offences have increased across the county in recent years - NSPC How-safe-children-2018-report.pdf

All Practitioners need to have the tools to **assess** quality of care and neglect concerns with parents/carers in order to:

- In order to ensure the **"voice of the child"** is heard and **evident** in all assessments and plans.
- Give parents/carers a greater understanding of quality of care concerns, and to make **specific areas** of concern clear when working together with them.
- Discuss and plan with parents/carers what actions will achieve better outcomes for their children
- Improve involvement of parents/carers in identifying care issues, and in making and carrying out plans to achieve change
- Have a clear and structured approach to identifying "indicators" of neglect

Chronology of Neglect

A good chronology of events can identify patterns of behaviour and show where risks may lie.
A chronology can identify: themes, patterns, risks, strengths, capacity to change. If no chronology exists then one should be started.

What is the Child Neglect Toolkit?

This Toolkit is to help parents and carers, with professionals, Voluntary organisations & Faith groups , to look at and think about the quality of care given to children, and whether the care meets the children's needs. It will help them to think about concerns as well as identify strengths and where care giving is good.

This needs to be for a purpose. After completing the Toolkit, the aim is most likely to be to offer support with parenting/caring in order to improve some areas of care.

Good Practice in Neglect

Research by Marion Brandon (2013; 2016) indicates we **must**:

- ✓ Keep the child at the centre at all times
- ✓ Undertake **holistic assessments** that identify family **strengths and build resilience**.
- ✓ Be mindful of drift and 'start again syndrome'
- ✓ Focus on **cumulative impact of neglect**.
- ✓ Guard against over optimism.
- ✓ Be **aware** of disguised compliance.
- ✓ **Assess** parental readiness and motivation to change

Remember to focus on the impact of the circumstances on the child.

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

Using the Toolkit should **not normally be a one-off exercise**. A review date should be set. Completing the Checklist again will **track** improvements in care, as well as **deterioration or 'drift'**.

When quality of care is regularly poor, there is a real risk of neglect of the child's needs, affecting them both now and in the future. Using this Toolkit will help to make clear where there is neglect. If neglect is highlighted, professionals need to be open and clear with parents/carers about that. Professionals must take safeguarding action. This is most likely to be about working with parents/carers to help them make significant changes. Sometimes using the Toolkit will highlight an area where a child is being abused or is at risk of abuse. Then professionals must take action to prevent that abuse.

The toolkit is designed to assist you in **identifying, assessing** and decision making for children who are at risk of neglect. This toolkit is designed to be used with families and will fit well with the ethos and practice of **"signs of Safety"**. It is to be used when you are suspect that the quality of care for 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 areas to make improvements in.

It can also be used in one to ones with managers or in supervision.

Practitioners need to understand the child's view of the care they are given. The practitioner may fill in the checklist with the parent/carer, but **needs to have spoken to the child or children** (where age appropriate) and include observations of child.

The tool can be used with families and does not replace assessments such as the, **Early Help Assessment** (EHA) achieving for children early-help-assessment or Children's Social Care assessments but should be used in conjunction with them.

Copies of this toolkit are available at Kingston and Richmond LSCB information on neglect

Practitioners may know very little about the family's culture; this should be explored and acknowledged and need to be respectful and ready to learn. They should gain wider **understanding** from other sources as well as from the family they are working with, and not make assumptions. They should take cultural differences into account when using the Toolkit. Practitioners should be aware that real or assumed cultural factors have sometimes resulted in acceptance of a parent/carer's neglect or abuse. This must not happen.

Children with disabilities are more likely to be neglected, and the neglect is less likely to be identified. Neglect of a child with a disability may be more difficult to identify where there are communication issues or the child has significant learning needs. Workers may only be relying on a parent/carer's view of the situation and should consider the neglect of medical needs in their overall assessment. .NSPCC.right-safe-disabled-children-abuse-report 2014.

The Signs of Safety (SOS) approach

As of April 2018 Achieving for Children (AFC) and its local partners in Kingston and Richmond have adopted The Signs of Safety approach to assess, plan and implement changes for children and parents with the boroughs of Kingston and Richmond.

The **Signs of Safety** approach to child protection casework was developed through the 1990s in Western Australia. It was created by Andrew Turnell and Steve Edwards, in collaboration with over 150 West Australian child protection workers (CPWs), and is now utilised in jurisdictions in the USA, Canada, the UK, Sweden, The Netherlands, New Zealand and Japan. The approach focuses on the question "How can the worker build partnerships with parents and children in situations of suspected or substantiated child abuse and still deal rigorously with the maltreatment issues?"

This strengths-based and safety-focused approach to child protection work is grounded in partnership and collaboration. It expands the investigation of risk to encompass strengths and Signs of Safety that can be built upon to stabilise and strengthen a child's and family's situation. A format for undertaking comprehensive risk assessment — **assessing both danger and strengths/safety** — is incorporated within the one-page Signs of Safety assessment protocol. (This form is the only formal protocol used in the model). The approach is designed to be used from commencement through to case closure in order to assist professionals at all stages of the child protection process, whether they be in statutory, hospital, residential or treatment settings.

If you suspect abuse or harm or a criminal offence to a child you **must immediately** discuss this with your Named/Designated Child Protection Officer and make a call/referral to the:

Single Point of Access (SPA) on 020 8547 5008 in Kingston or Richmond

The check list is designed to flow the same way as the signs of safety conversations.
at the bottom of each area there is a section to complete -

- **What we cannot change and**
- **What we need to know more about**

Both should be completed each time the check list is completed.

Time scale should be within 45 day, once agreed changes are identified with the parent/carer.

Using the Child Neglect Toolkit

The Child Neglect Toolkit separates the different aspects of caring for a child for which the parent/carer is responsible. Within each area the tool identifies (and gives examples of) whether or not the care giving is and is also colour coded;

- Child focused - green
- Child's needs are secondary to adults - orange
- Child's needs are not considered – red

Green	**Needs Met**
Orange	**Needs Sometimes Met**
Red	**Needs of the Child are not Met**

This can assist both the practitioner and parent/carer to identify areas of child care that is of concern whilst also recognising areas where the care giving is good.

When there are concerns about a child's needs or their needs are unclear, Early Help Assessment tool (EHA) should be considered in line with Kingston and Richmond's multi-agency-threshold-document-2018

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 and works in conjunction with all signs of safety assessments. The checklist can also be used to monitor and evidence improvements, deterioration or 'drift'.

Eight areas of need

The assessment of care focuses on **eight 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 guidance details indicators and possible impact on the child with three specific ratings where **1** is child focused care giving and **3** is where there are high concerns that the child's needs are **not being met**.

The eight areas of need are:

1. Basic care
2. Health and Wellbeing
3. Safety and supervision
4. Stability through love and care
5. Adult issues affecting care
6. Valuing the child and its identity
7. Stimulation, learning and development
8. Anything else

By working through the assessment and scoring individual sections you will be able to identify strengths as well as areas of concern. Score of 3 is a cause for concern and should be discussed with your Named/Designated Child Protection Officer as soon as possible.

When Completing the Toolkit

- Always think if there are any other areas which should be covered. Try adding these issues to the existing areas or in Section 8 - Anything else.
- Think about each child. If a parent/carer's approach is very different for each child, you may want to use each child's initials separately in the Checklist columns
- Complete with key carers. Make sure you know who provides care. If you know about one parent, find out whether a second parent **or new partner**, or extended family members, are present and involved
- Children's views **must be gathered** and taken into account, and you may where possible complete the Checklist with them.
- Record what you are doing and why, use your professional judgment to work with the Toolkit in the best way possible for the family

Practical Points:

Please print out **IN COLOUR** if this facility is available

- The Toolkit is long. You shouldn't usually try to do it all in one sitting. Plan with the person you are working with how many sessions you need.
- The Checklist can be completed on screen. Upload the form from the LSCB website.
- Record when the Checklist was completed, amended and/ or reviewed and who was present
- Plan and record a **review date** this should include updates from core groups, TAC meetings and child protection conferences
- Some areas will not need completing – please put N/A here

If any **REDS (**Needs not met**)** are ticked, this is an alert regarding neglect at the threshold level of **significant harm**. A number of **ORANGES** (Needs sometimes met) should also alert professionals to a significant level of risk. Bear in mind that one or more ORANGES may increase the level of risk for **a baby** or an unborn child, whereas the risk may be present but not as immediate for an older child. The professional may need to think about next steps before the Toolkit has been completed.

Referral to or Escalation in Children's Services

Professionals must immediately discuss neglect or abuse with their service's Named/Designated Child Protection Officer and make a referral to the SPA team on **0208 547 5008.** If they are social workers, they should discuss concerns straight away with their line managers.

CONTENTS

Child Neglect Toolkit - Checklist

AREA 1

BASIC CARE

Food and drink

Quality of Housing

Hygiene

Clothes & shoes

Handling & care of baby

Care as child develops

Animals

Basic Care - Food and Drink

1. Needs Met	2. Needs sometimes Met	3. Needs of the Child are not met (voice of the child not heard in care consideration)
Child is provided with a **healthy**, balanced diet and enough food, right for their age, stage of development, health needs or disability.	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.	Child's **diet is not balanced**, and is **unhealthy**. It is not right for their age, stage of development, health needs or disability. They **do not get enough food**, or are fed too much, some or all the time. They are observed to be **hungry or significantly overfed**.
Meals are o**rganised** and there is a r**outine** which includes the family sometimes eating together.	Meals are **sometimes** but **not always** at regular times. Families do **not often eat together** where it is possible.	There is **no established** mealtime routine and the family **never eat** together.
Children's **special dietary requirements are always met** Examples are a special diet for a child with a **disability**, or for a child with **diabetes**, or where the child has **an allergy or food intolerance.**	If child has **special dietary needs** they **are sometimes met**. [*See left-hand column for examples] This may fall into the RED category - depending on the risks whenever needs not met.*	**Special dietary needs are not met**. There are likely to be **health emergencies and hospital admissions.**
Carer understands importance of foods and is **aware of unhealthy foods** and drinks and limits them, e.g. fizzy drinks, crisps.	Parent/carer's approach to **unhealthy food and drink** is not consistent* (these are only sometimes limited.	Parent/carer does **not limit unhealthy foods or drinks** e.g. fizzy drinks, crisps. The carer feeds the child unhealthy foods regularly e.g. takeaway foods.
The child is **encouraged** and supported **to eat independently.**	The child is **sometimes** encouraged to eat independently.	The child is **not encouraged** to eat independently. The child is **fed against their will.**
Where a child has a disability or health need, parent/carer **meets** their feeding needs (e.g. gives child thickened feeds where recommended, feeds child in	Where a child has a disability or health need, parent/carer **sometimes but not always** meets their feeding needs (e.g. not always giving child	Where a child has a disability or health need, parent/carer **does not meet** their feeding needs (e.g. not allowing /hardly ever giving child thickened feeds, not feeding child in correct position). They **do not allow** recommended feeding

correct position). They **allow** recommended feeding equipment (e.g. tube feeding). They follow the feeding plan which is recommended.	thickened feeds where recommended, or feeding child in correct position). They may agree to but **not always** use feeding equipment (e.g. tube feeding). They often but do not always follow the feeding plan which is recommended.	equipment e.g. tube feeding. They **do not follow** the feeding plan that is recommended. They may create their own **unusual** feeding plan which does not meet the child's nutrition needs.

Basic Care - Quality of Housing

Needs met		Needs not met
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.	Some of these essentials may be **missing or not working** and although they are being bought, replaced or repaired this may not be done quickly enough.	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 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 wellbeing.
The Home is **clean.**	The kitchen and bathroom are usually but **not always clean** enough. Other areas are **sometimes** but not always clean.	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. Floors are regularly **dirty and sticky.** Likely to **smell -** can be airless and **musty** with remnants of previous meals apparent, takeaway food packaging. Children may have regular stomach upsets.
The home is in a **good state** of repair and has no dangerous areas.	The home may need **some** repairs and decoration. There may be some risks (e.g. broken window, electric wires showing). Parent/carer understands this could mean the child having an **accident**. Plans to get work done, but it may **not be done quickly**.	Many **repairs needed**. There is a risk of accidents. Children may have been injured due to the state of the home. Parent/carer has **not taken action to deal with this.**

Items including clothes and toys **are tidied away** at the end of the day. The family knows where things belong.	Items, including clothes and toys, are **regularly not tidied away**. They may be a **trip hazard** (risk of tripping over them). Family do not know where everything should go.	**The family does not try to tidy things up. No place** for things to go. There may be piles of items that are never moved and these **fill up rooms** which should be living spaces. They may be a **trip hazard and fire hazard** (risk of tripping over items, risk of fire).
The parent/carer understands that home conditions **affect a child's feelings of wellbei**ng, and their health and **safe care**.	Parent/carer **sometimes not able** to understand that home conditions affects child's feelings of wellbeing, physical health and care. Sometimes feel overwhelmed and unable to change things. But does follow advice.	Parent/carer does **not understand** home conditions affect the child's well-being. **Does not accept or follow advice** to improve home conditions, or if they do**, cannot keep conditions good enough**.

***Points & Principles for Practice**:
Some families may be in temporary accommodation, and **reduced finances,** this may impact on their ability to provide/replace worn out or broken items. Consideration of the suitability of the temporary accommodation will need to be made to **ensure safety** for the children and family.

Basic Care - Hygiene

Needs met	Needs sometimes met	Needs not met
Child's skin and **hair is clean**. Child encouraged to bath or shower (or if not possible, to wash daily).	Child's skin and hair is **mostly clean** enough. They do not smell unwashed. They **do not bath or wash every day.** They may not be encouraged/ helped enough or sometimes not asked to bathe/wash daily.	Child's skin and/or hair looks **dirty and may smell**. Other children may **not want to sit next** to them at school. The child gets **very little or no help / encouragement** or not asked **to bathe/wash.**
Teeth brushed at least twice daily. Child gets the help and encouragement they need to do this. Child is **unlikely to have tooth decay.**	Child's teeth are **only brushed once a day**, or sometimes not brushed. Parent/carer **does not regularly** encourage them to brush their teeth. Child **may have some tooth decay.**	Child's **teeth are not brushed**. They are **not encouraged** to use a toothbrush. Child **may have a lot of tooth decay.**
Where baby/child wears a nappy it is **checked and changed regularly** enough to avoid any nappy rash, and when it is wet or soiled.	Baby/child may be **left too long in a wet or soiled nappy** and not changed often enough (some nappy rash may be seen).	Baby/child is left in a **very wet and/or soiled nappy** for a long time (nappy rash will be seen).
The **direct care* and self-care* advice** given to the child is the right amount for their age, and for their own particular needs. **More and more self-care*** is encouraged as they grow and change, with supervision where	Direct care* given to the child is **not always enough.** Does not always meet their needs. Hygiene and self-care* advice **not always given**. Child is sometimes expected to do self-care* tasks too early for their age and	**Little or no help** or advice, or not enough, is given. Child is expected to do self-care* tasks **too early for their age** and **beyond what they are able to do**. Little or **no supervision** where needed.

needed	ability, **without enough supervision.**	

***Points & Principles for Practice**:
Some children will need more help with personal care than others (e.g. children with health conditions/disabilities).
Poor dental care and nappy rash can be a **sign of neglect** in other areas.
As children become teenagers they will need new, sensitive advice about personal hygiene (e.g. sweating, menstrual periods).
If a smell is noticed but there are no other hygiene concerns this can be linked to health problems (known or unknown).

Basic Care - Child's Clothing & Shoes

Needs met	Needs sometimes met	Needs not met
Child's **clothes** are **clean** at the start of the day. Clothes and shoes **fit well**. They are budgeted for and **repaired or replaced** as soon as possible when needed. Child has enough clothes, which belong to them.	Child's clothes are **usually clean** enough at the start of the day but **not always**. Most but **not all clothes fit**. Some may have holes/tears. Shoes are replaced **but not always as soon as needed**. Child has clothes of their own, but may **not have enough clothes.**	At the start of the day **clothes are dirty and may smell**. Clothes and shoes **do not fit well**. They may be torn, have holes or be worn out. The child may wear the **same** clothes during the **day** and for **sleeping**. They **do not have enough** clothes and may wear other people's clothes that do not fit them and/or are not right for their age.
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 **sometimes** wears the right clothes for the weather but at other **times does not**.	Clothes are mostly **not right** for the **weather.** This includes child being **overdressed** or **underdressed** for the temperature, and not protected from sun, rain or cold weather conditions.
Parent/carer **notices** clothing needs. **Meets needs** as far as is possible.	The parent/carer does **not always notice** clothing needs and sometimes **does not understand** what is needed.	The parent/carer **does not see the need** for clean well-fitting clothes or shoes, and/or does **not provide these**.

***Points & Principles for Practice:**
Consider any **financial circumstances**

Basic Care - Handling & Care of Baby

Needs met	Needs sometimes met	Needs not met
Parent/carer **responds** to the **baby's signals***. They respond calmly to the baby when **crying**, and try to **find out** what they **need** (e.g. food, a nappy change, attention -they are in tune with the baby).	Parent/carer **sometimes responds** to the **baby's signals signals*** but sometimes does not. They **often respond calmly** when the baby cries or claims attention but **sometimes** feel **agitated or angry.** They may shout at them. They sometimes leave the baby too long before responding, or sometimes ignore them. They sometimes walk away if the baby doesn't calm down quickly.	Parent/carer **often does not respond** to the **baby's signals***. The baby's **demands** (e.g. crying) makes the parent/carer agitated or angry. They **do not try** to find out what the baby needs or try to meet those needs. They **shout** at them. They **may hit or hurt** them. ***Hurting, hitting or shaking a child is physical abuse. Shaking a baby can cause permanent damage or death.***
Parent/carer **handles*** and holds the baby carefully at all times (supporting head).	Parent/carer is **usually careful** in handling* and holding the baby but not always.	Parent/carer **doesn't take care** handling* and holding the baby, who could fall or be accidentally injured.
Parent/carer **knows current advice** about **safe sleeping and safe co-sleeping*.** They **follow** the advice about bedding, temperature, adult smoking and that the baby should	Parent/carer **may know some or all of current advice about safe sleeping and safe co-sleeping***. They often, but **do not always, follow all advice** about bedding, temperature, adult	Parent/carer **does not know or follow current advice about safe sleeping and safe co-sleeping*** even if they have been given it. They **do not follow the advice** about bedding, temperature, adult smoking and that the baby should sleep on their back. They **share a bed** with the baby when they

sleep on their back. They **do not** share a bed with the baby when they have been **drinking, using drugs, or smoking.**	smoking and that the baby should sleep on their back. They may **sometimes share a bed with the baby** when they have been drinking, using drugs, or smoking. **This increases the risk of cot death.**	have been drinking, using drugs, or smoking. **This increases the risk of cot death.**
Parent/carer **seeks and follows** health visitor's advice about care of the baby, including feeding, stimulation and routines. They **ask for support** if they need it (e.g. if the baby doesn't stop crying).	Parent/carer **sometimes seeks** and follows **health visitor's advice** about care of the baby, but sometimes does not. They **don't always ask for support** when they need it.	Parent/carer **does not see health visitor** or follow their advice about care of the baby. Parent/carer does **not ask for support** when they need it. Parent has **not registered** the baby birth or registered with a GP.

***Points & Principles for Practice:**
Remember safer sleeping.
Young babies are extremely vulnerable and completely dependent.
Remember teenage parents.
Think attachment - see area 7.
Think - passive-smoking-protect-your-family-and-friends/#children-and-passive-smoking

Basic Care - Care as Child Develops

Needs met	Needs sometimes met	Needs not met
Parent/carer **helps** the child move step-by-step to further development stages* at the right time for them as they **grow up,** e.g. toilet training, progressing to drink from a feeder cup. For a child with disabilities this may take time, but it is done as soon as possible.	Parent/carer does **not always help** the child move step-by-step to further development stages* at the right time for them as they grow up. They sometimes do so late e.g. toilet training may be late – it would normally be done before age For a child with disabilities this is done but not as soon as it could be.	Parent/carer **does not help** the child move step-by-step to further development stages* as they grow up, or **does so very late and inconsistently***e.g. the child may be in nappies or pull-ups far too long (still using these in school nursery or reception) - or may carry on drinking from a bottle instead of moving to a cup. For a child with disabilities, parent/carer may choose not to help with these developmental steps, because this is easier for parent/carer to manage.
Parent/carer **responds to the child with affectionate emotional warmth***, and physical warmth and contact* which is right for their age/development. **Good & secure attachment.**	Parent/carer **sometimes does and sometimes does not** respond to the child with affectionate emotional warmth*, and physical warmth and contact* which is right for their age and development.	Parent/carer **does not respond** with or **show affectionate** emotional warmth*, or physical warmth and contact*, which is right for the child's age/ development. **Attachment is poor.**
Child is c**omfortable** and **confident** going to the parent/carer when they	Child usually goes to parent/carer when hurt or upset, but there are	Child does **not go to parent/carer** when hurt or upset. Child has learned they will **not reassure them** and may be **angry**.

are hurt or upset. Parent/carer reassures and supports the child. Parent speaks with child in an **appropriate caring voice.**	times when the parent/carer does **not reassure them** or is not able to. Parent **sometimes** speaks with the child in an **appropriate voice.**	Parent does not speak with the child in an **appropriate voice - shouts and is cross and negative towards child.**
Parent/carer is **aware of risks to child's emotional and mental** health as they grow and change. They **talk to the child** about their f**eelings** and **pay attention** to how they appear (mood, feelings, how they look), and to signs of distress *(e.g. self-harm, issues with eating and food)* They **seek help when needed** *e.g. taking child to GP.*	Parent/carer is **not always aware** of risks to child's emotional and mental health as they grow and change. They **sometimes talk** to the child about their feelings and **sometimes pay attention** to how they appear (mood, feelings, how they look), but not always. They notice some **signs of distress** but not others *(e.g. self-harm, issues with eating/food)* **Help is not always asked** for by the parent/carer *(e.g. taking child to GP)*	Parent/carer is **not aware of risks to child's emotional** and mental health as they grow and change. They do **not talk** to the child about their **feelings.** They do **not pay attention** to how the child appears (mood, feelings, how they look). They **do not notice**, **signs of distress** (*e.g. self- harm, anxiety issues with eating/food).* They **don't seek** help for the child - or may do so, but then **do not support them** to use services (e.g. go to CAMHS appointments).

***Points & Principles for Practice:**
See Appendix 2 for attachment relationships

Basic Care - Animals

Needs met	Needs sometimes met	Needs not met
Animals are **well cared for and well fed.**	Animals **look reasonably well cared** for, but contribute to a **sense of chaos** in the house.	Animals **not well cared** for and presence of **faeces and urine** in living areas.
Parent/carers **understand dangers** from animals to children or adults. Children are **never left alone with animals,** which could hurt them. Animals are **carefully supervised** when with children.	Parent/carers **do not always think** about how pets may **behave,** and if this may result in a child getting hurt. They **sometimes leave children alone** with animals that could **hurt them.**	**Danger** from animals is **not considered**. Animals may be encouraged or trained to be **aggressive**. Children are left unsupervised with **animals** which could **hurt** them.
Children and adults **behave** in a caring way to animals. Animals are **well trained.**	Parent/carers do **not always think** how what a child or adult does may **upset or hurt** an animal, and they do not always stop them doing it. This may mean the animal becomes **aggressive**. Limited training of animals	Parent/carer **does not prevent ill treatment of animals** by adults or children, do not think about the possibility an animal **may become aggressive**. **No** or **very poor** training of animals.

***Points & Principles for Practice:**

The care of animals in a family home often reflects the care given to children.

If an animal is being neglected, the RSPCA must be called.

AREA 2

HEALTH & WELLBEING

Preparing for a baby

Safe sleeping arrangements and co-sleeping for babies

Seeking health advice & help

Disability, health & wellbeing

Health & Wellbeing - Preparing for a Baby

Needs met		Needs not met
Mother **responds** to signs she may be pregnant, takes a test and then seeks antenatal care straight away (this is usually by going first to GP). She goes to **all antenatal appointments** and seeks medical advice. Mother is sure about continuing with the pregnancy. **All health appointments are attended**	Mother **may not confirm** she is pregnant (take a test) until late, and may seek care late. She goes to **some** antenatal appointments, and seeks medical advice, but **not always**. Mother may be ambivalent about continuing with the pregnancy**. Some** health appointments are attended.	Mother may not take test or confirm the pregnancy. She may **not seek antenatal care**. Or she may register but **not go** to antenatal appointments. Mother may be ambivalent about continuing with the pregnancy. **Most health appointments are not attended**.
Mother (& partner) **prepares** for the baby's birth in advance, with enough **clothes and equipment** ready.	**Some items** are ready before the baby's due date, but not everything that is needed.	**Nothing is prepared** to meet the baby's needs.
If this is their first child, mother (& partner) **takes advice** about birth and childcare, which may be from friends, family and/or professionals (including **antenatal classes**). They **find out enough** to **meet the baby's needs.**	First-time mother (& partner) gathers **some information** and **advice** in advance but **does not know enough** to meet the baby's needs.	**No advice or information** gathered or **preparation** in advance.
Mother (& partner) asks for and **follows advice** about the effect on the unborn child of harmful substances (e.g. medicines, smoking, drugs/alcohol), or other issues (e.g. health diagnosis such as HIV, mental health, domestic violence). She (&	Mother (& partner) **asks for and follow some advice** about the impact on the unborn child of **harmful substances**, or **health issues**, or other issues that mean there is an additional risk. She/they **work with professionals**, but **not all the time**.	Mother (& partner) **ignores advice** during pregnancy to **prevent harm** to the unborn baby. She/they for example **continue taking drugs** or **misusing alcohol** and **do not work** with drug/alcohol **services** to reduce/stop misuse or other services to reduce risks. Mother (& partner) may **take actions** which mean mother, and so the **unborn child, is at risk**.

partner) **works with** professionals and **follows advice** to reduce the risk as far as possible.	Risks are reduced, but not as far as they could be.	
Mother (& partner) **has good self-care and personal hygiene** skills and cares for her/their own health. Understands and looks after her /**their own emotional needs.** This makes it likely she/they will be able to **meet these needs** for the baby.	Mother (& partner) **does not always** have good **self-care and hygiene** skills. Does not always look after her/their **own health or emotional needs**. This makes it more likely she/they will find it **difficult to meet those needs for the baby**.	Mother (& partner) **has poor self-care and hygiene skills**. She/they **do not** look after her/their own **health or emotional needs**. This makes it likely she/they will **not be able to meet these needs for the baby**.

***Points & Principles for Practice:**

A new baby is **very** vulnerable.
Whilst unborn, it is important to think about future risk. A pre-birth assessment should be made if there are concerns about care not being good enough (neglect), or about abuse.
Think - passive-smoking-protect-your-family-and-friends/#children-and-passive-smoking

Health & Wellbeing - Safe Sleeping Arrangements and Co-sleeping for Babies

Needs met	Needs sometimes met	Needs not met
Carer has information on safe sleeping and **follows the guidelines.** There is suitable bedding and **an awareness** of the importance of the room temperature, sleeping position of baby and risk of smoke in household. Plans are made for sleeping when away from home.	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. Plans are **not always** made for sleeping when away from home.	Carer does **not follow** or understand or is **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. Plans are **not made** for sleeping when away from home.
Carer **aware** of **guidance around co-sleeping** and recognises the importance of the risk of alcohol and drugs for the baby when co-sleeping.	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.**	Parent/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 & young people are **adequate** taking into account their need for privacy.	Sleeping arrangements for children are **not always suitable** and carer is **not aware of the impact** of the lack of privacy. Carer **not concerned** about **impact on child**	Carer **not concerned or aware** of the impact on child or young person of such risks as **witnessing adult sexual behaviour.**

***Points & Principles for Practice:**

Failure to follow guidelines & safe sleeping raises the risk of Sudden Infant Death (SIDS). The lullaby trust.org.uk safer-sleep-advice

Helpful range of information for teenage parents regarding safe sleeping - The lullaby trust.org.uk young-parents project
Further understandings of risks and reducing risk evidence paper 2016. Lullaby Trust summary paper safe sleeping and risk factors.

Health & Wellbeing - Seeking Health Advice and Help

Needs met	Needs sometimes met	Needs not met
Parent/carer **monitors** (checks and observes) child's health. If concerned, **they seek** and then **follow advice**, e.g. from GP or health visitor. They **get urgent or emergency medical help** *(e.g. going to Accident & Emergency or calling ambulance).*	Parent/carer **does not always** monitor the child's **health** and **doesn't always notice** problems or take advice /action **as quickly** as they should. Sometimes they make an appointment but don't take the child. Can lead to delays starting treatment. (**Think** - ***Was Not Brought).***	Parent/carer does not monitor the child's health and **doesn't notice problems**. They **never/** hardly ever ask for health advice. The child's health **gets worse**, when treatment straight away would probably have prevented this**.** (**Think** - ***Was Not Brought).***
Child is **registered with GP**. Parent/carer makes and goes to **recommended health checkups** and **appointments** with child, including 6-week health review, 2-year check, immunisation appointments. *If appointments are not attended it is not often and for a good reason.*	Child is registered with a GP **but not straight away** (e.g. after move). Recommended appointments e.g. 6- week/ 2-year health checks and **immunisations not done** on **time** but are finally completed. This may be after making and not going to **several appointments**. (**Think** - ***Was Not Brought).***	Child **not registered with a GP.** Recommended appointments are **very delayed** or **do not take place**. Child's recommended health checks and immunisations are **very delayed. Presents at A&E department instead of registering with GP.**
Child is **registered** with a dentist and optician. Child has dental and sight **checkups regularly**. Parent/carer listens to dentist's and optician's advice and encourages child to follow	Parent/carer needed to be **prompted** to register child with optician and dentist. Child **does not get** to checkups **regularly.** Sometimes misses appointments. Parent/carer	Child is not registered with optician or dentist and **does not go to checkups. Sight problems** or **tooth decay** are not noticed. Parent/carer does **not seek advice or treatment** or does so very late**. Child has to have teeth extractions.**

this advice.	**sometimes but not always** listens to optician's/dentist's advice. Does not always encourage child to follow it. It **takes time** for parent/carer to notice sight problems/tooth decay. They do then seek advice and treatment.	
Skin problems including nappy rash are treated straight away. Head lice are found and treated. If the problem does not clear up, parent/carer seeks advice, e.g. from health visitor, pharmacist, GP. Prevention (e.g. nappy rash barrier cream) is used as advised.	Skin problems including nappy rash **not always noticed/treated correctly straight away**. Head lice **not always noticed** and **treated correctly/ straight away**. If problem continues, advice only sometimes requested. Prevention advice not always followed.	Skin problems including nappy rash not treated. Head lice are **not treated** or, if they are treated, it is not enough to achieve complete success. Problems may continue or get worse and no advice is requested. Prevention advice is **not asked for or followed**.
Parent/carer **allows** recommended treatment and surgery.	Parent/carer may **delay treatment** or surgery so child's health needs are not met as quickly as they should be.	Parent/carer **prevents treatment**/does **not allow surgery** where advised. ***Preventing treatment may be abuse.***
Parent/carer understands the **importance** of meeting the child's **health needs**, and does so.	Parent/carer **usually understands** the need for advice/appointments, medication or treatment but **does not** always make sure they happen.	Parent/carer **does not understand** need for advice or treatment. Explaining risk of harm **does not change** their behaviour.

***Points & Principles for Practice:**

Think - Was not brought LSCB policy- Kingston and Richmond LSCB WAS Not Brought Policy 2018

Registering with a GP creates an overview of health needs of a child or young person.

Tooth extraction for under 5's is a significant sign of neglect, as there is an available treatment unless there is an underlying medical condition.

Neglect of a child's health needs can result in long-term damage or can be fatal.

Some physical symptoms or emotional/mental health concerns in children can be a result of abuse.

Health & Wellbeing - Disability, Health & Well Being

Needs met	Needs sometimes met	Needs not met
If a child has a **disability** and/or health problems, parent/carer makes sure they **understand** their likely **development** and how to **support** their progress.	Parent/carer has **some knowledge** or **understanding** of their child's particular issues and likely development, but **not enough** to **fully support** this.	Parent/carer **does not understand h**ow their child is likely to develop and what their **related needs** will be.
Parent/carer seeks and listens to advice about the child's needs. They go to appointments and follow recommended programmes* that will help the child to develop, learn and achieve (e.g. Occupational Therapy, Speech and Language Therapy programmes).	Parent/carer sometimes but not always listens to advice about the child's needs. They **miss some** appointments. They do follow recommended programmes* that will help the child to develop, learn and achieve - but **not often enough** or intensively enough to fully meet the child's needs. It slows their progress.	Parent/carer **doesn't/often doesn't listen to advice**, or does not follow advice. They **miss appointments**. They **do not follow** recommended programmes* that will help the child to develop, learn and achieve. This prevents or slows the child's progress. **Think – Was Not Brought**.
Parent/carer **communicates with the child**, using **communication aids*** to help if needed. Parent/carer takes **child's views and wishes** into account. Parent/carer **advocates*** for the child to ensure they get support and services	Parent/carer **communicates** with the child but does **not always** take the time needed and only sometimes uses communication aids*. They **sometimes**, but **not always**, take the child's views and wishes into account,	Parent/carer **does not communicate** with the child, or not enough. **Do not use** (and may not allow) recommended communication aids*. They **do not take** the child's views and wishes into account. They do not advocate* for the child and the **child's voice is not heard.**

and their voice is heard.	including when they act as the child's advocate*.	
Parent/carer **does everything** they can to get equipment and adaptations* in the home as soon as possible.	Parent/carer agrees to have equipment and adaptations* to the home, but **does not** take action to get these quickly. They are **not provided** as soon as possible.	Parent/carer **does not allow** recommended equipment and adaptations* to the home. They may **not allow** a wheelchair or other equipment or adaptations in the home.
Although it may **take time** for parents to **accept a diagnosis***, they do so and **work with** professionals to support the child.	Parents take a **long time** to **accept** a diagnosis*, and this **prevent**s the child getting all the care and support they need quickly. They do work with professionals but not always. They follow advice not to try to "cure" the child.	Parents are **not able** or **not willing** to **accept a diagnosis***. They may believe a disability **can be cured.** They may **give the child medicine** to "cure" them or **do other things** which they **think will cure** the child. *Doing this is likely to be emotional or physical abuse.* .

***Points & Principles for Practice:**

Disabled children are 3.4 times more likely to be abused and 3.8 times more likely to be neglected than non-disabled children (Sullivan and Knutson, 2000).

AREA 3

SAFETY & SUPERVISION

Safety awareness & equipment (younger children)

Supervising the child

Keeping teenagers safe - (Appendix 2)

SAFETY & SUPERVISION - Safety Awareness and Equipment (Younger Children)

Needs met	Needs sometimes met	Needs not met
Where there are young children there is **awareness of safety issues** and evidence of safety equipment use and maintenance that helps prevent accidents (e.g. stair gates and safety plug covers).	Parent/carer puts away dangerous items, e.g. knives There is **some safety** equipment in the home but it is **not always used - inconsistent** (e.g. a stair gate not always closed).	Parent/carer **not always notices** and **removes dangerous** objects. Parent/carer **does not have safety equipment** in the home, or does not use it. They do not/often **do not** put **away dangerous objects.** Can hold child responsible for accidents and injuries.
If travelling by car, a child is **always strapped** in/uses a seatbelt, and if under 12* uses a car seat correct for their age and size.	A child is strapped in and if under 12* **usually uses a car seat**, but sometimes sits on an adult's lap or wears an adult belt if a car seat is not available. *Whenever this happens, the **child is at risk**.*	The parent/carer **does not use a car seat,** or not the right one for the age and size of the child. They may **not use a seat belt** for the child.
Child is **strapped into** pram/pushchair, and baby chair/seat.	Child is **usually strapped** into pram/pushchair, and baby chair/ seat, **but not always**.	Child is **often not strapped** into pram/pushchair or in a baby chair/seat. *Whenever this happens, the **child is at risk.***
Parent/carer **teaches traffic awareness skills at the right level** for the child's	Child is given **some guidance** about traffic skills but it is not regular and	Child is **not taught traffic** awareness skills. The adult is **not aware** of the dangers. The parent/carer **does not supervise**

age and understanding. Parent/carer always holds a young child's hand/reins, and supervises the child closely. They direct them (telling them when to wait and cross) until they are old enough to cross alone and have learnt to do so safely.	not always clear. Parent/carer sometimes but **not always** holds hand/reins of young child. Child may **not be close enough** to adult even though in sight and call distance. Parent/carer may not always direct the child, telling them when to wait and when to cross. Older child may be **allowed to cross alone without having learnt** traffic safety skills well enough.	the child near the road. A young child's hand is not held. Young children may be **allowed to run** ahead out of sight. Older and younger children may be allowed to **cross alone** without having been taught traffic skills.
Parent/carer is aware and thinks about **preventing accidents**. They think about what will be the changing risks as the child grows, develops and explores. They ask for and follow advice about accident risks. Parent/carer t**eaches** child about risk of accidents and **safety skills**.	Parent/carer is **aware** of some/most risks but **does not always** do everything they could to prevent accidents. They don't think enough about **new risks.** They **usually listen** to and follow advice when offered, but not always. Parent/carer sometimes talks to child about risk of accidents and **teaches some safety skills**.	Parent/carer **does not think** about **risk of accidents**. They **do not follow advice**. Parent/carer does not teach child about accident risks or **safety skills**. They may feel the child is **responsible** for accidents and injuries. Child is likely to have had a number of accidental injuries.

SAFETY & SUPERVISION - Supervision of the Child

Needs met	Needs sometimes met	Needs not met
The amount of supervision provided is what is needed to **keep the child safe**, taking into account age, stage of development and own particular needs - indoors and outside. Carer **understands and takes extra care** at times of high risk such as when the child is near or in water (e.g. bath time, in/near paddling pool), or near or in traffic.	The amount of supervision is **mostly right** to keep the child safe, taking into account age, stage of development and own particular needs. Parent/carer understands where there is high risk. They do **not always supervise** carefully enough, but are usually nearby. A child may have had an accident in the past or have wandered off.	The **amount of supervision is not what is needed** to keep the child safe. It **does not fit their age**, stage of development and needs. A child may be **left alone** when too young. The child may have had a number of accidents, opened the front door or wandered off.
Primary school age child **is not left at home alone.** Child is **not left in the care of another** child who is under secondary school		Primary school age child **is left at** home alone. Child is **left in the care of another child** who is under secondary school age.

age. Child is only **left in the care** of an older child or adult who is **responsible enough** and **knows what to do in emergenc**y. Child is only asked to care for other children when old enough and able to understand and meet their needs, and to take emergency action.		Child is left in care of older child or adult who is **not responsible** enough and/or **does not know what to do in an emergency**. Child who is not old enough is asked to **care for other children** - or although old enough, is **not able** to understand or **meet their needs, or take emergency action**.
Appropriate supervision and recognises the importance of **appropriate supervision to child's well-being**.	There is **very little supervision** in the home or outside areas, and carer does not always respond after accidents.	Complete **lack of supervision**. **Hostile about advice** from others regarding appropriate supervision and **does not recognise t**he potential impact on children's wellbeing.
Parent/carer **only leaves** child in the care of an adult or older young person if they believe they are reliable and safe. They have made all **reasonable** checks to allow them to feel confident about this.	Parent/carer has **sometimes** left child in care of adult or older young person, who they do not know is reliable and do not know is not a **risk**. They have **not** made all **reasonable checks** about them.	Parent/carer has **lef**t child in the care of an adult or older young person, who they **know is unreliable or a risk**

SAFETY & SUPERVISION - Keeping Teenagers Safe

Needs met	Needs sometimes met	Needs not met
When the young person goes out, there are clearly **agreed return** times. Parent/carer **knows where** the young person is and with whom, and how to make contact. If they don't return as agreed and are uncontactable, or can't be confirmed to be safe, parent/carer calls police. **Backup/ safety plans*** are made with the young person.	Return times are usually set by parent/carer. They sometimes, but don't always, know where the young person is, and who with and how to make contact. They don't always try to find the young person if they are late. **Hardly ever make backup/safety** plans* with the young person. Does call police if young person is missing overnight.	There are **no agreed return times.** Parent/carer does not know where the young person is, or who with. They do not try to get in touch. There are **no backup/safety plans*** made with the young person. Parent/carer **does not report** them **missing** to police, even if gone overnight.
If the young person is at risk related to: - Child sexual exploitation (CSE), or other abuse or exploitation by peers**,	If the young person is at risk [see left hand column], the parent/carer notices some of the signs of this. They	If the young person is at risk [see left hand column], parent/**carer does not notice** all or some of the signs of this. They **do not seek help**, follow advice or use services, or they

adults, groups or gangs (including online) - Drinking, smoking, drug taking, sex - Criminal activity - Youth violence, gang involvement, the parent/carer **notices** where there are signs of this, and **asks for** and uses advice, support and services, including Children's Services and police.	ask for professional advice, support and services. However, they do **not always follow advice or do not use** recommended support/services.	stop doing so before the young person is safe.
Parent/carer is **aware** of the young person's mood and **emotional needs.** They **recognise risks** *e.g. if the young person has mood swings, seems depressed, self-harms or might self harm.* They **ask** for professional help and support.	Parent/carer has **some** sense of the mood and emotional needs of the young person but may **not always** respond. They sometimes recognise risks [*see left hand column*]. They may feel mental distress is part of growing up. They may not react quickly enough to the young person's needs. Sometimes ask professional advice.	Parent/carer **does not show** interest in the young person's mood and emotional needs. They do **not see the risks** to the young person [see left hand column]. They do not seek professional advice for the young person, or they do so very late.

***Points & Principles for Practice:**

Review of research on identification, assessment & intervention **Children's society.org.uk - understanding-adolescent-neglect Report April 2018**

Effective practice to address teenage neglect - agencies need to work together to identify neglect of teenagers.

Sarah- Jayne Blakemore (2012) the mysterious working of the adolescent brain. A brief lecture, clearly explains how the structure of the brain changes in adolescence, this affects their mood and behaviour.

ted.com/talks/sarah_jayne_blakemore_the_mysterious_workings_of_the_adolescent_brain#t-184295

AREA 4

STABILITY THROUGH LOVE AND CARE

Parent/carers attitude to child – warmth and emotional care

Behaviour & boundaries

Daily routines

Housing Mobility & who lives at home

Youth Violence

Young Carers

Stability through Love and Care - Parent/Carer's Attitude to Child, Warmth and Emotional Care

Needs met	Needs sometimes met	Needs not met
Parent/Carer **talks warmly** about the child and is **able to praise** and give appropriate emotional reward. **Responding appropriately** to child's needs for physical care and **positive interaction.**	Parent/Carer **does not speak warmly** about the child and is indifferent to the child's achievements Often **does not provide praise** or reward and is **dismissive** of praise from others.	Parent/Carer **speaks coldly and harshly** about child and does not provide any reward or praise and is r**idiculing** of the child when others praise. The emotional response of parent/carers is **critical and lacking in any** Parent/Carer is **hostile to advice** about the importance of praise and reward to the child.
The parent/carer values the child's **cultural identity** and seeks to ensure child develops a **positive sense of self.**	Parent/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.	Parent/Carer **refuses** to acknowledge the child's cultural identity and to the **importance** of ensuring that the child develops a **positive sense of self.**
Child is **happy** to seek physical contact and care.	Child is main **initiator** of physical interaction with carer who **responds**	Carer does **not show any warmth** or **physical affection** to the child and **responds negatively** to overtures for warmth and

	inconsistently or passively to these overtures.	care.

Stability through Love and Care - Behaviour & Boundaries

Needs met	Needs sometimes met	Needs not met
The child is told what is **expected** about behaviour. Boundaries* and **limits** are **clear.** Parent/carer responds consistently (i.e. in the same way) to similar events. Clear reasonable **rewards** and **sanctions*** are given.	The child is **quite often told** what is **expected** about their behaviour, and about **boundaries*** and limits. Parent/carer does not always **respond consistently** to similar events. Child is sometimes but not always **rewarded** or given **sanctions***.	The child has **not been told** what **behaviour** is e**xpected**. There are **no clear boundaries*** which the child understands they should not cross. Parent/carer's **response** is unclear and variable so the child does not know how they will react. **Rewards and sanctions*** are never or hardly ever given. They **do not** help the child to **understand** how they should behave.
Parent/carer **thinks about** how to manage challenges and conflict as the child grows older. They make **step-by-step changes** to give more	Parent/carer usually thinks about **challenges and conflict** at the moment they take place. They do **not always** make **changes** as the child	The parent/carer **does not think** about how to manage challenges and conflict. They **do not** make changes as the child grows to give more independence within **safe boundaries***. They do not think about whether the young

independence as the child/young person learns to stay within agreed boundaries*. They challenge the child/young person if they believe they are **unsafe. They take advice.**	grows. They can give mixed **messages** about boundaries* and **independence.** They sometimes but not always **challenge t**he young person, if they believe they are **unsafe**.	person is **unsafe**, and if so **challenge** them. They do not take advice.

Stability through Love and Care - Daily Routines

Needs met	**Needs sometimes met**	**Needs not met**
There are regular routines* on week days which everyone in the family knows about (they are more flexible at weekends). They include bedtimes, mealtimes, going to school every weekday and homework.	Family members know what the household and school routines* should be, but only some of these are followed regularly.	There are no household/school routines* and daily events happen at very different times each day.
Child goes to bed at a **regular time,** in a quiet room where the light is off or a nightlight is on. They are in the **same bed** and bedroom **each night** *(if separated parents have shared care,*	Child does have a set time for bed, but they are **quite often late**. They may **not get enough sleep** and so are **tired,** or get up late and so are late to school. They usually sleep in the same	Child has **no set** bedtime. They are put to bed l**ate or go on their own** at any time. They sleep in a noisy room (others in it may be awake). Light is left on until late or all night. They may sleep in **different beds**/rooms on different nights, without having a bed which is **"theirs".** They may sleep on a

child will have a usual bed/bedroom in each home). They get **enough sleep** for their age so they are **not tired** during the day. There will be no inappropriate use of social media. The parents will be able to **establish appropriate** boundaries. *Sleep time for older children likely to be more flexible at weekends*.	bed/room each night. A **teenager** may regularly go to bed **very late** and wake up late/be very tired. Parent/carer **tries to change** this, but is **not often successful**. **Sometimes,** the young person will be using social media at night.	sofa or on the floor. A teenager may stay up most of the night and sleep during the day, so they **don't go to school.** Parent/carer **does not** try to change this. There will be **no attempt** to control social media use at night time.
Parent/carer makes sure child is up, washed, brushes their teeth, has breakfast and gets out of the house so they get to school on time and every day. Young children are given help to do this, and older children given **encouragement**. Collects child from school on time.	Parent/carer sometimes but not always makes sure child is up, washed, brushed their teeth, had breakfast and gets to school on time. They do **not get to school every day.**	Child **gets themselves up**, or parent/carer may get them up, but **late.** They are **not helped** or encouraged to **wash**, brush their teeth or have breakfast. They often leave home late and get to school late, or **do not get to school.**
Parent/carer **understands** importance of routines* to make child **emotionally secure** as well as healthy.	Parent/carer understands **routines*** are **important**. But they find it **difficult** to keep routines in place and follow them every day.	Parent/carer **does not understand a**nd importance of routines*, and this leaves the child insecure and affects **health and learning.**

Stability through Love and Care – Housing Mobility & Who Lives at Home

Needs met	Needs sometimes met	Needs not met
Child has not moved often. They have been in this home for enough time to feel settled. This means they are attending school locally, have made local friendships and are connected to local services e.g. GP.	Child has made a number of moves. They may have had to resettle in school and make new friendships. Registering with and using some new services has sometimes taken too long.	Child has moved **home many times**. This may be to somewhere unsuitable or overcrowded. They may stay with friends or relatives at short notice. They may have moved into and out of a number of local authorities. Local connections (e.g. school, friends, GP, services) are not made in good time to meet the child's needs. There may be concerns re eviction and rent-arrears.
Parent/carer understands the importance for a child of a settled	Parent/carer usually recognises the importance of stability for the child	Parent/carer **does not understand**, or does not see as important, the fact that moving around affects the child

home. If a move has to happen, the parent/carer understands and takes action to reduce the impact on the child (emotional and practical), helping them to settle.	but **does not always** make this a priority. They sometimes but not always take action to reduce the impact (emotional and practical) on the child.	emotionally and practically. They do not take this into account when they move.
Child lives with known family/ household members. Where new household members are introduced to the child, the impact (practical and emotional) is thought about and managed well by parent/carer. They also consider the child's privacy and safety.	Where new adult visitors or household members are introduced to the child, the practical and emotional impact of this is sometimes, but **not always** understood or managed well. Privacy and safety is sometimes but not always thought about.	A number of known and/or new adults visit and/or stay in the home. The child **does not know** who the new adults are. The parent/ carer does not recognise that this may affect how the child feels, their daily life, and their privacy and that it could be **a risk** to the child's safety

Stability through Love and Care- Youth Violence

Needs met	**Needs sometimes met**	**Needs not met**
Care offers good advice, discussed with child, supports and guides.	Inconsistent with advice or time to discuss any concerns the child may bring to them. Does not acknowledge there is any issues and underestimates the concerns the child may have. Fails to act on or seek assistance form external agencies.	Carer does not respond in any way to the needs of the child related to any forms of youth violence crime or gang culture. Does not see the risk.

Points of Practice:
Some housing issues may be beyond the parent/carer's control (e.g. they may have a mobile job, insecure housing or be moved for benefits reasons). What is important is what the adult can do to improve the situation, and whether they are taking or have taken these steps.
Where there are concerns about mobile families, including about them moving from one area to another, it is important these are passed on to the new Local Authority.
Some families are in Temporary housing - if the access is **considered dangerous or children at risk** - then this should be **escalated** to the relevant housing organisation by the parent/carer and the professional make a **referral to SPA**.

Stability through Love and Care - Young Carers

Needs met	Needs sometimes met	Needs not met
Child contributes to households tasks as would be e**xpected** for age and stage of development. Parent/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.	Child has caring responsibilities which **are inappropriate** and i**nterfere** directly with child's education/leisure opportunities. This may include age **inappropriate** tasks, and /or intimate care.

Does not take on additional caring responsibilities.	Carer recognises that the child should not be engaged in inappropriate caring responsibilities, but is inconsistent in their response.	The impact on the child's wellbeing is **not understood or acknowledged.** Parent/Carer is **hostile** to advice about the inappropriateness of caring responsibilities.

***Points of Practice:**

Please remember to refer or contact Kingston Young carers if you need advice or assistance Kingston carers.org.uk young-carers
Please remember to refer or contact Richmond carers if you need advice or assistance Richmond carers.org services-for-young-carers

AREA 5

ADULT ISSUES AFFECTING CARE

Mental health issues

Arguments, domestic abuse

Alcohol & drug use

Adult motivation to make changes

Finances

Adult Issues Affecting Care - Mental Health Issues

Needs met	Needs sometimes met	Needs not met
Parent/carer has knowledge, understanding and awareness of their own needs (insight). They understand how their own poor mental health could affect care of their child.	Either Parent/carer has some but not full enough knowledge, understanding and awareness of their own needs (insight). They do not fully understand how their own poor mental health is	Parent/carer has **no knowledge**, understanding and awareness of own needs (insight). They **do not understand** how **their own poor mental health** is affecting their care of the child. There are no contingency plans and often caring crises.

Parent/carer takes care of their own mental and physical health. A contingency plan is in place.	affecting their child's care. Or level of insight goes up and down depending on current mental health. Sometimes there are contingency plans for care.	
Parent/carer notices when they are becoming unwell. They make plans in advance so if they become unwell, their own and the child's practical and emotional needs will be met.	Parent/carer **does not always** notice when they are becoming unwell, but sometimes does. They do listen to people who know them when they tell them they notice a change. They **are aware** it is important to make advance plans - and sometimes do so, but not always.	Parent/carer **doesn't notice** when they are becoming unwell. They **don't listen** to other people who see a change in them. They **don't make plans** to make sure their own and the child's needs will be met if they become unwell.
Parent/carer **asks for** and accepts mental health support and services (including medication) as often as they need it.	Parent/carer **sometimes asks** for and accepts mental health support and services but **not always.** They sometimes don't take prescribed medication.	Parent/carer **does not ask** for and accept mental health **support and services** even when asked to do so.

***Points of Practice:**

Many people will face mental health issues at some point including anxiety, depression, bipolar disorder, eating disorders, OCD, schizophrenia, psychosis, post-traumatic stress (there are many others).

Very often mental health can go up and down, but there may be long periods of poor mental health

If a parent/carer's mental health needs **are not met**, it is likely to have an **effect on care** of children

Remember to specify which adults have mental health issues and what they are.

Adult Issues Affecting Care - Arguments & Domestic Abuse

Needs met	Needs sometimes met	Needs not met
All adults with caring responsibility understand the emotional impact on the child of witnessing arguments and domestic violence/abuse. They	Adults with caring responsibility do not fully understand the emotional impact on the child of witnessing arguments and domestic	None of the adults with caring responsibility understands or is concerned about the **emotional impact** on the child of witnessing arguments or domestic violence/ abuse, and the **risks** of them being hurt.

understand the child may also get caught up and hurt.	violence/abuse, and the **risks** of them being hurt.	
There is a history of one or more serious arguments, domestic violence and/or abuse, and one or both adults have taken actions to ensure these no longer take place. If there are circumstances beyond a parent/carer's control which mean there is still a risk, they have worked with advice and services to do everything they can to prevent this risk.	There is a history of one or more serious arguments, domestic violence and/or abuse, and one or both adults have taken some protective actions which may keep the children safe from significant harm. For example, they have called police, worked with recommended services, followed safety advice. However they may not always do this consistently or it may not yet have been tested enough.	There is a history of one or **more serious** arguments, domestic violence and/or abuse, and one or both adults do not (or **often do not**) take actions to keep the child **safe from significant harm**. For example, they do not call police or work with recommended services. The victim does not follow safety advice. Both adults minimise* the incidents or behaviour, and the **impact on the child.**
Adults resolve disagreements through discussion and are seen to be respectful of each others' points of view. There is not a concern at this point about serious arguments, domestic violence or abuse.	Adults **sometimes** or often resolve disagreements through discussion but there are still times when there are more disagreements and they may become more serious without the adults thinking about the impact on the child.	Adults are **not able to resolve** disagreements through discussion, and so disagreements happen more often and become more serious without the adults thinking about the impact on the child.

Points of Practice

Is there evidence of domestic abuse/ coercive control/ violence? This will have an **emotional impact** on the child and they may **get hurt.** Report - children living with domestic abuse September 2017.

www.rip.org.uk/news-and-views/latest-news/the-multi-agency-response-to-children-living-with-domestic-abuse-prevent,-protect-and-repair/

Adult Issues Affecting Care - Alcohol & Drug Use

Needs met	Needs sometimes met	Needs not met
If parent/carer drinks alcohol while caring/supervising, they don't drink enough to affect their judgement or	Ordinary care may sometimes be less good because the parent/carer is under the influence of alcohol/drugs.	Judgement and abilities are affected by drinking alcohol or taking drugs when caring for the child. Parent/carer returns home whilst under the influence.

abilities. If parent/ carer uses drugs, they only do so when they are not in sole care of or supervising a child. They do not care for a child while still under the influence (effects can last for different amounts of time). Parent/carer is able to provide ordinary care and also to deal with emergencies.	Their reactions may be slower and their mood and behaviour may be affected. This can leave the child anxious and confused. Parent/carer can still react and deal with emergencies.	The basic and regular needs of the child are not met and parent/carer is not capable of reacting and preventing accidents. They are often in bed with children left alone. Alcohol/drug use affects their moods and how they behave and act. This is likely to make the child anxious and worried.
All drugs including controlled drugs like methadone, street drugs like cannabis or heroin, prescribed drugs like paracetamol, and alcohol, are **stored safely** where children cannot get to them.	Substances (drugs/alcohol) normally **not kept within reach** of child but bottles/cans of alcohol may be left out or not cleared away.	Drugs and/or **alcohol** are **left out** and **in reach** of the child including paraphernalia (equipment/items), e.g. spliffs, needles, beer cans. Alcohol is **hidden in other bottles** e.g. for lucozade/water, stored **in reach of the child** so child may drink them.
Parent/carer keeps drug/alcohol use separate from their life with the child and **does not drink** over **healthy** limits and does not use drugs with child there. They do not glamorise* drug/alcohol use.	Parent/carer tries to separate their drug/alcohol use from their life with the child. Child **has sometimes** seen them drinking to excess, and is aware they use drugs. May give message to child that drug/alcohol use is exciting or desirable.	Parent/carer **uses** drugs/**excessive** alcohol with child present. They do not try to keep this separate. They glamorise* use as something exciting or desirable. Child may be **involved** by parent/carer, e.g. being sent to pick up drugs or given drugs/alcohol. **Other adults may visit the home to deliver, buy or use substances**.
Parent/carer **asks for** and **accepts** support from drug/ alcohol services to **reduce and stop misuse.**	Parent/carer **sometimes asks** for and accepts support from drug/alcohol services but not always. They may **not always follow advice** or use all the support recommended.	Parent/carer **does not ask for and accept s**upport from drug/alcohol services or they **start** but do not continue.

***Points of practice:**

There are a lot of different drugs that can affect ability to care and make judgements, including heroin, crack, cocaine, cannabis, diazepam, speed, ketamine & khat.

Since the aim of the Toolkit is to think about the health and wellbeing of the child, it is important to be able **to talk openly about drug and alcohol** use.

Alcohol and drug misuse can be a **"trigger"** of domestic abuse.

Adult Issues Affecting Care - Adult Motivation to Make Change

Needs met	Needs sometimes met	Needs not met

Parent/carer **puts the child's needs first** and wants to do the best for them.	Parent/carer **understands** it is important to put the child's needs first, and may want to, but **does not** always manage this. They may sometimes feel motivated*, and sometimes not. This can mean changes happen, **but do not last.**	Child's **needs are not put first**. Parent/carer does not show knowledge, understanding or awareness that they should prioritise the child's care and wellbeing. They do **not want to change.**
Parent/carer **asks for help** if they feel they are not managing or that they need support to give a child the best possible care. They listen when professionals are concerned about the quality of the child's care, and **try to understand the concerns**. They work with services in order to **make changes**.	Parent/carer **sometimes asks** for help. They listen to concerns but **do not always understand** them, which means making changes is more difficult for them. They work with **some** services but not others. Or they work some of the time with services (e.g. attend some but not all of a parenting programme).	Parent/**carer does not ask** for help. They **do not listen** or **understand** when professionals are worried about **poor care**. They **do not work** with services to make changes so that care is better.

Adult Issues Affecting Care - Finance

Needs met Adult Issues Affecting Care	Needs sometimes met	Needs not met
Parent/carer's priority is to pay for essential needs, e.g. food, clothes, electricity or rent.	Parent/carer knows essential needs should be paid for first but **may not** always do so. Their budgeting skills **may not be good** enough to make the best decisions with the money they have.	Parent/carer **does not prioritise** essential needs and may first **spend money on other things** e.g. drugs, alcohol or a gambling addiction. They are often difficulties with debt.

Points for Practice:
Parents/carers may face financial problems. What is important is what they can do to **improve the situation**, and whether they have taken these steps.

VALUING THE CHILD AND THEIR IDENTITY _ Attitude to Child

Needs met	Needs sometimes met	Needs not met
Parent/carer **speaks** in a **positive way** about the child. They **praise them** and **encourage** them. They c**riticise the behaviour** they are unhappy with, instead of being negative about **the child themselves.**	Parent/carer **sometimes speaks positively** about the child and them. But **sometimes they speak negatively** about them. They sometimes make the child feel it is the **child who is "bad"** rather than their **behaviour.**	Parent/carer speaks negatively about the child and hardly ever or never praises what they do or encourages them. They see the child **as the problem**, rather than the child's behaviour as the problem.
Parent/carer **talks to the child**, them and shows they have a sense of their **views, wishes** & needs.	Parent/carer **only sometimes** picks up on or **listens** to how the child is **feeling**, or **talks** to the child.	Parent/carer **hardly ever picks** up on child's feelings and doesn't often talk to or listen to them.
Parent/carer **values** the child's cultural, racial and sexual identity, and any disability. Parent/carer encourages child to **make their own choices** as long as they are **safe**, and c**hallenges** them if not.	Parent/carer **sometimes** tries to value the child's cultural, racial and sexual identity or disability, but also **expresses negative views.** This may be because the **parent/carer's identity is different** from their child's, or to do with the **opinions and beliefs** which were part of their own upbringing. Parent/carer **may believe** the child's disability or sexuality is a **punishment.** They do **not always support** the child to **make their own choices** and decisions where safe. They do **not always challenge** them if they are **unsafe.**	Parent/carer **does not value** the child's **cultural, racial and sexual identity** or **disability**. They may express **negative/racist/ homophobic*** views about the child. This may be because the **parent/carer's identity is different** from their child's, or to do with **strong opinions and prejudices** which were part of their own upbringing. Parent/carer **may believe** the child's disability or sexuality is a **punishment.** They **don't support** the child's **choices** and decisions. They don't challenge them if **not safe**
The emotional response of the parent/carer **warm**.	Emotional response is **sometimes brisk/flat and lacks warmth**.	Emotional response is **lacking,** parent/carer **responds aggressively and or dismissively**.

VALUING THE CHILD AND THEIR IDENTITY - Values & Guidance

Needs met	Needs sometimes met	Needs not met
Parent/carer **encourages** child to understand **right from wrong**, and to be respectful and **kind** to others. They demonstrate this in their **own behaviour**.	Parent/carer **usually encourages** the child to understand **right from wrong** and be respectful and **kind** to others. They **do not always** demonstrate this in their own behaviour and this can be **confusing.**	Parent/carer **does not** explain **right from wrong** and show children how to be **kind** and respectful to others. They may **demonstrate anger and aggression** to the child, who is likely to **copy this behaviour.**
Parent/carer **guides** child and gives them **thoughtful advice** as they grow and change, e.g. about, puberty, drugs and alcohol, smoking, sex, healthy relationships, sexual harassment, social media, pornography. They make sure they **find out information and advice to help** the child.	Parent/carer **understands** the importance of giving advice and guidance, e.g. about, puberty, drugs and alcohol, smoking, sex, healthy relationships, sexual harassment, social media, pornography. They **sometimes** give this advice and guidance. But they may not make enough time to talk as the child grows older. They **may not find out information and advice** when this would help the child. They may not **feel able to talk** about all these areas.	Parent/carer **does not give guidance or advice** as children grow and change, e.g. about, puberty, drugs and alcohol, smoking, sex, healthy relationships, sexual harassment, social media, pornography. They may **not understand risks**. They may **not make time to talk** or feel able to talk about these areas. They may **encourage behaviour** which will result in the child's being **at risk.** They **may share** drugs, alcohol or pornography (this is abusive to the child)
Watching /streaming films or programmes, playing games or using sites/apps/social media: Parent/carer **ensures** as **far as possible** that the child does not access **unsuitable content** when **too young** or **not aware** about **staying safe** (*including using parental controls/blocks*). Parent/carer **discusses risks** and keeping **safe** with child. They **talk** to them about what is **legal and illegal**. They discuss the risks of **sharing images** of themselves or others. They make it clear the child **can come to them**	Watching /streaming films or programmes, playing games or using sites/apps/social media: Parent/carer **knows there are risks** if child accesses **unsuitable** content when too young or not aware about staying safe. But they may not understand or monitor this well. Parent/carer has sometimes talked about risks and keeping safe with the child, including what is legal/illegal and risks of sharing images - but not enough. The child may **not feel** the parent/carer is **available** or able to **solve problems**.	Watching /streaming films or programmes, playing games or using sites/apps/social media: Parent/carer **allows** the child to access unsuitable content/does not monitor what the child is watching and using. They do not discuss risks and keeping safe with the child. They do not understand or talk to them about what is legal/illegal, or the risks of sharing images. They do **not** make themselves **available** to **deal with problems** the child may be facing.

with a problem.		

VALUING THE CHILD AND THEIR IDENTITY - Voice of the Child

Needs met	Needs sometimes met	Needs not met
Parent/carer **listens & speaks** to the child in a **positive** caring manner. Parent makes time to have conversations with their child and **understands the importance** of talking with their child.	Parent/carer **sometimes** listens & speaks to the child. **Some** conversations are positive at times, but can also be **negative.** Knows why they should speak to their child but does **not make time** to do this.	Parent/carer **does not listen** to the child at all, **speaks over them, gives instructions** and does **not have time** to have conversations with their child. **Parent/carer fails to understand** why there is a need to talk to the child. Most communications are of a **negative** manner.
Child is **confident.**	Child can appear confident **some of the time** and at times be **unsure of themselves**.	Child can present **withdrawn** and **silent/watchful or unruly and loud- seeking attention.**

Points for practice:
Remember to **always** capture the child's **"lived experiences"** and voice in assessments and chronologies.

Stimulation, Learning & Development - Unborn

Needs met		Needs not met
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.	The mother **acknowledges** the pregnancy is **unsure** of her feelings towards the pregnancy. Delays to **seeks care** as soon as the pregnancy is confirmed	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 **prepares** for the birth of the baby and has the **appropriate** clothing, equipment and cot in time.	She has **erratic attendance** at antenatal appointments.	She **engages** in activities (*e.g., substance misuse*) that could **hinder /harm** the development, **safety and welfare** of the unborn.

Stimulation, Learning & Development - Age 0 -12 Months

Needs met		Needs not met
Parent/carer takes **regular time** with the baby (as much as needed for their age and stage of development and particular needs), **focusing** on them, **speaking** to them, **smiling** at them, holding them, making **eye contact** and responding with words, looks and cuddles.	Parent/carer **sometimes focuses** on the baby but **not as much** as needed for their age, stage of development and particular needs. Interacts and responds with words, sounds, looks, smiles, cuddles but **needs** to do so more.	Parent/carer **does not focus** on the baby. Does **not respond** to them except occasionally. **No eye** contact given & Parent on their mobile phone all the time
Care from one or more **regular** carers (parents/family members), so the baby makes a bond and **safe attachment***.	A number of **different carers**, some for a very short time. This means there may be difficulties in bonding and safe **attachment***.	The baby is **left alone** too much. **Different carers** to whom the baby is **not attached*** are asked to care for the baby. Carers are **not experienced** and may **not be safe.**
The baby is **stimulated** by activities and playing with **safe** objects/toys, which are right for the baby's age and stage of development and particular needs. Parent/carer **plays** with the baby. Encouraged to explore and move around within a **safe environment**. Regular **time spent** playing and being with other children *e.g. siblings, relatives, at baby and toddler groups*.	Parent/carer is **aware** of **importance of activities**, and of the baby playing with **safe** objects/toys Parent/carer knows they should play with the baby. But they **do not provide** or do these things enough. The baby may not be **encouraged enough** to explore and move around. Some time is spent playing and being with other children every week, but not each day.	The baby is **not stimulated** with activities and through playing with objects/toys. Parent/carer **does not often play with them.** The baby is **not encouraged** to explore and move around and **may be strapped** into chair or pushchair or **left** in cot for **long periods** *(the worker should see the baby out of their cot, pushchair or chair).* Does **not often** meet and spend time playing with other children.
Parent/carer **alert** to the baby's signals* (including burbling, crying, body language). **Responds/ in tune** to them and **meets their needs.**	Parent/carer **does not always understand** the baby's **signals*** (*including burbling, crying, body language)* or **meet** the baby's needs. Parent/carer **may not feel confident** in understanding what they need. The baby does not get **a consistent response**, which will affect their **emotional wellbeing**.	Parent/carer **does not listen** to or **respond** to the baby's signals* *(including burbling, crying, body language)* unless they make very **noisy** demands. This has become the baby's **way of getting attention**. The parent/carer may **become angry** when the baby cries or

		demands attention.

Points for practice:

Think - attachment theory*.
A new baby is physically **very vulnerable**. **Any risk** is of great concern.
If a carer focuses on phones/screens for a lot of the time when they are caring for a young child, they **won't provide the interaction** the child needs to **grow and develop** as well as possible.

Stimulation, learning & Development - Age 1 - School Age

Needs met		**Needs not met**
Parent/carer spends **regular time** with the child, **focusing** on them as much as needed for their age and stage of development and particular needs. They **talk** to them, **smile** and **make eye contact**, and offer them affection and **physical warmth**. They **respond** to what the child says and does, and when they call them.	Parent/carer **sometimes** pays **direct attention** to child but **not as much as needed** for their age, stage of development and particular needs. They **sometimes** provide **words, looks, smiles** and **physical warmth**, but not always, and need to do so more. They do not **always respond** to the child. There may be other demands on parent/carer's time which mean they do **not give enough** time to child.	Parent/carer **pays little/no direct** attention to child. Does **not or does not often smile, make eye contact, speak** to the child or provide **physical warmth**. They often **do not respond** to them, and their response **may be angry. Parent/carer constantly on their mobile phone .**
Care from one or more **regular carers**, so child makes a **bond** and **safe attachment***. *The number of carers which is reasonable will depend on the child's age and stage of development, and will later include nursery or class teachers.* *Parent/carer Begins the process for child to*	A number of different carers, some for a very short time. This risks **difficulties in bonding** and safe **attachment*.** **Taken up** the child's 2 or 3 year old Early Education funding* place at an early years setting but does not have regular attendance.	Child is **left alone too much. Different carers** to whom the child is **not attached***, who are **not experienced** or who may **not be safe** are asked to care for them. **Has not taken up** the child's 2 or 3 year old Early Education funding* place at an early years setting- **no stimulation or interaction**

*attend early years setting in the correct timescale - 2yr or 3yr old Early Education Funding *.*		**with peer.**
Child is **stimulated** by **activities** and playing with safe objects/toys, right for the child's age and stage of development and particular. Parent/carer **plays with the child**. Encouraged to explore and run around within a **safe** environment. Child has some time outside during the week.	Parent/carer aware of importance of stimulation, but **does not provide** enough activities and play with safe objects/toys. Parent/carer **sometimes** has time to play with child but often **says no**. Child may **not** be encouraged enough to explore and run around. Time spent outside is often due to parent/carer's needs *(e.g. child has to sit and wait),* but **sometimes** it meets child's needs *(e.g. going to the park)*	Child is **not stimulated** with activities and playing with objects/toys, and what they do play with may be unsafe for their age. Adult **does not or hardly ever plays** with child. Not encouraged to move around and may be **strapped into chair** or pushchair **or left** in cot for **long periods** *(the worker should see child out of cot, pushchair or chair)* Time outside is usually for **adult outings**, to meet adult needs.
Regular time spent with other children e.g. siblings, relatives, at toddler groups.	Under 3, **some time** spent playing and being with other children but not each day.	Does **not often** meet and spend time playing with other children.

Points for practice:

Think attachment*

Think - Attendance at Early Years setting is a protective factor

If a carer focuses on phones/screens for a lot of the time when they are caring for a young child, they **won't provide the interaction** the child needs to **grow and develop** as well as possible.

Good attendance will make an **impact on the child's learning** & Development. Poor attendance should be **challenged.**

NB-Some 2yr olds may be entitled to 15 hrs of Free Early Education if they meet the criteria.

All 3yr olds are entitled to 15hrs of Free Early Education

Stimulation, Learning & Development - School Age

Needs met	Needs sometimes met	Needs not met
Starts **Reception** at the **right age**. Parent/carer makes sure child gets to school on time every day unless they are ill, and collects on time (until child comes home independently). Parent/carer attends parent teacher meetings. They **help/support** child to do home school tasks (homework). Parent/carer **reads** to child of primary school age.	Child may have been **registered** for **school late** and started Reception **late**. Child is **often late** to school. **Sometimes** does **not go to school** although **not ill**. May be **collected late**. Parent/carer has some contact with school, but **misses** some parent-teacher meetings. **Does not always** help or support child's home-school tasks (homework). Does **not often read** to primary age child.	Child may **not be registered** for school. Does **not attend** school or has **very low** attendance. Parent/carer **has little or no contact** with school and **hardly** ever comes to meetings. Parent/carer **does not help** with home-school tasks (homework) or **read** to primary age child.
If **home schooled**, parent/carer has a plan for the **child's education** and follows it. This **meets learning needs** for a child at their age/stage of development. They also make **sure the child socialises** with children their own age.	Parent/carer may have taken child **out of school** because they thought it would solve a problem (e.g. bullying). But they are **not** able to provide a good enough level of home education for the child's age/stage of development, or enough stimulation or social **contact** with other children.	Parent/carer may say child is home schooled, but they **do not have an education plan**, or it is **not good enough** to meet educational needs, or they **do not follow** it. The child may **not** be **stimulated** and have little or no contact with children of their age.
If a child **will** not go to school, or has **behaviour difficulties** at school, or is bullied, parent/carer **works with school** (and other advice, support and services) to solve this.	If a child will not go to school, or has behaviour difficulties in school, or is bullied, parent/carer sometimes but not always works with school (and other advice, support and services). They do some of but not all of what has been **planned** to solve the	If there are problems for the child such as not going to school, behaviour difficulties or bullying, parent/carer **does not** work with school or other services to solve these.

	problem.	
Parent/carer **encourages** child to see school and education as important. Child & parent/carers **actively involved** & engaged in the school and its activities.	Parent/carer **tries to be positive** about **school** and **education**, but may have had **a bad experience** themselves. They may give the child a sense school is **not very important.**	Parent/carer **does not see** school or education as important. They **do not help** the child **value** these.

Points for practice:

Very low attendance causing concern is defined as under 90% (equal to one day missed every 2 weeks). Children might get to school far less than this.
Think - School is a protective factor.
If a carer focuses on phones/screens for a lot of the time when they are caring for a young child, they **won't provide the interaction** the child needs to **grow and develop** as well as possible.

Stimulation, Learning & Development - Activities, Friendships

Needs met	**Needs sometimes met**	**Needs not met**
Child **encouraged** to **take part** in sport and activities. Parent/carer **supports** child to do activities**, helping** them to get there, collecting them and including these in budgeting as far as possible.	Parents **allows child** to go to some sport and activities, but only **sometimes** offers support to get there or to **pay** for these. Child **attends some** of the school activities- fetes, afterschool clubs.	Child is **not encouraged** or may not be allowed to take part in after- school or out-of-school **sport** or activities. Family **do not engage** with the school activities.
Parent/carer understands importance of friendships for child and encourages this. This may include the child having friends round or going to friends' houses.	Parent/carer seems to understand the importance of friendships for the child, but does not often prioritise these. They sometimes but not often allow the child to have friends round or go to friends' houses.	Parent/carer does not encourage or may not allow friendships. They may not allow the child to have friends round or go to friends' houses. Alternatively, they may allow this all the time, without considering risks or setting limits.

Parent/carer talks to the child about **safe** friendships and helps them to solve friendship problems. They are supportive and take reasonable actions if a child is bullied or harmed in any way (e.g. if necessary contacting school, police or Children's Services).	Parent/carer **sometimes** talks to the child about **safe friendships** and **friendship problems** but not often. They sometimes take reasonable actions if they find out a child is bullied or has been harmed. But they may not find out this is happening, and if they do, they may not contact the right professionals for help (e.g. school, police, Children's Services), who can help solve the problem.	Parent/carer **doesn't talk** to the child about friendships and **friendship problems.** **Does not prevent** child from being engaged in unsafe/unhealthy activities. If a child is being bullied or harmed they may **take no action**, or **actions in anger** which are unreasonable (e.g. threats to another child). They **do not contact** professionals for help (e.g. school, police or Children's Services).

Points for Practice:

Some families may have financial difficulties - unable to pay for clubs.

Stimulation, Learning & Development - Addressing Bullying

Needs met	**Needs sometimes met**	**Needs not met**
Parent/carer **responds** to any form of bullying and addresses it immediately with assistance from school.	Parent/carer **seems concerned** about child and aware of possible bullying but **sometimes responds in angry** manner and does **not resolve** the situation.	Parent/carer **indifferent** to the child being bullied.

Acknowledgements

Richmond and Kingston LSCB have adopted this guidance from Islington. Islington adapted it from work initially developed by Jane Wiffin on behalf of Hounslow LSCB which was further refined by Brent LSCB and refreshed with thanks to Harrow Safeguarding Children's Board. 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.

Appendices

Appendix 1 - Attachment Relationships

Persistent, severe neglect indicates a breakdown or a failure in the relationship between parent and child. This may be reflected in maladaptive attachment patterns; for example, *neglected children are as likely as children maltreated in other ways to develop disorganised attachment styles.*

However, they differ from other maltreated children in that they show more evidence of delayed cognitive development, poor language skills, and poor social skills and coping abilities (Hildyard and Wolfe, 2002).

They may also present as dependant and unhappy, and display a range of pathological behaviours (see Egeland et al, 1983; Ward, Brown and Westlake, 2012). Children who are neglected from early infancy may find that as their need for nurturing or responsive relationships goes ignored, they withdraw from relationships, feel a greater sense of failure and may even blame themselves for the neglect they experience (Manly et al, 2001).

Type of Attachment	**Indicators**
Secure attachment	Child has strong feelings of self-confidence and self-worth
Avoidant attachment	Child does not seek out physical contact Child is generally wary Child's play is inhibited Child is indiscriminate regarding who they interact with Parent/carer fails to recognise or are indifferent to child's signals and needs
	Child seeks contact, but does not settle when he/she receives it

Ambivalent attachment	Child resists attempts at pacification Child demands parental attention, but angrily resists it Child nervous of new situations This behaviouroften reflects parents/carer behaviour that is inconsistent and insensitive, rather than hostile and rejecting
Disorganised attachment	Child is confused and has difficulty in controlling feelings of aggression Child has no impulse control Child experiences parents/carers as frightening and/or frightened and not as a source of safety and comfort

Appendix 2 - Teenage Neglect

Research shows that neglect at home during teenage years can be as damaging as neglect during early years. The Children's Society conducted research with 1000 adolescents in 2016 which found 8% of teenagers experienced some form of neglect, with lack of supervision being the most common (58%). More young people age 14 and 15 years (3 times as many) than 12 and 13 years reported that their parents hardly ever or never helped them if they had a problem or provided emotional support. This may indicate that as children get older parents think they need less of this kind of support.

Research shows a strong correlation between young people's **risk taking** behaviour and their not being **emotionally supported at home**. There is also a very strong correlation between young people experiencing very poor health and being exposed to neglectful parenting. Young people that experience neglect report low levels of general competence, feel that no one cares for them, are negative about their future, have difficulty in engaging in education and are generally unhappy with their lives overall.

If the young person experienced different forms of neglect then their emotional wellbeing deteriorated with an increase in externalising behaviours e.g. *drinking alcohol and truanting from school* and internalising behaviours *(depression, anxiety and post- traumatic stress disorder).* Maltreatment that begins during adolescence is more damaging than neglect that starts andfinishes duringchildhood as it causes problems during late adolescence and early adulthood including involvement in criminal behaviours, substance misuse, health-risking sexual behaviours and suicidal thoughts (Thornberry et al 2010).

The children's society what-we-do/research/troubled-teens-understanding-adolescent-neglect

Age of Concern, Ofsted found that SCRs of teenagers showed practice focused on a young person's challenging behaviour rather than the causes of this behaviour and that young people were being treated as adults rather than as children. Ages_of_concern_learning_lessons_from_serious_case_reviews.pdf

Appendix 3 - LSCB Neglect Tools

http://kingstonandrichmondlscb.org.uk/practitioners/what-is-child-abuse-and-neglect-113/neglect-128.php