The London Children's Practice

Sloane Square | Golders Green
www.londonchildrenspractice.co.uk

deeper insights - higher outcomes

The London Children's Practice (LCP) Safeguarding and Child Protection Policy

Date policy updated: 20th August 2020
Annual review date: 20th August 2021

The **Designated Safeguarding Lead (DSL)** *is*:	Katie Pennycuick Katie.pennycuick@londonchildrenspractice.com
In her absence, the **Deputy Designated Safeguarding Lead (DDSL)** *is*:	Jackie Harland Jackie.harland@londonchildrenspractice.com
The **Designated Safeguarding Officers (DSOs)** *for concerns relating to clinic/home based clients are*:	Hui Ee (Vicky) Chow Hui.ee.chow@londonchildrenspractice.com Mikaela Shalders Mikaela.shalders@londonchildrenspractice.com
The **Designated Safeguarding Officers (DSOs)** *for concerns relating to school based clients are*:	Orla Morrison Orla.morrison@londonchildrenspractice.com Christine Cano Christine.cano@londonchildrenspractice.com

Key Information:

Contact Details for the Safeguarding Authority at LCP's Clinic Location:

Local Safeguarding Children's Board Contact Details for Kensington and Chelsea Borough (Sloane Square Clinic)

(information correct as of 20th August 2020)

https://www.rbkc.gov.uk/lscb/information-professionals-and-volunteers/contacts-safeguarding-kensington-and-chelsea

If you are concerned about a child who lives outside of this borough, you can find their local Safeguarding Authority by searching "___ Borough Safeguarding" and using the relevant contact details there.

If you are concerned about a person working with a child, find the local Safeguarding Authority in the borough in which the person works, following the steps above, and contact the Local Authority Designated Officer (LADO).

1. Introduction and Key Policies/Legislation Informing this Policy

The London Children's Practice is committed to provide an environment where children feel safe and are kept safe and all staff contribute to the culture of vigilance which is embedded in our Practice. All staff form part of the wider safeguarding system for children.

This system is described in statutory guidance *Working together to safeguard children (2018).* Safeguarding and promoting the welfare of children is everyone's responsibility. Everyone who comes into contact with children and their families and carers has a role to play in safeguarding children. In order to fulfil this responsibility effectively, all staff should make sure their approach is child-centred. This means that they should consider, at all times, what is in the best interests of the child. No single professional can have a full picture of a child's needs and circumstances. If children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

There are three elements to our policy to safeguard children:

Prevention - Providing an environment in which children and young people feel safe, secure, valued and respected, feel confident and know how to approach adults if they are in difficulties. Raising awareness of all staff, of the need to safeguard children and of their responsibilities in identifying and reporting possible cases of abuse. Ensuring that all adults within our Practice who have access to children have been rigorously checked as to their suitability using safe recruitment procedures.

Protection - Through the establishment of a systematic means of monitoring children, known or thought to be at risk of harm. Through the establishment of structured procedures within the Practice which will be followed by all members of the Practice in cases of suspected abuse. All staff receive regular training and up-dates. Through the development of effective working relationships with all other agencies, involved in safeguarding children.

Support - Ensuring that key concepts of child protection are integrated within our induction and Practice policies as well as supervision of staff. Ensuring that children are listened to and their concerns taken seriously and acted upon. Working with others to support children who may have been abused to access therapeutic support within the Practice's remit.

Key documents that inform this policy are:

- Keeping children safe in education (Sept 2018)
- Working together to safeguard children (July 2018)
- What to do if you are worried a child is being abused (March 2015)

2. Role and Responsibilities

The Role of the Designated Safeguarding Lead (DSL), their Deputy, and Officers

The Designated Safeguarding Lead will be appointed from the senior leadership team and will take the lead responsibility for safeguarding and child protection. Deputy Safeguarding Lead(s) have also been appointed to take on the responsibility in the absence of the Designated Safeguarding Lead. Designated Safeguarding Officers will support the Designated Safeguarding Lead and his/her Deputy in carrying out tasks relevant to safeguarding and child protection. The ultimate responsibility for safeguarding and child protection remains with the Designated Safeguarding Lead and this lead responsibility will not be delegated.

The Designated Safeguarding Lead is expected to **manage referrals**, as follows:

- refer cases of suspected abuse to the local authority children's social care as required;
- support staff who make referrals to local authority children's social care;
- refer cases to the Channel programme where there is a radicalisation concern as required;
- support staff who make referrals to the Channel programme;
- refer cases where a person is dismissed or left due to risk/harm to a child to the Disclosure and Barring Service as required; and
- refer cases where a crime may have been committed to the Police as required.

The Designated Safeguarding Lead is expected to **work with others**, as follows:

- as required, liaise with the "case manager" and the designated officer(s) at the local authority for child protection concerns in cases which concern a staff member;
- liaise with Practice staff on matters of safety and safeguarding (including online and digital safety) and when deciding whether to make a referral by liaising with relevant agencies; and
- act as a source of support, advice and expertise for all staff.

The Designated Safeguarding Lead (and any deputies) should **undergo training** to provide them with the knowledge and skills required to carry out the role. This training should be updated at least every two years. Other training responsibilities include:

- understand the assessment process for providing early help and statutory intervention, including local criteria for action and local authority children's social care referral arrangements.
- have a working knowledge of how local authorities conduct a child protection case conference and a child protection review conference and be able to attend and contribute to these effectively when required to do so;
- ensure each member of staff has access to, and understands, the Practice's child protection policy and procedures, especially new staff;
- are alert to the specific needs of children in need, those with special educational needs and young carers;
- are able to keep detailed, accurate, secure written records of concerns and referrals;
- understand and support the Practice with regards to the requirements of the Prevent duty and are able to provide advice and support to staff on protecting children from the risk of radicalisation;
- obtain access to resources and attend any relevant or refresher training courses; and
- encourage a culture of listening to children and taking account of their wishes and feelings, among all staff, in any measures the Practice may put in place to protect them.

The Designated Safeguarding Lead also has the responsibility of **raising awareness**:

- ensure the Practice's Safeguarding and Child Protection policies are known, understood and used appropriately;
- ensure the Practice's child protection policy is reviewed annually (as a minimum) and the procedures and implementation are updated and reviewed regularly.
- ensure the Safeguarding and Child Protection Policy is available publicly.

The Designated Safeguarding Lead also co-ordinates the Practice's representation at child protection conferences/core groups and the submission of written reports for such meetings. The Designated Safeguarding Lead will ensure that if staff members attend a child protection meeting, they have the authority to make decisions and commit resources on behalf of the Practice. The Designated Safeguarding Lead will disseminate information relating to safeguarding and child protection concerns to relevant staff members as appropriate. The Designated Safeguarding Lead and or a deputy will be available for staff to discuss any safeguarding concerns. The Designated Safeguarding Lead will ensure that there is adequate and appropriate cover arrangements (usually a Deputy) if they are away.

The Role of Staff Members

The Practice staff are particularly important as they are in a position to identify concerns early, provide help for children and prevent concerns from escalating. If staff members have any concerns about a child's welfare they should report the matter to the Designated Safeguarding Lead using the Practice's Concerns form. The form is available on the Practice's Shared Drive, which is accessible to all staff members.

If a child is in immediate danger or is at risk of harm, the Designated Safeguarding Lead will refer to children's social care and/or the police immediately. Although the responsibility to refer to children's social care lies with the Designated Safeguarding Lead, anyone can make a referral. Where referrals are not made by the Designated Safeguarding Lead, they should be informed as soon as possible that a referral has been made.

3. Working with Parents, Carers, and Schools

The Practice recognises the importance of working together in partnership with parents, carers and schools to ensure the welfare and safety of children.

In terms of working with parents/carers, the Practice will:

- make parents aware of their statutory role in safeguarding and promoting the welfare of children, including the duty to refer children when necessary.
- policies will be available on the website and on request.

The Practice will ensure a robust complaints procedure is in place to deal with issues raised by parents and carers, and are able to discuss any issues with a member of senior leadership (for general complaints) or the Designated Safeguarding Lead (for safeguarding/child protection issues) on request.

In terms of working with schools, the Practice will:

- ensure that schools are made aware of the following:
    - that the Practice has its own Safeguarding and Child Protection Policy;
    - that Practice staff will adhere to procedures outlined in the school's own Safeguarding and Child Protection policy by reporting concerns to the school's Designated Safeguarding Lead, but
    - Practice staff will also report any safeguarding concerns directly to the Practice's Designated Safeguarding Lead for follow up.

4. Confidentiality and Information Sharing

The Practice recognizes that effective information-sharing underpins integrated working and is a vital element of both early intervention and safeguarding. Research and experience have shown repeatedly that keeping children safe from harm requires practitioners and others to share information about:

- A child's health and development and any exposure to possible harm;
- A parent who may need help, or may not be able to care for a child adequately and safely; and
- Those who may pose a risk of harm to a child.

The Practice will endeavor to ensure the following when recording a Safeguarding and Child Protection concern:

- That concerns are recorded using the appropriate form and include the appropriate details, using the Practice's Safeguarding Concerns form
- That any completed forms are stored securely on Practice electronic storage
- That if any documents containing sensitive personal data need to be shared with external agencies such as children's social care, they are sent via secure means.

The Practice will also endeavor to do the following with regards to Safeguarding and Child Protection:

- To share information with consent where possible; unless in our judgement, there is a lawful reason to do so, such as where safety may be at risk (see references to GDPR regulations on information sharing where safeguarding is concerned, below).
- To be open and honest with the child or young person (and/or their family, where appropriate), about why, what, how, and with whom the information will, or could be, shared, and seek their agreement, unless it is unsafe or inappropriate to do so;
- To seek advice from relevant bodies (such as the Local Safeguarding Authority) if we are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible;
- To consider the safety and well-being of the individual concerned, and others who may be affected by their actions.
- To ensure that the information shared is necessary for the purpose for which we are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely , in accordance with the Practice's policy on handling personal information.
- To keep a record of decisions made regarding information sharing and the reasons for it - whether it is to share information or not. If the Practice shares information, a record

will be kept on the individual's Safeguarding Concern form, listing what the Practice has shared, with whom, and for what purpose.

A Note on GDPR:

The General Data Protection Regulations (GDPR) and the Data Protection Act 2018 supersede the Data Protection Act 1998. The Practice recognizes that we must have due regard to the relevant data protection principles which allow us to share personal information.

The GDPR and Data Protection Act 2018 do not prevent, or limit, the sharing of information for the purposes of keeping children and young people safe.

In the Practice's Safeguarding and Child Protection responsibility, we recognize that:

- Information which is relevant to safeguarding will often be data which is considered 'special category personal data' meaning it is sensitive and personal;
- Where the Practice needs to share special category personal data, we note that the Data Protection Act 2018 includes 'safeguarding of children and individuals at risk' as one of conditions that allows practitioners to share information with others without consent:
    - Information can be shared legally without consent, if a practitioner is unable to/cannot be reasonably expected to gain consent from the individual, or if to gain consent could place a child at risk;
    - Relevant personal information can also be shared lawfully if it is to keep a child or individual at risk safe from neglect or physical, emotional or mental harm, or if it is protecting their physical, mental, or emotional well-being.

If the Designated Safeguarding Lead concludes that the Practice needs to share information without consent in relation to a safeguarding or child protection concern, he/she will consider which processing condition in the Data Protection Act 2018 is most appropriate in the particular circumstances of the case. This may be the safeguarding processing condition or another relevant provision.

For more information on Information Sharing in Safeguarding and Child Protection, please refer to government guidance on "Information Safeguarding Advice for Safeguarding for Practitioners":https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice

5. Guidance for Practice Staff

Indicators of Abuse

See Appendix A for guidance on 'What is a Safeguarding Matter?', including some types of and indicators of abuse.

Confidentiality

See *Section 4: Confidentiality and Information Sharing* for guidance on when and under what circumstances it is appropriate to share information.

You can never guarantee confidentiality to a child as some kinds of information may need to be shared with others. A suggested form of words that may help when talking to children is as follows:

"I can't promise to keep it a secret because I may need to tell someone else who can help you. But if I do have to tell someone else I will let you know."

Talking to and listening to children

If a child chooses to disclose, staff SHOULD:

- be accessible and receptive;
- listen carefully and uncritically at the child's pace;
- take what is said seriously;
- reassure the child that they are right to tell;
- tell the child that you must pass this information on;
- make a careful record of what was said.

Staff should NEVER:

- take photographs or examine an injury;
- investigate or probe aiming to prove or disprove possible abuse – never ask leading questions;
- make promises to children about confidentiality or keeping 'secrets';
- assume that someone else will take the necessary action;
- jump to conclusions or react with shock, anger or horror;

- speculate or accuse anybody;
- confront another person (adult or child) allegedly involved;
- offer opinions about what is being said or about the persons allegedly involved;
- forget to record what you have been told;
- fail to pass the information on to the correct person;
- ask a child to sign a written copy of the disclosure.

For children with communication difficulties or who use alternative/ augmented communication systems, you may need to take extra care to ensure that signs of abuse and neglect are identified and interpreted correctly, but concerns should be reported in exactly the same manner as for other children.

What to do if you have a concern

- Consider what you know, what you have seen and things about the child which cause concern.
- Listen to the child if s/he tells you of abuse. Reassure the child that they did the right thing to tell you. Never promise to keep something a secret. Let the child know you will be telling the Designated Safeguarding Officer/Lead as you all have a responsibility to keep the child safe. Don't probe or interrogate the child. Avoid asking leading questions. Write down what the child told you using the child's own words.
- Discuss your concerns urgently with the Designated Safeguarding Officer/Lead. If a Designated Safeguarding Officer is the first point of contact, they will be responsible for informing the Designated Safeguarding Lead.

The Designated Person will discuss and review the concerns and advise on what actions to take next, including whether a child protection referral is necessary. The Practice's Designated Safeguarding Lead should lead on the referral process.

Unless consultation with parents/carers is likely to place the child at risk of significant harm through delay or the parents'/carer's actions, the Designated Safeguarding Lead should:

- Speak with the child's parents/carers: Be open and honest, explain the reasons for the Practice's concerns and seek explanations for these concerns.
- Explain the duty to report concerns and try to get parental agreement for a referral to the appropriate borough within 24 hours.

If the parent/carer refuses to give permission for the referral, and if a referral is necessary to secure the child's safety, a referral can be made without consent.

Record keeping

Well-kept records are essential in situations where it is suspected or believed that a child may be at risk from harm.

Records should:

- state who was present, time, date and place;
- use the child's words wherever possible;
- be factual/state exactly what was said;
- differentiate clearly between fact, opinion, interpretation, observation and/or allegation;

Records must be made using the Practice's formal Safeguarding Form, which is available on the Practice shared drive.

Protecting staff against allegations of abuse

Staff should seek to keep personal contact with children under review and seek to minimise the risk of any situation arising in which misunderstandings can occur. The following sensible precautions can be taken when working alone with children:

- ensure that parents and/or carers are present in the vicinity if carrying out a home visit – staff should not be left alone in a premise with a child or young person.
- work in a room where there is a glass panel in the door or leave the door open
- make sure that other adults visit the room occasionally
- avoid working in isolation with children unless thought has been given to safeguards
- must not give out personal mobile phone numbers or private e-mail addresses
- must not give children/young people lifts home in your cars
- must not accompany children/young people outside of the clinic and/or school premises unless external visits are part of the therapeutic process and have been consented to by parents or carers
- must not arrange to meet them outside of the remit of their association with the Practice (e.g. outside of sessions or assessments, or outside of school for school sessions)
- must not chat to children or young people we work with on social networking websites
- must not have children or young people we work with as friends on any social networking site

Under the Sexual Offences Act 2003 it is a criminal offence for anyone working in an education setting to have a sexual relationship with a child or young person even when the child or young person is over the age of consent.

If at any point it is necessary to use physical action to prevent a child from injury to themselves or others parents will be informed and the action and outcomes recorded in the child's case notes.

Children will not be punished by any form of hitting, slapping, shaking or other degrading treatment.

Safety in the Clinic

If parents/ carers leave the clinic whilst staff are working with children, staff should take a mobile number as an emergency contact.

No child must be left in the waiting room unattended. If a parent/carer is late to collect and there is no other staff member available to look after the child, the child will have to sit in the therapy room whilst the next session begins.

The door to the clinic should only be opened by a staff member, who will check the following:

- the child's name
- who they are here to see
- if it is an adult alone, staff must check who they are here to collect and ensure that the adult is either
    - the person who brought the child to the clinic, OR
    - a named person collecting the child (e.g. a nanny, and that parents have informed us that nanny is collecting the child)

The door to the clinic must be kept securely closed (latched) at all times to ensure no unknown persons can enter the premises, and that no children can leave the premises without accompaniment of parents/carers.

If the client is a young person and is expected to arrive or leave alone/is an independent traveller, please ensure that parents have stated the Practice has permission to let the young person leave on their own.

6. Practice Procedure for Reporting Safeguarding Concerns

If a Safeguarding Concern about a child or young person has been raised, the Practice Procedure is as follows:

- The staff member will fill in the Practice's Safeguarding Concern form and note that this has been done in the child's case notes.

- The Concern Form will be forwarded to the Designated Safeguarding Officer or Lead.
- The Designated Safeguarding Lead will discuss the concern with the staff member and determine if:
    - Advice needs to be sought, in which case the Designated Safeguarding Lead will contact the local safeguarding authority and request advice without disclosing the child's identity; OR
    - More information needs to be gathered, in which case the Designated Safeguarding Lead may speak to the child's parents or carers, if appropriate; ask other staff members (if applicable) or other agencies working with the child, to share information if they have any concerns; OR
    - A referral needs to be made, in which case the Designated Safeguarding Lead will make a referral to the Safeguarding Authorities in the Borough/Local Authority where the child or young person lives, utilizing contact information available on the Local Authority's website. Parents or carers may be informed of the referral if this will not put the child at further risk of harm (see *Section 4: Confidentiality and Information Sharing*, for more information on decision making for information sharing with and without consent)
- All decisions made and actions taken will be recorded thereafter by the Designated Safeguarding Lead in the relevant Safeguarding Concern Form.
- The Designated Safeguarding Lead will also follow up Safeguarding Concerns reported by staff and/or reported to the local safeguarding authorities in a timely manner.

If a child is believed to be at immediate risk of harm, or if a crime has been committed, the staff member or Designated Safeguarding Lead will call the police.

7. Practice Procedure for Allegations of Abuse Made Against Staff, and Safer Recruitment

The Practice fully recognizes that children can be the victims of abuse by those who work with them in any setting. All allegations of abuse of children carried out by any staff member or volunteer will therefore be taken seriously.

If anyone wishes to report a concern about a staff member, either in a school or at the Practice, you may do one of the following:

- Call our office and ask to speak to the Designated Safeguarding Lead urgently, and explain your concerns **only to the Designated Safeguarding Lead** (or Deputy, in their absence).

- Report your concerns to the Local Authority Designated Officer (LADO) of the Borough or Local Authority that the staff member works in – this information can be found on the Local Authority website.

If an allegation about a staff member is received by the Practice's Designated Safeguarding Lead, he/she will consider the following: Has the member of staff:

- behaved in a way that has harmed a child, or may have harmed a child?
- possibly committed a criminal offence against or related to a child?
- behaved towards a child or children in a way that indicates s/he is unsuitable to work with children?
- bullied children?

Allegations of abuse made against staff, whether historical or contemporary, will be taken very seriously and dealt with by the Designated Safeguarding Lead. The Designated Safeguarding Lead will then:

- Speak to the person reporting the concern and obtain all relevant information
- Record the concern raised.
- Speak to the member of staff and anyone who may have additional information.
- If the enquiries made indicate a valid concern and a referral is required, a meeting will be called by the Designated Safeguarding Lead.
- The decision of the meeting could result in:
    - investigation by the Local Authority Designated Officer (LADO)
    - police investigation if there is a criminal element to the allegation

The fact that the staff member offers to resign or does resign should not prevent the allegation procedure reaching a conclusion.

Should an allegation against a member of staff fulfil the 2 referral tests set out by the Disclosure and Barring Service the Designated Safeguarding Lead will report the staff member to the safeguarding authorities as well as the Disclosure and Barring Service.

<u>Safer Recruitment</u>

When recruiting new members of staff (including our administration staff, and assistants), the Practice ensures the following:

- that an Enhanced Disclosure and Barring Service Check is undertaken
- that at least two references are taken up and checked
- that qualifications are verified.
- that identity documents are checked and recorded on our HR system.

- That the person has a right to work in the United Kingdom
- That all staff who have worked or lived abroad are asked to supply a clear police check from the countries in which they have worked or lived.

Newly appointed staff will have initial training in Safeguarding and Child Protection as part of their induction program. They will be made aware of this policy and of the procedures and guidelines followed by the Practice in Safeguarding and Child Protection.

Volunteers and External Staff

The Practice accepts volunteers from time to time to help run our holiday groups. Volunteers are not allowed to work unsupervised with children and will usually bring an existing Disclosure and Barring Check certificate with them, along with identification documents, which are then checked and recorded by a Practice staff member for our records.

External (subcontracted) or part-time staff, as well as the consultants we work with, will always have an Enhanced Disclosure and Barring Service Check certificate and references checked as well.

8. Raising Concerns About Safeguarding Practice

Initially concerns should be raised with the line manager of the person concerned. The concern should be escalated to the Designated Safeguarding Lead if it has not been addressed to the satisfaction of the person raising the concern. Where staff feel unable to raise an issue or feel that their concern is not being addressed, follow the whistle blowing procedures outlined in the Practice's whistleblowing policy.

APPENDIX: What is a Safeguarding and Child Protection Concern?

Staff should be aware of the following types of and indicators of abuse. This list is not exhaustive.

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:

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 feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as over protection and limitation of exploration and learning, or preventing the child from 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.

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)
- Ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

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.

There are three thresholds for and types of referral that need to be considered:

Is this a child with additional needs where their health, development or achievement may be adversely affected?:

- Age appropriate progress is not being made and the causes are unclear; or

- The support of more than one agency is needed to meet the child or young person's needs.

Staff should also be aware that there is a danger of the abused becoming abusers which may involve child on child issues. Any intimation of this type of behaviour must be taken very seriously.

INDICATORS OF ABUSE

Physical Indicators of Neglect
(Many indicators listed in the physical abuse section can also indicate neglect.)

- abandonment
- lack of shelter
- unattended medical and dental needs
- consistent lack of supervision
- ingestion of cleaning fluids, medicines, etc.
- consistent hunger
- nutritional deficiencies
- inappropriate dress for weather conditions
- poor hygiene
- persistent (untreated) conditions (e.g. scabies, head lice, diaper rash, or other skin disorders)
- developmental delays (e.g. language, weight)
- irregular or non attendance at school or child care
- not registered in school
- not attending school
- underweight and is very small for their age
- if they are regularly left alone, or in charge of younger brothers or sisters

Behavioural Indicators of Neglect

- depression
- poor impulse control
- demands constant attention and affection
- lack of parental participation and interest
- delinquency
- misuse of alcohol/drugs
- regularly displays fatigue or listlessness, falls asleep in class
- steals food, or begs for food from classmate(s)
- reports that no carer or parent is at home

- frequently absent or late
- self-destructive
- drops out of school (adolescent)
- takes over adult caring role (of parent)
- lacks trust in others, unpredictable
- plans only for the moment

Physical Indicators of Physical Abuse

Bruises, black eyes and broken bones are obvious signs of physical abuse. Other signs might include:

- Injuries that the child cannot explain or explains unconvincingly
- Untreated or inadequately treated injuries
- Injuries to parts of the body where accidents are unlikely, such as thighs, back, abdomen, face
- Bruising which looks like hand or finger marks or have the shape of an object
- Cigarette burns, human bites
- Scalds and burns.
- presence of several injuries (3+) that are in various stages of healing
- repeated injuries / accidents over a period of time
- injuries not consistent with the child's age and development
- bald patches on child's head where hair may have been torn out
- injuries where the child and parents' account of their happening differ

Behavioural indicators of Physical Abuse

- Child is sad, withdrawn or depressed
- Has trouble sleeping
- Behaves aggressively or is disruptive
- Shows fear of certain adults
- Has a lack of confidence and low self-esteem
- Uses drugs or alcohol
- Attempts to run away and fear of going home
- Stilted conversation, vacant stares or frozen watchfulness, no attempt to seek comfort when hurt
- Describes self as bad and deserving to be punished
- Lack of confidence and low self esteem
- Cannot recall how injuries occurred, or offers an inconsistent explanation
- Wary of adults or reluctant to go home
- Often absent from school/child care
- May flinch if touched unexpectedly

- Extremely aggressive or withdrawn
- Displays indiscriminate affection-seeking behaviour
- Abusive behaviour and language in play
- Overly compliant and/or eager to please
- Poor sleeping patterns, fear of the dark, frequent nightmares
- Cries frequently
- Drug/alcohol misuse
- Poor memory and concentration
- Depression
- Suicide attempts

Physical Indicators of Sexual Abuse

- pain, itching, bruising or bleeding in the mouth or genital or anal areas
- genital discharge or urinary tract infections
- stomach pains or discomfort walking or sitting
- sexually transmitted infections
- fatigue due to sleep disturbances
- sudden weight change
- cuts or sores made by the child on the arm (self-mutilation)
- recurring physical ailments
- difficulty in walking or sitting
- torn, stained or bloody underwear
- pregnancy

Behavioural Indicators of Sexual Abuse

In a younger child:

- sad, cries often, unduly anxious
- poor concentration
- inserts objects into the vagina or rectum
- change or loss of appetite
- sleep disturbances, nightmares
- excessively dependent
- fear of home or a specific place, excessive fear of men or women, lacks trust in others
- age-inappropriate sexual play with toys, self, others (e.g. replication of explicit sexual acts)
- age-inappropriate sexual language
- age-inappropriate, sexually explicit drawings and/or descriptions
- bizarre, sophisticated or unusual sexual knowledge

- reverts to bedwetting/soiling
- dramatic behavioural changes, sudden non-participation in activities
- poor peer relationships, self-image
- overall poor self-care
- absence from school
- child talks of receiving special attention from a particular adult, or refer to a new, "secret" friendship with an adult or young person

In an older child:

- sudden lack of interest in friends or activities
- fearful or startled response to touching
- overwhelming interest in sexual activities
- hostility toward authority figures
- fire setting
- need for constant companionship
- regressive communication patterns (e.g. speaking childishly)
- academic difficulties or performance suddenly deteriorates
- truancy and/or running away from home
- wears provocative clothing or wears layers of clothing to hide bruises (e.g. keeps jacket on in class)
- recurrent physical complaints that are without physiological basis (e.g. abdominal pains, headache, nausea)
- lacks trust in others
- unable to "have fun" with others
- suicide attempts
- drug/alcohol misuse
- poor personal hygiene
- promiscuity
- sexual acting out in a variety of ways

<u>Physical Indicators of Emotional Abuse</u>

- bedwetting and/or diarrhoea
- frequent psychosomatic complaints, headaches, nausea, abdominal pains

<u>Behavioural Indicators of Emotional Abuse</u>

- mental or emotional development lags
- behaviours inappropriate for age
- fear of failure, overly high standards, reluctance to play
- fears consequences of actions, often leading to lying

- extreme withdrawal or aggressiveness, mood swings
- overly compliant, too well-mannered
- excessive neatness and cleanliness
- extreme attention-seeking behaviours
- poor peer relationships
- severe depression, may be suicidal
- runaway attempts
- violence is a subject for art or writing
- complains of being left out
- contact is forbidden with other children
- low self esteem