CHILD OBESITY AS A CHILD PROTECTION CONCERN IN THE UNITED STATES AND THE UNITED KINGDOM: A PROPOSED FRAMEWORK

Victoria Elissa Garel*

TABLE OF CONTENTS

I. INTRODUCTION ............................................................................... 559

II. OBESITY AND NEGLECT IN THE UNITED STATES ......................... 562
   A. The Constitutional Right to Parent .............................................. 562
   B. Neglect Statutes in the United States ........................................ 563
   C. Medical Neglect in the United States ........................................ 564
   D. Inclusion of the Failure to Obtain Medical Care in Judicial
      Interpretations of Neglect .......................................................... 565
   E. Obesity as a Form of Medical Neglect in Judicial
      Decisions .................................................................................. 567
   F. Viewpoints on Criteria Under Which Obesity Should be
      Characterized as Medical Neglect .............................................. 569
   G. Issues with Treating Child Obesity as Neglect .......................... 571

III. OBESITY AND NEGLECT IN THE UNITED KINGDOM .................. 572
    A. Authority for Child Welfare Protection in the United
       Kingdom ................................................................................... 573
    B. Child Protective Interventions in the United Kingdom ............. 574
    C. Concern Regarding the Inclusion of Child Obesity as a
       Child Protection Issue in the United Kingdom ......................... 576
    D. When Does Child Obesity Become a Child Protection
       Issue? ........................................................................................ 577

IV. A COMPARISON OF UNITED STATES AND UNITED KINGDOM
    AUTHORITY GOVERNING CHILD NEGLECT .................................. 578

V. THE INCLUSION OF CHILD OBESITY AS A CHILD PROTECTION
    CONCERN IN THE UNITED STATES AND THE UNITED KINGDOM.....580

* J.D., University of Georgia, 2014; B.A., Barnard College, Columbia University, 2005.
VI. PROPOSED FRAMEWORK FOR DETERMINING WHETHER CHILD OBESITY SHOULD BE CONSIDERED A CHILD PROTECTION ISSUE WARRANTING COURT INTERVENTION IN THE UNITED STATES AND THE UNITED KINGDOM .............................................. 580
   A. Does the Child Meet the Medical Definition of Obesity and Have at Least One or More Comorbid Diseases? .......... 581
   B. Does the Child Have a Disease or Genetic Disorder That Predisposes Him or Her to Obesity? ................................. 583
   C. Have the Child’s Parents Sought the Advice of a Medical Professional and Adhered to the Recommendations of This Professional? ................................................................. 584
   D. Are Interventions or Treatment Options Available to the Child That are Likely to Improve the Child’s Health but Refused by the Child’s Parents? .................................................... 584

VII. CONCLUSION ................................................................................... 585
Childhood obesity is one of the most serious and widespread public health challenges of this century. In 2010, the global prevalence of overweight children under the age of five was approximately forty-two million. Childhood obesity “currently affects at least ten to twenty-five percent of the [child] population in most developed countries.” In the United States, the percentage of obese children age six to eleven has increased from 7% in 1980 to almost 20% in 2008. During the same time period, the percentage of obese adolescents increased from 5% to 18%. In the United Kingdom, over two million children are overweight and 700,000 are obese.

The Center for Disease Control (CDC) defines overweight as “having excess body weight for a particular height from fat, muscle, bone, water, or a combination of these factors” and obesity as having “excess body fat.” Obesity is also characterized as a child with a Body Mass Index above the ninety-fifth percentile. Children in both the United States and the United Kingdom become overweight or obese as a result of a caloric imbalance resulting from the consumption of too many calories with the expenditure of too few. The CDC notes that “[A]merican society has become characterized by environments that promote increased consumption of less healthy food and physical inactivity.”

---

2. Id.
5. Id.
9. Todd Varness et al., Childhood Obesity and Medical Neglect, 123 PEDIATRICS 399, 399 (2009).
American children have making healthy choices as they are provided with sugary drinks and unhealthy food at school, are exposed to constant advertising of unhealthy foods, are not meeting guidelines that recommend at least sixty minutes of aerobic activity daily, and are not given adequate access to healthy, affordable foods. Furthermore, American children between the ages of eight and eighteen spend an average of 7.5 hours daily watching television, using computers, and talking on cell phones, reducing time spent on physical activity. Similarly, in the United Kingdom, approximately 27% of children are overweight and research indicates the primary problem is a continuous decrease in daily exercise and an increase in the consumption of unhealthy foods.

Over time, an increase has taken place not only in the prevalence of obesity, but also in its severity. The increase in childhood and adolescent obesity has brought with it a host of comorbid diseases, some formerly seen only in adults, including diabetes, obstructive sleep apnea, asthma, nonalcoholic fatty liver disease, hypertension, atherosclerosis, and depression. Obese children are also more likely to have poor emotional health, experiencing lower self-esteem and self-confidence compared to their thinner counterparts. Additionally, obese children are more likely to have poor social health and academic performance as a result of teasing and bullying, discrimination, social marginalization, and negative stereotyping.

Individuals who are obese as children are more likely to be obese as adults. Such individuals are at an increased risk for developing a host of diseases later in life, including heart disease, stroke, diabetes, and cancer. Furthermore, this population is likely to experience social and economic repercussions of obesity, such as fewer successful job interviews, denied

12 Id.
13 Id.
14 What Are the Health Risks of Obesity, supra note 10.
15 Melissa Mitgang, Childhood Obesity and State Intervention: An Examination of the Health Risks of Pediatric Obesity and When They Justify State Intervention, 44 COLUM. J.L. & SOC. PROBS. 553, 554 (2011); see also Overweight and Obesity: Basics About Childhood Obesity, supra note 8.
16 Mitgang, supra note 15, at 555.
18 Overweight and Obesity: Basics About Childhood Obesity, supra note 8; Prevention and Treatment of Childhood Overweight and Obesity, supra note 17.
19 Childhood Obesity Facts, supra note 4; What Are the Health Risks of Obesity, supra note 10.
20 Childhood Obesity Facts, supra note 4.
promotions, lost jobs, and a lower overall income. Obese adults often face stereotypes as employers assume that obese employees are in poor health, resulting in “higher absenteeism, increased insurance rates, and greater workers’ compensation costs.”

Over the past decade, a global debate has emerged as to whether childhood obesity should constitute neglect on the part of parents and warrant government intervention. Courts in the United States have included obesity in their statutory interpretation of neglect. However, this issue is inconsistently pursued in United States courts, as decisions of whether a child should be adjudicated neglected and whether court intervention should be implemented as a result of obesity remain discrepant. Similarly, in the United Kingdom, the media, social services agencies, and courts have also begun to identify child obesity as warranting child protection. However, very little, if any, case law from the United Kingdom considers circumstances under which the state should intervene and possibly remove a child from the care of his or her guardian due to child obesity. Consequently, more guidance is needed as to how courts in both the United States and the United Kingdom should pursue this issue.

This Note will provide background information regarding child obesity and its current status as a child protection issue in the United States and the United Kingdom. This Note will then compare the current approach utilized in both the United States and the United Kingdom to determine whether child protection is warranted for an obese child. Recommendations will be

---

25 Id.  
26 Russell Viner et al., Childhood Protection and Obesity: Framework for Practice, 341 BRIT. J. MED. 375, 375 (2010).
made as to the approach that should be adopted in both the United States and the United Kingdom in determining whether a child has been neglected as a result of his or her obese condition and whether court intervention is necessary. This Note will conclude by noting why the recommended framework is better suited at addressing the current lack of clarity present in court considerations of this issue.

II. OBESITY AND NEGLECT IN THE UNITED STATES

A. The Constitutional Right to Parent

The Fourteenth Amendment’s Due Process Clause of the United States Constitution “provides heightened protection against government interference with certain fundamental rights and liberty interests.” Family law in the United States acknowledges “that freedom of personal choice in matters of family life is a fundamental liberty interest protected by the Fourteenth Amendment.” In 1923, the Supreme Court established in *Meyer v. Nebraska* that the “liberty” interest protected by the Fourteenth Amendment includes the right to “establish a home and bring up children.” Over seventy-five years later in *Troxel v. Granville*, the Supreme Court reiterated “the interest of parents in the care, custody, and control of their children—is perhaps the oldest of the fundamental liberty interests recognized by this Court.”

United States family law also makes clear that the “[f]undamental liberty interest . . . of parents in the care, custody, and management of their child[ren] does not evaporate simply because they have not been model parents . . . .” Courts have given deference to the choices parents make in the upbringing of their children because of the importance that society places on family integrity and the assumption that parents act in the best interest of

---

31 *Santosky*, 455 U.S. at 753; see also *Troxel v. Granville*, 530 U.S. 57, 65 (2000) (“[T]he Due Process Clause does not permit a State to infringe on the fundamental right of parents to make child rearing decisions simply because a state judge believes a ‘better’ decision could be made.”).
their children. Despite this right, parental liberty interests are diminished once parents’ ability to act in the best interest of their children is questioned and the parents “fail to provide necessary care.” Child neglect statutes in the United States mirror the sentiment that parental custody may be terminated if parents compromise the wellbeing of their children.

B. Neglect Statutes in the United States

Federal legislation addressing child abuse and neglect in the United States was first introduced in 1974 with the Child Abuse Prevention and Treatment Act (CAPTA). Under CAPTA, “child abuse and neglect” means “at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.” CAPTA also mandates that states create a statute defining child abuse and neglect in order to receive federal funds for programs that target the prevention and treatment of child abuse and neglect. All states currently have a statute defining abuse and neglect, although these statutory definitions tend to vary by state. For example, under the New York state statute, a neglected child is defined as “a child younger than eighteen years of age whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his parent or other person legally responsible for his care to exercise a minimum degree of care.”

33 Mitgang, supra note 15, at 556; see generally In re D.K., 58 Pa. D. & C.4th 353, 359 (Pa. Com. Pl. 2002) (evidencing the court process of evaluating a parent’s ability to act in the best interest of her child based on her ability to provide necessary care).
34 Mitgang, supra note 15, at 556–57.
37 Id. § 5106a.
Similarly, in Massachusetts, “neglect” is defined as:

failure by a caretaker, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition.40

In each state, child abuse and neglect statutes permit the removal of a child from parental custody in the event that the care provided by the parents is insufficient to protect the welfare of the child.41 In most states, however, the criterion under which lack of parental fitness warrants the removal of a child from custody is unclear.42 Many states base this determination on a finding that “serious harm” or “imminent danger” will befall a child absent removal or that the parents failed to provide minimum care.43 However, the definitions of these terms are not well delineated and interpretation is often left to the discretion of state courts.44 Typically, state statutes allow for the removal of a child from the home only in extenuating circumstances and when in-home interventions are ineffective.45 Such extenuating circumstances include parental behavior that creates or contributes to the grave health risks affecting a child’s physical and emotional health.”46

C. Medical Neglect in the United States

Medical neglect is characterized by the United States Department of Health and Human Services as the failure of parents (1) to provide or permit

40 110 MASS. CODE REGS. § 2.00 (2008).
41 Mitgang, supra note 15, at 556–57.
42 Id. at 557.
43 Id. at 556–62.
44 Id. at 557–58.
45 Id. at 558–59; In re D.K., 58 Pa. D. & C.4th 353, 358–59 (Pa. Com. Pl. 2002) (“The purpose . . . is to preserve, whenever possible, the unity of the family; children should be separated from their families only in cases of clear necessity. . . . Even where there are inadequacies in the child’s home, the court should first consider . . . steps necessary to instruct parents in the skills needed, and to provide follow-up supervision in the home, where feasible.”).
necessary care as recommended by a health care provider, or (2) to attain timely and suitable care for a health condition that reasonable parents would acknowledge as needing medical attention. The parental right to dictate the medical treatment that a child receives is a legal standard resulting from the presumption that parents will make decisions that are in the best interest of a child. The majority of states permit child neglect statutes to allow state intervention, and possibly removal, when parents do not provide what the court determines to be “necessary” medical care. Child obesity may be categorized as neglect when parents fail to attain medical care, fail to adhere to recommended treatments, or fail to control their child’s behavior, and thereby put their child at risk of significant injury.

D. Inclusion of the Failure to Obtain Medical Care in Judicial Interpretations of Neglect

Courts have included parental failure to attain medical care for a child in judicial interpretations of neglect. However, there remains wide disparity in the criteria courts use to determine when the failure to provide medical care warrants state intervention. For example, in In re Hamilton, the Tennessee Court of Appeals ordered state intervention to administer chemotherapy treatment to a twelve-year-old girl despite the refusal of her parents due to religious beliefs. The court determined that intervention was justified despite a mere 25% chance of recovery as the alternative was imminent suffering and death.

In In re CFB, the Missouri Court of Appeals used a different rationale and reversed the lower court adjudication of neglect after the Court of Appeals interpreted “neglect” to mean failure to deliver the “minimum quality of care which the community will tolerate.” The court denied state intervention

---

47 Child Neglect, supra note 24.
49 Id. at 184.
50 Varness et al., supra note 9, at 400.
51 In re Hamilton, 657 S.W.2d at 429 (justifying intervention because “our Constitution guarantees Americans more personal freedom than enjoyed by any other civilized society, but there are times when the freedom of the individual must yield. Where a child is dying with cancer and experiencing pain which will surely become more excruciating as the disease progresses . . . is one of those times when humane considerations and life-saving attempts outweigh unlimited practices of religious beliefs.”).
52 Id. at 427.
53 Arani, supra note 46, at 884.
after finding that the transfer of a hyperactive child from a state treatment facility to a private facility at the behest of the child’s parents met a minimal degree of care.54

In *In re Hofbauer*, the New York Court of Appeals also upheld the parents’ right to determine appropriate treatment for a child. In this case, the court allowed a child with Hodgkin’s Lymphoma to remain in custody of his parents after they declined radiation and chemotherapy treatment.55 This court determined that the most prominent factor in deciding whether adequate medical care has been provided is whether the parents have sought credible medical assistance and have provided a method of treatment that is physician-recommended and not completely discredited by current medical authority.56 The court ultimately held that the parents’ preferred treatment by a physician that provided alternative metabolic and nutritional treatment met the requirement that parents take reasonable efforts to provide acceptable medical treatment for a child.57

In contrast to the “minimum” and “adequate” standard preferred by the New York court in *Hofbauer* and the Missouri court in *CFB*, the Massachusetts Supreme Judicial Court utilized the standard of “necessary” and “proper” care in *Custody of a Minor*.58 In applying this standard, this court determined that the removal of a child with leukemia was justified after the parents exchanged physician-prescribed chemotherapy with a vitamin diet.59 This court’s decision, in addition to those aforementioned, further exemplifies that the standard applied in judicial determinations of neglect is highly discretionary and varies by jurisdiction.

54 Id.
55 *In re Hofbauer*, 393 N.E.2d at 1014.
56 Id.
57 Id.
58 Arani, *supra* note 46, at 885.
59 *Custody of a Minor*, 379 N.E.2d at 1066–67 (“Where, as here, the child’s very life is threatened by a parental decision refusing medical treatment, this State interest clearly supersedes parental prerogatives . . . the State has an interest in the preservation of life . . . [T]here is a ‘substantial distinction in the State’s insistence that human life be saved where the affliction is curable . . . and the State interest where . . . the issue is not whether, but when, for how long, and at what cost to the individual that life may be briefly extended.’ ” (quoting Superintendent of Betchertown State School v. Saikewicz, 373 Mass. 728, 742 (1977))).
E. Obesity as a Form of Medical Neglect in Judicial Decisions

In the United States, many courts include child obesity as a form of medical neglect and use it to justify state intervention in the right of parents to raise their child as they see fit.\(^{60}\) Typically, once a finding of neglect is established, courts balance the state’s obligation to protect the child against the parents’ fundamental right when determining whether to remove the child from parental custody.\(^{61}\) However, like cases involving medical neglect, the criteria courts use to determine an outcome is highly varied. Some courts take the position that in order to maintain a child in foster care, parents must willfully disregard orders to implement interventions to improve the health of their child, while other courts consider whether removal is “a clear necessity” to improve a child’s health and do not give much credence to whether parental inadequacies are willful.\(^{62}\)

In In Re Brittany T., Respondents, the parents of the minor at issue, consented to a finding of neglect based on their daughter’s obesity and placement in the ninety-ninth percentile of body mass index for children her age.\(^{63}\) Brittany T. suffered from health issues as a result of her obesity including fatty liver disease, gallstones, hypertension, and insulin resistance.\(^{64}\) A court ordered Respondents to implement interventions to improve the child’s diet and health.\(^{65}\) After Respondents failed to improve their child’s condition, a petition was filed to place the child in foster care.\(^{66}\) In addressing the petition, the Supreme Court of New York, Appeals Division, determined that a willful violation of the court order had to be established in order for the child to remain in foster care.\(^{67}\)

In In re D.K., the Pennsylvania Court of Common Pleas kept a sixteen-year-old child weighing 451 pounds in the custody of the county.\(^{68}\)

---

\(^{60}\) Child Neglect, supra note 24.


\(^{62}\) See, e.g., In re Brittany T., 48 A.D.3d at 996 (finding that parents were not neglectful when the child attended exercise classes, but ate unhealthy food when outside parental supervision); In re D.K., 58 Pa. D. & C.4th at 353 (finding that intervention was necessary when the mother’s issues prevented her from appropriately helping her child).

\(^{63}\) In re Brittany T., 48 A.D.3d at 996.

\(^{64}\) Id.

\(^{65}\) Id.

\(^{66}\) Id.

\(^{67}\) Id. at 997.

\(^{68}\) See In re D.K., 58 Pa. D. & C.4th at 353 (explaining how the mother’s own conditions prevented her from attending to her son’s obesity).
According to the child’s physician, the child’s condition had become a “life threatening situation.” The court noted that under Pennsylvania statute “interference with the family unit [is limited to] those cases where the parents have not provided ‘a minimum standard of care’ . . . [which] is not the best care possible but that care which . . . at a minimum, is likely to prevent serious injury to the child.” The court further noted the standard set forth in In the Interest of Whittle, under which family unity should be preserved when possible. Under this standard, a child should only be removed “in cases of clear necessity” and the court should first consider interventions that will provide the child’s parents with needed skills and in-home supervision. Using the same standard, the court in In re D.K. still found it necessary that the child at issue temporarily remain in foster care. The court’s decision was based on the fact that reasonable efforts were made to preserve the family unit prior to removal and continued concern remained regarding the inability of the child’s mother to adequately meet his health needs.

In In re G.C., the Texas Court of Appeals affirmed a decision to terminate the parental rights of a parent of a morbidly obese child. The five-year-old child at issue in this case weighed 136 pounds. Despite interventions offered to the parent to assist in decreasing the weight of her child, the parent remained non-compliant. The child’s weight continued to increase until he was eventually hospitalized for difficulty breathing, an enlarged heart, and mild congestive heart failure. Due to parental non-compliance with interventions to improve the health of the child and the severity of the child’s condition, the state moved to terminate parental rights and such termination was granted by the court.

69 Id. at 355.
70 Id. at 357.
71 Id. at 358.
72 Id. at 358–59.
73 Id. at 361.
74 Id.
75 In re G.C., 66 S.W.3d at 520.
76 Id.
77 Id.
78 Id. at 521.
F. Viewpoints on Criteria Under Which Obesity Should be Characterized as Medical Neglect

Court decisions regarding the removal of a child from the home based on child obesity have attempted to answer the question as to where to draw the line between the right of parents to raise their child as they see fit and the right of the state to protect the best interest of the child. Most courts have justified state intervention when the need for medical intervention is “life-saving,”79 while other courts have permitted state intervention when medical treatment would be “life-prolonging”80 or merely improve “quality of life.”81 Courts have also taken the position that state intervention is permissible only when a child’s condition is “life threatening.”82

Using trends in court decision on this issue, several commentators have attempted to fashion a rationale as to when state intervention is warranted in cases of child obesity. In State Intervention in Cases of Obesity-Related Medical Neglect, Shireen Arani identifies factors that courts should consider in adjudicating medical neglect cases based on child obesity, regardless of the precise terms of the state child neglect statute.83 Under this framework, courts will first evaluate whether the intervention needed to combat a child’s obesity is “life-saving, life-prolonging, or quality-of-life-enhancing” prior to determining whether the state has a right to intervene.84 This evaluation will depend on what accompanying ailments the child has, if any.85 Second, courts must decide whether they will consider the potential role that genetics play in obesity.86 Third, under Arani’s framework courts must determine under what conditions the state may interfere when parents do not comply with mandated medical treatment.87 This determination is based on the applicable state neglect statute.88 Arani suggests that states should not justify intervention for circumstances other than those that are necessary to protect the child from “imminent danger” or are necessary to permit the child to

79 Arani, supra note 46, at 882.
80 Id. at 883.
81 Id. at 885.
82 Id. at 883.
83 Id. at 887.
84 Id.
85 Id. at 893.
86 Id.
87 Id.
88 Id.
have a “normal life.”89 Arani supports judicial intervention in cases of child obesity when physical and psychological impairment could lead to immediate harm or poor quality of life.90

In *Childhood Obesity and State Intervention: An Examination of the Health Risks of Pediatric Obesity and When They Justify State Involvement*, Melissa Mitgang focuses on the point at which child obesity advances from a condition associated with undefined risk to a condition with significant immediate risk is necessary in determining a standard for state intervention.91 State intervention, she proposes, is justified when required to “prevent loss of life or to address a current risk of serious harm” and rejects intervention merely when it is “reasonably necessary in the best interest of the child.”92 Mitgang notes that obesity as an independent condition does not pose a significant immediate risk and, instead, the association of obesity with comorbid diseases is the necessary indicator of “imminent harm.”93 Ultimately, she argues that it is difficult to channel obesity and its comorbidities into a bright-line rule and stresses that the determination must be based upon the particular facts of each case.94

Mitgang’s framework proposes four factors, which accompany the central indicator of actual harm from obesity, to evaluate whether state intervention is necessary to “prevent loss of life or to address a current risk of serious harm.”95 These factors are: (1) the severity of the child’s comorbid conditions; (2) the extent to which medical assistance can alleviate these conditions; (3) the child’s overall physical and mental health condition; and (4) the likelihood that the child will remain obese as an adult.96

In *Childhood Obesity and Medical Neglect*, the authors argue that the removal of a child from parental custody is justified only when the following conditions are present: (1) a high probability that the child will experience “serious imminent harm”; (2) “a reasonable likelihood” that state intervention will lead to successful treatment of the child’s condition(s); and (3) a deficiency of alternative means by which to assist the child and his family.97 The authors indicate that the risk of serious imminent harm should

89 Id.
90 Id.
91 Mitgang, supra note 15, at 566.
92 Id. at 569.
93 Id. at 566–67.
94 Id. at 568.
95 Id. at 569.
96 Id.
97 Varness et al., supra note 9, at 401–03.
be assessed by the presence of comorbid conditions, as childhood obesity itself is not significant enough to warrant state intervention. The authors take the position that parents should be charged with medical neglect and the child should be removed from the home when “serious comorbid conditions are present and when all reasonable alternative options have been exhausted.”

G. Issues with Treating Child Obesity as Neglect

A number of complications have been identified in treating obesity as neglect. First, each state adjudicates neglect using different neglect statutes. As a result, a case concerning an obese child could conceivably be adjudicated as neglect in one state, but escape such adjudication if tried in a different state. Second, a court’s determination regarding neglect is typically made by considering factors other than a child’s weight or the parents’ attempts at reducing the child’s weight. Third, state intervention in parental rights imposes risks on a child by denying the child permanent relationships and by disrupting the child’s environment and continuous relationship with caregivers. Furthermore, removal from parents and placement in the over-burdened foster care system puts a child at risk for substance abuse, delayed reunification with parents, separation from siblings, and placement in several different foster care homes. Lastly, the cause of a child’s obesity is sometimes difficult to identify, and as a result it is unfair to solely fault the parents. Factors that may contribute include genetics, socioeconomic factors, environment, and even children sneaking excessive amounts of food without parental awareness.

---

98 Id. at 401.
99 Id. at 402.
100 Id. at 399.
101 Cohen, supra note 32, at 385.
102 Id.
103 Arani, supra note 46, at 880–81.
106 Id.
III. OBESITY AND NEGLECT IN THE UNITED KINGDOM

The recommendation that child obesity become a child protection issue in the United Kingdom is a fairly recent proposition with mixed reviews from media, government, and health professionals. In 2007, the British Medical Association overruled a motion to grant legal protection to obese children less than twelve years of age by charging parents with neglect. The motion arose, in part, out of concern for a seven-year-old child who weighed over 200 pounds. The child’s mother was threatened with removal of the child if she was unable to effect recommended treatments to control the child’s weight. Proponents of the British Medical Association resolution argued that the extent of the child’s weight necessitated intervention while challengers branded the resolution as “bonkers.” Despite the failure of the British Medical Association to pass this 2007 resolution, a growing number of children in the United Kingdom have since been taken into custody, or have had their parents threatened with removal of the child due to the child’s obesity.

108 The British Medical Association is a trade union and professional body of physicians in England. The association creates policies in legal, regional, and national forums of physicians based on motions that are made to the Representative Body, the main policy making arm of the association. The Representative Body is comprised of over 500 physicians that meet at an Annual Representative Meeting to discuss motions and vote on them. How We Work, BMA, http://bma.org.uk/about-the-bma/how-we-work (last visited Aug. 22, 2013).
109 Andrew Cole & Zosia Kmietowicz, BMA Rejects Call for Parents of Obese Children to be Charged with Neglect, 334 BRIT. J. MED. 1343, 1343 (2007).
110 Varness et al., supra note 9, at 399.
111 Id.
112 Cole & Kmietowicz, supra note 109, at 1343.
113 See Alastair Jamieson, Fat Family: All Seven Children Taken into Care, TELEGRAPH (Oct. 22, 2009), http://www.telegraph.co.uk/health/healthnews/6404313/Fat-family-all-seven-children-taken-into-care.html (discussing cases of removal of children from parental care due to obesity); see also Council ‘Put Child, 5, into Care for Being Obese,’ TELEGRAPH (Dec. 5, 2011), http://www.telegraph.co.uk/health/healthnews/8934809/Council-put-child-5-into-care-for-being-obese.html (noting incidents in which at least twelve children have been removed from parental care since 2007 due to obesity).
114 Varness et al., supra note 9, at 399.
A. Authority for Child Welfare Protection in the United Kingdom

Like those in the United States, authorities in the United Kingdom are able to intervene when parental inadequacies harm children.\textsuperscript{115} The Children Act of 1989 permits government authorities and the judiciary to protect a child’s welfare.\textsuperscript{116} The Act gives authorities “the duty to investigate . . . if they have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.”\textsuperscript{117} The Act defines “harm” as “ill-treatment . . . or the impairment of health or development.”\textsuperscript{118} The Act, however, does not define “significant harm” and leaves this definition to the discretion of courts when assessing the propriety of intervention in each individual case.\textsuperscript{119}

In addition to the Children Act of 1989, authorities in the United Kingdom investigate issues concerning child welfare under guidelines entitled \textit{Working Together to Safeguard Children}.\textsuperscript{120} While these guidelines were originally propagated by the Department of Health in 1999, as of 2010, these guidelines have been superseded by new guidance disseminated by the Department of Education.\textsuperscript{121} The guidelines define how organizations should work in unison to promote the welfare of children in accordance with the Children Act of 1989.\textsuperscript{122} The guidelines also define child neglect as “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.”\textsuperscript{123} Potential instances of neglect indicated within the guidelines include parental failure to: (1) provide food, clothing, and

\begin{footnotesize}
\begin{enumerate}
\item[115] Elliott, \textit{supra} note 6.
\item[118] \textit{Id.}
\item[119] \textit{Id.}
\item[122] \textit{Id.}
\item[123] \textit{Id.} at 39.
\end{enumerate}
\end{footnotesize}
housing; (2) protect a child from physical or emotional injury; (3) provide adequate supervision; or (4) provide access to adequate medical care or treatment.124

B. Child Protective Interventions in the United Kingdom

In addition to designating the circumstances under which authorities may investigate, the Children Act of 1989 provides statutory guidelines for interventions courts and authorities may make to safeguard child welfare and when such interventions should occur.125 Interventions may include placement of the child on the Child Protection Register or removal of the child from parental custody.126 Working Together to Safeguard Children provides that when the duty to investigate arises under the Children Act of 1989 and the determination is made that a child “may continue to, or be likely to, suffer significant harm,” a child protection conference should establish a plan on how best to help the child.127 The conference should

124 Id. at 40.
125 See Children Act of 1989, 1991, c.41, Pt. V, § 44 (“Where any person applies to the court for an order to be made under this section with respect to a child, the court may make the order if, but only if, it is satisfied that—(a) there is reasonable cause to believe that the child is likely to suffer significant harm if—(i) he is not removed to accommodation provided by or on behalf of the applicant; or (ii) he does not remain in the place in which he is then being accommodated; (b) in the case of an application made by a local authority—(i) e nquiries are being made with respect to the child . . . and (ii) those enquiries are being frustrated by access to the child being unreasonably refused to a person authorized to seek access and that the applicant has reasonable cause to believe that access to the child is required as a matter of urgency; or (c) in the case of an application made by an authorized person—(i) the applicant has reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm; (ii) the applicant is making enquiries with respect to the child’s welfare; and (iii) those enquiries are being frustrated by access to the child being unreasonably refused to a person authorized to seek access and the applicant has reasonable cause to believe that access to the child is required as a matter or urgency.”); see also id. § 31 (“(1) On the application of any local authority or authorized person, the court may make an order- (a) placing the child with respect to whom the application is made in the care of a designated local authority; or (b) putting him under the supervision of a designated local authority. (2) A court may make a care order or supervision order if it is satisfied- (a) that the child concerned is suffering or is likely to suffer, significant harm; and (b) that the harm, or likelihood of harm, is attributable to- (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give him; or (ii) the child’s being beyond the parents control.”).
127 Working Together to Safeguard Children, supra note 121, at 161.
include the child’s family members, as well as any authorities, foster care families, or professionals that have been involved with the child. The goal of the conference is to determine whether the child has suffered serious harm and whether this harm is likely to occur again in the future. The test for whether a child is likely to suffer from future harm is as follows:

[whether]the child can be shown to have suffered ill-treatment or impairment of health or development as a result of physical, emotional, or sexual abuse or neglect, and professional judgment is that further ill-treatment or impairment are likely; or professional judgment, substantiated by the findings of enquiries in this individual case or by research evidence, is that the child is likely to suffer ill-treatment or the impairment of health or development as a result of physical, emotional, or sexual abuse or neglect.

If a determination is made that the child is likely to suffer significant future harm, interventions are designated through a formal child protection plan. The ways in which these interventions interface with child obesity cases were demonstrated in the instance of a morbidly obese eight-year-old. An investigation was implemented by the Local Safeguard Children Board because authorities were concerned that the child’s obese condition was likely to cause significant harm. Although authorities considered whether the child should have been placed on the child protection register or taken into the care of the state to oversee his weight loss, the child was permitted to remain in his mother’s care and a child protection agreement was reached to “safeguard and promote [his] welfare.”

---

128 Id. at 162.
129 Id. at 167.
130 Id.
132 Obese Boy to Remain with Mother, supra note 132; Paul Willis & Agencies, supra note 132.
133 Obese Boy to Remain with Mother, supra note 132; Paul Willis & Agencies, supra note 132.
In addition to local authorities, courts in the United Kingdom have a role in determining whether intervention is necessary for child protection.\textsuperscript{135} Courts consider both fact and law to establish whether or not a parent has “persistently failed without reasonable cause to safeguard and promote a child’s health, development, and welfare.”\textsuperscript{136} Courts have categorized “persistent failure” as behaviors that are not temporary or excusable and identify “persistent failure” by first considering what the action of a reasonable parent would be.\textsuperscript{137} If a court finds that parents have persistently failed to safeguard the health of the child, the court has discretion in determining whether to remove the child from parental care.\textsuperscript{138}

C. Concern Regarding the Inclusion of Child Obesity as a Child Protection Issue in the United Kingdom

There are a number of concerns that surround the removal of a child from parental care due to obesity. First, removing an obese child from his or her parents may be seen as a slippery slope as “[i]t is a short step from seeing parents as agents of change to blaming them for their child’s obesity.”\textsuperscript{139} Additionally, removing a child from his or her parents does not always combat obesity.\textsuperscript{140} One research study found that 37\% of 106 children removed from parental care were overweight or obese.\textsuperscript{141} Most of the overweight or obese children from the study became overweight while in custody and the risk of being overweight increased with the length of time that the children spent removed from their parents.\textsuperscript{142} The study concluded that children in custody were more likely to be overweight or obese compared to standard norms.\textsuperscript{143}

A second barrier to the inclusion of obesity as a child protection issue is the etiology that surrounds child obesity. One research study in the United Kingdom has shown that child obesity may be caused by a rare genetic

\textsuperscript{136} Id.
\textsuperscript{137} Id.
\textsuperscript{138} Id.
\textsuperscript{139} Viner et al., supra note 26, at 375.
\textsuperscript{140} Id.
\textsuperscript{141} Id. (citing S.C. Hadfield & P.M. Preece, Obesity in Looked After Children: Is Foster Care Protective from the Dangers of Obesity?, 34 CHILD: CARE, HEALTH & DEV. 710, 710–12 (2008)).
\textsuperscript{142} Hadfield & Preece, supra note 141, at 710, 710–12.
\textsuperscript{143} Id.
mutation associated with overeating. This mutation manifests in the inability of the brain to respond to appetite controlling hormones. Researchers found that five of the children in their study, each of which had the genetic mutation, were placed on the at-risk register.

D. When Does Child Obesity Become a Child Protection Issue?

Despite increased media and government attention to child obesity, limited information is available as to how many children have been removed from parental care in the United Kingdom where obesity was the deciding factor. Equally limited is the availability of specific factors considered in determining whether removing the child was warranted. Most hearings that take place in family court are restricted and seldom reported, making public access to this information difficult.

Indicators of whether to remove a child from parental care as described by the Association of Directors of Children’s Services include “whether the harm is significant in terms of the child’s development and whether the harm is due to the parents or caregivers behavior.” The interpretation of what constitutes “harm [that] is significant in terms of the child’s development” varies among local authorities. For example, in one instance, the case of a 700-pound teenager was not taken to court. However, in other instances, court proceedings have been initiated for less extreme cases.

Another suggested method of determining when child obesity should be considered a child protection issue comes from Russell Viner. Viner recommends that childhood obesity alone not be considered a child protection concern given the complex etiology of obesity. Viner indicates that the failure to reduce weight alone, without any other factors indicating


145 Id.

146 Id.

147 Grady, supra note 107.

148 Id.

149 Id.

150 Id.; see also Council ‘Put Child, 5, into Care for Being Obese,’ supra note 113 (“The point at which obesity turns into a child-protection issue is a complex and difficult area.”).

151 Grady, supra note 107.

152 Id.

153 Viner et al., supra note 26, at 376.

154 Id.
abuse, should not raise concern about a child’s welfare. This view flows from the premise that it is unfair to punish parents for such failure if they have made the necessary efforts to seek and follow through with treatment for the child. Viner does, however, suggest that consistent inattention to a child’s obese condition, lack of lifestyle changes, failure to seek outside support, failure to heed the advice of professionals, and active disruption of weight loss initiatives does indicate neglect and may warrant child protection. According to his framework, obesity becomes a child protection issue when parents actively endorse treatment failure in a child who faces grave risks resulting from his or her obese condition.

IV. A COMPARISON OF UNITED STATES AND UNITED KINGDOM AUTHORITY GOVERNING CHILD NEGLECT

The criteria utilized by the United States and the United Kingdom in determining cases of child neglect are remarkably similar yet equally vague. In the United States, child abuse and neglect is characterized as an act or failure to act on the part of parents that causes death or serious harm or the risk of imminent harm to a child. Although state neglect statues vary to some degree, most statutes mirror the definition recognized under CAPTA. Many state statutes define neglect as the caretaker’s failure to prevent imminent danger or the risk of imminent danger to a child. Some statutes, however, take a different approach and instead of defining neglect as a failure to prevent danger or the risk of danger, these states characterize neglect as the failure to provide a minimum level of care or essential care.

In characterizing neglect, courts in the United States typically utilize state statutes in determining when neglect has in fact occurred. However, much variation remains in the criteria courts use in defining such standards as

---

155 Id.
156 Id.
157 Id.
158 Id.
159 THE CHILD ABUSE PREVENTION AND TREATMENT ACT, supra note 36, at 6.
160 See generally CHILD WELFARE INFORMATION GATEWAY, supra note 39 (outlining definitions of abuse and neglect as prescribed by state statutes).
161 See, e.g., 110 MASS. CODE REGS. § 2 (2008) (defining neglect as the “failure of a caretaker . . . to take those actions necessary to provide a child with . . . essential care”).
162 See, e.g., Santosky v. Kramer, 455 U.S. 745, 748 (1982) (“New York authorizes its officials to remove a child temporarily from his or her home if the child appears ‘neglected,’ within the meaning of Art. 10 of the Family Court Act.”).
“imminent harm,” “adequate care,” “risk of imminent harm,” or “essential care.” For example, one court characterized “adequate care,” in a determination of medical neglect, as reasonable efforts to provide minimally acceptable medical treatment, while another court characterized the standard as seeking credible medical assistance and providing a method of physician-recommended treatment that has not been completely discredited by current medical authority.

The framework by which neglect is characterized in the United Kingdom is somewhat similar to that of the United States. Like CAPTA, the authority to suspect a child’s welfare may be at issue is statutorily granted through the United Kingdom’s Children Act of 1989. The Act provides a standard under which authorities may suspect a child’s welfare is endangered, specifically when a child is suffering or likely to suffer significant harm. This standard closely resembles the failure to prevent harm or the “imminent risk of serious harm” standard set forth in CAPTA, and is similarly vague in that, like CAPTA’s failure to characterize harm or “imminent risk of serious harm,” the Children Act fails to provide specific criteria as to what constitutes significant harm.

Just as courts in the United States may reference state statutes in addition to CAPTA, courts in the United Kingdom have additional authority, such as the United Kingdom Department of Health’s publication Working Together to Safeguard Children, to reference when determining cases involving child welfare. Working Together to Safeguard Children, defines neglect as the persistent failure to meet a child’s basic needs likely to result in serious impairment to the child’s health.

In R. v. Young, the court solely looked to the Children’s Act in determining whether to uphold a conviction of willful assault, ill treatment, and neglect when the appellant failed to seek adequate medical treatment for injuries sustained to her children because of fear of being accused of causing the injuries. However, in Re X, the court looked to both the Children’s Act of 1989 and Working Together to Safeguard Children in determining

---

163 Arani, supra note 46, at 884.
164 In re Hofbauer, 393 N.E.2d at 1014.
165 NSPCC FACTSHEET, supra note 116, at 2.
166 Id.
170 Working Together to Safeguard Children, supra note 121, at 39.
whether definitions of abuse had been met when adjudicating a child welfare case concerning emotional abuse.\textsuperscript{172}

V. THE INCLUSION OF CHILD OBESITY AS A CHILD PROTECTION CONCERN IN THE UNITED STATES AND THE UNITED KINGDOM

The inclusion of child obesity as a child protection issue in both the United States and the United Kingdom remains widely debated. Only a minority of states in the United States has acknowledged obesity as a form of neglect, and, similarly, in the United Kingdom, courts have adjudicated very few cases concerning child obesity. In both the United States and the United Kingdom, government involvement in child neglect begins with the local social services agencies.\textsuperscript{173} Interventions aimed at safeguarding the child’s welfare are recommended, and, in the event that parents do not heed recommendations, court involvement is often sought.\textsuperscript{174} Courts in both the United Kingdom and the United States determine whether a child is endangered given his or her obese condition using criteria typically set forth by statute.\textsuperscript{175} Courts also determine whether further interventions are necessary and if removal from the home is warranted.\textsuperscript{176} In both the United States and the United Kingdom, courts typically balance the rights of the parent and the best interest of the child in making such a determination.\textsuperscript{177}

VI. PROPOSED FRAMEWORK FOR DETERMINING WHETHER CHILD OBESITY SHOULD BE CONSIDERED A CHILD PROTECTION ISSUE WARRANTING COURT INTERVENTION IN THE UNITED STATES AND THE UNITED KINGDOM

Child obesity should be considered a child protection issue warranting court intervention in both the United States and the United Kingdom. This


\textsuperscript{173} Working Together to Safeguard Children, supra note 121, at 161; NSPCC FACTSHEET, supra note 116; Santosky v. Kramer, 455 U.S. 745, 753 (1982) (noting that officials may temporarily remove a child from the home and into the care of an authorized agency if the child “appears” neglected).

\textsuperscript{174} Santosky, 455 U.S. at 753 (“[T]he state’s first obligation is to help the family with services to . . . reunite it . . . .’ But if convinced that ‘positive, nurturing parent-child relationships no longer exist,’ the State may initiate ‘permanent neglect’ proceedings.”).

\textsuperscript{175} See Children Act of 1989, (1991) c.41 Pt. V, § 44 (providing statutory guidelines as to the types of interventions that courts and authorities may take to safeguard child welfare and when such interventions should be undertaken).

\textsuperscript{176} Id.

\textsuperscript{177} Aberdeenshire Council v. R, (2004) Fam. L.R. 93, 102 (Scot); Kelley, supra note 61, at 8.
issue is inconsistently pursued in both United States and United Kingdom
courts, and decisions of whether a child should be adjudicated neglected and
court intervention implemented as a result of obesity remain discrepant.
Scholars including Mitgang, Arani, and Varness have recommended a
number of factors aimed at clarifying this judicial process in the United
States.178

This Note extracts and combines the four factors best equipped to
streamline the judicial process in both the United States and the United
Kingdom. These four factors are: (1) whether the child meets the medical
definition of obesity and has at least one or more comorbidities; (2) whether
the child has a genetic predisposition or disease process to which the obese
condition is attributed; (3) whether the child’s parents have sought the advice
of a medical professional and have adhered to the recommendations of this
professional; and (4) whether interventions or treatment options are available
to the child that are likely to improve the child’s health, but have been
refused by the child’s parents.

A. Does the Child Meet the Medical Definition of Obesity and Have at Least
One or More Comorbid Diseases?

The first factor proposed in this analysis is whether the child meets the
medical definition of obesity and whether the child has any accompanying
comorbid diseases. The American Academy of Pediatrics, among others, has
characterized obesity as a Body Mass Index above the ninety-fifth
percentile,179 the standard recommended for the purposes of this Note.
Obesity places a child at risk for the development of a host of diseases and
conditions.180 Once a child develops one or more comorbid conditions
commonly associated with obesity, the child’s health will likely continue to
decline as the obesity progresses.181 Furthermore, an obese child is likely to
remain obese as an adult,182 and the continuation of obesity into adulthood

178 Mitgang, supra note 15, at 565–67; Arani, supra note 46, at 887–92; Varness et al., supra
note 9, at 401–03.
179 Prevention of Pediatric Overweight and Obesity, supra note 8, at 424; Overweight and
Obesity: Basics About Childhood Obesity, supra note 8.
180 See Overweight and Obesity: Basics About Childhood Obesity, supra note 8 (stating
child obesity places children at an increased risk for the development of high blood pressure,
high cholesterol, cardiovascular disease, diabetes, asthma, sleep apnea, joint problems, fatty
liver disease and gallstones).
181 Id. at 555.
182 Childhood Obesity Facts, supra note 4.
almost guarantees the progression of a comorbid disease.\textsuperscript{183} As a result, courts should consider a child’s obese condition \textit{and} the presence of one or more comorbid conditions when determining whether a child has been or is in danger of being neglected.

Such an objective analysis with a seemingly low threshold is preferred because it creates a more streamlined approach that reduces judicial discretion and variation in judicial adjudication. This proposal only requires a child be obese and have at least one comorbid disease. This analysis does not include an evaluation of the severity of comorbid diseases as recommended by other scholars.\textsuperscript{184}

This recommendation also intentionally fails to include characterizations such as when intervention is needed to implement “life-saving,” “life-prolonging,” or “quality of life” improving treatment as has been utilized by some courts and favored by some commentaries.\textsuperscript{185} Such characterizations are too subjective and unnecessary given that a child’s obesity will almost undoubtedly contribute to the development of a comorbid disease that will likely necessitate “life-prolonging” treatment.\textsuperscript{186} Subjective standards create confusion among parents and caregivers as to what behaviors may be considered neglectful. As a result, the mere presence of obesity and at least one comorbidity are enough to deem the child’s life and health at risk due to an obese condition.\textsuperscript{187} Thus, it is unnecessary to delay intervention until the child’s condition progresses to require “life-saving,” “life-prolonging,” or “quality of life” improving therapy.

\textsuperscript{183} Mitgang, \textit{supra} note 15, at 583.

\textsuperscript{184} \textit{Id.} at 569.

\textsuperscript{185} Arani, \textit{supra} note 46, at 882–83; Mitgang, \textit{supra} note 15, at 569.

\textsuperscript{186} See generally S. Jay Olshansky et al., \textit{A Potential Decline in Life Expectancy in the United States in the 21st Century}, 352 \textit{NEW ENG. J. MED.} 1138, 1139 (2005) (“Death rates from cardiovascular disease were substantially elevated among people with higher BMIs . . . . [F]or any degree of excessive body weight, young age was associated with greater years of life lost.”).

\textsuperscript{187} See generally \textit{id.} at 1139 (“Being overweight in childhood increases the risk among men of death from any cause and death from cardiovascular disease . . . . if left unchecked, the rising prevalence of obesity . . . . is expected to lead to an elevated risk of a range of fatal and nonfatal conditions for these cohorts as they age.”).
B. Does the Child Have a Disease or Genetic Disorder That Predisposes Him or Her to Obesity?

Some genetic disorders and hormonal imbalances predispose a child to obesity. In such situations, parents should not be deemed neglectful, and court intervention is unnecessary if the parent has sought adequate treatment for the underlying disorder. In these cases, the child’s obesity is likely outside of the parents’ control. For example, congenital disorders such as Prader-Willi syndrome result in intense food cravings in a child. The condition usually results in uncontrollable weight gain and morbid obesity. Parents of a child with Prader-Willi syndrome may have extreme difficulty in controlling their child’s weight, as a child with this disorder will go to great lengths to acquire food.

Additionally, in recent years genetic mutations have been identified that contribute to severe obesity in some children. Research has found that certain parts of the genome were missing in patients with severe obesity and that certain deletions may cause severe obesity at a young age. Such deletions cause a strong drive to eat and result in affected individuals gaining weight very rapidly. Given the strong indication that parental activities, or lack thereof, are not at fault in contributing to child obesity in these cases, a child’s predisposition to a genetic condition should be given heavy consideration and deference should be given to parents in child welfare adjudication.

---

190 Id.
191 Id.
192 Genetic Studies Reveal New Causes of Severe Obesity in Childhood, SCIENCE DAILY (Dec. 7, 2009), http://www.sciencedaily.com/releases/2009/12/091206162957.htm (discussing Elena Bochukova et al., Large, Rare Chromosomal Deletions Associated with Severe Early-Onset Obesity, 463 NATURE 666 (2010)).
193 Id.
194 Id.
C. Have the Child’s Parents Sought the Advice of a Medical Professional and Adhered to the Recommendations of This Professional?

A consideration of whether parents have sought and adhered to treatment consistent with standard recommendations for combatting obesity, such as changes to diet, exercise, and possibly medication, will assist courts in analyzing whether a child has been neglected and whether court intervention is necessary. If parents have sought treatment consistent with established guidelines to address their child’s obese condition and adhere to the recommendations given by medical professionals, neglect adjudication and intervention into the family unit is unnecessary because the parents are likely acting in the best interest of the child.

Also, in such circumstances, courts are unlikely to find that the parents’ actions caused their child to meet the suffering or likely to suffer significant harm threshold identified in the United Kingdom’s Children Act; or that the parents’ behavior has met the failure to prevent harm or the risk of serious imminent harm standard set forth in CAPTA. It is also unlikely in such scenarios that the rights of the parents will be outweighed by the interest of the state in protecting a child where parents have taken an active interest in the health of their child by seeking standard treatment options.

D. Are Interventions or Treatment Options Available to the Child That are Likely to Improve the Child’s Health but Refused by the Child’s Parents?

In analyzing child obesity cases, courts should consider whether there are treatments recommended by health care professionals that are likely to improve the child’s obese condition, but have been refused by the parents. This analysis includes a consideration of parental noncompliance despite agreements to implement certain therapies as well as recommendations that the parents directly reject. Some judicial discretion is necessary in assessing this factor, as it may be less objective in certain circumstances.

The reasonableness of therapies rejected by parents and the likelihood that the therapies will be effective in ameliorating the child’s condition should be balanced with the severity of the child’s condition. For example, a

---

196 NSPCC FACTSHEET, supra note 116, at 2.
morbidly obese child with life-threatening comorbidities may benefit from drug treatment therapy or surgery that may not be favored by parents. Given the severity of the child’s condition, court mandated intervention may be necessary. However, such treatment may be deemed unnecessary, although an available option, for a child who is mildly obese with comorbidities that are not immediately life-threatening, particularly when parents are taking other measures to ameliorate their child’s condition.

This factor is crucial to the suggested analysis because it can help shield a child from neglect adjudication and court intervention when the child remains obese through no fault of the parents. This may be the case when a child has an undiagnosed genetic disorder or disease process. In such circumstances, interventions recommended by health care professionals may be unsuccessful despite parental adherence to treatment or where a disease process contributes to a child’s obese condition. In a time where research continues to reveal previously unknown genetic mutations and disease processes that contributes to child obesity, court analyses should consider the possibility that a child’s obesity has not been caused through parental fault by acknowledging when parents have sought and adhered to recommended treatments.

VII. CONCLUSION

Child obesity should be pursued more vigorously as a child protection issue in both the United States and the United Kingdom. Obesity poses harmful health risks to a child, including death. Once an obese child becomes an obese adult, he or she may develop comorbid diseases including heart disease, stroke, type 2 diabetes, and certain types of cancer, some of the leading causes of preventable death. Furthermore, obesity has negative emotional implications, such as poor-self esteem and discrimination, and societal economic implications, such as higher healthcare costs.

In order for judicial and legislative efforts to more effectively combat incidents of child obesity, a more defined approach is needed in both the

---

198 Genetic Studies Reveal New Causes of Severe Obesity in Childhood, supra note 192.  
200 Prevention of Pediatric Overweight and Obesity, supra note 8.  
201 See Adult Obesity Facts, supra note 199 (stating that in 2008, medical costs connected with obesity were approximately $147 billion and “medical costs for people who are obese were $1,429 higher than those of normal weight).
United States and the United Kingdom in characterizing such incidences as neglect. Four factors that will elucidate and objectivize court adjudicate of this issue are: (1) whether the child meets the medical definition of obesity and has at least one or more comorbidities; (2) whether there is a genetic predisposition or disease process to which the child’s obese condition is attributed; (3) whether the child’s parents have sought the advice of a medical professional and have adhered to the recommendations of this professional; and (4) whether there are interventions or treatment options available that are likely to improve the child’s health, but have been refused by the child’s parents.

Given the similarities in applicable legislation in the United States and the United Kingdom that target child welfare and neglect and the similar inconsistencies in the adjudication of this issue, the same approach should be equally effective and consistent with current legislation in both locales. More streamlined, bright-line criteria are needed to evaluate case facts in light of the definitions provided by neglect statutes to eliminate the ambiguity inherent in most statutory neglect definitions. The current recommendations acknowledge the presence of this ambiguity and attempt to ameliorate potential effects on judicial decisions regarding child neglect by providing a more objective approach to adjudication.