



# **Northumberland**

## **Strategic Safeguarding Partnership**

Safeguarding Disabled Children and Young People.

**Guidance for practitioners working with Disabled Children and Young  
People: recognising and responding to safeguarding concerns**

Northumberland Safeguarding Children's Committee

## INTRODUCTION

NSCC takes a broad view of the definition of disability, using the World Health Organisation Definition as follows:

***“Disability is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations”***

This definition is deliberately broad and reflects a social model of disability, i.e. that children and young people are not disabled by their impairment but by social factors and attitudes.

Whilst disabled children are likely to suffer much the same types of abuse as other children, research suggests that disabled children are 3 to 4 times more likely to be abused than non-disabled children (Sullivan & Knutson, 2000). Research has also shown that children with communication impairments, behavioural disorders, learning disabilities and sensory impairments are particularly vulnerable (Stalker et al, 2010), (Spencer et al 2005).

The most common forms of abuse experienced by disabled children are neglect and emotional abuse, although they may experience multiple forms of abuse. Prevalence rates of abuse of disabled children have been found to be 20% for physical violence, 18% for emotional abuse and, 14% for sexual violence and 9.5% for neglect.

Disclosing abuse can be more difficult for children who have a wide range of communication styles, and this can be more problematic if a perpetrator is also in a trusted role (Hershkowitz et al 2007).

Ensuring disabled children's wellbeing is everybody's responsibility and it is critical that all practitioners are aware of the potential vulnerability of disabled children and to recognise and respond to safeguarding concerns.

This document is for all professionals working with disabled children and young people and highlights indicators of abuse and neglect, along with safe-guarding practice considerations. It should be considered alongside the Northumberland multi-agency threshold document and, of course, Northumberland's multiagency Policies and Procedures:

[https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Safeguarding/thresholds-10-2018\\_2.pdf](https://www.northumberland.gov.uk/NorthumberlandCountyCouncil/media/Child-Families/Safeguarding/thresholds-10-2018_2.pdf)

In preparing this guidance, we have drawn heavily on the excellent National Guidance for Child Protection in Scotland (2014) Notes for Practitioners: Protecting Disabled Children from Abuse and Neglect. The full document can be found here:

<https://www.gov.scot/publications/national-guidance-child-protection-scotland-2014-additional-notes-practitioners-protecting-disabled-children-abuse-neglect/>

<b>Why DC&amp;YP may be at greater risk of abuse and neglect?</b>
Many disabled children are at increased likelihood of being socially isolated with fewer outside contacts than non-disabled children. They may particularly lack the support of peers in whom they can confide.
They may not know they are being abused or neglected because they lack the life experience to make that judgement.
Their dependency on parents, carers and service providers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour.
They may be reluctant to share worries or concerns, for fear of getting familiar adults into trouble, or may not have access to someone they can trust to disclose that they have been abused.
There may be established practices within the family which minimise or hide risk factors or actual abuse.
They may have an impaired capacity to resist or avoid abuse.
They may have speech, language and communication needs which may make it difficult to tell others what is happening.
They are especially vulnerable to bullying and intimidation.
Looked after disabled children are also vulnerable to the same issues that exist for all children living away from home e.g. foster/kinship care. They are particularly susceptible to abuse due to their additional dependency on residential and hospital staff for their day to day physical and other care and support needs as they may not have the vigilance of family members to be alert to such abuse.
They may lack self-worth and feel that the abuse is their fault, even be desensitised to abuse.
They are less likely to know about/understand their rights.
There is an even greater power imbalance between disabled children and other non-disabled children and adults.
They are less likely to have had sex education.
They may not have the communication aids which allow them to describe body parts and abuse.
They may have less choice, be used to obeying/complying to survive, lack belief that they can control things in their lives.

**Practitioner's attitudes may contribute to the vulnerability of disabled children in respect of the risk of abuse and neglect:**

The beliefs that disabled children are not abused; or are not at risk of certain types of abuse and harm i.e. child sexual exploitation; cyberbullying; forced marriage.

Assuming that an investigation cannot take place without a disclosure of abuse.

Beliefs that minimise the impact of abuse on disabled children, e.g. that due to their impairment they are less likely to remember or be adversely affected by an abusive incident.

Workers feeling overwhelmed by the child's disability.

A lack of knowledge about the child, e.g. not knowing the child's usual behaviour or the impact of disability on the child.

Not being able to understand the child's method of communication, therefore not seeking their views.

Assumptions being made about the impairment rather than the needs of and risks to the child i.e. accepting a parent or carer's explanation that an injury or behaviour is the result of the impairment rather than considering other possible causes.

Being uncomfortable with, or in denial of, the child's stages of sexual development and sexuality.

Lack of understanding of a disabled child's health care needs, e.g. medication being delayed by one hour can cause significant risk of life threatening seizures which is not the case with typically developing children.

Not considering behaviour, including harmful sexual behaviour or self-injury, which may be indicative of abuse.

Not being aware of how certain health/medical complications may influence the way symptoms present or are interpreted i.e. some conditions cause spontaneous bruising or fragile bones potentially resulting in more frequent fractures.

Assessments which focus on needs relating to impairment rather than general wellbeing.

A lack of time for thorough assessment which considers family history, chronologies, concerns about or actual harm to other children within the family group.

Making assumptions that disabled children who can communicate will disclose abuse – an assumption not made for other children.

Not being alert to the possibility of abuse by professionals caring for disabled children.

**Features of abuse and neglect particular to disabled children and young people:**

Missing medical appointments, misuse of medication, failure to provide treatment or providing inappropriate or unnecessary invasive procedures carried out against the child's will.

Using ill-fitting equipment or not allowing adaptations a child might need such as splints, safe space, inappropriate splinting or inappropriate physical confinement.

Threats of abandonment/exclusion and/or depriving access to visitors.

Exclusion: from family events, overuse of respite, unnecessary schooling away from home.

Not feeding the child enough in order to keep them light for lifting, or overfeeding.

A disregard for a child's right to privacy i.e. poor toileting arrangements.

Fear of carers.

Inappropriate use of physical restraint.

Rough handling, extreme behaviour modification.

Lack of communication or stimulation; unwillingness to try to learn a child's means of communication or withholding a child's means of communication.

Teasing, bullying or blaming because of their impairment.

Verbal abuse; achievements ridiculed or ignored.

Punitive responses to behaviour.

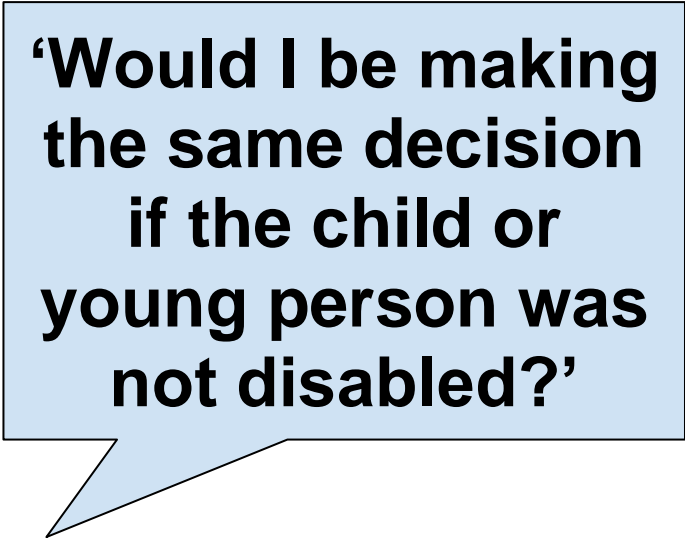
Having too high/low expectations of child.

Over protection.

Misappropriation of a child's finances.

It is crucial when considering whether a disabled child or young person has been abused and/or neglected or is at risk of abuse and/or neglect that the disability does not mask or deter appropriate investigation of child protection concerns. There should be no distinction made in acting on concerns where a child is disabled.

When working with a disabled child/young person always ask:



**‘Would I be making  
the same decision  
if the child or  
young person was  
not disabled?’**

## Barriers to communicating abuse

Communicating abuse is difficult for any child: they may be confused, fearful, traumatised and uncertain about what has happened and what might happen in the future. The recognition of concerns in relation to the protection of children and young people from abuse and harm cannot be determined by disclosure alone.

### Barriers to communicating abuse for DC&YP:

For a disabled child it may be especially difficult, as they may not have the means to communicate about their abuse experience(s).

For some disabled children with speech, language and communication needs, making known that they have been subject to abuse, neglect or ill treatment is dependent on the ability of practitioners to recognise and respond appropriately to a range of verbal and non-verbal cues.

It may be necessary to seek support and advice from practitioners with specialist skills who are most familiar with the child and their means of communication, for example Picture Exchange Communication System (PECS).

**Behaviour** should be recognized as a form of communication by all children, including disabled children and young people. A child should not be blamed for challenging behavior: the reasons for the behavior should be sought.

**Always ask:**

**‘What is the child/young person trying to communicate through their behaviour?’**

### **Working with family members and carers**

Most parents and carers of disabled children provide safe and loving homes. However, there must be awareness that this is not always the case: some fail to offer acceptable care, overwhelmed by the pressures upon them and their family or receiving inadequate support from services and some do deliberately harm their children.

#### **Working with family members and carers of DC&YP**

Some parents and carers are reluctant to seek help from professionals, particularly those in statutory services, when under pressure as they are afraid of being labelled as unable to cope and harbour a fear that if they do seek help their children will be removed from their care. Early intervention with these families can be, therefore, more difficult.

Often parents and carers feel they have not had sufficient help and support with their disabled child and describe having to fight for any services they have received. Not surprisingly, then, some families are particularly hostile to intervention – especially when they perceive this as the blame being put on them by services who have previously failed them.

Services for disabled children are encouraged to work with parents and carers as partners and, in reality, parents usually understand the needs of their disabled child best. This can, though, create complexity when there are suspicions of abuse. The parents and carers may be seen as part of the team around the child by those professionals who have been working with them and there can be resistance to re-assessing a situation which shows them in a different light. Sometimes parents will actively try to enlist the help and support of these professionals and dealing with these issues can divert focus away from the central issue of the welfare and safety of the child.

There is a general difficulty for all who work with families of disabled children of over identifying with the parents' situation. This is particularly the case for professionals who may have been working with the family for sometime but it can affect all who come into contact with the family. Workers may feel sorry for parents, or indeed to view them as "heroic carers". The child becomes seen as a passive recipient of parental care, which is disempowering and may divert attention away from the parenting needs of the children. This is significant in a child protection context, where a risk assessment must include consideration of the adequacy or safety of parenting, as opposed to the provision of care.

Parents and carers may feel that only they are able to understand their child and be able to interpret their wishes. This may lead to an oversight of the child's wishes.

Families with disabled children may also have issues about the misuse of alcohol and drugs, mental health, domestic abuse just as in other families.

The parent or carer may be disabled and not receiving the support they require meet the additional demands of being a parent.



## Reporting and investigating child protection concerns

Where a practitioner has concerns that a disabled child may be being abused or neglected, they should follow their own agency policies and procedures, including prompt discussion with an appropriate manager or with the designated member of staff who has responsibility for child protection in the agency/service provider and referral made in a timely manner. Referrals should be made using the Multi-agency Referral Form which follows the Signs of Safety format now adopted in Northumberland.

<b>Reporting and investigating child protection concerns for DC&amp;YP:</b>
In line with any referral of a child protection concern, state specifically what the concern is, include recent changes in behaviour, responses to individuals in addition to other indicators of concerns or descriptions of incidents.
State the child's diagnosis (if known), the main difficulties affecting day to day functioning and avoid describing solely in broad terms such as learning disability.
State the child's medical conditions, associated treatments and how they are managed. Clarify whether the impairment/condition has been medically assessed and diagnosed.
Describe how the child communicates (thoughts, behaviours, feelings and wishes) and what aids to support communication are used, e.g. symbols/picture communication symbols, Makaton.
Describe how the child expresses distress.
In the absence of direct substantiation of a concern (e.g. a disclosure), state a hypothesis based on professional judgement (the person raising concern is likely to be someone who knows the child/family more than others so his/her judgement is valid).
Detail the other agencies/services that are involved and what their specific role/ service is (e.g. support, respite care), including those supporting adult carers.
Detail child's network – e.g. family members, friends, neighbours. Specifically identify those who provide care and/or support.
Not delay passing on a concern and/or making a referral because of lack of any of the above information.
Accurately record concerns and actions taken.

## **Investigation of allegations of abuse involved DC&YP**

Local policies and procedures must be followed where there is reasonable cause to believe that any child, is suffering, or is at risk of suffering, significant harm. The first responsibility, as with any investigation into allegations of abuse and/or neglect is to ensure that the child is safe including when the child is living away from home in foster, residential, secure or hospital care. Consideration also needs to be given to the wellbeing and protection needs of any siblings living in the family home. As with all enquiries, the need for accurate, detailed, contemporaneous recording of information is essential.

### **Investigation of allegations of abuse involved DC&YP**

Any enquiries planned or undertaken should be carried out with sensitivity and an informed understanding of a disabled child's needs and impairment. This includes taking into consideration matters such as the venue for the interview/s; the care needs of the disabled child; whether additional equipment or facilities are required; who should conduct the interview; who should be present at the interview and whether someone with specialist skills in the child's preferred method of communication needs to be involved.

Throughout the process, all service providers must ensure that they take time to communicate clearly and objectively the relevant information, with the disabled child and family, and with one another, as there is likely to be a greater number of practitioners involved with a disabled child than with a non-disabled child. This should be coordinated through the lead professional as consideration should be given to the impact of information sharing on any criminal investigations.

The disabled child's preferred communication method for understanding and expressing themselves needs to be given the utmost priority, and where a child has speech, language and communication needs, including those with non-verbal means of communication and deaf children, arrangements will need to be made to ensure that the child can communicate about any abuse or neglect she/he is experiencing and their views and feelings can be made obtained.

When assessing/considering the child's needs, the focus should always be: "what are their abilities?" Even if the child cannot communicate through the usual communication media, this should not prevent investigative agencies from attempting to obtain their account.

Some disabled children may not be able to state dates/times when particular events (such as an abusive experience) occurred but may be able to describe an event as before or after some other event e.g. at mealtime.

The collation of medical information concerning the health needs of the child is important as it may have a bearing on the outcome of any enquiry/investigation. Consider and identify who may have the best knowledge about the child's medical condition, for example, paediatrician; school doctor or school nurse. Where there is a need for a medical examination, consideration needs to be given to the most appropriate medical professional who should undertake the examination, the venue, timing and the child's ability to understand the purpose of the medical procedure.

The number of carers involved with the child should be established as well as where the care is provided and when. A disabled child's network of carers could include short break foster carers, befrienders, sitters, personal assistants, community support workers, residential care staff, independent visitors and learning support assistants.

Do not underestimate the important information that others can provide (including, for example, transport drivers/escorts).

Is there someone who can support the child's communication, e.g. a speech and language therapist or teacher?

### **Specific Safeguarding considerations for DC&YP - links to guidance/resources**

Exploitation:

<http://csethesigns.scot/parents/keep-your-child-safe/disability-a-risk-factor/>

[https://www.nwgnetwork.org/wp-content/uploads/2018/05/tcs\\_cse\\_physicaldisabilities\\_toolkit.pdf](https://www.nwgnetwork.org/wp-content/uploads/2018/05/tcs_cse_physicaldisabilities_toolkit.pdf)

Child to Parent Violence:

[https://www.proceduresonline.com/nesubregion/p\\_adolescent\\_par\\_vio\\_abuse.html](https://www.proceduresonline.com/nesubregion/p_adolescent_par_vio_abuse.html)

Perplexing Presentations:

<https://childprotection.rcpch.ac.uk/resources/perplexing-presentations-and-fii/>

Transition:

[Safeguarding Transitional Protocol](#)