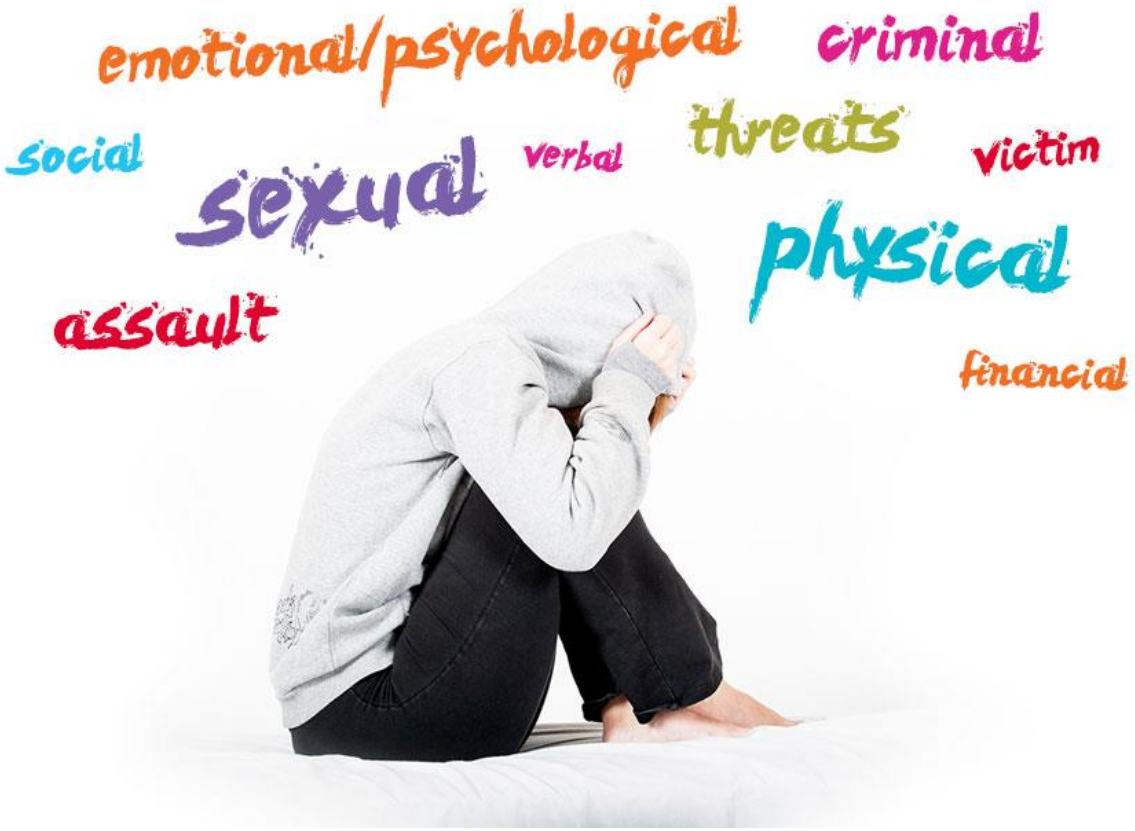
SIGNS, SYMPTOMS & CONSIDERATIONS OF ABUSE

CB Childcare Consultancy (CB) A Guidance document, NOT a definitive list

A toolkit researched and collated by CB, with thanks to the contributions from front line professionals attending Cornwall Multi-Agency child protection training and additional specialist input from Lorraine Faulkner; Designated Safeguarding Lead, Pencalenick School and Tabi Fergus; Practice Development Nurse Child Health, Royal Cornwall Hospital (formerly Treliske). Highlighted in blue are contributions from Pencalenick School, considering factors for those working with disabled children…



INTRODUCTION

The aims of this CB document is to help professionals identify signs and symptoms which may indicate child abuse. The identification and confirmation of child abuse is rarely simple, this document should be viewed as a guide and **not** a blueprint as to whether abuse has taken place. We have undertaken research through a range of resources and worked in partnership with specialist agencies in Cornwall where necessary to be able to include additional considerations (please see front page for acknowledgements). In addition, we have included collated feedback from activities we have facilitated through the delivery of multi-agency child protection training days, creating a truly organic document in partnership with front line professionals within Cornwall, for the benefit of colleagues in Cornwall.

A DEFINITION OF "CHILD ABUSE"

An abused child is a boy or girl under the age of 18 years who has suffered physical injury, neglect emotional or sexual abuse which the person or persons who have custody of the child either caused or knowingly failed to prevent.

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.

(Definition provided by Working Together March 2015)

A child is considered to be abused or at risk of abuse when the basic needs of that child are not being met through avoidable acts of either commission or omission by parents or carers.

Whilst understanding child abuse, those working with disabled children need to also follow the link to specific practice guidance: https://www.gov.uk/government/publications/safeguarding-disabled-children-practice-guidance and for specific procedures go to the South West Child Protection Procedures; http://www.proceduresonline.com/swcpp/cornwall_scilly/p_disabled_ch.html

THE CONCEPT OF SIGNIFICANT HARM

The concept of "significant harm" was introduced by the Children Act 1989 as the threshold for intervention in family life for the protection of children. No specific criteria exists to follow, but it is crucial to use sound assessment methods to consider all factors throughout the identification of the severity of ill-treatment; the degree and extent of physical harm and the duration and frequency of abuse and neglect.

According to Working Together, significant harm refers to "the threshold that justifies compulsory intervention in family life in the best interests of children, and gives LAs a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or likely to suffer significant harm".

The legislation, however, does not define the line between 'harm' and 'significant harm'. As a practitioner, you should give 'significant' its ordinary meaning (i.e. considerable, noteworthy or important). The child's particular characteristics also need to be taken into consideration. For

example, a child left home alone at the age of 3 could be at risk of significant harm, whereas a child aged 13 years may be less likely so. The test will be subjective to the particular circumstances.

Whether the harm is significant is determined by comparing the child's health and development with what could reasonably be expected from a similar child. For example, if a child is failing to meet developmental or physical milestones, it is necessary to determine whether this is the result of a lack of "good enough" parenting. There is no clearly defined criteria to judge whether harm meets the threshold of 'significant'—it can be the result of a traumatic event or a compilation of acute and long-standing events. As highlighted in Working Together, "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."

Working Together lists the following as factors to consider in understanding and identifying significant harm:

- The nature of harm, in terms of maltreatment or failure to provide adequate care;
- The impact on the child's health and development;
- The child's development within the context of their family and wider environment;
- Any special needs, such as a medical condition, communication impairment or
- disability, that may affect the child's development and care within the family;
- The capacity of parents to meet adequately the child's needs; and
- The wider and environmental family context.

EARLY HELP AND EMERGING SAFEGUARDING CONCERNS

All organisations should work to the Early Help protocol in Cornwall (Cornwall Early Help Strategy and Neglect Strategy) which aims to ensure that services to support children, young people and their parents are there when they need them. Early Help is about identifying problems at an early stage and providing purposeful and effective help as soon as possible once they have been identified, working with families to solve those problems before they get worse.

You should use the Threshold Tool as a guide to identify the four levels of need and appropriate service intervention to ensure families are referred to services in a timely way to reduce the need for a child protection referral. Your Locality Team Early Help Co-Ordinator contact details are available on: www.cornwallfisdirectory.org.uk/integratedworking/localityteams.

Emerging safeguarding concern referrals will be either through a request for service support through the Early Help Hub or initiation of an Early Help assessment, where a child may have additional needs that cannot be met solely by universal services *and where there is no perceived risk of significant harm*. **Early Help Hub advice/consultation line: 01872 322277** (www.cornwall.gov.uk/earlyhelphub) with consent from the parent or primary carer with parental responsibility or the young person aged over 13 years where they are deemed to be competent to do so (follow Fraser Guidelines www.nspcc.org.uk). To access a copy of the Early Help Strategy, follow this link: www.supportincornwall.org.uk/kb5/cornwall/directory/site.page?id=ZCjt2hiYx4w

If you are concerned about a child's well-being at a higher level of need call the Multi-Agency Advice Team on 0300 123 1116 without delay.

CONFIDENTIALITY

In all matters relating to Child Protection the highest degree of confidentiality must be maintained. However, this has to be balanced against the need to protect children from significant harm. Children who disclose abuse need to know that the information will be passed on to the appropriate statutory agency, either the Social Services (via the **Multi-Agency Referral Unit 0300 123 1116**) or the Police so that it can be properly investigated and to guarantee that the necessary help is obtained. Information must not be passed on to any other individual or organisation, unless in the event of the need to protect a child, in which case MUST be shared securely.

If there is a conflict of interest between the needs of a child, who is suspected of suffering significant harm, and the needs of an adult, the welfare of the child is paramount.

POSSIBLE SIGNS AND SYMTOMS OF PHYSICAL ABUSE

DEFINITION OF 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.
(Source: Working Together to Safeguard Children March 2015 Appendix A: Glossary)

SHAKEN BABY SYNDROME (SBS)

SBS is a form of abusive head trauma and inflicted traumatic brain injury, it is a severe form of physical child abuse and is the consequence of aggressively and repeatedly shaking an infant by the shoulders, arms or legs. The resulting whiplash effect can cause…

- Inconsolable crying (primary trigger)
- Bleeding within the brain or the eyes
- The child may appear floppy and unresponsive
- Sudden severe vomiting
- Appear to have a bulging fontanel
- It has been stated that 1 in 4 victims lose their life (see serious case reviews in appendix)

BRUISES

All children, especially toddlers, obtain injuries from time to time, and the vast majority of those injuries are accidental, even those which are unexplained. Some features should alert us when identifying the possibility of a non-accidental injury:

- There may be a delay in seeking medical help or such help may not have been sought at all.
- The account of the accident may be vague or may vary from one telling to another. Parents reliving a genuine accident will usually tell a detailed vivid story.
- The parents may be more concerned about their own problems than about the child's injury, and they may be hostile and leave before the discussion is finished.
- The interaction between the child and parents may be abnormal and the child may appear sad, afraid or even withdrawn (frozen watchfulness).
- The child may be unwilling to say what has happened while the adults are present. Given a safe environment the child may well give an accurate account of the incident.
- A child with a disability may be unable to say what has happened.

- The child's disability may be used by the abuser as an explanation for bruising and non-accidental injury either because of challenging or self-injurious behaviour by the child or because of athetoid (*cerebral palsy or dyskinetic cerebral palsy (a type of cerebral palsy primarily associated with damage, like other forms of CP, to the basal ganglia in the form of lesions that occur during brain development due to bilirubin encephalopathy and hypoxic-ischemic brain injury*) or uncontrolled movements.

Bruises identified on a non-mobile child (unless a medical professional has identified a vitamin D deficiency) should present immediate warning signs in addition to the location of the injury and the need for medical examination to detect the possibility of further injury. For further guidance for injuries on non-mobile children please follow: http://www.proceduresonline.com/swcpp/cornwall_scilly/p_bruising.html.

There may be discrepancies between the injuries and the story given, or the explanation may even be impossible, for example a four-week-old baby with facial bruising could not have been injured whilst falling over because they are physically unable to sit up. Bruising to areas including cheeks, ears, palms, feet, back, buttocks, tummy, hips and back of legs are all sites associated with child abuse.

Practitioners should be aware, however, that the ageing of bruises is not an exact science; as they age, bruises change colour from red to blue and through brown to yellow, but the timing of these changes vary from one individual to another and from one site to another.

- There may be a series of different marks or bruises suggesting repeated injury. Repetition and quantity increases the likelihood that the injury was not accidental.
- The pattern of bruises may suggest that a particular implement was used: slap marks, fingertip bruises and the imprint of weapons are commonly seen. Fingertip bruises on the upper arm or chest wall may suggest that the child has been held tightly and then shaken. In this situation, the fragile blood vessels in the eyes and on the surface of the brain may be torn. Examination by a paediatrician may then reveal retinal haemorrhages, rib fractures and subdural haematomas. This constitutes a medical emergency.
- The site of bruising may give cause for concern. Accidental bruises commonly occur over bony prominences; bruising on other sites is more suspicious. Fresh or healed tears of the frenulum of the upper lip are caused by a blow to the mouth or by a feeding bottle being forced into the moth. Such injuries seldom occur accidently.

BURNS AND SCALDS

Burns, scalds and bruises are often particularly difficult to discuss for children who have been abused due to the emotional associations. Neglected children are more prone to accidental burns whereas physically abused children may be deliberately burned.

Parents who have accidentally burnt their child may display a defensive and guilty attitude, although they do continue to demonstrate appropriate concern and compassion for the child.

FRACTURES

In young children fractures should be great cause for concern, it has been suggested that as many as half of all fractures under the age of two years are non-accidental. Spiral fractures of long bones in babies are especially suspicious as are rib fractures. Spiral fracture suggest a pulling and twisting force which would be an unusual mechanism in an accident to a non-mobile infant, however for older children this may be a likely accident. Rib fractures often indicate that a young child's chest wall has been violently squeezed.

In the event of a fracture a child may demonstrate great unwillingness to use the affected area. If questioned the parent may respond with inconsistent, unrealistic or even an impossible explanation, which as the child matures may hugely differentiate from their personal account.

FABRICATED OR INDUCED ILLNESS BY MAIN CAREGIVERS

This describes a situation where a parent or carer fabricates or cause illness in their child. There are three main types of fabricated illness: verbal fabrication; tampering with chats and specimens and producing physical signs to suggest illness. By the time of diagnosis, the child's apparent ill health may have been a problem for months or even years.

Typical symptoms include seizures, spontaneous bleeding (mouthy, ears or urine), not breathing for short period of time, diarrhoea and fever. If left untreated or unnoticed, the problem is likely to escalate and lead to serious effects on the emotional health of the child, including the uncertainty and confusion into their personal health concerns.

For parents of disabled children, there may be denial of or failure to administer medication or treatment which a child might need to maintain their health or manage a medical condition. This is especially pertinent for children with severe or profound disabilities who are wholly dependent on their primary carers.

CHILD BEHAVIOUR

Insecure attachment to their main caregiver is likely. Recognisable fear and anxiousness of the parent may be apparent from the child's sudden mood alteration, body language and so on. They may be unable to make or maintain eye contact, accept praise due to a low self-esteem, display a variety of facial expressions (frozen watchfulness) and emotions, or demonstrate limited capacity to effectively partake in play situations – inappropriate boundaries, aggressive language and acts of excessive violence may be apparent throughout play. The child may lack social skills and appear introverted, they may fixate on possessions and are at risk of developing eating disorders or harming themselves. Although eager to please, the child may have personal space issues and fear of exposure, for example having to change for P.E. professionals may have identified the child's limitations or delay in reaching developmental milestones and failure to thrive, without a medical explanation. Later in life the young person may not demonstrate the ability to form successful relationships and eventually become a perpetrator themselves (peer on peer abuse/domestic abuse).

PARENTAL BEHAVIOUR

Parents who are mistreating their children commonly delay/avoid seeking medical attention or advice upon their child's health. Their admission of punishment may appear excessive, for example a mother punishing (shouting and smacking) her 6-month old daughter for having a wet nappy, after she had been sat on a potty for 30 minutes prior. Multi-Agency professionals may begin to notice

that the child is becoming increasingly isolated e.g. poor attendance at school, due to the parents' protection of the supposed signs and symptoms.

Additional feedback from activities at Cornwall Multi-Agency Child Protection Training

Possible signs and symptoms of physical abuse will vary with age.

Physical abuse can be more common when parents drink or misuse substances.

For many reasons the child will be increasingly absent from school.

The child might become very aware of their surroundings and come to be very watchful.

Child may appear reluctant to remove clothing or wears inappropriate clothing to cover up sites of injury.

Non Accidental Injury's (NAI's) become apparent.

Behaviour with other children may become aggressive (see peer on peer abuse).

Parents may fabricate illnesses in children for personal benefits or through their need to gain attention.

Bruises on inner arms especially on children with mobility issues are indicative or push or pulling injures.

Children with disabilities who are not able to communicate either verbally or via other means are dependent on higher levels of awareness and knowledge of the child by adults who care for them on a daily basis.

Health Professionals Only

Thumb shaped bruises to the xiphisternum, turn baby/ child over, often finger shaped bruising down the back – indicative of shaken baby- child must have full skeletal survey.

Thumb shaped bruise on one cheek, finger shaped on the other – check for intra oral injures.

Baby/Child presenting with breathing difficulties may have broken ribs.

Non accidental burns will often present in a gloving or socking pattern- burn is cut off in a line like a glove or sock, child unable to fight against perpetrator so no splash marks as expected in an accidental burn.

Bruised ears are a red flag as are within the triangle of safety (area around side of neck and ear – difficult to injure in an accident) often affected by blows to the head or slap/slam injuries.

A child whose condition gets better under surveillance and worse at home or present on multiple occasions with no findings or unexplained unusual findings MAY be due to fabricated illness- 90% of perpetrators are mothers, usually with some medical knowledge themselves. Do not directly confront – seek medical and safeguarding assistance as escalation of abuse is likely. Samples are often contaminated so a witnessed sample is advised.

Adult hands make large bruises on a child's face and body – they are often blamed on cot sides, toys, falling mobiles etc. Think about the size an adult hand makes on a small face.

Babies and children who are distressed or uncomfortable must be properly examined – they may have injuries.

POSSIBLE SIGNS AND SYMTOMS OF EMOTIONAL ABUSE

DEFINITION OF 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 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 of 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 development 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 cyberbullying), 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.

Source: Working Together to Safeguard Children March 2015 Appendix A: Glossary

COMPONENTS OF EMOTIONAL ABUSE

1. Rejecting the child
2. Isolating the child
3. Terrorising the child
4. Ignoring the child
5. Corrupting the child

There are tremendous variations in the delivery of care and parenting. The most important aspects of emotional abuse are the effects on children and the consequence for them. Those effects and consequences are diverse and vary significantly with age. Some parents of children with disabilities may struggle with acceptance of their child. They may feel disappointed, angry or 'cheated' that they have a child who is different. Parents may struggle to form positive emotional bonds to children with profound disabilities or life limiting conditions. The practical aspects of caring for a child with disabilities and high levels of need may impact on the relationship between parent and child.

Conversely the parents/parents may put all their energies into supporting and caring for the child with disabilities to the detriment of siblings.

INFANTS

Lack of encouragement shown towards infants can result in the impairment of social and psychomotor skills; infants can appear withdrawn with developmental delay. They may appear anxious and avoid attachment to their main caregiver. They may cry for prolonged periods of time or display little emotion (frozen watchfulness).

Infants may indulge in acts of self-stimulation (banging of the head or rocking movements); there may be noted lack of social responsiveness and appear emotionally absent from life experiences.

PRE-SCHOOL CHILDREN

At the age where language development is at its most sensitive, emotional abuse can result in significant delay in language acquisition and, in severe cases, the child may be effectively mute or non-communicative. Behavioural problems are also common, and may be manifested as a reduced attention span, which often goes along with hyperactivity and professionals could otherwise identify this as a child with challenging behaviour. Emotionally abused child may show significant growth and

emotional delay. Children may be aggressive, especially towards their peers (see peer on peer abuse), and may at other times be significantly withdrawn, lacking natural exploration and curiosity to play. A lack of selective attachment is quite frequently seen, and inappropriate physical contact to strangers, even in the presence of the main carer, is common.

SCHOOL-AGE CHILDREN

Learning difficulties are a manifestation of emotional abuse in this age group, with poor concentration and significant over-activity. Such children may be disruptive in schools, and may also show behavioural abnormalities such as aggressive, or inappropriate or unusual patterns of defecation in urination. These children often have low self-esteem and/or depression, which in its mildest form shows very poor social interaction and may result in other behaviour patterns, such as repetitive rocking, self-mutilation or masturbation.

The vulnerable children are often rejected by fellow peers and susceptible to bullying, being deemed as being an 'attention seeker'. Due to their emotional turmoil schooling and education is likely to be lacking in terms of attendance, performance and educational attainments. Poor attendance needs to consider the wider needs of the family in terms of safeguarding. Later in life they may suffer with mental health issues resulting in self-harming or eating disorders, forever experiencing the inability to trust and form successful relationships.

As with neglect, if the abuse is substituted by sensitive care and displays of appropriate emotions (usually in an alternative environment), there is a rapid and dramatic improvement in growth, developmental attainment, behaviour and social and emotional adjustment.

ATTACHMENT DISORDER

Attachment is the deep and enduring connection established between a child and main caregiver in the first several years of life. It profoundly influences every component of the human condition – mind, body, emotions, relationships and values.

Children who begin their lives with compromised and disrupted attachment due to irregular or inconsistent responses from their primary caregiver are at risk of serious problems as development unfolds:

- Low self-esteem
- Needy, clingy or pseudo-independent
- Lack resilience when faced with stress or adversity
- Lack of self-control
- Unable to develop and maintain friendships
- Aliened from and oppositional with parents, caregivers and other authority figures
- Antisocial attitudes and behaviours
- Aggression and violence
- Difficulty with genuine trust, intimacy and affection
- Negative, hopeless and pessimist views of self, family and society

- Lack empathy, compassion and remorse

Additional feedback from activities at Cornwall Multi-Agency Child Protection Training [redacted]

Infants are at a higher risk of the impact of a parent suffering post-natal depression.

With the lack of emotional comfort, the infant will be passive and quiet and often non interactive with the parent.

Pre-school children's development in learning may be delayed. Children could be socially inactive, lacking engagement and failing to make new friendships because of confidence issues. Other signs may include, the inability to try new things, ask for help and to accept praise.

Bed wetting is also a sign of emotional abuse and is apparent at all ages.

Children may isolate themselves from others, thus relationship and friendship issues will occur. Child may obtain inappropriate relationships, for example, with much older individuals.

Children kept at home to care for parents, other children.

Children who do not attend any after school activities, or go to others houses for tea, or parties.

Children from homes where there is domestic violence will often show a loyalty to their abuser or may not want to get things wrong so can be the best behaved children at school – they are often reluctant to leave the home environment as they feel they keep the environment safer.

Child may experience psychological issues because of fear, for example, blurred boundaries between fact and fiction.

POSSIBLE SIGNS AND SYMPTOMS OF NEGLECT

DEFINITION OF 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. 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); or*
- *Ensure access to appropriate medical care or treatment*

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

Source: Working Together to Safeguard Children March 2015 Appendix A: Glossary

Follow the link below to access a copy of the Cornwall Neglect Strategy 2016 - 2019 and ensure this is embedded in your organisational practice as specific strategic planning:

www.cornwall.gov.uk/health-and-social-care/childrens-services/cornwall-and-isles-of-scilly-safeguarding-children-board/safeguarding-topics/neglect/

Parental neglect is the most common cause of significant harm to children and young people in Cornwall.

60% of all the child protection plans in Cornwall result from the effect of neglect on children. The Safeguarding Children Board has therefore identified working together to prevent neglect, identify the risks early and tackle the impact of neglect on children as a strategic priority for this and the coming business year.

Neglect is difficult to diagnose because by definition it has to be present for a period of time.

All ages groups can be affected by neglect but the pre-school child is the most vulnerable. The diagnosis is made by collecting vital pieces of the jigsaw. A child is neglected if its basic needs are unmet. Manifestations of this are when the child is:

1. Malnourished
2. Live in squalid, unhygienic or dangerous home conditions
3. Are repeatedly dressed inadequately, appear unkempt or have poor hygiene
4. Prolonged dental problems, skin or illnesses that require essential medical care which does not appear to be addressed (or is perhaps being completely ignored)
5. Caregivers may leave the child alone for very long periods, with little or no protection/supervision from danger and adversity.
6. Removed of normal experiences that produce the feeling of begin loved, wanted, secure and worthy (emotional neglect)
7. The child appears uninterested, withdrawn, unusually quiet, fearful and overly compliant. Lacks confidence and is unhappy
8. The child's progress in school/nursery may be declining and professionals may begin to notice a sudden alteration in the child's behaviour. The child may regularly arrive late or parents may be continuously late for collection, providing excuses for the child's irregularity. In addition, the child may be failing to attend at all.
9. Adults with mental health problems, substance abusers, alcoholics and adults who are regularly involved with violent behaviour can be significant identification that a child is being neglected. The issues of standards of parental care and behaviour is a major problem in proving neglect. The lack of clear definitions makes it problematic to prove, particularly in a court of law. General neglect may be difficult to prove but 'failure to thrive' a specific type of neglect, is easier to define.

Additional feedback from activities at Cornwall Multi-Agency Child Protection Training

Caregivers may appear to be distance and lack compassion for the child.

Child has delay in reaching developmental milestones and may be unable to ask for help.

Bullying may arise due to lack of basic social skills or isolation from other children.

Child may appear different to the rest of the family or parents – for example everyone else has a warm coat and shoes that fit except for the neglected child.

Baby or child who is self-sufficient- baby can lie for long periods of time in cot with no interaction or stimulation, would not cry when soiled nappy or hungry but will down a bottle of mil when fed. Signs of neglect would include insufficient nutrition including weight gain and or weight loss. Child will hunt and hoard food, take food for siblings, and possibly forward plan (save half a sandwich for the next day).

Child with no expectations! Does not ask for things or get upset when they do not get something.

Faltering growth (new word for failure to thrive)

Parents of children with disabilities may have insecure attachments to their child.

Parents with their own learning difficulties may find it challenging to provide their children with basic physical and psychological needs.

DEFINITION OF SEXUAL ABUSE

Sexual abuse 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 assault by 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. Woman can also commit acts of sexual abuse, as can other children.

Source: Working Together to Safeguard Children March 2015 Appendix A: Glossary

PRESENTATION OF SEXUAL ABUSE POSSIBLE SIGNS AND SYMPTOMS OF SEXUAL ABUSE

1. **Statement of the Child**
   The abuse is rarely disclosed at the time. Children only talk about the trauma of sexual abuse after much thought. They also choose the person to talk to carefully. This might be a teacher or leader of a children's group whom they feel that they can trust. It is important to know how to respond to this situation. Please see *Appendix 1* for guidance on dealing with a disclosure.

2. **Symptoms due to local trauma or infection**
   Perineal soreness, vaginal discharge, urinary tract infection, and pain or bleeding are non-specific symptoms which may be indicative of sexual abuse. Bruising, lacerations, burns, bites or scratches on inner thighs, breast, genitals or anal region should be thoroughly investigated and deserve a full explanation. Bruising or trauma to the penis or scrotum is a strong indicator that sexual abuse has occurred. Fissures, scars and skin tags around the anal verges might suggestive of sexual abuse in the absence of an alternative explanation. In boys the genitalia should be examined; bruising or trauma to the penis or scrotum may occur in sexual abuse, anal laxity Perianal bruising or bleeding without reasonable explanation raises substantial suspicion.
   NOTE: ***Examinations are a health responsibility and not that of other agencies.***
3. **Symptoms attributable to emotional effect**
   Loss of concentration, enuresis, encopresis and anorexia may be related to various emotional factors but sexual abuse should be considered.
4. **Self-harm**
   Many victims of sexual abuse will in some way act out their distress. Common amongst adolescent behaviour is drug abuse, alcohol abuse and prostitution. Attempts at suicide are often of self-loathing and inability to betray the abuser who may be quite close. Self-mutilation can be a symptom of sexual abuse. Victims may burn or scar themselves or purposely make themselves ill.
5. **Sexualised conduct or inappropriate sexual knowledge of young children**
   Such conduct or knowledge may be acquired by observing others or pornographic videos/literature. Children who have been sexually abused may describe pain or other features, such as the quality of semen, which cannot be acquired by observation only. You are advised to use the Brook Traffic Light Tool in Cornwall to understand sexual development and behaviours. www.brook.org.uk/trafficlight
6. **Sexually transmitted disease**
   A small proportion of sexually abused children may have sexually transmitted disease (STD). STD after infancy in children and adolescent who are not sexually active is strongly suggestive but not proof of sexual abuse.
7. **Pregnancy**
   A girl who seems lost to explain her pregnancy, or who refuses to identify the father, may have been abused by a member of the family.

Additional feedback from activities at Cornwall Multi-Agency Child Protection Training

Possible signs and symptoms of sexual abuse will vary with age.

Inappropriate injuries and bruises indicating physical abuse.

Apparent change in behaviour and personality; more withdrawn and may seek attention.

High absence rate.

The child's awareness may increase leading them to become very vigilant.

Over sexualised behaviour may lead to inappropriate behaviour with other children

Health Professionals Only

Blood in nappy.

Unexplained abdominal pain – research shows a percentage or young girls presenting with unexplained abdominal pain are either feeling gynaecological pain from abuse or are not in pain but trying to disclose.

POSSIBLE SIGNS AND SYMPTOMS OF CHILD SEXUAL EXPLOITATION (CSE)

DEFINITION OF CHILD SEXUAL EXPLOITATION

Sexual exploitation of children and young people under 18 involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities. Child sexual exploitation can occur through the use of technology without the child's immediate recognition; for example being persuaded to post sexual images on the Internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child/young person have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child or young person's limited availability of choice resulting from their social/economic and/or emotional vulnerability.

Source: National Working Group for Sexually Exploited Children and Young People (NWG) 2008

In addition to the above definition it is known that children and young people are trafficked into or within the UK for the purpose of sexual exploitation.

It is a possibility that any child or young person can be a victim of sexual exploitation, but children are believed to be at a greater risk of being sexually exploited if they are:

- Homeless
- Have feeling of low self-esteem or self-confidence
- Have a recent bereavement or loss
- In residential care, hotel, bed and breakfast accommodation or a foyer
- Living in a chaotic or dysfunctional household (including parental substance use, domestic violence, parental mental health issues, parental criminality)

- Are a young carer
- History of abuse (including familial child sexual abuse, risk of forced marriage, risk of 'honour'-based violence, physical and emotional abuse and neglect)
- Gang association either through relatives, peers or intimate relationships (in cases of gang associated CSE only)
- Attending school with young people who are sexually exploited
- Learning disabilities
- Unsure about their sexual orientation or unable to disclose sexual orientation to their families
- Friends with young people who are sexually exploited
- Lacking friends from the same age group

Signs of child sexual exploitation and grooming often presented within children and young people:

- Missing from home or care for period of time or regularly return home late
- Unexplained physical harm, such as bruising and cigarette burns
- Drug or alcohol misuse
- Involvement in offending
- Repeat sexually-transmitted infections, pregnancy and terminations
- Absent from school or being presenting problematic/disruptive behaviour
- Change in physical appearance
- Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites (see online abuse)
- Estranged from their family
- Receipt of unexplained gifts or possessions from unknown sources
- Recruiting others into exploitative situations
- Poor mental health
- Self-harm
- Thoughts of or attempts at suicide
- Displaying inappropriate sexualised behaviour, such as over-familiarity with strangers, dressing in a sexualised manner or sending sexualised images by mobile phone ("sexting")

Additional feedback from activities at Cornwall Multi-Agency Child Protection Training

Unexplained gifts may be hidden by the child.

Estranged from their usual friends and new friendship groups may arise, maybe with older peers of even adults.

Apparent changes in the child's behaviour.

Child may appear to have more money.

Our young people know about CSE they talk about the older boys that drive round and pick up the year 9's after school, they know about the kids that go in cars for rewards- if you discuss these issues with young people they are well aware of what goes on and will sometimes almost normalise it.

Child with learning difficulties may view everyone as a friend.

Parents with learning difficulties may be vulnerable to exploitation as a means of gaining access to their child or children.

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POSSIBLE SIGNS AND SYMTOMS OF FEMALE GENITAL MUTILATION (FGM)

DEFINITION OF FEMALE GENITAL MUTILATION

Female genital mutilation (sometimes referred to as female circumcision) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.

There are four main types of FGM:

- *Type 1 – clitoridectomy – removing part or all of the clitoris.*
- *Type 2 – excision – removing part or all of the clitoris and the inner labia (lips that surround the vagina), with or without removal of the labia majora (larger outer lips).*
- *Type 3 – infibulation – narrowing of the vaginal opening by creating a seal, formed by cutting and repositioning the labia.*
- *Type 4 - Other harmful procedures to the female genitals, which include pricking, piercing, cutting, scraping and burning the area*

Source: http://www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx

Suspicions may arise in a number of ways that a child is being prepared for FGM, both within the UK or in their country of origin. These include knowing that the family belongs to a community in which FGM is practised and are making sudden preparations for a child to take a holiday/visit home, arranging vaccinations or planning absence from school, particularly between the ages of 5/8 years of age. The visit of an older female relative is also a strong indication. The child may talk of a special procedure/ceremony that is planned to take place where she will “become a woman”.

Indicators that FGM may have occurred include:

- Prolonged absence from school or other activities
- Noticeable behavioural alteration
- The young person may speak of somebody doing something to them but it’s a secret
- Difficulty passing urine, and persistent urine infections
- Abnormal periods
- Chronic vaginal and pelvic infections
- Kidney impairment and possible kidney failure
- Damage to the reproductive system, including infertility
- Cysts and the formation of scar tissue
- Complications in pregnancy and newborn deaths
- Pain during sex and lack of pleasurable sensation
- Psychological damage, including low libido, depression and anxiety (see below)
- Flashbacks during pregnancy and childbirth
- The need for later surgery to open the lower vagina for sexual intercourse and childbirth

Additional feedback from activities at Cornwall Multi-Agency Child Protection Training

Early warning signs of FGM would include; faith and culture, age, family background, unplanned holidays or change in victims personality.

Child would be more at risk if their mother or older sister has been a victim of FGM or if they come from a country with high incidence of FGM.

Other indicators that FGM may have occurred include; a lack of communication skills or language barriers. Also failure to seek healthcare and attend routine weighing clinics or receive vaccinations etc

Family may have history of sexual abuse.

POSSIBLE SIGNS AND SYMPTOMS OF RADICLISATION AND EXTREMISM DEFINITION OF RADICLISATION AND EXTREMISM

The UK Government (since the 2011 Prevent review) has defined 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 faith and belief. We also include our definition of extremism calls for the death of members of our armed forces.

Radicalisation is defined by the UK Government within this context as "*the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups.*"

The following identifies possible signs and symptoms that a young person is being radicalised

- They may become isolated, abruptly abandoning friends and family members for new friends often referred to as "brother"
- Making new friends (particularly online)
- The individual may no longer participate in activities that once occupied a great deal of their time, such as sports or community associations
- Overall they will turn their back on their life as it was before radicalisation
- An increased desire to spend lengthily periods of time on the internet – surfing violent jihadi/anti-government and pornography websites
- The development of obsessive patterns of behaviour for martyrdom and the apocalypse
- The use of a new language and vocabulary
- Increased development in rigid and inflexible religious beliefs and politics – declaring that they have found the true path to religious enlightenment usually radical Sunnism
- Individuals often exhibit growing hatred and intolerance towards those who do not adhere to their beliefs – stating that they are of less worth
- Displaying extremely secretive behaviour
- The individual may possesses unexplained gifts and clothing from their 'new friends'
- They may also change their appearance (unexpectedly growing a beard, shaving their head, getting tattoos displaying various messages and wearing religious clothing)
- Developing hatred for the government
- The individual may change name
- Displaying power hungry behaviour – increasing challenging attitude

- The reference to extremists' groups in a positive, admirable and defensive manner

Additional feedback from activities at Cornwall Multi-Agency Child Protection Training

Mental health issues may arise.

May become more opinionated and wanting to protest.

School attendance may decrease as well as focus on studies.

Child might have new interests, for example an interest for weapons.

Child may develop a sense of belonging or making a difference.

Changes in belief systems and religion, may even change their name.

Look and speak about terrorists as role models.

Health Professionals Only

A child or young person may disclose information accidentally whilst under sedation or recovering from a general anaesthetic – this must be escalated and taken seriously.

Child with disabilities may be socially isolated and rely on an on-line life for friendships

PEER ON PEER ABUSE

There is no clear boundary between incidents that should be regarded as abusive and incidents that are more properly dealt with as bullying, sexual experimentation etc. This is a matter of professional judgement.

If one child or young person causes harm to another, this should not necessarily be dealt with as abuse: bullying, fighting and harassment between children are not generally seen as child protection issues. However, it may be appropriate to regard a young person's behaviour as abusive if:

- There is a large difference in power (for example age, size, ability, development) between the young people concerned; or
- The perpetrator has repeatedly tried to harm one or more other children; or
- There are concerns about the intention of the alleged perpetrator.

If the evidence suggests that there was an intention to cause severe harm to the victim, this should be regarded as abusive whether or not severe harm was actually caused.

Despite the current focus on child sexual exploitation, peer-on-peer abuse is captured in four key definitions (Firmin 2013a):

- The definition for domestic abuse (Home Office 2013) relates to young people aged 16 and 17 who experience physical, emotional, sexual and/or financial abuse, and coercive control, in their intimate relationships
- The definition for child sexual exploitation (DCSF 2009) captures young people aged under-18 who are sexually abused in the context of exploitative relationships, contexts and situations by a person of any age – including by another young person

- The definition for young people who display harmful sexual behaviour refers to any young person, under the age of 18, who demonstrates behaviour outside of their normative parameters of development (this includes, but is not exclusive to abusive behaviours) (Hackett 2011, NICE 2014)
- Serious youth violence is defined with reference to offences (as opposed to relationships/contexts) and captures all those of the most serious in nature including murder, rape and GBH between young people under-18

Individual behaviour early warning signs to consider:

- Describing themselves as different from others
- Treated differently by adults
- Isolation from activities and other friends
- Difficulty communicating
- Changes in demeanour and significant low self esteem
- Reluctance or refusal to participate in activities they would normally do so
- Avoiding other friends and groups
- Clinging to adults and seeking constant adult supervision
- Significant decline in performance and engagement
- Unexplained injuries
- Vague disclosures
- Sudden dissatisfaction with school or service
- Servitude

Group behaviour early warning signs to consider

- One or more young person dominating others or being followed by others
- Bullying
- Verbal aggression
- Exclusion of a particular young person or small group
- Changes in leadership and group dynamics with no known cause
- Avoiding supervision
- Sexualised nicknames and language used without empathy or care of impact
- Teasing about sexual orientation
- Exchanges of personal items
- Testing privacy and personal boundaries

ONLINE ABUSE is any type of abuse that happens on the web, whether through social networks, playing online games or using mobile phones. Children and young people may experience cyberbullying, grooming, sexual abuse, sexual exploitation or emotional abuse. Children can be at risk of online abuse from people they know, as well as from strangers. Online abuse may be part of abuse that is taking place in the real world (for example bullying or grooming). Or it may be that the abuse only happens online (for example persuading children to take part in sexual activity online). Children can feel like there is no escape from online abuse – abusers can contact them at any time of the day or night, the abuse can come into safe places like their bedrooms, and Cyberbullying can make children and young people feel more frightened and helpless than bullying because they feel like they can't escape. It can also have a similar impact as bullying causing school failure, depression, anxiety and other mental health problems (Munro, 2011) images and videos can be stored and shared with other people. (WWW.nspcc.org.uk).

A child may be experiencing abuse online if they:

- spend lots, much more or much less time online, texting, gaming or using social media
- are withdrawn, upset or outraged after using the internet or texting
- are secretive about who they're talking to and what they're doing online or on their mobile phone
- have lots of new phone numbers, texts or e-mail addresses on their mobile phone, laptop or tablet.

SERIOUS CASE REVIEWS

The Local Safeguarding Children Board (LSCB) are expected to maintain a local learning and improvement framework within their geographical area of responsibility. They undertake a series of case reviews and the **purpose** of these case reviews (Including **Serious case reviews)** is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from **reviews** into programmes of action which lead to sustainable improvements and the prevention of death, **serious** injury or harm to children.

A SELECTION OF LEARNING FROM SERIOUS CASE REVIEWS PUBLISHED 2015 (Key issues/findings)

January 2015 - Surrey – Child X**: Key issues:** identifies issues including: insufficient knowledge of parental history; administrative weaknesses including the loss of papers and delayed transfer of information; insufficiently robust assessments; failure to follow procedures in relation to bruises in non-mobile children; optimistic thinking, failure to revise judgments and insufficient professional challenge; invisible fathers; and failure to undertake multiagency discussions.

January 2015 - Leeds – Child Y**: Key issues:** poor assessments, not carried out in a timely manner contributing to 'drift'; and lack of appreciation of the long-term impact of neglect and belief that better outcomes would be achieved by maintaining parents' cooperation
Recommendations: various, focusing on conflict resolution, multi-agency working and training.

January 2015 – Liverpool – Mary**: Findings:** lack of a common language and understanding between agencies; insufficient professional recognition of parental failure to meet a child's education or health needs, as significant indicators of neglect; and ineffective follow-up from health services for a baby with on-going health needs in the care of parents with a poor history of engagement.

March 2015 – Nottingham City – Child G: **Key issues:** professionals didn't consider the impact of parents' mental health, domestic abuse and substance misuse on children and some decisions were based on self-reported information from the parents as opposed to thorough assessments.

March 2015 - Kirklees – Subject child: **Learning:** identifies analysis and learning, including: focus on parental behaviour sometimes diverting professional attention away from the child; GPs treating episodes of maternal depression in isolation with insufficient attention to broader issues of family life, parenting capacity and child wellbeing; and need for professionals to remain alert to

safeguarding issues and to think critically and reflectively whilst performing routine professional activities.

February 2016 – Manchester – B1: **Key issues:** professional focus on domestic abuse as an anger management issue; parental fear of statutory intervention; manipulative and obstructive parental behaviour; delays in follow-up to incidents; lack of recognition of indicators of neglect such as dental cavities; the limited use of assessment tools or frameworks; and the impact of excessive workloads and reconfiguring of services on the capacity of professionals.

More locally in Cornwall, follow the link below to access Serious Case Reviews published by the Cornwall Local Safeguarding Children Board (LSCB):

http://www.safechildren-cios.co.uk/health-and-social-care/childrens-services/cornwall-and-isles-of-scilly-safeguarding-children-board/learning/serious-case-reviews/

In addition, the Cornwall LSCB run a series of Lessons Learned workshops to share learning from case reviews and learning/ policy developments from practice and encourage all agencies to attend. Follow the link to access the information on these essential sessions:

http://www.safechildren-cios.co.uk/health-and-social-care/childrens-services/cornwall-and-isles-of-scilly-safeguarding-children-board/learning/learning-lessons-newsletter-workshops/

The Triennial Analysis of serious case reviews has analysed 293 Serious case Reviews between 2011 and 1014 is now published, **Pathways to harm, pathways to protection (July 2016).** To access a copy of the document please **follow the link the link to the main report and also there is a series of practice briefings that has been developed for specific agencies.**

Main report:

www.gov.uk/government/publications/analysis-of-serious-case-reviews-2011-to-2014

Practice Briefings:

http://seriouscasereviews.rip.org.uk/resources/practice-briefings/

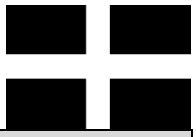
The report researchers highlight that 25-30 children are killed each year on average by their parents, 30- 50 children that were killed sight abuse and neglect as a contributing factor but not the cause of death and a significant amount of 55% OF ALL SCR's (293 of them), children were not in the CP system at the time of their death. This tells us that the CAF process in all cases may not be robust enough in dealing with our most sensitive cases where child protection is a concern. So as professionals who know the families, we recommend the continued use of persistence AND use of the Threshold Tool and Conflict Resolution Policy where we have on-going concerns about children.

APPENDIX 1 **- DEALING WITH A DISCLOSURE**

Only a minority of children/young people actively disclose abuse, in 2013 The NSPCC stated on average abuse is experience for 7.8 years prior to a disclosure. It has been suggested that abuse is commonly identified through the observation of a professional, taking the child's behaviour and physical appearance into consideration. Consider actions on how to deal with a 'discovery'.

Therefore, when a child discloses abuse it is critical to take the situation extremely seriously ensuring that the case can be handle in the appropriate manner. This is to both certify the physical safety and psychological wellbeing of the child and to also ensure that your doing's do not jeopardise future legal action against the perpetrator.

If a young person informs you that she/he is concerned about someone's behavior towards them or makes a direct allegation you can follow the points below…



DO'S	DON'TS
• Reassure the child that it was right to tell you. • Accept and listen – Take what they are saying seriously, even If it involves someone you feel sure would not harm them. • Make them aware that you have to seek guidance and cannot maintain confidentially. It is important to confirm that you will only inform people who will help (e.g. the Designated Safeguarding Lead (DSL) in your setting, the Police or a Doctor). • Once the conversation has concluded seek **immediate** support from the designated DSL. • Let the child know what you are going to do next and stress that you will keep them informed and up-to-date. • Remain calm and do not appear shocked. • Record accurately all relevant and important information that the young person has told you. Records should be detailed and precise, signed, timed and dated and kept in a secure place for an indefinite period of time. This documentation is essential in helping your setting/Social Services/the Police decide what is best for the child, and as evidence if necessary. • Ensure the child's spoke words are punctuated with "speech marks". • Specifically record the time of the disclosure AND the time you record the disclosure AND if using notes include the time you transfer those notes to the report form. Secure any note papers to the report form as this acts as first hand evidence. If you do not have paper to hand, record the information on your hand, sign, date and time it and take a photo of your hand with your face also included.	• Do not promise confidentiality and or to hold any form of secret. • Do not make judgements and allow your personal opinions or doubts to dominate the outcome of the accusation. • Do not show any form of reaction, withhold neutral and open exterior (both facial expressions and body language). • Do not asking leading questions. • Do not FORCE or coerce a child to speak. • Do not fill in words, finish sentences or make assumptions on what the child is saying or from reading the child's body language. • Do not rush or push the investigation. • Do not ask the child to repeat the disclosure themselves to any other person. • Do not share information where it is not necessary. • **Never** confront the offender!

• Be open and honest with the child at all times. • Assure them that they are not to blame for the abuse. • Be aware that the child may have been threatened. • Take proper steps to ensure the physical safety and psychological well-being of the child. This may include referring them for medical treatment or to a psychologist. • Make certain you distinguish between what the child has actually said and the conclusions you may have made. Accuracy is paramount at this stage of the procedure!	

Dealing with a discovery of abuse should be considered in addition to staff understanding of how to deal with a disclosure, where the child does not recognise 'abuse' and disclose themselves (the discovery may have come from another adult, who has shared information and therefore the information shared will be deemed an unauthorised disclosure from the child's perspective). *The child **may not** be ready to TALK.*

Why Children Don't disclose abuse

There are lots of reasons why children don't tell an adult when they have been abused. Some children who have been sexually abused do not make a disclosure until 8 years later. Sometimes, the perpetrator tells the child that it's 'a secret,' and that they shouldn't tell anybody. Sometimes the person makes threats and says things like 'if you tell anyone, I'll hurt you, or I'll hurt your family (CSE). The perpetrator may even tell the child that no-one will believe them if they tell. Sometimes, children don't tell because they're ashamed or embarrassed or afraid that they'll get in trouble. It's important to understand what happened is not the child's fault. The child needs support and acceptance from adults working with them and their family. You may have many feelings about the child being abused and it is important to show now emotional reaction.

Consider use of the following strategies in addressing the DISCOVERY of abuse that the child survivor denies:

Stay neutral:
Do not confirm or deny what the child is saying. Let the child know that you are not there to judge but to listen, understand and help.

Get more facts:
Talk with the child and the person who has referred the child separately. Ask questions that provide a bigger picture of what may be happening: What is the age of the child and the alleged perpetrator? What is their relationship? What is the relationship between the person who reported the case and the child?

Be patient:
Children may not be willing or able to talk about sexual abuse because of the associated shame or stigma. Do not force children to talk about sexual abuse. We need to meet children at their current capacity to share and communicate.

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Childcare in safe hands

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