Lambeth Safeguarding Children Partnership

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LSCP factsheet:
Working with children who have chronic medical needs

What do we mean by chronic medical needs?

We use the term 'medical needs' to describe the broad range of diagnosed and undiagnosed conditions relating to children's physical and mental health which ought to require some input from NHS Services.

Medical needs might be temporary or chronic:

- Temporary conditions are short-term and can be recovered from, for example, a broken leg or short-term mental health crisis.
- Chronic conditions are long-term, i.e. life-long or lasting for several years, and whilst recovery may not be possible, these conditions can generally be managed.

Some children with chronic medical needs will also be considered disabled. The Disability Discrimination Act 2005 and Equality Act 2010 define a disabled person as someone who has "*a physical or mental impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day to day activities*". As such, when we talk about children with chronic conditions this encompasses those children who may not typically be thought of as disabled but who share some of the same challenges and vulnerabilities.

This factsheet explores the reasons why children with chronic medical needs are at increased risk of abuse, neglect and exploitation and highlights best practice when working with these children and their families.

Can you give me some examples of chronic medical needs?

These are some common examples of chronic medical needs children might experience:

Asthma	A condition which affects breathing, with symptoms including wheezing, coughing, shortness of breath and a tightness in the chest. It cannot be cured, but if well treated then there should not be any symptoms.
Anxiety disorders	A group of conditions characterised by excessive worry and fear which affects children's behaviour and thoughts on a daily basis, with symptoms including panic attacks. Treatment is available to manage symptoms, and recovery is possible.
Cerebral Palsy	A condition that affects movement and co-ordination, with symptoms including developmental delay, stiffness or floppiness, weakness in arms/legs and fidgety, jerky, clumsy, random or uncontrolled movements. It cannot be cured, but treatments are available to help children living with the condition be as active and independent as possible.

Chronic constipation	A condition which affects defecation, with symptoms including finding it hard or painful to poo, unusually small/large poo or dry, hard or lumpy poo. When symptoms last more than 3 months, it is classified as chronic. Treatment is available to manage symptoms, and recovery is possible.
Crohn's Disease	A condition which affects the gut, with symptoms including diarrhoea, blood/mucus in poo, stomach pain, anus pain, fatigue, loss of appetite and delayed growth/puberty. It cannot be cured, but there are treatments to help prevent or manage symptoms.
Depression	A condition characterised by depressed mood, with symptoms including sadness, low mood, irritability, loss of interest and fatigue. Treatment is available to manage symptoms, and recovery is possible.
Diabetes	A condition which affects blood sugar, with symptoms including thirst, fatigue, weight loss and increased urination. Type 1 Diabetes is lifelong and cannot be prevented or cured, but if well treated then there should not be any symptoms. Type 2 Diabetes can be stopped with lifestyle changes and treatment.
Eating disorders	A group of conditions characterised by unhealthy eating behaviours, symptoms might include excessive worry about weight and body shape, eating very little food, use of laxatives or forced sickness after eating, excessive exercise or strict habits and routines around food. It is possible to recover from eating disorders with time and the right treatment.
Eczema	A condition that causes itchy skin, with symptoms including itchy skin, dry skin, cracked skin, crusty skin, scaly skin, thickened skin and blistering or bleeding. There is no cure for eczema, although symptoms tend to improve with age and treatment is available to manage and improve symptoms.
Epilepsy	A condition affecting the brain which causes seizures. It cannot be cured, but treatment can help to manage the symptoms.
Impairments	A range of conditions resulting in loss of, or impairment to, hearing, mobility and sight. These can be caused for a number of reasons, and are generally life-long and cannot be cured. However, support is available to help children living with these conditions be as active and independent as possible.

Although we don't classify neurodivergent conditions, like autism or ADHD, as a chronic medical need (because these are more about differences in how the brain functions

compared to a neurotypical person), a lot of the complexities and best practice advice is also applicable to this cohort of children.

What's this got to do with safeguarding?

By definition, safeguarding requires taking action to prevent impairment to children's health and wellbeing. Health and safety are intertwined: children's medical needs can make them more vulnerable to abuse, neglect and exploitation and conversely maltreatment can cause or worsen medical needs. This makes this area of safeguarding practice particularly complex and challenging and requires safeguarding practitioners to be aware of and explore these complexities.

Are children with chronic medical needs at increased risk of maltreatment?

Data and research tells us that these children are at increased risk of abuse, neglect and exploitation. For example, it is estimated that disabled children are over 3 to 4 times more likely to be abused or neglected, with increased likelihood of experiencing multiple types and repeated occurrences of abuse.[1] 21% of children who died or suffered serious harm in England between 2023/2024 had a mental health condition.[2]

Why are these children at increased risk of maltreatment?

There are a number of reasons why children are at increased risk, including reasons why it can be more difficult to identify and respond to indications of abuse, neglect and exploitation.

Increased vulnerability

Children might be more vulnerable because, for example:

- They might be reliant on caregivers to enable or administer treatment,
- They might be reliant on caregivers to seek medical advice,
- They might be dependent on carers for personal assistance,
- They might have reduced capacity to resist or avoid abuse.

Limited communication

Some medical needs make it more difficult for children to communicate maltreatment. They might not have the right words, or any words, to explain what is happening to them. They may not understand what is happening to them. For example, disabled children are less likely to receive sex education or information about their own bodies and so may be unable to distinguish between the different types of touch.

Isolation

Children might be isolated from peer groups, family and professionals due to their chronic medical needs. They may have less opportunities to disclose harm, or for others to notice signs and indicators of abuse, neglect and exploitation.

Interpreting indications

Sometimes signs and indicators of abuse, neglect and exploitation might be misinterpreted as symptoms of a medical condition. For example, if a child struggles with emotional regulation this might be attributed to a mental or neurodivergent condition and not considered as a possible indication of harm.

Parenting ability & adult focus	There might be additional emotional, physical and financial demands on parents and caregivers which increase their stress and ability to provide consistent care. There might be a tendency to focus on what the adult needs, which means that the needs of the child can get lost and sometimes lead to a failure to protect.
Attitudes and assumptions	Practitioners might be willing to accept a lower standard of care for children with chronic medical needs. For example, if a disabled child is locked in their bedroom for their own 'safety' this may be more readily accepted than for a non-disabled child. If a child is missing education, there may be an assumption this is due to medical needs as opposed to educational neglect or exploitation. Additionally, practitioners may assume that the main needs of the child relate to their condition and develop plans around this, but which lose sight of their need for protection.
Lack of professional expertise	If practitioners do not understand the chronic medical need, they may be more likely to make assumptions and accept parental explanations and accounts. For example, if the parent of the child who is missing education says this is due to their symptoms it may be assumed to be true despite this being medically inaccurate.

Children may also be at increased risk of impaired health and development due to unsuitable housing, for example, children with respiratory conditions may be at higher risk of illness when there is damp or mould and children with mobility conditions may be restricted from leaving their home if they don't have access to a ground floor or functioning lift.

How can I ensure I am effectively considering children's chronic medical needs within safeguarding responses?

Here are some dos and don'ts regarding best practice when safeguarding children with chronic medical needs. **You will need to consult a relevant medical professional to obtain expert input and advice to answer some of these questions**.

☑ Do	☒ Don't
☑ Be specific whether the medical need is diagnosed or undiagnosed.	☒ Make assumptions about whether or not the need exists in the first place (especially as some needs may be historic if the child has recovered).
☑ Be clear about the impact the medical need has on day-to-day life and functioning, including what the child can or cannot be reasonably expected to do based on their condition.	☒ Make assumptions about what the child can or can't do based on vague or incomplete information. For example, if the condition is cited as the reason a child can't attend school, is this factual?

☑ Do	☒ Don't
☑ Be clear about prognosis and what treatment is needed to recover from or manage the medical need.	☒ Use vague terms like 'poor health' or 'unwell' and ignore what the child actually needs to recover from or manage the condition.
☑ Be clear about parental understanding of the medical need and their ability to support the child.	☒ Assume that the parent/carer understands the condition and is able or willing to comply with treatment plans.
☑ Address any evidence that the child was not brought to appointments and explore associated risks and likely impact for the child.	☒ Just accept missed medical appointments; even if these are for a valid reason, intervention is needed to ensure the child can access treatment.
☑ Explore all possible causes why a child may be distressed, injured or behaving in a different way.	☒ Attribute all signs of distress or injury to the child's medical condition without considering abuse.
☑ Tailor communication and education to the child's needs.	☒ Assume the child cannot understand or report abuse due to their condition.
☑ Ensure multi-agency collaboration and oversight.	☒ Rely solely on medical professionals to identify safeguarding risks.
☑ Obtain evidence of medical impact when addressing unsuitable housing.	☒ Advocate or make representations without good supporting evidence of increased medical risk.
☑ Make sure plans include goals and actions relating to the child's need to be protected from abuse and neglect.	☒ Create plans which focus solely on supporting the child's medical needs.

Which medical professionals should I consult?

This will depend on the medical need of the child. **The Family GP should always be consulted as a minimum to explore some of the factors above**. However, you may also need to consult other NHS Services, for example: community health services (like community paediatrics, health visitors or school nurses), mental health services (like CAMHS) or hospital services (like diabetes or epilepsy teams).

If unsure, you should ask the family and their GP which health services are involved.

Further reading:

- Children not brought to appointments
- London Safeguarding Children Practice Guidance: Disabilities

References:

1 Jones, L. et al (2012) Prevalence and risk of violence against children with disabilities: a systematic review and meta-analysis of observational studies. The Lancet, 380(9845):899-907.

2 Child Safeguarding Practice Review Panel: annual report 2023 to 2024