Safeguarding Response to Obesity when Neglect is an Issue

1. Introduction

This is a multi-agency policy to support professionals when working with children and young people when it is considered that a child's obesity may be related to neglect.

The policy should be read with reference to the NSCP Threshold Guide, Neglect Policy and consideration of the Fabricated or Induced Illness Policy.

Obesity in childhood is a significant public health issue. In England more than 1 in 3 children leaving primary school are overweight or living with obesity. The prevalence is increasing – in 2021/22, 23.4% of Year 6 children in England were obese compared with 17.5% in 2006/07 (*National Child Measurement Programme*). Obesity is the greatest risk factor for Type 2 diabetes and the rates for Type 2 diabetes have risen significantly over the last decade. Obesity is also a risk factor for cardiovascular disease, osteoarthritis, sleep apnoea and various cancers.

The fundamental cause of obesity is an energy imbalance between calories consumed and calories expended. However, the reasons underpinning the development of obesity in individuals are complex and challenging and the condition remains very difficult to treat. The National Institute for Health and Care Excellence (NICE) published Guidance for assessing, identifying and managing Obesity in 2014 (updated 2022), and the population-level NICE clinical guideline for prevention of obesity was published in 2004 (updated 2015).

Weight management is an emotive issue for both families and practitioners, and many families struggle to maintain a healthy diet and take the recommended amount of physical activity. This is on a background of a modern lifestyle with diets high in processed foods and sugar, availability of sugary drinks, food advertising and sedentary activities resulting in reduced physical activity.

Wherever possible, it is important to work with families to understand potential risks and signs of safety. Obesity can affect a child's academic achievement and emotional wellbeing, as well as their physical health, and in a minority of cases obesity can be life threatening. It is therefore imperative that any parent or carer who is trying to manage their child's weight understands the risks and has access to appropriate support and guidance.

Professionals working with obese children should also be mindful of the possible role of abuse or neglect in contributing to obesity. When assessing such children, a comprehensive picture of the child's functioning from a health, psychological, and educational perspective is necessary and older children and adolescents should be offered the chance to talk apart from their parents to explore their understanding of their weight issues - as for any clinical condition which is having a significant impact on health and wellbeing of a child.

2. The Child and Family

Obesity is the most common nutritional disorder affecting children and is much more common in families living in poverty and in certain ethnic groups. In 2021-22 children living in the most deprived areas of England were more than twice as likely to be obese, than those living in the least deprived areas National Child Measurement Programme, England, 2021/22 school year.

Consideration must be given to cultural and ethnic influences when considering obesity as a potential harm in safeguarding children. In particular, an understanding of varying approaches to what constitutes healthy foods, food preparation, exercise and a healthy weight must be explored in the cultural context of the family. It is important not to make assumptions about, or stigmatise, certain cultural beliefs regarding weight, nor the belief system which sits behind those values. This may require some education and wider consultation to be undertaken by the practitioner when working with culturally diverse groups to ensure a parity of approach and assessment of risk.

Consideration too must be given to any disabilities, including learning difficulties or neurodiversity, affecting family members, which may influence the support required to enable them to successfully implement changes to improve health outcomes for their child.

Obese children are more often ill, experience more day-to-day health issues (e.g. breathlessness, discomfort, fatigue), have greater school absence, healthcare attendances and hospital admissions. In addition, 79% of adolescents who are obese are likely to remain obese as adults. Being overweight or obese in childhood has both short-term and longer-term consequences for health, with greatly increased risks of disability, chronic ill-health and premature death. Moreover, once severe, obesity is very difficult to treat effectively.

In addition to the physical consequences of obesity, obese children can experience significant emotional and psychological distress. Teasing and discrimination is not uncommon, with resultant low self-esteem, anxiety and depression.

Severe obesity may have serious health implications for the child (see Appendix 3 below). The health risks increase with duration and severity of obesity and in rare instances may have a fatal outcome.

Obesity may be part of a more complex health problem, which further jeopardises a child's wellbeing. Examples include obesity:

- in a child with a genetic condition, such as Prader-Willi Syndrome.
- in a child with autism or learning difficulties.
- in a child with an eating disorder.
- associated with other health problems, such as blindness or arthritis which hamper mobility.
- related to treatment with steroids or other treatment known to increase risk of obesity.
- complicated by asthma, obstructive sleep apnoea, Type 2 Diabetes or other obesity-related illness.

Some families, and even professionals working with the family, will use the attendant health issues to justify, explain or excuse the child's obesity and whilst a medical condition may be an additional challenge it should be considered in the context of the parents' engagement. A dual diagnosis of obesity and another health condition may place additional strains on a family's ability to cope and amplifies the risks to the individual child. It is this group of children in whom obesity most commonly becomes a safeguarding concern. It is important to consider these cases under the Management of Complex Health Issues Policy. It is imperative to use professional judgement when considering each case.

3. When does obesity become a safeguarding issue?

In July 2010, the British Medical Journal published an article by Dr Russell Viner from the UCL Institute of Child Health in London, in which he and a group of child health experts set out to review the existing evidence and propose a framework for practice, linking some obesity cases to safeguarding.

In the article Dr Viner suggests a framework to help understand child protection concerns in children who are obese. He argues that childhood obesity and failure to lose weight, whilst concerning in themselves, are not necessarily a child protection concern if it can be demonstrated that parents are engaging adequately with treatment.

However, the article goes on to describe that ***consistent failure to change lifestyle and engage with outside support can indicate neglect,*** particularly in younger children, as parental failure to provide their children with adequate treatment for a chronic illness is a well-accepted reason for a child protection registration for neglect. For example, parents or carers may fail to provide their child adequate treatment or behave in a way that actively promotes treatment failure (see *Safeguarding Trigger Points* below). These behaviours are of particular concern if an obese child is at imminent risk of comorbidity—for example, obstructive sleep apnoea, hypertension, Type 2 diabetes, or mobility restrictions.

It is also discussed that ***obesity may be part of wider concerns about neglect or emotional abuse*** (see *Identifying Children Where There Are Safeguarding Concerns* below). Consequently, it is essential to evaluate other aspects of the child's health and wellbeing and determine if concerns are shared by other professionals such as the family's general practitioner or education services. This approach requires a multi-agency collaborative assessment, including psychology or other mental health assessment, and where concerns are expressed, a multi-agency meeting is appropriate.

Assessment should include family and environmental factors. Assessment of parental capacity to respond to a particular child's needs is central to this, such as parental learning difficulties, or parents/carers struggling to control their own weight and eating, but these are not the only factors. Admission to hospital or another controlled environment may be useful because it allows a more detailed assessment of behaviours and parent-child interactions. However, admission removes a child from his or her wider familiar environment, as well as from parents, so weight loss in a controlled environment needs to be evaluated carefully and although on its own is not evidence of neglect or abuse does indicate the potential for the child to be able to lose or avoid gaining weight.

4. Legal Framework, 1989 Children Act

Where there is clear medical advice that the child is, or is likely to, suffer significant harm because of obesity and/or obesity related issues, as well as evidence that the care givers are unable or unwilling to engage in a plan that will realistically lead to improvements for that child, then the case requires action under Section 47 of the Children's Act (Child Protection).

Where there is medical evidence that the child is unlikely to achieve/maintain a reasonable standard of health/wellbeing, but parents are engaging and/or there is no immediate risk of significant harm, then the case requires action under Section 17 of the Children's Act (Child in Need).

It is envisaged that only a very small number of children will reach the child protection threshold in relation to neglect.

Case management should be regularly reviewed to ensure that the risks to the child's health and wellbeing are monitored carefully to ensure appropriate and timely actions are taken under the legal framework.

5. Safeguarding Trigger Points

All trigger points need to be understood in terms of managing lifestyle, including healthy eating, physical activity, and behaviour change, linked to the child's overall health, safety and wellbeing.

Lack of capacity to engage

- Parents/carers unable to effectively provide for the child's health needs due to additional family factors, such as learning difficulties, socio-economic issues, unmet parental needs.
- Unable to attend appointments and make necessary changes to lifestyle.
- Weight continues, or appears to continue, to increase or rate of increase does not slow

Unwilling to engage

- Not attending health appointments
- Transient or intermittent engagement
- Unwilling to make any changes to child's lifestyle even with appropriate support and intervention by agencies
- Parent/carer refusing, rejecting, or ignoring professional advice regarding ongoing significant health risks to their child if the weight continues to increase
- Actively not supporting efforts of professionals or child to reduce weight gain
- Oppositional behaviour: parents/carers unable/unwilling to set and maintain boundaries with child to manage lifestyle changes and allow further weight gain.

Disguised compliance

- Parents/carers appear to follow advice, but are not making any changes to lifestyle which would make a significant difference to the child's wellbeing and improve child's health outcomes
- Parents/carers unwilling/unable to model appropriate behaviour to facilitate lifestyle changes

Parents/carers playing one professional off against another

- Agencies need to be aware of how parents/carers can distract professionals both within one agency and across agencies from focusing on the child by favouring one agency/professional over another. Behaviours can include:
    - Being aggressive and/or confrontational
    - Appearing helpless or overwhelmed
    - Using media and/or politicians and/or legal advisers to challenge the professionals
    - Sensationalising comments/issues to detract from the significant harm being experienced by the child/young person.

- Parents/carers may use medical diagnoses to justify their inability to adhere to recommended advice. Professionals need to be cognisant of the child's needs and prepared to challenge both parents and other practitioners working with the child/family.

6. Identifying Children where there are Safeguarding Concerns

There are several warning signs and indicators that will support practitioners working with children and young people to identify safeguarding concerns for children who are visibly overweight. The following list should be considered in the context of the child's overall presentation and not in isolation:

- Sleep deprived and/or sleep apnoea: effects of inadequate rest affecting day to day functions
- Incontinence
- Inability/unwillingness to participate in physical activity
- Requires medical assessment to manage weight
- Avoidance of school weight/height measurements (National Child Measurement Programme)
- A & E attendance with mobility related injuries
- Co-morbidity, i.e., presence of one or more additional disorders (or diseases), whether related to obesity or not (see Appendix 3 for obesity related co-morbidities)
- Continuous and persistent weight gain after obesity diagnosed
- Unkempt appearance
- Depression
- Low self-esteem
- Self-harm
- Poor or non-school attendance
- Socially isolated
- Parents/carers not engaging in weight management programmes
- Parents/carers poor mental health
- Family identity linked to obesity/intergenerational weight issues
- Any other feature or indicator of neglect

7. The Role of Professionals

Professionals and the public need to recognise that safeguarding is everybody's responsibility. However, when dealing with complex issues such as obesity there are specific contributions that can be and should be made by different agencies and these interventions and assessments need to be child focused, co-ordinated, and shared appropriately.

Paediatricians

It is important that the child's health needs are properly assessed, including, where possible, assessment of any environmental factors that are having a negative impact on their weight gain or loss. This will enable close monitoring of the parents'/carers' ability to support the child to maintain

a healthy weight and active lifestyle. It is important that the paediatrician ensures health provision is well co-ordinated and there is good communication between those involved including, for example sharing of growth charts.

Where an obese child is on a Child Protection (CP) Plan, there are two key practice points to follow:

- The CP Plan should ensure that a paediatric assessment takes place where obesity is presenting as a safeguarding issue
- The paediatrician or a representative should aim to attend all child protection conference reviews and, where appropriate, core group meetings, so that the effectiveness of the weight management programme can be reviewed in line with ongoing parenting capacity monitoring

In identified safeguarding cases, consideration should be given to appointing the paediatrician as medical lead for all the child's presenting conditions. There should also be regular communication with the child's GP to assess whether any other arising health concerns need to be considered or addressed. This principle should be applied for any health professionals responsible for primary care, such as school nurses or health visitors, to ensure that the paediatrician maintains a holistic overview of the risks

Other Health Professionals

All health professionals who are involved in caring for a child including GP, school nurses, health visitors and paramedics, should be mindful of the differences between obesity as a health issue and a safeguarding concern, using the indicators above. Most cases of obesity will be managed by health, working with parents. However, when a health professional recognises that their interventions alone are not having any impact on the weight management and the health risks are escalating, they need to ensure that their concerns are shared with the wider children's workforce, including consideration of referral to a paediatrician.

Mental Health

There is an association between obesity in children and an increased risk of mental health issues such as depression, anxiety, and low self-esteem. It is important that any mental health needs are considered, and appropriate support offered/referrals made. Information about how to access mental health advice and support can be found at https://www.justonenorfolk.nhs.uk

Education

Schools (including Early Years settings and colleges) who have concerns about a child's weight must establish that the child's health is being managed and, with parents' consent, confirm with health colleagues that an appropriate weight management programme is in place. If consent is not gained, the school should clearly record its concerns, including documentation of their discussions with the family, how weight is being managed and whether the parents are supporting the child to exercise and eat healthily. The assessment tool (see below) could be used to facilitate this.

The school is in a strong position to monitor the day-to-day impact of persistent weight gain and the parents' ability to manage the child's weight and should not rely solely on the health professionals' interventions. Schools should be prepared to challenge any barriers presented by parents in addressing lifestyle changes such as not allowing the child to participate in physical activities. All concerns should be recorded and where appropriate shared with partners to better assess the risks. Early Help Assessment and Plan (EHAP) may be an appropriate forum to discuss and monitor

concerns where parents are willing to engage, and Joint Agency Group Supervision (JAGS) may also be helpful where cases are complex or felt to be 'stuck' or drifting. If the child's weight continues to increase and the indicators noted above are identified, a referral to CADS (with parents' consent) should be made. Challenges need to be recorded clearly.

Schools should be involved in child protection conferences and/or core groups where obesity is a concern and should ensure that they record on a regular basis any information that the child gives them regarding their eating and exercise patterns so that they can provide information to the wider team about how effective the CP plan is. Consideration should be given to the impact of obesity on the child's emotional wellbeing and the school should record observations on any signs of emotional harm, such as depression, isolation, or bullying. Any activities that the child cannot engage with due to their weight should be noted in terms of the impact of social isolation as well as affecting educational attainment. This should be recorded in the child's safeguarding record.

Children's Social Care

Social workers – including frontline staff, their managers, and conference chairs – with caseloads containing children with obesity related safeguarding concerns should be aware of the safeguarding warning signs and indicators noted above. As safeguarding leads, they should ensure that all aspects of non-compliance with a CP Plan are communicated to all core group members as and when this occurs, and not wait until reporting the incidences at the next core group. This will enable any patterns to be identified and, where the parent/carer fails to comply with a particular agency or agencies, to be identified quickly and challenged. Parents/care givers and young people will need to be informed that this will happen and the reasons why.

Non-compliance includes:

- Not attending school
- Missing medical appointments
- Not participating in physical activity unless there is clear medical evidence which is signed off by the paediatrician overseeing the child's health plan
- Parents/carers intervening to prevent their child from participating in physical activity
- Parents/carers consistently providing inappropriate lunches/snacks/drinks.

Independent Reviewing Officers working with Looked After Children (LAC) who are obese should challenge any lack of progress to reduce/manage weight within the care plan. Carers need to be supported to understand the risks and ensure that the child in their care makes appropriate progress.

Police

Childhood Obesity per se should be managed primarily by parents and carers with incremental support from Health and Children's Social Care.

The police may well engage in multi-agency strategy discussions in cases where a child is considered likely to suffer significant harm (Section 47 of the Children Act 1989) where their obesity is cited as a primary factor. However, the role of the police within the Child Safeguarding Partnership is to investigate and prosecute criminal offences. To that end any neglect or ill-treatment of a child would ordinarily be considered under Section 1(1) of the Children and Young Persons Act 1933 which states:

'If a person who has attained the age of sixteen years and has responsibility for a child or young person under that age, wilfully assaults, ill-treats, neglects, abandons, or exposes him, or causes or procures him to be assaulted, ill-treated, neglected, abandoned, or exposed, in a manner likely to cause him unnecessary suffering or injury to health (including injury to or loss of sight, hearing, limb, or organ of the body, and any mental derangement), that person is guilty of a misdemeanour'.

Any police involvement must be determined by the facts presented. There must be a very distinct line drawn where the potential harm is directly attributable to wilful acts or omissions by the parent or carer. In any event the police involvement will be reliant on the combined information of the agencies engaged with the child and information sharing will be crucial to any action taken by police.

Whilst not prescriptive, the below should be considered as the threshold to police involvement.

- The child is obese, and their weight is continuing overall to increase disproportionately to age **OR** is not reducing in line with a realistic and achievable health plan **AND**
- Paediatric examination shows that this is leading to co-morbidity factors (other medical factors as a direct result of the obesity) **AND**
- The parents or carers are aware of the risks and have the capacity and capability to engage in their child's treatment **AND**
- They are frustrating, or unnecessarily failing to engage in, a coordinated plan to improve the child's health **AND**
- The child is likely to be caused unnecessary suffering or injury to health.

It will be important to be able to discern cases where the parents or carers require significant support in the management of their child's obesity. Such cases may include genetic conditions (e.g., Prader-Willi Syndrome) or perhaps cases where the parents or carers do not have the ability to properly manage these more complex needs. Except in exceptional circumstances these cases will be managed by Health and Children's Social Care.

8. Referrals and Risk Assessment

It can be difficult to discuss obesity with parents who may be hostile, unreceptive or who lack capacity to recognise the safeguarding implications. Regardless, the protection and welfare of the child is the priority, and it is everyone's responsibility to act on their concerns. It is likely that professionals will have attempted to engage families over a period of time.

Concerns should be raised with the Children's Advice and Duty Service (CADS) with the parents'/carers consent (unless there are significant safeguarding concerns - see Legal Framework above). Any professional considering referring a child where the safeguarding concerns are linked to obesity should consider the contents of this policy, including the Analysis Tool, and refer to the NSCP Threshold Guide before making the referral, specifically the safeguarding indicators and triggers.

To aid professionals in making this decision an analysis tool has been developed and is attached as Appendix 1: Analysis Tool below.

This information should form part of the conversation with the Consultant Social Worker in CADS

Appendices

Appendix 1: Childhood Obesity Safeguarding Analysis Tool

Name of Child:

DOB:

NHS No:

Weight:

BMI (centile):

BMI Trend (consider attaching charts):

School/Nursery:

	YES	NO	COMMENTS
Is the child currently engaged with Children's Social Care? (eg Early Help, FSP, S17/47, Looked After Child)	☐	☐	
Are other services involved? (eg CAMHS)	☐	☐	
Has the child been reviewed by a paediatrician/known to CEW team?	☐	☐	
Is the child severely obese? (BMI >99.6th centile)	☐	☐	
Does the child have a weight management plan?	☐	☐	
Has any progress been made towards the plan?	☐	☐	
Does the child and/or parent have known neurodevelopmental/learning difficulties?	☐	☐	
Are there concerns about school attendance?	☐	☐	
Have ACEs been considered?	☐	☐	
Are there other child safeguarding concerns?	☐	☐	

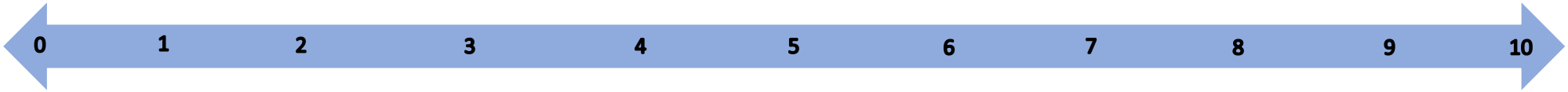
PHYSICAL AND CO-MORBIDITY FACTORS	EMOTIONAL/ MENTAL HEALTH FACTORS	PARENTAL, FAMILY & HOME FACTORS
☐ Sleep deprivation/fatigue ☐ Sleep apnoea ☐ Continence issues ☐ Joint pain/mobility problems ☐ Type 2 diabetes ☐ Asthma ☐ Raised BP or cholesterol ☐ Diagnosed health conditions ☐ Genetic condition ☐ Eating disorder ☐ Other ……..	☐ Worry/anxiety ☐ Depression/self-harm ☐ Low self-esteem ☐ Unkempt appearance ☐ Socially isolated ☐ Anger/frustration ☐ Concerns about bullying ☐ Trigger e.g. separation of parents/bereavement ☐ Comfort eating/using food to regulate emotions ☐ Other ……..	☐ Little to no routines or boundaries at home, including sleep and/or mealtimes ☐ Parents unaware of what the child is eating ☐ The child makes their own food choices ☐ Parents do not see that child is obese ☐ Family identity linked to obesity/intergenerational weight issues ☐ Parents/others family in the home are obese ☐ Parents/carers poor mental health ☐ Home educated ☐ Other ……

Appendices

Appendix 1: Childhood Obesity Safeguarding Analysis Tool

SAFEGUARDING TRIGGER POINTS	YES	NO	COMMENTS
Do the child and parents understand the concerns around the child's weight?	☐	☐	
Are the parents/carers or child willing to engage? (eg non-attendance, intermittent engagement, unwilling to make changes, refusing or ignoring professional advice, unwilling to set/ maintain boundaries)	☐	☐	
Do parents/carers lack capacity to engage? (Parents unable to provide for health needs of child, unable to attend appointments, unable to make changes to lifestyle, weight continues to increase rapidly)	☐	☐	
Is there disguised compliance? (Appear to follow advice but not making changes, using medical diagnoses to justify inability to make change, distracting from harm being experienced, aggressive/ confrontational)	☐	☐	
Parents/carers play one professional off against another?	☐	☐	

Please use the scale below to highlight the impact that obesity is having on the child's health (developmentally, emotionally, physically and physiologically)



Multiple comorbidities and evidence of significant harm to physical and/or emotional health

One comorbidity, multiple health risks developing, quality of life reduced

Impacting development, struggles to play with friends, easily breathless and tired

May become breathless, poor self-esteem and body image, emerging impact on emotional health

Weight/ lifestyle is having little or no impact on health

Appendices

Appendix 1: Childhood Obesity Safeguarding Analysis Tool

WHAT ARE WE WORRIED ABOUT	WHAT IS WORKING WELL	WHAT NEEDS TO HAPPEN

Have we heard the child's voice?

……
……
……
……
……

"I want to be able to play with my friends and keep up with them and not be out of breath", "I want to be able to run around and climb trees", "I don't want to be so tired after being active"

Appendices

Appendix 1: Childhood Obesity Safeguarding Analysis Tool

ADDITIONAL INFORMATION AND/OR TIMELINE

If this tool forms part of a CADS Referral:

Has the referral been discussed with parents/carers? Yes ☐ No ☐

(This should be done unless it is thought that it would increase the risk of significant harm)

Are the parents likely to be receptive to support? Yes ☐ No ☐

Name of Referrer:

Organisation/Agency:

Appendices

Appendix 1: Childhood Obesity Safeguarding Analysis Tool

Obesity Safeguarding Tool User Guide

Introduction and Context of Obesity Safeguarding Tool

- The aim of this tool is to enable practitioners to complete a holistic assessment of a child where obesity is highlighted as a concern
- It focusses on how obesity affects the child's health and well-being and can help to determine if there are safeguarding concerns within the context of the child's health
- The tool can be completed with the family or within a safeguarding or case supervision context

Obesity in the Context of Safeguarding

- Obesity needs to be considered within the context of the family and their current situation. Obesity in children is not usually a safeguarding concern, however, professionals working with obese children should be mindful of the possible role of abuse or neglect in contributing to obesity
- Failure to reduce a child's weight alone is not necessarily a child protection concern. However, if a child's weight is continuing to increase and parents are unable and/ or unwilling to make changes, then this may present as a safeguarding concern (Viner, 2010) and Child in Need support or Child Protection investigation can be sought under Section 17 or Section 47 of the Children's Act as appropriate
- Obesity in children may be present as one aspect of broader concerns about neglect, an indicator and response to abuse or neglect, or a presenting factor of safeguarding concerns and neglect

Growth charts

Please consider attaching height, weight and BMI growth charts

Acknowledgements

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Appendix 2: Intervention Scale

Obesity Intervention Scale
Engagement & Early Help
• Parent / Carer engagement • Consents to communicate with GP • Share information on health, lifestyle and concerns between School, GP and Parents • Supported through the Healthy Child Programme, including health visitors and school nurses
Referral
Health Referral or Social Referral (School, Children's Services etc)
Multi Agency Assessment (MASH)
Referral from Health Professional • What are the medical concerns? • What are the issues with lifestyle and care that are impacting on the child's health? • What is the background to this (Multi Agency)? • Are School or Children's Services engaged? • Is there a need for a co-ordinated approach to information sharing? • Is this single agency approach (Health) able to deliver improvements to the child's overall health? Referral from Social Perspective • Background checks • Does this child appear to be socially disadvantaged • Could the physical impacts described amount to S.17 / S.47? • Is the referrer engaged with health? • What is the health perspective? – Is there one? Should there be one?
Action
• Key agency personnel need to be identified at the earliest stage • Live information sharing should be employed between the key people. Absences from school, GP visits, Parental comments etc must all be taken in context between agencies. • Medical Management - Consider agreeing a paediatrician to lead on medical matters. This will ensure that all health information from GP and other medical sources assessed holistically by one expert to be able to give the most accurate picture of harm in a potentially fast changing environment. For example, visits to GP outside of the Paediatric appointments. • School, Children's Services, Dieticians, Health visitors etc to be identified to ensure that all facets of the child's life are taken into account. • Risks of Social isolation, bullying etc • Is there a need for a S.47 Strat?

Appendix 3

Childhood overweight and obesity is a critical risk factor for a range of health and social consequences summarised

Figure 1: Health risks associated with childhood overweight and obesity
Ebbeling CB, Pawlak DB, Ludwig DS. Childhood obesity: public-health crisis, common sense cure. Lancet 2002;360:473-82.