Child Protection - Forms of abuse

Physical Abuse

This can involve hitting, shaking, throwing, poisoning, punching, kicking, scalding, burning, drowning and suffocating. It can also result when a parent or carer deliberately causes the ill health of a child in order to seek attention through fabricated or induced illness. This was previously known as Munchausen's Syndrome by Proxy.
See also appendix 1

Emotional Abuse

Emotional Abuse is where a child's need for love, security, recognition and praise is not met. It may involve seeing or hearing the ill-treatment of someone else such as in Domestic Violence or Domestic Abuse. A parent, carer or authority figure is considered emotionally abusive when they are consistently hostile, rejecting, threatening or undermining toward a child or other family member. It can also occur when children are prevented from having social contact with others or if inappropriate expectations are placed upon them. Symptoms that indicate emotional abuse include:
Excessively clingy or attention seeking.

- Very low self-esteem or excessive self-criticism.
- Withdrawn behaviour or fearfulness.
- Lack of appropriate boundaries with strangers; too eager to please.
- Eating disorders or self-harm

See also appendix 1

Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. This may include physical contact both penetrative and non-penetrative, or viewing pornographic material including through the use of the internet. Indicators of sexual abuse include: allegations or disclosures, genital soreness, injuries or disclosure, sexually transmitted diseases, inappropriate sexualized behaviour including words, play or drawing. ***See also appendix 1***

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs which can significantly harm their health and development. Neglect can include inadequate supervision (being left alone for long periods of time), lack of stimulation, social contact or education, lack of appropriate food, shelter, appropriate clothing for conditions and medical attention and treatment when necessary. ***See also appendix 1***

Sexual exploitation of children

Sexual exploitation involves an individual or group of adults taking advantage of the vulnerability of an individual or groups of children or young people, and victims can be boys or girls. Children and young people are often unwittingly drawn into sexual exploitation through the offer of friendship and care, gifts, drugs and alcohol, and sometimes accommodation. Sexual exploitation is a serious crime and can have a long-lasting adverse impact on a child's physical and emotional health. It may also be linked to child trafficking.

A common feature of sexual exploitation is that the child often doesn't recognise the coercive nature of the relationship and doesn't see themselves as a victim. The child may initially resent what they perceive as interference by staff, but staff must act on their concerns, as they would for any other type of abuse.

All staff are made aware of the indicators of sexual exploitation and all concerns are reported immediately to the DLO who will follow the correct procedures. ***See also appendix 2***

Fabricated Illness

The fabrication or induction of illness in children by a carer has been referred to by a number of different terms, most commonly Munchausen Syndrome by Proxy (Meadow, 1977), Factitious Illness by Proxy (Bools, 1996; Jones and Bools, 1999) or Illness Induction syndrome (Gray et al, 1995). This terminology is also used by some as if it were a psychiatric diagnosis.

The use of terminology to describe the fabrication or induction of illness in a child has been the subject of considerable debate between professionals. These differences in the use of terminology may result in a loss of focus on the welfare of the child. In order to keep the child's safety and welfare as the primary focus of all professional activity, this guidance refers to the two Safeguarding children in whom illness is fabricated or induced 'fabrication or induction of illness in a child' rather than using a particular term. If, as a result of a carer's behaviour, there is concern that the child is or is likely to suffer significant harm, this guidance should be followed. The key issue is not what term to use to describe this type of abuse, but the impact of fabricated or induced illness on the child's health and development, and consideration of how best to safeguard and promote the child's welfare.

There are three main ways of the carer fabricating or inducing illness in a child.

Fabrication of signs and symptoms:

- This may include fabrication of past medical history;
- fabrication of signs and symptoms and falsification of hospital charts and records, and specimens of bodily fluids.
- This may also include falsification of letters and documents; induction of illness by a variety of means.
- Where families bring in medication staff should follow the correct ***Health procedure.***

In the guidance the term 'carer' is used to mean 'parent or carer', i.e. any adult who is exercising parenting responsibilities for a child. Those with parenting responsibilities may include, for example, grandparents, foster-parents, child minders, as well as those who have parental responsibility as defined in the Children Act 1989. In situations where a staff member is suspected of causing harm to a child by inducing or fabricating illness, the procedures set out in paragraphs 6.20 – 6.30 in Working Together (2006).

Children have varying needs which change over time. Judgements on how best to intervene when there are concerns about harm to a child will often and unavoidably entail reporting the concern. In most cases it is appropriate to seek consent, however, there are some cases where it is not. Consent should not be sought if doing so would: Place a person (the individual, family member, worker or a third party) at increased risk of significant harm. Refer to Somerset Direct following the regular procedure by completing a CRIFT which can be found at http://www.proceduresonline.com/swcpp/somerset/index.html Report a Concern. ***See also appendix 3***

Bullying

While bullying between children is not a separate category of abuse and neglect, it is a very serious issue that can cause considerable anxiety and distress. At its most serious level, bullying can have a disastrous effect on a child's wellbeing and in very rare cases has been a feature in the suicide of some young people. ***See also appendix 4 & Promoting Positive Behaviour Policy.***

Bruising in Pre-mobile Babies

Bruising is the commonest presenting feature of physical abuse in children. The younger the child the higher the risk that the bruising is non-accidental, especially where the child is under the age of six months. Bruising in any child 'not independently mobile' should prompt suspicion of maltreatment. An accident from home form will be completed immediately and will need be referred to your local Safeguarding board. ***See appendix 5, Child Protection Statement for contact details and Health Procedures Policy for the appropriate form.***

Children with sexually harmful behaviour

Children may be harmed by other children or young people. Staff will be aware of the harm caused by bullying and will use the setting's **Promoting Positive Behaviour procedures** where necessary. However, there will be occasions when a child's behaviour warrants a response under child protection rather than anti-bullying procedures. In particular, research suggests that up to 30 per cent of child sexual abuse is committed by someone under the age of 18.

The management of children and young people with sexually harmful behaviour is complex and the setting will work with other relevant agencies to maintain the safety of the provider. Young people who display such behaviour may be victims of abuse themselves and the child protection procedures will be followed for both victim and perpetrator. Anyone who becomes concerned about a child's sexual behaviour, including any known online sexual behaviour, should speak to the DLO as soon as possible. ***See also appendix 6***

Female genital Mutilation

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.
The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. In many settings, health care providers perform FGM due to the erroneous belief that the procedure is safer when medicalized[1]. WHO strongly urges health professionals not to perform such procedures.
FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death. ***See also appendix 7***

Radicalisation and Extremism

The government defines extremism as vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs.

Some children and families are at risk of being radicalised: adopting beliefs and engaging in activities which are harmful, criminal or dangerous. Islamic extremism is the most widely publicised form and providers should also remain alert to the risk of radicalisation into white supremacy extremism.
Staff receive training to help to identify signs of extremism. Opportunities are provided for children to discuss issues of religion, ethnicity and culture and the provider follows the DfE advice Promoting fundamental British Values as part of the Early Years Foundation Stage September 2014.

Further information on Preventing Radicalisation' has been included in *Keeping Children Safe in Education* in line with:

Prevent **Duty Guidance: for England and Wales*****,*** published in March 2015 as part as the UK's Counter Terrorism strategy. (p.10-15 for schools, registered childcare providers and further education).

The Prevent Duty, Departmental advice for schools and childcare providers, published in June 2015. This non-statutory departmental advice is for Management committees, proprietors, managers and staff in registered childcare settings. The document clarifies what the *prevent* duty means for schools and childcare providers and what actions are necessary to demonstrate compliance with the duty. It also provides sources of information, advice and support. ***See also British Values Policy***

Forced Marriage

A forced marriage is a marriage in which a female (and sometimes a male) does not consent to the marriage but is coerced into it. Coercion may include physical, psychological, financial, sexual and emotional pressure. It may also involve physical or sexual violence and abuse.
A forced marriage is not the same as an arranged marriage. In an arranged marriage, which is common in several cultures, the families of both spouses take a leading role in arranging the marriage but the choice of whether or not to accept the arrangement remains with the prospective spouses.
Children may be married at a very young age and well below the age of consent in England.   Staff receive training and should be particularly alert to suspicions or concerns raised by a child about being taken abroad and not be allowed to return to England.Since June 2014 forcing someone to marry has become a criminal offence in England and Wales under the Anti-Social Behaviour, Crime and Policing Act 2014. ***See also appendix 8***

See also:
Children Moving Across Local Authority Boundries ***- Appendix 9***
Children with Disabilities – Appendix 10