# BRITISH ASSOCIATION FOR PERFORMING ARTS MEDICINE

## Safeguarding of Children and Young People Policy & Practice

**December 2008**

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# 1. Introduction

BAPAM's **Mission** is

> To achieve the creation of nationwide occupational health provision for professional, semi-professional and student performing artists, including health promotion and education, and clinical advice for performance-related health problems.

As part of this mission, BAPAM offers clinical services nationwide to a wide variety of performing artists, a small number of whom are under the age of 18 years. These services are generally limited to clinical assessment and advice for performance-related medical problems, and health promotion and education. BAPAM does not offer treatment for medical problems, with the exception of occasional soft-tissue injections and courses of physiotherapy.

BAPAM is a small charity whose services are run by two full and two part time paid administrative staff, based in our London office, and a disparate group of volunteer clinicians in many centres throughout the UK. Volunteer clinicians include medical practitioners (especially GPs, Occupational Health Physicians, and Consultants in Rheumatology, Orthopaedics, ENT, and Psychiatry) and specialist Physiotherapists. These clinicians are authorised by BAPAM's Clinical Governance framework to deliver clinical services on behalf of BAPAM, through BAPAM Clinics and the AMABO scheme.

For the purposes of this policy, "Staff" includes all paid staff and volunteers, whether clinical or non-clinical, whenever they are working for, with, or on behalf of BAPAM, on BAPAM premises or elsewhere. It does not include members of BAPAM's two Directories (Directory of Specialists in Performing Arts Medicine or Directory of Practitioners) working in independent practice but seeing patients who have come to them via BAPAM.

## 1.1 BAPAM Policy Statement

This policy is binding on all staff as defined above.

BAPAM clinics will only see children over the age of 12 years for assessment and advice.

BAPAM recognises that:

- The welfare of children and young people is paramount (Children Act 1989) and that working in partnership with their parents, carers and other agencies is key to promoting this (Children Act 2004).

- All children and young people, whatever their age, culture, disability, gender, language, racial origin, religious beliefs, or sexual identity have the right to protection from abuse.

- All suspicions and allegations of abuse should be taken seriously and responded to swiftly and appropriately.

- All staff whether paid or voluntary should be provided with basic information and access to training on the safeguarding of children and young people.

- All staff whether paid or voluntary should be clear about their responsibilities, and develop awareness of the issues which can cause children harm.

- All staff whether paid or voluntary should be clear on how to respond to a concern about abuse appropriately and about what might happen after a concern is reported.

- It is not the role of staff to investigate possible child abuse. Only social workers, the NSPCC, and the police have statutory power to investigate when a child is considered to be at risk.

- Appropriate recruitment and selection procedures for staff and volunteers are required in the context of child protection.

- BAPAM's *Safeguarding Children Policy* will be reviewed and updated after one year, and subsequently every three years.

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## 1.2 What is a child/young person?

Throughout this policy the terms 'children' and 'young people' will refer to the following definitions:

**Child / Children** – In this document, as in the Children Acts 1989 and 2004, a child is legally defined as anyone who has not yet reached their 18th birthday. 'Children' therefore means 'children and young people' throughout. The fact that a child has reached 16 years of age, is living independently or is in further education, does not change his or her status under the Children Act 1989.

**Young people** – This term has no legal status but acknowledges that people aged 16 or 17 or in the upper age ranges of the official definition of a child may not think of themselves as 'children'.

## 1.3 The Designated Child Protection Person (DCPP)

The lead at BAPAM for Safeguarding Children (DCPP) is consultant paediatric orthopaedic surgeon, and BAPAM volunteer clinician, Mr. Rowan Pool.

If he is unavailable you should seek advice from the CEO, Naomi Wayne, or, if the CEO cannot be contacted, from the Medical Director, Dr Penny Wright.

Contact details for these people are as follows:

- BAPAM Office: 0207 404 5888
- Mr Rowan Pool: 01483 768051 (wk), 07909 960305 (m), 01344 868441 (h)
- Ms Naomi Wayne: 07803 614255 (m), 020 8318 6266 (h)
- Dr Penny Wright: 01285 821413 (h), 07969 224002 (m)

If none of the above are contactable, advice about a particular child/child protection concern can be obtained by ringing the Duty Social Worker for the area in which the child lives. The DSW can be contacted by ringing the relevant Town Hall and asking for the Local Authority Social Care Duty Team for Children and Families.

In any event the DCPP and CEO should be informed as soon as possible that advice from Social Care has been sought.

**<u>The role of the DCPP</u>** is as follows:

- Provide information and advice on child protection within BAPAM both in general matters and where a member of staff has a concern about a child;
- Advise BAPAM of child protection training needs;
- Know which child protection agency to contact in the event of a child protection concern arising within BAPAM;
- Liaise with *Children's Social Care* and other agencies as appropriate, including making a referral where this is required;
- Ensure that appropriate information is available at the time of any referral to *Children's Social Care*, and that the referral is confirmed in writing under confidential cover using a locally approved form if appropriate;
- Keep relevant people within BAPAM informed about action taken or required, including disciplinary action against a member of staff;
- Ensure that a proper record is kept of any concern, referral and action taken, and that this is kept in safety and confidence;
- Review the BAPAM *Safeguarding Children* policy regularly to ensure that the procedures are working and that it complies with current law and best practice.

## 2 Abuse and Neglect

### Key points

- Abuse and neglect are generic terms encompassing all forms of maltreatment of a child or young person
- Somebody may abuse or neglect a child or young person by inflicting harm, or by failing to prevent harm
- Children and young people may be abused in a family or in an institutional, community or educational setting, by those known to them or, more rarely, by a stranger
- They may be abused by an adult or adults, or another child or children
- There are four main categories of abuse:
    1) **Physical Abuse** – Hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm.
    2) **Emotional Abuse** – Persistent emotional maltreatment.
    3) **Sexual Abuse** – Forcing or enticing a child or young person to take part in sexual activities.
    4) **Neglect** - Persistent failure to meet basic physical and/or psychological needs.

    **For full definitions see Appendix 1.**

- **Domestic Violence** and its impact on children is a child protection issue. Domestic violence is considered as physical abuse where the child has been the victim of violence, and emotional abuse where the child has witnessed adult violence.

## 3 Procedure for reporting concerns: what to do if worried

**Key points**

- If you are worried that child abuse is or has been taking place, you should inform the DCPP and CEO (if she is present or can be reached) straight away
- If you are reporting a specific incident or worries about a specific child you should make a written record within 24 hours
- The DCPP will decide whether or not to refer the matter to the authorities
- If neither DCPP nor CEO is available, you should seek advice from the appropriate Duty Social Worker for the area in which the child lives (see 1.3)

### 3.1 The Law

The major law on child protection is contained in the Children Act 1989 which places local authorities under a statutory duty to investigate where they have reasonable cause to suspect that a child is likely to suffer 'significant harm'. *Children's Social Care* carries out these responsibilities on behalf of the local authority.

The Children Act 2004 provides a framework for 'safeguarding' children which includes an emphasis on integrated working and cooperation between agencies. The Act includes a duty to cooperate to improve the wellbeing of children, and a duty to put in place arrangements to safeguard and promote the welfare of children.

### 3.2 How to recognise Abuse and Neglect

There are several circumstances under which you might have concerns that a child or young person has been or is being abused:

- **Disclosure from a child or young person** – A child may tell you about abuse they have experienced either currently or historically.

- **Disclosure from a third party** - A parent, relative, carer, tutor or another child or young person may share their concerns with you.

- **Observation** - You may be concerned through observing one or more signs of abuse, including an injury for which there is no adequate explanation, or behavioural changes.

- **Colleague conduct** – There may be concern about the conduct of a colleague(s) when working with children or young people.

For a full list of indicators of abuse see appendix 2. The presence of an indicator is not proof that abuse has occurred, and, conversely, the absence of such an indicator does not mean that abuse has not taken place.

## 3.3 How to respond appropriately to a child making an allegation of child abuse

If a child or young person trusts you enough to tell you s/he is being abused in some way, however unlikely it may seem, it is very important to take this seriously: children almost never lie about abuse.

You should respond in the following ways:

- **Stay calm** – panic or anxiety will silence the child/young person
- **Reassure** the child/young person that he/she was right to tell
- Elicit enough information to know what to do next – no more than this. Where abuse is alleged, the initial response should be limited to **listening carefully** to what the child/young person says so as to clarify concerns.
- Allow the child/young person to **use his/her own words** and go at his/her own pace. The child/young person must **not** be pressed for information, led or cross-examined or given false assurances of absolute confidentiality.
- Find an early opportunity to **explain** that it is likely that the information will have to be shared with others, but only with other people who need to know about it in order to keep the child safe.
- Offer **re-assurance** that he/she will be kept safe and explain what action will be taken.
- If the child/young person can understand the significance and consequences of making a referral to *Children's Social Care*, he/she should be asked for his/her view. (For issues of consent to a referral to *Children's Social Care* see Section 5.2.3).
- Make a full **record** of what the child/young person has said at the earliest opportunity. (See section 3.8 on Record Keeping).
- You should immediately **inform** the DCPP and the CEO (if she is present or can be reached). The DCPP will decide what action to take. In the event that they are unavailable you should seek advice from the appropriate Duty Social Worker for the area in which the child lives (see 1.3). In any event the DCPP and CEO should be informed as soon as possible that advice has been sought from Social Care.
- You should consider the **safety** of that child, (and any other children/young people who might be involved), to be paramount, and take steps to ensure that safety if necessary, even if that means going against the wishes of the child/young person.

You should **not**:

- Promise to keep secrets.
- Ask in detail about the abuse – this is for *Children's Social Care* and/or the Police to investigate.
- Try to eliminate other alternative explanations prior to referral, for example of a suspicious injury. This is a matter for *Children's Social Care* or the police.
- Put pressure on the child if he/she is reluctant to speak.

## 3.4 What to do if worried about a child's immediate safety

- You should consider whether or not any child that you are concerned about is in immediate danger. You may have concerns, for example, about whether the child can safely return home. In these cases a Duty Social Worker must be contacted.

- You should, for example, take all reasonable steps to offer a child immediate protection from an aggressive parent/carer.

- In an emergency situation, for example if a child is in imminent danger, you should contact the police.

## 3.5 What to do if treatment is required for an injury

- If the child/young person requires treatment for an injury, arrangements must be made for them to attend A & E straightaway, and *Children's Social Care* and the duty consultant paediatrician must be informed. In an emergency phone 999. You must not transport children in your own car. Out of hours, the emergency Duty Social Worker should be contacted.

- Parents/carers must be contacted immediately if possible. Parents/carers should be informed of the specific symptoms or injuries which make it urgent that the child should attend A & E, but not that abuse is suspected.

## 3.6 Child Sexual Abuse

In cases where the child makes a disclosure of sexual abuse, or where there is a strong suspicion of sexual abuse, the procedure is slightly different.

- You must not question the child for further information. This is a specialist task and is the responsibility of *Children's Social Care* in conjunction with the police Child Abuse Investigation Team. Inappropriate (eg leading) questions can lead to vital evidence being inadmissible in court.

- You must immediately report concerns to the DCPP, and to the CEO if she is present or can be reached. The DCPP will discuss with the Duty Social Worker to decide what action to take.

- If neither the DCPP nor the CEO is available, you should take advice from the Duty Social Worker in the area where the child lives (see 1.3) and inform the DCPP and CEO as soon as possible.

- Concerns should NOT be discussed with parents before being reported, because one or more parent may be involved.

- You must record your concerns as soon as possible and record details of disclosures verbatim. These records may be used as evidence in court.

- If a decision is made to investigate, a social worker and possibly the police Child Abuse Investigation Team are likely to visit to discuss the matter.

## 3.7 Barriers to Disclosure

Staff

Be aware that you may find it hard to realise that child abuse is taking place, for any of the following reasons:

- Finding it hard to believe what you are hearing
- Fear of being mistaken
- Anxiety about starting a process which may lead to the break up of a family
- Ignorance about what might happen next
- Anxiety that the matter is trivial
- Interpreting abuse of one child or young person by another as 'normal'.

Children and young people

It is rarely easy for a child or young person to disclose that they are being abused. Factors which can inhibit a child/young person telling about abuse are:

- Being unable to recognise the abusive experience as abuse, having been bribed or tricked into acquiescence
- Not having the language to explain what is happening to them
- Being scared because they've been threatened
- Belief they will be taken away from home
- Belief they are to blame
- Feelings of embarrassment
- Not wanting the abuser to get into trouble

## 3.8 Record Keeping

Staff, whether clinical or non-clinical, should make a written record of the allegation/incident/suspicion as soon as possible and definitely within 24 hours.

It's important that all concerns are properly recorded and that the account is kept factual. It should include the name, address, and age of the child/young person; date and time of alleged incident; description of incident, preferably using the child's own words, and any visible sign of injury.

If available, the name and address of adults involved and their version of the incident can be included. Staff should not pursue the questioning of a child/young person for this information if it is not given freely.

Your *opinions* or those of other staff may be helpful but must be clearly recorded as opinions.

Record any actions taken, for example whether the DCPP has been informed, and also state with whom the information has been shared (for example parents, carers, other staff, educational personnel and *Children's Social Care* workers).

The record should be dated and signed by the person recording the incident. It should then be attached to the child/young person's Medical Record and stored securely according to BAPAM's Medical Records Policy and the Data Protection Act.

## 3.9 Summary: Key principles of safeguarding children and young people

Respond

Reassure ⇨ Record ⇨ Report ⇨ (Refer)

**Respond** to the situation – do not ignore your concerns

**Reassure** the child / young person without promising to keep secrets

**Record** concerns as soon as possible signing and dating your notes

**Report** concerns to the DCPP, and to the CEO if she is present or can be reached.

**Refer** – The DCPP will ultimately decide whether or not to refer concerns to *Children's Social Care,* or what other action to take. Should the decision be made NOT to refer concerns to *Children's Social Care* then the reasons for that decision must be explained and recorded in writing by the DCPP.

## 4 Referral to *Children's Social Care*.

The following circumstances may indicate that an immediate referral is required by the designated person:

- The child/young person has told someone he/she is being abused
- The child/young person has a suspicious injury for which there is no satisfactory explanation
- There are concerns and the child/young person is afraid to return home
- The child/young person (or another e.g. sibling) is at immediate risk
- A child/young person has abused another child/young person
- Medical treatment is required
- There is a concern about Child Sexual Abuse

**Making a referral**

- If staff report a concern to the DCPP and referral is required, it should be made by phone within the same working day.
- Children (or their parent if they lack the capacity to consent) should be asked for their consent to referral, but referral can be made without consent in order to safeguard the child. See Section 5, especially Section 5.2.3.
- Referrals should be confirmed in writing within 48 hours. In some areas, this may involve the use of a locally approved form, which would be supplied by the relevant Duty Social Worker. *Children's Social Care* should acknowledge a written referral within one working day of receiving it; so if you haven't heard back within 3 working days, contact the relevant Social Care service again.
- Referrals should generally be made to the *Children's Social Care* duty officer of the area where the child/young person is living, unless specific arrangements exist otherwise.
- In urgent situations, out of office hours, the referral should be made to the Emergency Duty/Out of Hours Team.
- If the child/young person is known to have an allocated social worker, referrals should be made to her/him or in her/his absence to the manager or a duty officer.
- It is important when reporting any incident that a social worker or social work manager from *Children's Social Care* is spoken to directly. Referrals should not be passed to clerical or administrative staff. The designated person who refers the incident / allegation should record whom they spoke to and the proposed action by relevant Social Care service / police.

# 5 Consent and Confidentiality

## 5.1 CONSENT

This is about a young person's right and ability to make decisions on their own behalf, and includes consent to both treatment and medical investigation. (Issues involved in seeking consent for referral to *Children's Social Care* are dealt with in Section 5.2.3 below.)

**General Principles**

- At 16 it is legally presumed that a child has the ability to make decisions about his/her own care i.e. at 16 a child is presumed to *have the capacity to consent.*
- Under 16, a child *may* have the capacity to consent, depending on their maturity and the complexity of what they are being asked to understand.
- Assessing capacity to consent must be done on an individual basis by the practitioner involved. If you are uncertain about a child's capacity, you should seek advice from the DCPP.
- Assessing capacity involves assessing the child's ability to understand the nature, purposes and consequences of any investigation or treatment. Only if they are able to understand, retain, use and weigh this information, and communicate their decisions to others do they have capacity to consent.

If a child is under 16 and lacks the capacity to consent, a parent must consent on their behalf.

**Parental Responsibility**

This always rests with mothers. Fathers who were married to the mother at the time of the child's birth also have parental responsibility, and even if they divorce or separate both parents retain parental responsibility. Unmarried fathers, married step-fathers, or registered civil partners, can *acquire* parental responsibility via the courts (Parental Responsibility Order). [NB Unmarried fathers of children born after 1.12 03 automatically have parental responsibility if named on the child's birth certificate.]

Where parental consent is required, the consent of one parent is sufficient. In situations where family members are in conflict, you should seek the advice of the DCPP to decide whose consent should be sought.

## 5.2 CONFIDENTIALITY

You have the same duty of confidentiality to children as to adults. However the law permits disclosure of confidential information without consent if it is necessary in order to safeguard children.

### 5.2.1 Sharing information with parents

Children should always be encouraged to involve their parents in decision making, but you should abide by any decision they have the capacity to make themselves, even if a parent disagrees. Children who lack capacity to consent must have parental consent to medical investigation and treatment, in any event.

### 5.2.2 Access to medical records

- Children with capacity have the legal right to access their own medical records, and can allow or prevent access by other people, including their parents.
- You should let parents access their child's records if the child consents, or lacks capacity to consent, *and* it does not go against the child's best interests.
- When a request is received to access a child's medical record, the clinician involved is responsible for ensuring compliance with the above criteria and requests to paid staff should therefore be referred to the clinician involved.
- Access is governed by BAPAM's Access to Medical Records Policy, including the recording of all requests to access medical records in the Access to Medical Records Register.
- If a child requests help in understanding the content of their medical record, suitable arrangements must be made.

### 5.2.3 Sharing information with other people, including *Children's Social Care*

Confidential information about a child should not normally be disclosed to *any* third party without the consent of the child, or, if the child lacks capacity, of the parent. However the safety of the child, or other children, can override this general principle, allowing BAPAM staff to disclose otherwise confidential information without consent if necessary. Indeed a child protection concern may only become apparent on sharing information with other agencies, particularly *Children's Social Care.*

If confidential information is disclosed, it should be limited to information that is relevant, and only disclosed to those who have a need to know. Situations in which this might arise include referrals by BAPAM to *Children's Social Care* and requests from *Children's Social Care* for information about a child who has previously been seen at BAPAM.

Where a child protection concern arises in BAPAM, the following must be observed:

- it should be explained to the child what information needs to be shared, with whom and why, and their consent should be sought if they have the capacity to give it. However it should also be made clear to them that some information might have to be shared against their wishes (for example, a referral to *Social Care*) if their safety is endangered.
- If a child lacks capacity to consent, and the parent withholds consent to sharing information, again explain that information necessary to protect the child or other children might have to be shared without consent.
- If you are concerned that a parent may be responsible for abuse, or might try to silence or harm the child, you should NOT inform the parents, but seek advice from *Children's Social Care* about how to proceed.
- If a child makes an allegation of sexual abuse, concerns should NOT be discussed with parents before being reported (see Sec.3.6)
- If a request for information is received from *Children's Social Care* as part of a child protection investigation, confidential information may be disclosed without consent, if it is in the interests of the safety of the child or other children. Disclosure must be on a need-to-know basis both in respect of the information disclosed and the person to whom it is disclosed.

  NOTE that while it is not obligatory to secure consent to disclose (confidential) information about a child on receipt of a request from *Children's Social Care*, BAPAM regards it as a matter of good practice, at least to seek such consent.
- Liaison with a conservatoire or educational institution must only occur with the consent of the child, or parent if the child lacks capacity. If there is a child protection concern, BAPAM's responsibility is to refer to *Children's Social Care* and they will in turn liaise with other agencies as appropriate.

**NOTE: All requests for information about a child from third parties should be discussed with the CEO.**

## 6 What happens after a referral has been made?

It is the responsibility of the DCPP to ensure that BAPAM personnel involved in a referral to *Children's Social Care*, and any others who may be affected, are fully briefed about what may happen next, and are supported in respect of any concerns they may have, either about the child in question, or their own or a colleague's position.

It will, additionally, be stressed that a confidentiality policy and 'need to know basis' of sharing information must be observed. No matter how distressed BAPAM personnel may be, the dignity and right to some privacy of the victim/s (and sometimes the accused abuser) should be paramount.

## 7 Recruitment and selection procedures for staff and volunteers

Appropriate recruitment and selection procedures for staff and volunteers who may have unsupervised contact with children whilst engaged in work for BAPAM, have been adopted, and include the following:

- Provision of statements of job context, duties and skills/experience requirements in respect of paid staff members (Staff handbook) and clinic and AMABO volunteers (Clinical Governance Policy, Appendices 1 & 8)
- Procedure for confirmation of identity and disclosure of previous convictions
- Conduct of formal checks re CRB and List 99 (the list kept by the Department for Children, Schools and Families of those barred from working with children)
- Procedure for annual reconfirmation of volunteers' Qualification/Registration
- Interview/vetting procedures as appropriate
- Procedure for securing references.

See BAPAM Staff Handbook and BAPAM Clinical Governance Policy for all the above

Note: members of BAPAM's Specialist and Practitioners Directories who work in independent practice and do not provide clinical services directly for BAPAM, are not covered by this policy, but are asked to provide evidence of appropriate professional registration with a recognised body on an annual basis

## 8 Staff training in Child Protection

Basic in-house training on child protection, and an introduction to BAPAM's Safeguarding Children Policy, will be provided to paid staff at the start of their employment, and at 3 yearly intervals, by the DCPP.

All professional clinical volunteers will be sent a copy of BAPAM's Safeguarding Children Policy on joining BAPAM, and invited to join in-house training sessions. The Policy document will be made easily accessible at all BAPAM Clinic venues.

## 9 Allegations against staff

BAPAM will be guided by *London Safeguarding Children Board* Child Protection Procedures Chapter 15. As BAPAM is a national organisation with a London base, it will apply this guidance nationally.

If an allegation of abuse is made against a member of staff, or if a member of staff is concerned about the behaviour of a colleague, the DCPP and CEO must be informed straight away (unless the allegation or concern involves either of those people). The DCPP and CEO will decide what further action should be taken and will consider both internal disciplinary procedures and referral to *Social Care*. In the case of volunteer healthcare professionals, referral to the General Medical Council or other professional regulatory body will also be considered.

## 10 Research

Children and young people should not be involved in research unless research on adults cannot provide the same benefits. Before involving children in research, advice must be taken and ethics committee approval secured.

## 11 Complaints

Children's complaints must be taken seriously and they must be helped to complain if necessary. A separate complaints form for children is available.

# Appendix 1: Forms of Abuse and Neglect

# BACKGROUND INFORMATION

## 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.

## Emotional Abuse

Emotional abuse is 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 a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectation 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, 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.

## Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities or encouraging children to behave in sexually inappropriate ways.

## 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 or development. Poverty is not the same as neglect, but it may affect ability to meet a child's needs. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing and 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.

## Wilful Neglect

Wilful neglect is persistent ill treatment or neglect of a person who lacks the mental capacity to be able to make and understand a particular decision at a particular time

# Appendix 2: Indicators of Abuse and Neglect

In an abusive relationship the child may:

- Appear frightened of the parents
- Act in a way that is inappropriate to their age and development (though full account needs to be taken of different patterns of development and different ethnic groups)

The parent or carer may:

- Persistently avoid health promotion services and treatment of any illnesses in the child
- Have unrealistic expectations of the child
- Frequently complain about/to the child and may fail to provide attention or praise (high criticism/low warmth environment)
- Be absent or misusing substances
- Be involved in domestic violence

## Recognising Physical Abuse

The following are often regarded as indicators of concern:

- An explanation, which is inconsistent with an injury
- Several different explanations provided for an injury
- Unexplained delay in seeking treatment
- The parents/carers are uninterested or undisturbed by an accident or injury
- Parents or carers are absent without good reason when their child is presented for treatment
- Repeated presentation of minor injuries (which may represent a 'cry for help' and if ignored could lead to a more serious injury)
- Family use of different doctors and A&E departments
- Reluctance to give information or mention previous incidents

## 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 following may be indicators of emotional abuse:

- Developmental delay
- Abnormal attachment between a child and parent/carer e.g. anxious, indiscriminate or no attachment
- Aggressive behaviour towards others
- Scapegoated within the family
- 'Frozen watchfulness' (mainly in pre-school children)
- Low self-esteem and lack of confidence
- Withdrawn or seen as a 'loner' – difficulty relating to others

## Recognising Sexual Abuse

Children and young persons of all ages may be sexually abused and are frequently scared to say anything because of guilt and/or fear. This is particularly difficult for children and young people to talk about and full account should be taken of the sensitivities of any individual and their family.

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

Some behavioural indicators associated with sexual abuse are:

- Inappropriate sexualised conduct
- 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
- Involvement in prostitution or indiscriminate choice of sexual partners
- An anxious unwillingness to remove clothes for e.g. sports events (though note that this may be related to cultural norms or physical difficulties)

Some physical indicators associated with sexual abuse are:

- Pain or itching of genital area
- Blood on underclothes
- Pregnancy in a younger girl where the identity of the father is not disclosed
- Physical symptoms such as injuries to the genital or anal area, bruising to buttocks, abdomen and thighs, sexually transmitted disease, presence of semen on vagina, anus, external genitalia or clothing

## Recognising Neglect

Evidence of neglect needs to be built up over a period of time and can cover different aspects of behaviour by parents & carers. Indicators include:

- Failure by parents or carers to meet the basic essential needs e.g. adequate food, clothes, warmth, hygiene and medical care.
- A child is seen to be listless, apathetic and unresponsive with no apparent medical cause.
- Failure to grow within normal expected pattern, with accompanying weight loss.
- Child thrives away from home environment
- Child frequently absent from school
- Child left with adults who are intoxicated or violent
- Child abandoned or left alone for excessive periods

## Appendix 3: CONTACT INFORMATION FOR BAPAM'S LONDON CLINICS (HELD IN THE LONDON BOROUGH OF CAMDEN)

### LB CAMDEN SAFEGUARDING & SOCIAL CARE OUT OF HOURS

Emergency Duty Team (9am – 5pm):
0207 974 1621

Out of Hours (5pm – 9am):
0207 278 4444 (Town Hall)

### LB CAMDEN SAFEGUARDING & SOCIAL CARE

**CROWNDALE CENTRE –** *Safeguarding and Social Care (South)*
218 Eversholt Street, London NW1 1BD

Duty & Assessment Team - 0207 974 4094

NOTE: BAPAM clinics around the country will need to refer to the *Children's Social Care* services provided by the local authority where the child/young person resides.

For details of other local authorities please see www.local.communities.gov.uk or phone Directory Enquiries