Safeguarding Children and Young People Procedure

1. Reporting Safeguarding concerns

1.1 Housing Solutions are committed to stopping abuse or neglect wherever possible, prevent harm and reduce the risk of abuse, maltreatment or neglect to children. We will ensure that everyone, is clear about their individual and corporate roles and responsibilities in preventing and responding to abuse, maltreatment or neglect.

1.2 Housing solutions operates within a number of different counties and works in partnership with a large number of local authorities. Each local authority has its own Safeguarding Children Partnership Board and local safeguarding policy and good practice guides. The various boroughs and areas of operation include;

- Royal Borough of Windsor and Maidenhead
- Slough
- Reading
- Wokingham
- Bracknell Forest
- Basingstoke and Dean
- Hertfordshire
- Hampshire
- Marlow
- Abingdon
- Beaconsfield
- Aylesbury
- High Wycombe
- Milton Keynes

1.3 When a Safeguarding concern is raised, it is essential to establish which local authority the concern relates to and what their reporting procedures are. Below you will find a breakdown of each local authority and a hyper link to their Safeguarding children procedures;

1.4 Local safeguarding children policies and reporting procedures:

Local authorities	Hyper link to relevant Safeguarding policy and procedures	Contact details for safeguarding information/referrals
Royal Borough of Windsor and Maidenhead	The Royal Borough of Windsor and Maidenhead - Safeguarding Children procedure MASH@achievingforchildren.org.uk	Office hours Tel: 01628 683 150 Out of hours duty service (5pm – 9am & weekends) Tel: 01344 786543
Slough Borough Council	Slough Borough Council - Safeguarding Children procedure	Office hours Tel: 01753 875 362 Out of hours duty service (5pm – 9am & weekends) Tel: 01344 786 543
Reading Borough Council	Reading Borough Council - Safeguarding Children procedure	Office hours Tel: 0118 937 3641 Out of hours duty service (5pm – 9am & weekends) Tel: 01344 786 543
Wokingham Borough Council	Wokingham Borough Council- Safeguarding Children procedure	Office hours Tel: 0118 908 8002 Out of hours duty service (5pm – 9am & weekends) Tel: 01344 786 543
Bracknell Forest Council	Bracknell Forest Council- Safeguarding Children procedure	Office hours Tel: 01344 352005 Out of hours duty service (5pm – 9am & weekends) Tel: 01344 786 543
Basingstoke and Dean	Hants - Safeguarding Children procedure	Office hours Tel: 0300 555 1384 Out of hours duty service (5pm – 8.30am & weekends) Tel: 0300 555 1373

Buckinghamshire; • **Marlow** • **High Wycombe** • **Beaconsfield** • **Aylesbury**	Buckinghamshire County Council - Safeguarding Children procedures	Office hours Tel: 0845 460 0001
		Out of hours duty service (5pm – 9am & weekends) Tel: 0845 460 0001
Milton Keynes Council	Milton Keynes Council - Safeguarding Children procedure	Office hours Tel: 01908 253 169
		Out of hours duty service (5.15pm – 9am & weekends) Tel: 01908 253 169
Abingdon Town Council	Oxfordshire County Council - Safeguarding Children procedure	Office hours Tel: 0845 050 7666
		Out of hours duty service (5pm – 9am & weekends) Tel: 0800 833408

1.5 Where the child is seen to be in immediate danger or at immediate risk, immediate action must be taken to safeguard/protect the child. This can include but is not limited to;

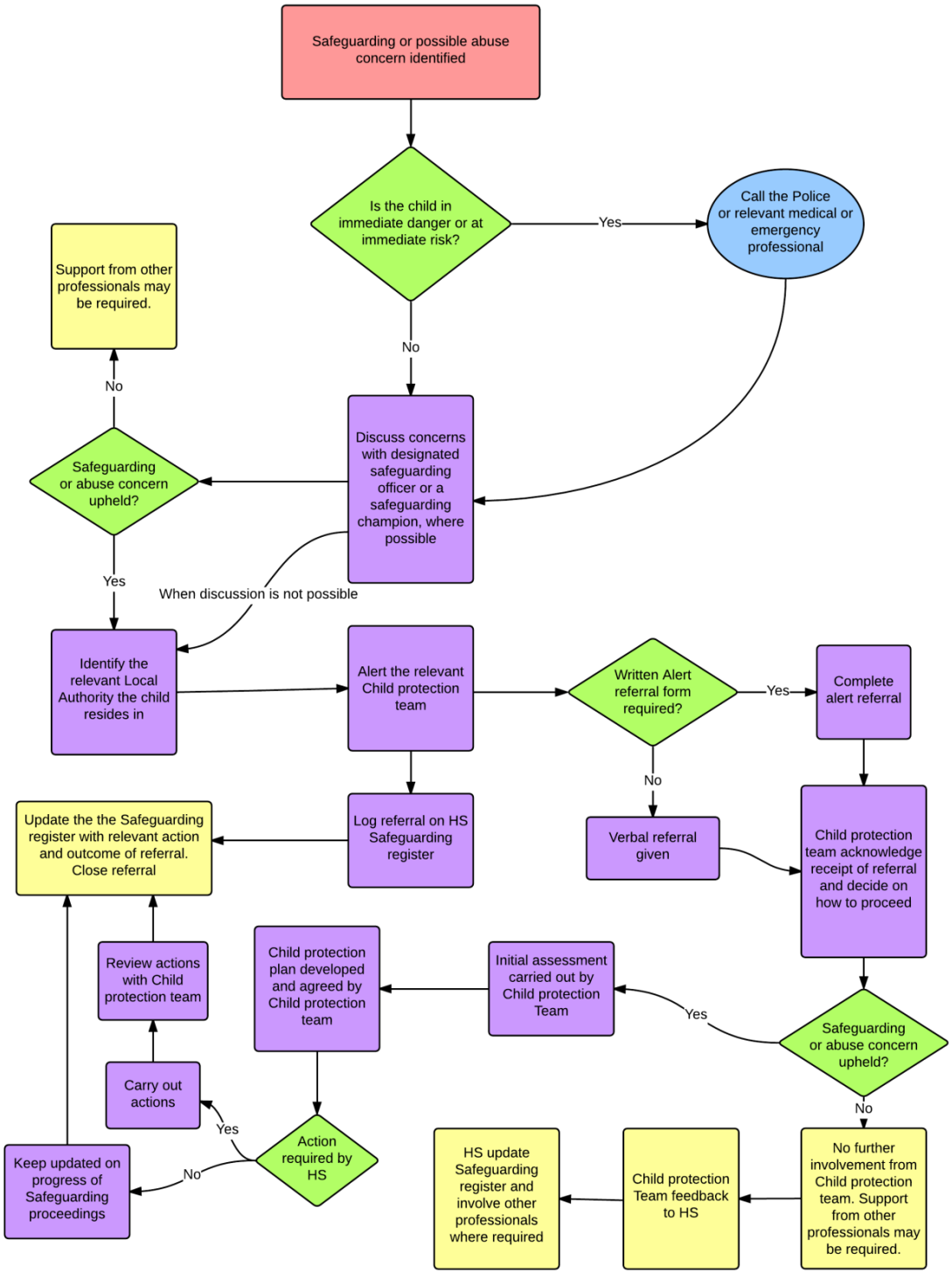
- Police interventions
- Emergency medical assistance
- Removing the child from the immediate danger or risk where possible

1.6 Once the relevant Local Authority Safeguarding team has been established, it is the responsibility of the alerter to contact the Safeguarding team and inform them of the suspected abuse, maltreatment and or neglect.

1.7 If the child is in immediate danger or at risk, it is the alerter's responsibility to report this immediately, explaining what danger and or risks are present and what interventions have been put in place to remove/safeguard the child from the identified danger or risk.

1.8 It is the alerter's responsibility to give a detailed report of events, which include all of the relevant information, as outlined in section 15 of this policy.

2. Safeguarding Children Process Map



2.1 The safeguarding children referral process map above, provides a guide to the processes and procedures, which need to be followed when suspecting abuse, maltreatment and or neglect of a child. Please note this is a guide and each local authority may use a different process/procedure.

3 Recording and reporting safeguarding concerns (Child/Young Person)

3.1 If an allegation or suspicion of abuse is discovered by a member of staff or Housing Solutions representative or contractor, they should inform the designated safeguarding officer or a safeguarding champion, as soon as possible.

3.2 Where a child is seen to be at risk of serious/immediate harm, the Police must be contacted immediately. Information is to then be shared with the designated safeguarding officer or a safeguarding champion, as soon as possible.

3.3 Anyone can report abuse and complete a safeguarding concern. Housing Solutions supports this practice but asks that the designated safeguarding officer or a safeguarding champion is informed in advance, where possible. They may take on the responsibility of raising a concern with the relevant safeguarding team or may delegate this duty.

3.4 Staff's role is to respond and record, unless specifically asked to do so you should not carry out an investigation of the incident. This will be carried out by the relevant local authority or Housing Solutions designated Safeguarding officer, where directed by the Local Authority Child Protection Team.

3.5 The persons reporting the alleged or suspected abuse of a child should make a written record of the concern, including a detailed personal record of what has been seen, heard or been told about the incident/allegation and report this to the designated safeguarding officer or a safeguarding champion.

3.6 If the child or young person is suspected to have experienced physical abuse/harm and there are visible marks, bruises, scratched, cuts or any other signs of physical harm, these should individually be recorded on the relevant body map. Staff must note that they should only record what they see and never ask a child or young person to remove clothing. When using the body maps to record visible marks, the staff member should give an accurate indication of where the marks are located and a description of what has been seen.

3.7 The person reporting the abuse should complete Housing Solutions Safeguarding Concern Form. The form is to be handed to the designated safeguarding officer or a safeguarding champion. The information provided will need to be accurate, as an edited version may be used in the event of criminal prosecution. The concern form will be stored securely in an electronic format on the risk register by the designated safeguarding officer or a safeguarding champion.

3.8 It is not the organisation's responsibility to decide whether abuse has taken place or not, however it is the organisations responsibility to pass on information to the appropriate authority immediately.

3.9 Making and retaining records is important at all stages of the process. All records/notes must be retained. This includes any information obtained during an investigation and copies of any information passed to outside authorities. All material will be kept in a secure file by the designated safeguarding officer or a safeguarding champion.Everyone should also be aware of the need to ensure that any relevant evidence is preserved.

4. Recording a Concern.

4.1 The written record of the abuse should be completed to the best of the person's knowledge. Do not interrogate the child but if possible or appropriate aim for the report to contain the following:

- Known details including name, date of birth address and contact numbers
- Whether or not the person making the report is expressing their own concerns or those of someone else.
- Date, Time, Place
- What happened - Precise details in child's own words
- Did anyone else witness it, if so their contact details?
- Did the child go to hospital?
- A description of any visible bruising or other injuries. (To be recorded on a body mapping sheet – Appendix 1 and 2).
- Were there any indirect signs, such as behavioural changes.
- Were the police called?
- How often have the assaults taken place?
- Does the child know the name of the person who assaulted or abused them?

You must make a distinction between what is fact, opinion or hearsay.

Consideration needs to be given to:

- The scale of the abuse
- The risk of harm to others
- The capacity of the child to understand the issues of abuse and consent (This pertains to those young people who are Gillick Competent)
- If there is any doubt about whether or not to report an issue to Social Services, then it should be reported.
- Where the alleged abuser is a member of staff/volunteer, the Disciplinary procedure will be followed, commencing with removal from active duty where there is a risk to others.

4.2 Housing Solutions operates a Safeguarding register, which is managed by the designated safeguarding officer and the safeguarding champions. Every safeguarding concern/concern will need to be recorded in the register, including the outcome of the concern. The safeguarding register is stored securely in an electronic format with restricted access and can only be shared in line with our confidentiality and data protection procedures.

4.3 The safeguarding form can be found here:

Housing Solutions

Child or young person safeguardin

5. Advice and support

The following organisations can provide expert advice and support on issues of abuse;

Organisation	Telephone	Website	Notes
Children's Commissioner	020 7789 8330	www.childrenscommissioner.gov.uk	Resources and information on safeguarding children and young people
Public Concern at Work	(020) 7404 6609 (Monday-Friday, 9.00am-6.00pm).	www.pcaw.org.uk	Initial enquires can be made anonymously.
Ann Craft Trust	0115 9515400	www.anncrafttrust.org	Support for people with learning disabilities who have been abused.
Mind	0300 123 3393	www.mind.org.uk	Help and advice for people with mental health needs.
Women's Aid	0808 2000247	www.womensaid.org.uk	Domestic abuse support for women and children
Childline	0800 1111	www.childline.org.uk	Help and advice on a wide range of child related issues
NSPCC	0808 800 5000	www.nspcc.org.uk	Help and advice line for children who are childs of abuse
Broken rainbow	0300 999 5428	www.brokenrainbow.org.uk	National Lesbian, Gay, Bisexual and Transgender Domestic abuse helpline

Samaritans	08457 90 90 90	www.samaritans.org.uk	Help and advice line for persons experiencing suicidal thoughts

Appendix 1 – Child body map

(This must be completed at time of observation)

Names for Child: .....

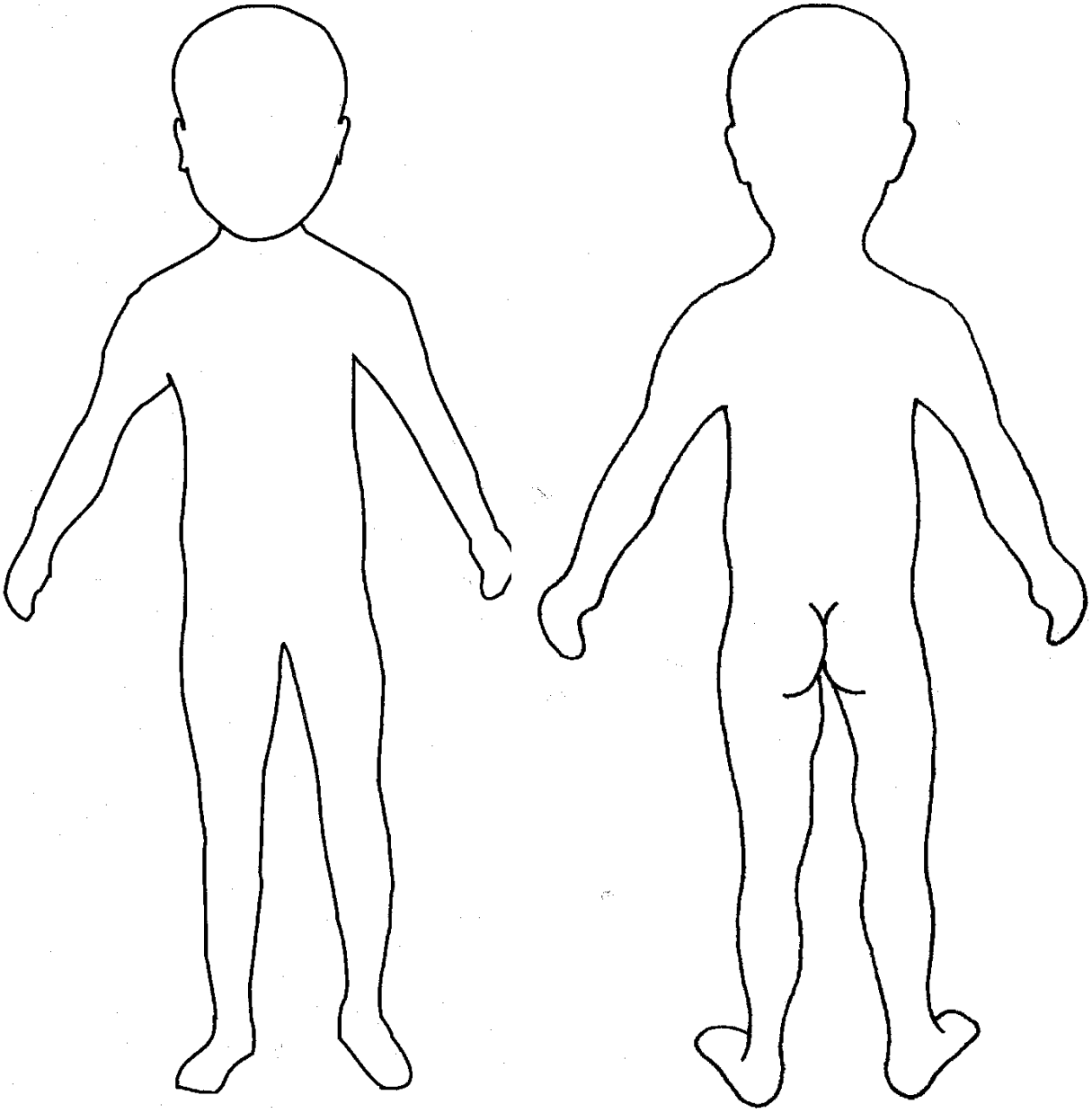
Date of Birth: .....

Name of Worker: .....

Agency: .....

Date and time of observation: .....

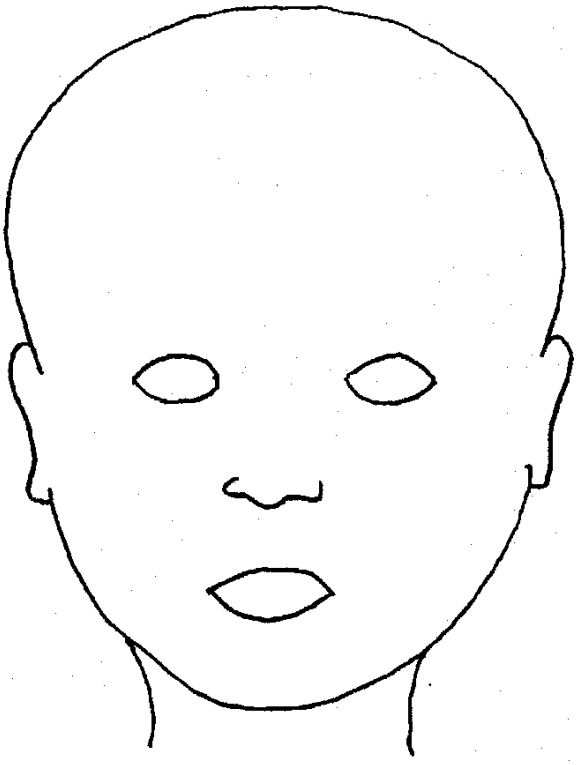
Housing Solutions



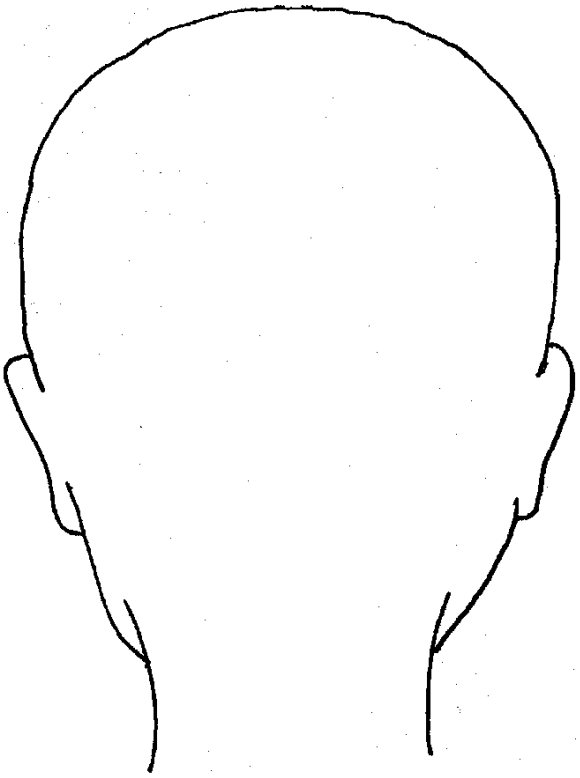
Housing Solutions

Name of Child: .....

Date of observation: .....



FRONT



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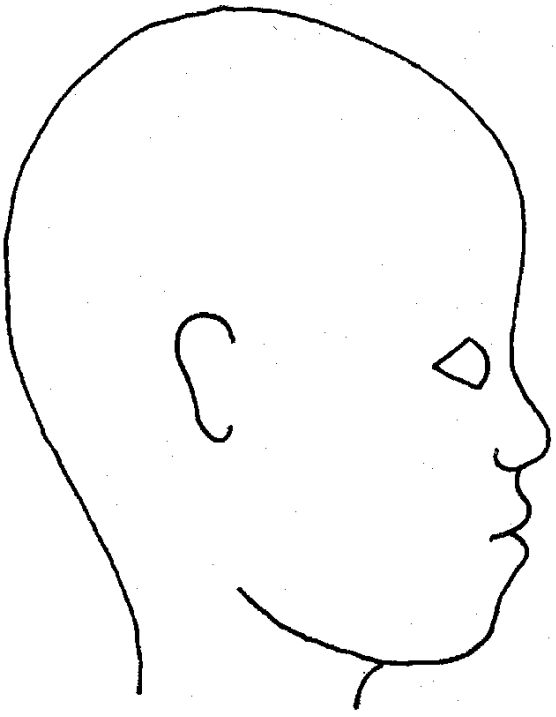

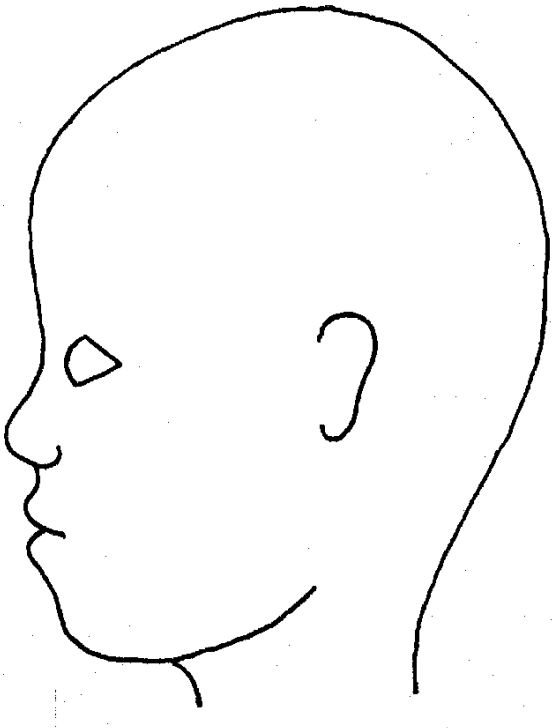

RIGHT LEFT

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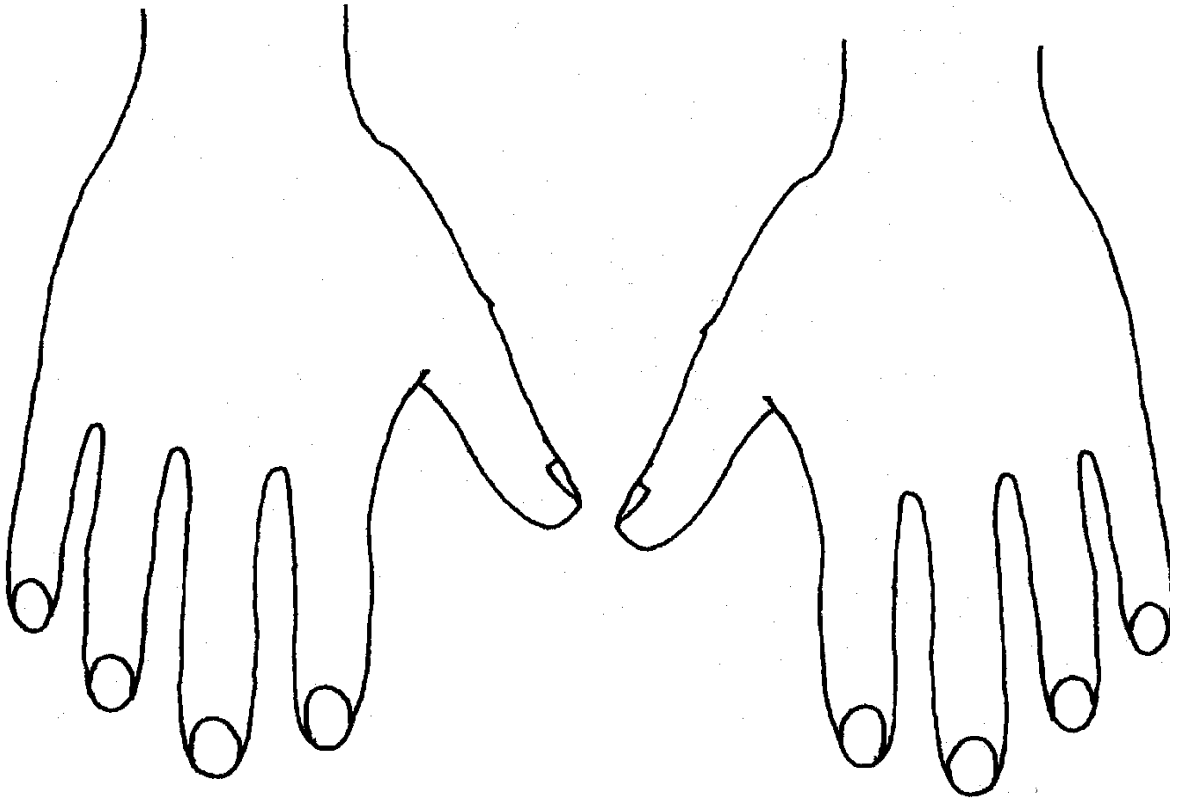
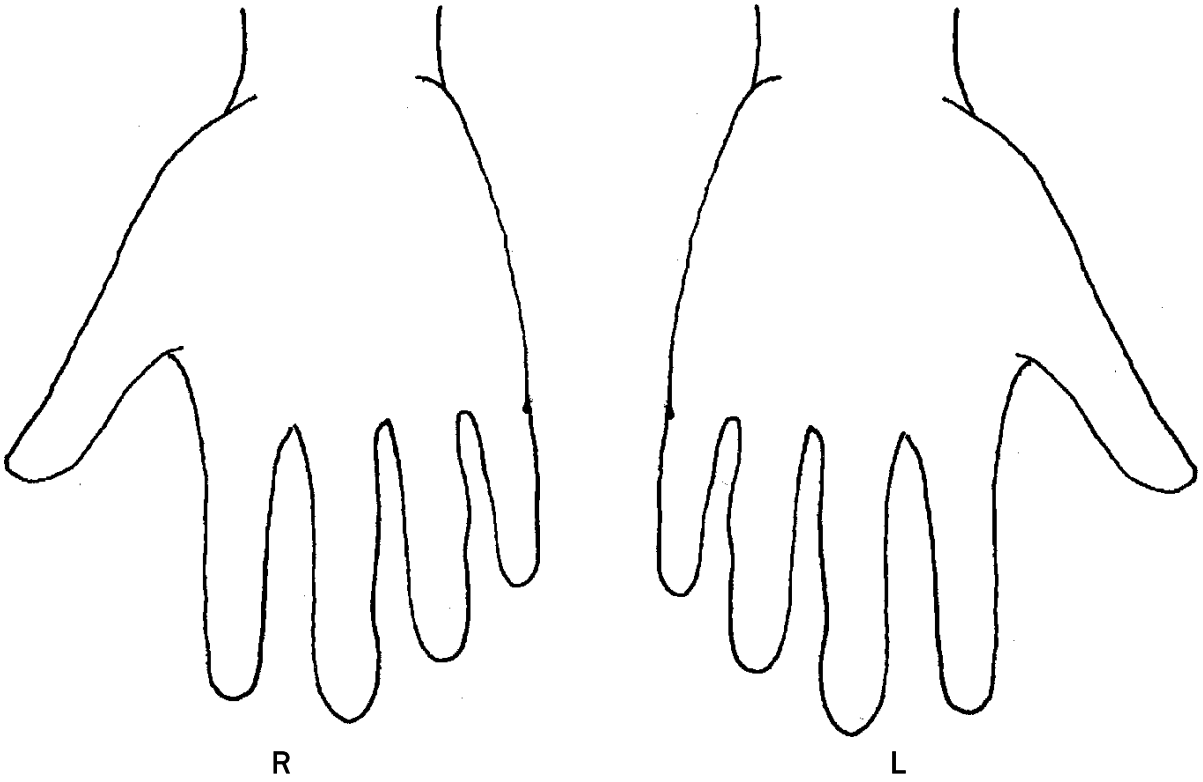
Name of Child: ..... Date of observation: .....



R L

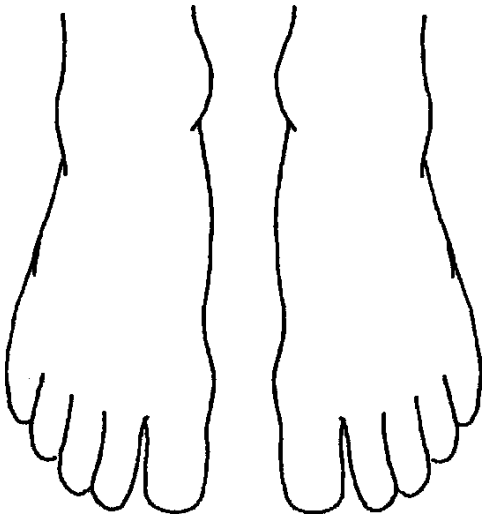
BACK



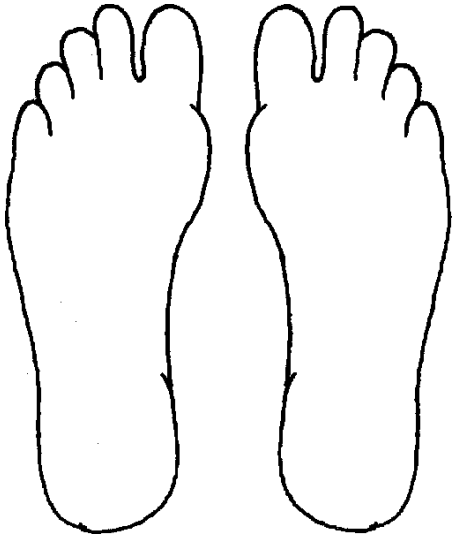
PALM

Name of Child: ..

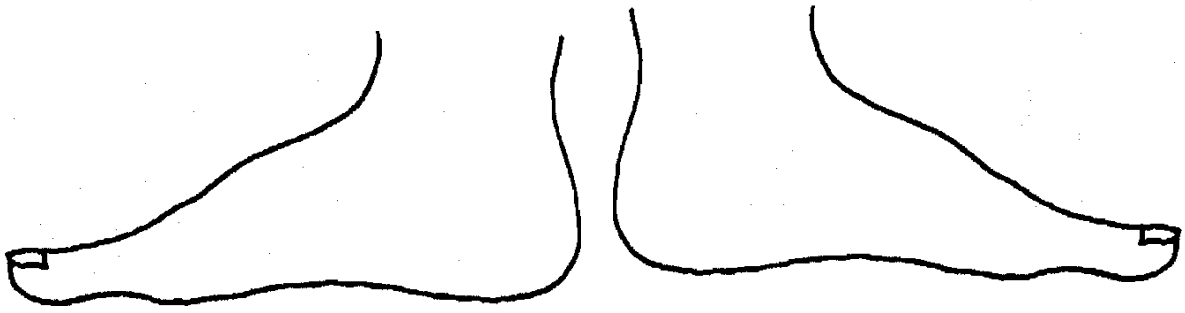
Date of observation: .....



R TOP L

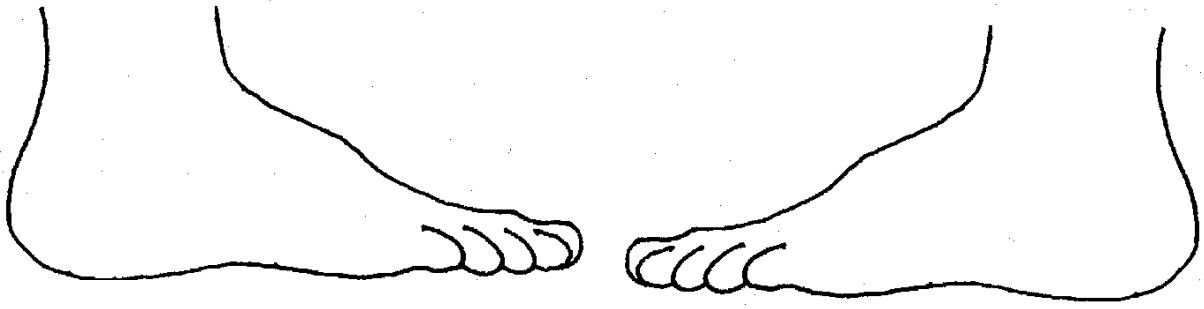


R BOTTOM L



R L

INNER



R L

OUTER

Printed Name and Signature of worker: .....

Date:

Time: .....

Role of Worker .....

Other information: .....

Appendix 2: Types and Symptoms of abuse in Children

1. The Definition of Significant Harm

The Children Act 1989 introduced the concept of Significant Harm as the threshold which justifies compulsory intervention in family life in the best interests of children.

Section 47 of the Act places a duty on local authorities to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering or is likely to suffer significant harm. A court may only make a **Care Order** or **Supervision Order** in respect of a child if it is satisfied that:

- The child is suffering, or is likely to suffer Significant Harm; and
- That the harm or likelihood of harm is attributable to a lack of adequate parental care or control (Section 31).

Under Section 31(9) of the Children Act 1989, as amended by the Adoption and Children Act 2002:

- '**Harm**' means ill-treatment or the impairment of health or development, including for example impairment suffered from seeing or hearing the ill-treatment of another;
- '**Development**' means physical, intellectual, emotional, social or behavioural development;
- '**Health**' means physical or mental health; and
- '**Ill-treatment**' includes sexual abuse and forms of ill-treatment that are not physical.

There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, the degree of threat, coercion, sadism, and bizarre or unusual elements in child sexual abuse. Each of these elements has been associated with more severe effects on the child and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment.

Sometimes a single traumatic event may constitute significant harm, e.g. a violent assault, suffocation or poisoning. More often, significant harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development. Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long term emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm. In each case, it is necessary to consider any ill treatment alongside the family's strengths and supports.

To understand and establish Significant Harm, it is necessary to consider:

- The family context, including protective factors;
- The child's development within the context of his or her family and wider social and cultural environment;
- Any special needs, such as a medical condition, communication difficulty or disability that may affect the child's development and care within the family;
- The nature of harm, in terms of ill-treatment or failure to provide adequate care;
- The impact on the child's health and development; and
- The adequacy of parental care.

Sometimes 'significant harm' refers to harm caused by one child to another (which may be a single event or a range of ill treatment), which is generally referred to as 'peer on peer abuse.'

2. Categories of Abuse and Neglect

The abuse or neglect of a child can be caused by inflicting harm or by failing to act to prevent harm. Children may be abused in a family, in a community or institutional setting, by those known to them or, much more rarely, by a stranger.

The following definitions are taken from Chapter 1 of Working Together to Safeguard Children and Keeping Children Safe in Education.

They have been included to assist those providing services to children in assessing whether the child may be suffering actual or potential harm.

2.1 Abuse

A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults or another child or children.

2.2 Physical Abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child.

Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child. Further information about this form of abuse is set out in the **Fabricated or Induced Illness Procedure**.

2.3 Emotional Abuse

Emotional abuse is a form of **Significant Harm** which involves the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.

It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children.

These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill treatment of another. It may involve serious bullying (including cyber-bullying) causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

2.4 Sexual Abuse

Sexual abuse is a form of Significant Harm which involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetration (for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the Internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

2.5 Neglect

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

Neglect may occur during pregnancy as a result of maternal substance misuse.

Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food and clothing, shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care-givers);
- Ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

3. Indicators of Abuse

The following guidance is intended to help all colleagues who come into contact with children. It should not be used as a comprehensive guide, nor does the presence of one or more factors prove that a child has been abused, but it may however indicate that further enquiries should be made.

The following factors should be taken into account when assessing risks to a child. This is not an exhaustive list:

- An unexplained delay in seeking treatment that is obviously needed;
- An unawareness or denial of any injury, pain or loss of function;
- Incompatible explanations offered or several different explanations given for a child's illness or injury;
- A child reacting in a way that is inappropriate to his/her age or development;
- Reluctance to give information or failure to mention previous known injuries;
- Frequent attendances at Accident and Emergency Departments or use of different doctors and Accident and Emergency Departments;
- Frequent presentation of minor injuries (which if ignored could lead to a more serious injury);
- Unrealistic expectations/constant complaints about the child;
- Alcohol misuse or other substance misuse;
- A parents request to remove a child from home or indication of difficulties in coping with the child;
- Domestic violence and abuse;
- Parental mental ill health;
- The age of the child and the pressures of caring for a number of children in one household.

4. Recognising Physical Abuse

This section provides a guide to professionals of some common injuries found in child abuse. Whilst some injuries may appear insignificant in themselves, repeated minor injuries, especially in very young children, may be symptomatic of physical abuse.

It can sometimes be difficult to recognise whether an injury has been caused accidentally or non-accidentally, but it is vital that all concerned with children are alert to the possibility that an injury may not be accidental, and seek appropriate expert advice. Medical opinion will be required to determine whether an injury has been caused accidentally or not.

Situations of particular concern

Situations that should cause particular concern for professionals include:

- Delayed presentation / reporting of an injury;
- Admission of physical punishment from parents / carers, as no punishment is acceptable at this age;
- Inconsistent or absent explanation from parents / carers;
- Associated family factors such as substance misuse, mental health problems, and domestic violence and abuse;
- Other associated features of concern e.g. signs of neglect such as poor clothing, hygiene and / or nutrition;
- Observation of rough handling;
- Difficulty in feeding / excessive crying;
- Significant behaviour change;
- Child displaying wariness or watchfulness;
- Recurrent injuries;
- Multiple injuries at one time.

Bruising

Children can have accidental bruising, but it is often possible to differentiate between accidental and inflicted bruises. It may be necessary to do blood tests to see if the child bruises easily.

The following must be considered as non-accidental unless there is evidence or an adequate explanation provided:

- Any bruising to a pre-crawling or pre-walking
- Bruising in or around the mouth, particularly in small babies, for example 3 to 4 small round or oval bruises on one side of the face and one on the other, which may indicate force feeding;
- Two simultaneous bruised eyes, without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive);
- Bruising on the head or on sites unlikely to be injured accidentally, for example the back, mouth, cheek, ear, stomach, chest, under the arm, neck, genital and rectal areas;
- Variation in colour possibly indicating injuries caused at different times – it is now recognised in research that it is difficult to age bruises apart from the fact that they may start to go yellow at the edges after 48 hours;
- The outline of an object used e.g. belt marks, hand prints or a hair brush;
- Linear bruising at any site, particularly on the buttocks, back or face;
- Other shapes of bruising, for example crescent shape bruising, which may be suggestive of a bite mark;

- Bruising or tears around, or behind, the earlobe(s) indicating injury by pulling or twisting;
- Bruising around the face;
- Grasp marks to the upper arms, forearms or leg or chest of small children;
- Petechial haemorrhages (pinpoint blood spots under the skin). These are commonly associated with slapping, smothering/suffocation, strangling and squeezing;
- Multiple bruises of the same or varying colour;
- Clusters of small round bruises suggestive of a grip.

It should be noted that bruising in black children and some minority ethnic children might be more difficult to see. Tenderness or minor swelling over the area of injury is important.

Dark pigmentation (commonly known as blue spot), usually over the lower central back or sacral areas, is normal and common in infants with pigmented skin and usually fades as the infant grows.

Injuries or Physical Abuse in Infants under One Year Old

Any injury in a non-mobile infant causes concern. Of particular concern are injuries to infants six months and under.

Any injuries are unusual in this age group, unless accompanied by a full consistent explanation. Even small injuries may be significant, and may be a sign that another hidden injury is already present. Such injuries include:

- Small single bruises e.g. on face, cheeks, ears, chest, arms or legs, hands or feet or trunk;
- Bruised lip or torn frenulum (small area of skin between the inside of the upper and lower lip and gum);
- Lacerations, abrasions or scars without a consistent explanation particularly where they are on sites usually covered by clothing and/or are shaped like ligature marks and/or are systematically distributed on the baby's body;
- Burns and scalds - accidental burns or scalds only occasionally occur in non-mobile infants and will be of particular concern where they have clearly defined borders and/or are burns to the trunk or lower limbs and/or are situated on the back of hands, soles of feet, back and other usually protected areas such as inner arms and/or where they are in the shape of an implement for example a cigarette lighter, iron or the tip of a cigarette and/or are in a glove/stocking distribution or symmetrical which suggests submersion in hot water;
- Pain, tenderness or failing to use an arm or leg which may indicate pain and an underlying fracture;
- Small bleeds into the whites of the eyes or other eye injuries, which require investigation, as they may be indicative of a sub-conjunctival haemorrhage;
- Soft swellings on one or both sides of the head, which requires medical examination as it may be indicative of a skull fracture.

Occasionally an infant can be harmed in other ways, for example:

- Deliberate poisoning which can present as sudden collapse, coma;
- Suffocation - which can present as collapse, cessation of breathing (apnoeic attack), bleeding from the mouth and nose.

These infants are most at risk of serious deliberate harm and as such require careful consideration.

Fractures

Fractures may cause pain, swelling and discolouration over a bone or joint. It is unlikely that a child will have had a fracture without the carers being aware of the child's distress.

If the child is not using a limb, has pain on movement and/or swelling of the limb, there may be a fracture.

There are grounds for concern if:

- The history provided is vague, non-existent or inconsistent with the fracture type;
- There are associated old fractures;
- Medical attention is sought after a period of delay when the fracture has caused symptoms such as swelling, pain or loss of movement;
- There is an unexplained fracture in the first year of life;
- Non-mobile children sustain fractures.

Rib fractures are only caused in major trauma such as in a road traffic accident, a severe shaking injury or a direct injury such as a kick.

Skull fractures are uncommon in ordinary falls, i.e. from three feet or less. The injury is usually witnessed, the child will cry and if there is a fracture, there is likely to be swelling on the skull developing over 2 to 3 hours. All fractures of the skull should be taken seriously.

Subdural haematoma is a very worrying injury, seen usually in young children; it may be associated with retinal haemorrhages and fractures particularly skull and rib fractures. The cause is usually a severe shaking injury in association with an impact blow. There may or may not be a fractured skull. The baby may present in the Accident and Emergency Department with sudden difficulty in breathing, sudden collapse, fits or as an unwell baby - drowsy, vomiting and later an enlarging head.

Joints

A tender, swollen "hot" joint with normal X ray appearance may be due to infection in the bone or trauma. There may be both. A further X ray will usually be required in 10 to 14 days. Where there is infection, this of course will require treatment.

Mouth Injuries

Tears to the frenulum (tissue attaching upper lip to gum) often indicate force feeding of a baby. There is often finger bruising to the cheeks and around the mouth. Rarely, there may also be grazing on the palate. Blunt trauma to the mouth causes swelling and damage to the inner aspect of the lips.

Internal Injuries

There may be internal injury e.g. perforation or a viscus with no apparent external signs of bruising to the abdomen wall.

Poisoning

Ingestion of tablets or domestic poisoning in children under 5 is usually due to the carelessness of a parent or carer, but it may be self-harm even in young children.

See also **Fabricated or Induced Illness Procedure**.

Bite Marks

Bite marks can leave clear impressions of the teeth when seen shortly after the injury has been inflicted. The shape then becomes a more defused ring bruise or oval or crescent shaped. Those over 3cm in diameter are more likely to have been caused by an adult or older child.

A medical/dental opinion, preferably within the first 24 hours, should be sought where there is any doubt over the origin of the bite.

Burns and Scalds

It can be difficult to distinguish between accidental and non-accidental burns and scalds, and will always require experienced medical opinion. Any burn with a clear outline may be suspicious e.g.:

- Circular burns from cigarettes (but may be friction burns if along the bony protuberance of the spine or impetigo in which case they will quickly heal with treatment);
- Linear burns from hot metal rods or electrical fire elements;
- Burns of uniform depth over a large area;
- Scalds that have a line indicating immersion or poured liquid (a child getting into hot water of its own accord will struggle to get out and cause splash marks);
- Old scars indicating previous burns/scalds which did not have appropriate treatment or adequate explanation.

Scalds to the buttocks of a small child, particularly in the absence of burns to the feet, are indicative of dipping into a hot liquid or bath.

The following points are also worth remembering:

- A responsible adult checks the temperature of the bath before the child gets in;
- A child is unlikely to sit down voluntarily in a hot bath and cannot accidentally scald its bottom without also scalding his or her feet;
- A child getting into too hot water of his or her own accord will struggle to get out and there will be splash marks.

Scars

A large number of scars or scars of different sizes or ages, or on different parts of the body, or unusually shaped, may suggest abuse.

5. Recognising Emotional Abuse

Emotional abuse may be difficult to recognise, as the signs are usually behavioural rather than physical. The manifestations of emotional abuse might also indicate the presence of other kinds of abuse.

The indicators of emotional abuse are often also associated with other forms of abuse.

The following may be indicators of emotional abuse:

- Developmental delay;
- Abnormal attachment between a child and parent/carer e.g. anxious, indiscriminate or no attachment;
- Indiscriminate attachment or failure to attach;
- Aggressive behaviour towards others;
- A child scapegoated within the family;
- Frozen watchfulness, particularly in pre-school children;
- Low self-esteem and lack of confidence;
- Withdrawn or seen as a ‘loner' difficulty relating to others.

Professionals should be aware of potentially harmful interactions of a parent / carer towards their child. At this age their ability to communicate their needs is limited. However, most children will respond to how adults are interacting

with them, and this may have an impact on them and their development. Therefore, professionals should have cause for concern if they feel parents / carers:

- Are negative or hostile towards the child;
- Reject them or use them as a scapegoat;
- Have inappropriate interactions with them, including threats or attempt to discipline them;
- Use them to fulfil their own needs (for example, in marital disputes);
- Fail to promote their development, by not providing appropriate stimulation, or isolating them from other children / adults as applicable;
- Are emotionally unavailable to the child, by being withdrawn or unresponsive, for example (emotional neglect).

6. Recognising Sexual Abuse

Children of both genders and of all ages may be sexually abused and are frequently scared to say anything due to guilt and/or fear. This is particularly difficult for a child to talk about and full account should be taken of the cultural sensitivities of any individual child / family.

Recognition can be difficult, unless the child discloses and is believed. There may be no physical signs and indications are likely to be emotional / behavioural.

Some behavioural indicators associated with this form of abuse are:

- Inappropriate sexualised conduct;
- Sexual knowledge inappropriate for the child's age;
- Sexually explicit behaviour, play or conversation, inappropriate to the child's age;
- Continual and inappropriate or excessive masturbation;
- Self-harm (including eating disorder), self-mutilation and suicide attempts;
- Running away from home;
- Poor concentration and learning problems;
- Loss of self-esteem;
- Involvement in prostitution or indiscriminate choice of sexual partners;

- An anxious unwillingness to remove clothes for - e.g. sports events (but this may be related to cultural norms or physical difficulties).

Some physical indicators associated with this form of abuse are:

- Pain or itching of genital area;
- Recurrent pain on passing urine or faeces;
- Blood on underclothes;
- Pregnancy in a younger girl where the identity of the father is not disclosed and/or there is secrecy or vagueness about the identity of the father;
- Physical symptoms such as discharge, bleeding or other injuries to the genital or anal area, bruising/bite marks on buttocks, abdomen and/or inner thighs, sexually transmitted infections, presence of semen on vagina, anus, external genitalia or clothing.

7. Recognising Neglect

The growth and development of a child may suffer when the child received insufficient food, love, warmth, care and concern, praise, encouragement and stimulation.

Professionals need to be aware of the possibility of parents / carers neglecting to adequately care for their children. Factors of neglect may include:

- Parents / carers not giving their child prescribed treatment for a medical condition that has been diagnosed;
- Repeated failure by parents / carers to take their child to essential follow-up medical appointments;
- Persistent failure by parents / carers to engage with relevant child health promotion programmes such as immunisation, health and development reviews, and screening;
- Not seeking medical advice when necessary, jeopardising their health and wellbeing, particularly if they are in pain;
- Dental neglect – rotten or grossly discoloured teeth with noticeable odour; child unable to eat normally; covers mouth with hand; child in chronic pain;
- Being cared for by a person who is not providing adequate care, including hygiene, either through inability or negligence;
- Not feeding properly, or being fed an inadequate or inappropriate diet;
- Suffering severe and / or persistent infestations such as scabies or head lice;
- Being consistently dressed in inappropriate clothing for example, for the weather or their size;

- Red/mottled skin, particularly on the hands and feet, seen in the winter due to cold;
- Swollen limbs with sores that are slow to heal, usually associated with cold injury;
- Recurrent diarrhoea;
- Abnormal voracious appetite at school or nursery;
- Being persistently smelly and / or dirty;
- Being listless, apathetic and unresponsive with no apparent medical cause;
- Being excessively clingy, fearful, withdrawn or unusually quiet for his or her age;
- Being inadequately supervised;
- An incident that suggests a lack of supervision, such as sunburn or other burn, ingestion of a harmful substance(s) near-drowning, a road traffic accident or being bitten by an animal;
- Being indiscriminate in relationships with adults.

A clear distinction needs to be made between organic and non-organic failure to thrive. This will always require a medical diagnosis. Non-organic failure to thrive is the term used when a child does not put on weight and grow and there is no underlying medical cause for this.

8. Impact of Abuse and Neglect

The sustained abuse or neglect of children physically, emotionally, or sexually can have long-term effects on the child's health, development and well-being. It can impact significantly on a child's self-esteem, self-image and on their perception of self and of others. The effects can also extend into adult life and lead to difficulties in forming and sustaining positive and close relationships. In some situations it can affect parenting ability and lead to the perpetration of abuse on others.

In particular, physical abuse can lead directly to neurological damage, as well as physical injuries, disability or at the extreme, death. Harm may be caused to children, both by the abuse itself, and by the abuse taking place in a wider family or institutional context of conflict and aggression. Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems and educational difficulties.

Severe neglect of young children is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, and long term difficulties with social functioning, relationship and educational progress. Neglect can also result in extreme cases in death.

Sexual abuse can lead to disturbed behaviour including self-harm, inappropriate sexualised behaviour and adverse effects which may last into adulthood. The severity of impact is believed to increase the longer the abuse continues, the more extensive the abuse and the older the child. A number of features of sexual abuse have also been linked with the severity of impact, including the extent of premeditation, the degree of threat and coercion, sadism and bizarre or unusual elements. A child's ability to cope with the experience of sexual abuse, once recognised or disclosed, is

strengthened by the support of a non-abusive adult or carer who believes the child, helps the child to understand the abuse and is able to offer help and protection.

There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, than other more visible forms of abuse in terms of its impact on the child. Domestic violence and abuse, adult mental health problems and parental substance misuse may be features in families where children are exposed to such abuse.

The context in which the abuse takes place may also be significant. The interaction between a number of different factors can serve to minimise or increase the likelihood or level of significant harm. Relevant factors will include the individual child's coping and adapting strategies, support from family or social network, the impact and quality of professional interventions and subsequent life events.

9. Historical Abuse

Allegations of child abuse are sometimes made by adults and children many years after the abuse has occurred. There are many reasons for an allegation not being made at the time including fear of reprisals, the degree of control exercised by the abuser, shame or fear that the allegation may not be believed. The person becoming aware that the abuser is being investigated for a similar matter or their suspicions that the abuse is continuing against other children may trigger the allegation.

Reports of historical allegations may be complex as the alleged victims may no longer be living in the situations where the incidents occurred or where the alleged perpetrators are also no longer linked to the setting or employment role. Such cases should be responded to in the same way as any other concerns. It is important to ascertain as a matter of urgency if the alleged perpetrator is still working with, or caring for, children.

Organisational responses to allegations by an adult of abuse experienced as a child must be of as high a standard as a response to current abuse because:

- There is a significant likelihood that a person who abused a child/ren in the past will have continued and may still be doing so;
- Criminal prosecutions can still take place despite the fact that the allegations are historical in nature and may have taken place many years ago.