



Safeguarding Support Document

CONTENTS

1	Introduction	3
2	General Principles	3
3	Definitions of Abuse	5
3.1	Concealed Pregnancy	5
3.2	Cyber Abuse	7
3.3	Discriminatory Abuse and Hate Crime	8
3.4	Domestic Abuse	8
3.5	Emotional or Psychological Abuse	10
3.6	Fabricated Induced Illness	11
3.7	Female Genital Mutilation	12
3.8	Financial or Material Abuse	12
3.9	Forced Marriage	13
3.10	Migrant Abuse and Human Trafficking	15
3.11	Neglect and Acts of Omission	18
3.12	Organisational (Institutional) Abuse	20
3.13	Physical Abuse	20
3.14	Sexual Abuse / Sexual Exploitation	21
3.15	Prevent Strategy and Violent Extremism	26
3.16	Dangerous Dogs	27
4	Recognition of Abuse	29
5	Parental Engagement	34
5.1	Toxic Trio	35
5.2	Parental Mental Health	36
6	Child Mental Health	38
7	Sudden Unexpected death in Children	43
8	Whistleblowing	47

1 Introduction

Following the review of child protection and safeguarding practice by Professor Munro the government issued the current statutory guidance of Working Together to Safeguard Children (WTSC) 2015; this document is the current legal guidance for child protection procedures for agencies. This is supported by other legislation such as the Children Act 1989, 2004, 2009. Other relevant legislation is indicated within the WTSC 2015 document.

Whilst local authorities play a lead role, safeguarding children and protecting them from harm is everyone's responsibility. Safeguarding and promoting the welfare of children is defined 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.

Local agencies, including the police and health services, have a duty under section 11 of the Children Act 2004 to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions.

With regards to adults Chapter 14 of the Care and Support Statutory Guidance (Issued under the Care Act 2014) replaces the 'No secrets' guidance. Safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs) and:
- Is experiencing, or at risk of, abuse or neglect: and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

Again, the safeguarding duties have a legal effect in relation to the NHS and the Police.

2 General Principles

A child is defined as anyone who has not reached their eighteenth birthday. Effective safeguarding systems for children are those where:

- The child's needs are paramount, and the needs and wishes of the each child, be they a baby or infant, or an older child, should be put first, so that every child receives the support they need before a problem escalates;
- All professionals who come into contact with children and families are alert to their needs and any risks of harm that individual abusers, or potential abusers, may pose to children;
- All professionals share appropriate information in a timely way and can discuss any concerns about an individual child with colleagues and local authority children's social care.
- High quality professionals contribute to whatever actions are needed to safeguard and promote a child's welfare and take part in regularly reviewing the outcomes for the child against specific plans and outcomes:
- Local Safeguarding Children Boards (LSCB) coordinate the work to safeguard children locally and monitor and challenge the effectiveness of local arrangements:

- When things go wrong Serious Case Reviews (SCRs) are published and transparent about any mistakes which were made so that lessons can be learnt: and
- Local areas innovate and changes are informed by evidence and examination of the data. (WTSC 2015)

The aims of adult safeguarding are to:

- Stop abuse or neglect whenever possible;
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs:
- Safeguard adults in a way that supports them in making choices and having control about how they want to live:
- Promote an approach that concentrates on improving life for the adults concerned:
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect:
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult: and
- Address what has caused the abuse or neglect.

3 Definitions of Abuse

'Abuse' is a violation of an individual's human and civil rights by any other person or persons and can take many different forms. Incidents of abuse may be one –off or multiple, and affect one or more persons. Abusive acts can take place anywhere- there is no such thing as an assumed safe place as any individual may be an abuser.

Professionals and others should look beyond single incidents or individuals to identify patterns of harm. Repeated instances of poor care may be an indication of more serious problems and of what is now described as organisational abuse (previously institutional). In order to see these patterns it is important that information is recorded and appropriately shared.

Abuse varies and includes:

Long-term- on-going family relationship such as domestic violence between spouses or generations or persistent psychological abuse; or

Opportunistic- such as theft occurring because money or jewellery has been left lying around. Sexual abuse can also be opportunistic.

Serial- when the perpetrator seeks out and 'grooms' individuals. Sexual abuse, some forms of cyber abuse and some forms of financial abuse fall into this category.

Situational- comes from external circumstances; it could arise because unrelated pressures have built up or because of challenging behaviours.

3.1 Concealed Pregnancy

Challenges of Concealed pregnancy

The concealment of pregnancy represents a real challenge for professionals in safeguarding the welfare and the wellbeing of the foetus and the mother. While concealment by its nature limits the scope of professional help, experience shows that better outcomes can be achieved by co-ordinating an effective inter-agency approach once the fact of the pregnancy is established.

This will also apply to future pregnancies where there has been a previous concealed pregnancy. In some cases, pregnancies may be concealed until or after delivery, when particular attention should be given to safeguarding the child's welfare, and indeed to the wellbeing of the mother.

A concealed pregnancy is:

When a woman knows she is pregnant but does not tell anyone or those who are told conceal the fact from all caring and health agencies.

- Where a woman appears genuinely not aware she is pregnant. Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought.
- Concealment of pregnancy may be revealed late in pregnancy, in labour or following delivery.

The birth may be unassisted whereby there are additional risks to the child and mother's welfare and long-term outcomes.

Child protection issues may arise where a pregnancy is disclosed late as the focus will always be on the child regardless of whether unborn or born, and so where there would normally be concerns about an unborn child, child protection procedures would be likely to

be initiated early in the pregnancy.

There is no national agreed definition of what constitutes a concealed pregnancy however there have been many studies carried out. The Crisis Pregnancy Agency (CPA) revealed that the main reasons for concealing or denying a pregnancy are fear of the social stigma of becoming pregnant in unconventional circumstances and fear of the family's reaction.

The report "Concealed Pregnancy, A Case Study in an Irish Setting" looked at 51 women who concealed their pregnancies between July 2003 and December 2004. The most striking aspect of the study was that the sample of women used including women of all ages, and of all social backgrounds, both married and single.

Concealment Definitions

Conscious Denial; When the woman recognises that she is pregnant but denies this to herself and others. Her denial is a coping strategy invoked because the reality of the pregnancy is unimaginable and threatening to her.

Concealment of Pregnancy; When a woman acknowledges the pregnancy to herself but hides it from others, because external stresses make it difficult for her to reveal the pregnancy or because she wants to retain control over the outcome. An additional sub group here relates to women who are not aware of being pregnant because of significant unusual features in the pregnancy cause her to deny it or makes diagnosis difficult.

Crisis Pregnancy; Defined as a "pregnancy which is neither planned nor desired by the woman concerned", and which represents a personal crisis for her. This can be the case in some forced marriages.

Late Booker; For the purpose of this document, late booking is defined as presenting for maternity services after 24 weeks of pregnancy.

Reasons are mixed but may include the woman who wants a baby against the wishes of others, or to serve a purpose known only to herself.

Un-booked women presenting in labour must be regarded as high risk as their medical, obstetric and antenatal histories will not be known. As such, they should be taken to the nearest Hospital without exception, either before or after the birth.

Reasons for concealment

There is limited research into concealed pregnancy and even less into the link between this and child abuse. The reality is that women may have a variety of reasons for their behaviour.

A Review of forty Serious Case Reviews (*DH 2002*) identified one death was significant to concealment of pregnancy. Earl (2000), Friedman et al (2005), Vallone & Hoffman, highlight that there is a well-established link between neonaticide – infanticide in the 24 hours following birth – and concealed pregnancy.

Studies have shown that late commencement of antenatal care may be a feature of teenage pregnancy, for a variety of reasons. These include not fully understanding the consequences and complications of risk factors in pregnancy, poor motivation to keep appointments and concealment or denial of pregnancy.

In some cases the woman or young girl may be truly unaware that she is pregnant until very late into the pregnancy. For example a young woman with a learning disability may not understand why her body is changing. Denial may persist as a result of thinking that the problem will go away if it is ignored. Due to stigma, shame or fear, concealment may be a deliberate means of coping with the pregnancy without informing anyone.

A woman or girl may conceal their pregnancy if it occurred as the result of sexual abuse,

either within or outside the family, due to her fear of the consequences of disclosing that abuse.

A woman who has had a previous child removed from her may be reluctant to inform the authorities that she is pregnant. There have been cases where the mother not only conceals the pregnancy and birth, but also the baby's body, should the baby die.

Concealed birth (including concealed still birth) represents a criminal offence, though enquiries into these circumstances should be conducted sensitively and with due regard to the context in which this takes place.

A pregnancy may be concealed in situations of domestic violence. Domestic abuse is more likely to begin or escalate during pregnancy.

In some religions and cultures, a pregnancy outside of marriage may have life threatening consequences for the woman involved. In these instances, women have been known to conceal their pregnancy or 'disappear' to avoid bringing shame to the family.

General Information

Although there is minimal evidence available, staff should remain alert to a future pattern of concealed pregnancies once one has been identified. To assess the longer-term prognosis for the child it is important to gain some understanding of what outcome the mother intended for the child i.e. did she hope it would survive?

There are also concerns in relation to the age of the mother. The Sexual Offences Act 2003 note that sexual activity with a child under the age of 13 is not acceptable and that regardless of the circumstances, children of this age can never legally give their consent and penetrative sex with a child under the age of 13 is classed as rape regardless of the age of the perpetrator/s and must be referred to Social Care/Police as a child protection issue.

Sexual activity with a child under 16 is also an offence, but where the child is between 13 and 16 consideration must be given to discussion with other agencies.

Remember the child is at risk at all times during the pregnancy through to the birth. If you are aware the mother has not yet engaged with Maternity services you need to ensure this is highlighted to Social Care, ensure the mother is taken to the Hospital.

3.2 Cyber Abuse

Sadly, cyber abuse is now a widespread problem, the Internet providing a useful medium for those wishing to exploit young people, and children particularly. At the same time other information communication technology (ICT) methodologies are increasingly being used by perpetrators to prey on their victims, for example, using webcams, texting and other mobile phone technologies.

Internet chat rooms, discussion forums and bulletin boards are known to be used by perpetrators as a means of contacting children or young people as a way of establishing deceptive relationships with them. They then 'groom' the victims, either psychologically on the Internet itself, or by arranging to actually meet with them. Often victims believe that they are actually chatting to genuine people on-line. Alternatively, the perpetrators may ask the victim to transmit pornographic images of themselves, or to perform sexual acts live in front of a webcam.

The perpetrators are very adept at manipulating their victims and particularly in the case of children blackmailing a child or young person this can lead to a child feeling threatened, unsafe embarrassed, ashamed, worried, anxious and suicidal.

As well as these risks the internet possess a risk regarding a child or young person accessing explicit or dangerous web pages that can lead to the child or young person by people who can groom them.

Examples of these web cases worries can include web pages that allow the child to watch sexual content, learning how to become anorexic, social networking suicide sites etc. This list is not exhaustive as the internet has many different access points and can present a significant risk to the most vulnerable.

3.3 Discriminatory Abuse and Hate Crime

Hate crimes are any crimes that are targeted at a person because of hostility or prejudice towards that person's:

- disability
- race or ethnicity
- religion or belief
- sexual orientation
- transgender identity

This can be committed against a person or property. A victim does not have to be a member of the group at which the hostility is targeted. In fact, anyone could be a victim of a hate crime.

These characteristics are referred to as equality strands. Primarily, this was to ensure a consistent working definition to allow accurate recording and monitoring. Crimes based on hostility to age, gender, or appearance, for example, can also be hate crimes, although they are not centrally monitored.

Hate crime can take many forms including:

- physical attacks such as assault, grievous bodily harm and murder, damage to property, offensive graffiti and arson;
- threat of attack including offensive letters, abusive or obscene telephone calls, groups hanging around to intimidate, and unfounded, malicious complaints; and
- verbal abuse, insults or harassment – taunting, offensive leaflets and posters, abusive gestures, dumping of rubbish.

Hate Incidents

Hate Incidents can feel like crimes to those who suffer them and often escalate to crimes or tension in a community. For this reason the police are concerned about incidents and you can use this site to report non-crime hate incidents. The police can only prosecute when the law is broken but can work with partners to try and prevent any escalation in seriousness.

Why should I report hate crime?

Hate crimes and incidents hurt; they can be confusing and frightening. By reporting them when they happen to you, you may be able to prevent these incidents from happening to someone else. You will also help the police understand the extent of hate crime in your local area so they can better respond to it.

http://report-it.org.uk/what_is_hate_crime

3.4 Domestic Abuse

Domestic abuse is incidents or patterns of controlling, coercive or threatening behaviour,

violence or abuse... by someone who is or has been an intimate partner or family member regardless of gender or sexuality. Domestic abuse includes psychological, physical, sexual, financial, emotional abuse; honour based violence; female genital mutilation and forced marriage. The age range has been extended down to 16.

Domestic abuse is sadly becoming a bigger and bigger issue in today's society. Clinicians' and ambulance staff are – as always – in the front line and come into increasing contact with domestic violence and both its victims and perpetrators.

Incidence of Domestic Abuse / Violence

It is estimated that on average two women are killed each week as a result of domestic violence. However, it is not 'gender neutral' - 1 in 4 women and 1 in 6 men will experience DV in their lifetime.

Domestic violence occurs across society, regardless of age, gender, race, sexuality, wealth, and geography. It can be part of a larger spectrum of relationship violence, which also includes sexual assault, child and elder abuse, animal abuse. Also, drug and alcohol misuse is also known to be a factor in many situations.

All ambulance staff clearly have a duty to protect anybody from abuse, which in the case of domestic abuse may be adults and / or children. Domestic Abuse and Violence can have a profound and long term effect on children in particular and staff should be aware of this at all times.

Domestic abuse can be a manifestation of any one or more known categories of abuse. Emotional abuse is a major factor in many domestic abuse cases, and the victim may exhibit one or more of the following;

- Psychological / emotional abuse: intimidation and threats (e.g. To kill or maim, to report victims to agencies, to remove or hurt children or family pets)
- Social isolation
- Verbal abuse
- Humiliation
- Constant criticism
- Enforced trivial routines
- Over intrusiveness
- False allegations

Awareness

Staff need to be aware of the inter-relationship between domestic violence and the abuse of children.

There may be serious and long term effects on children who witness domestic violence, which in its own right can produce behavioural problems in the child, including low esteem, depression, absenteeism, ill health, bullying and many more.

Children can be harmed by overhearing or witnessing violence within their family setting.

Staff may be in a unique position to witness or hear about first hand, abusive situations in family settings. By nature of our work we often have access to locations where other professionals would not be welcome.

Responsibilities

As is already well documented, as professionals we have both a statutory and moral duty to share concerns that we may have in relation to a child or vulnerable adult that may be being

abused. That duty extends to reporting concerns about the possibility of domestic violence or abuse having happened.

Additionally, staff should consider very carefully the position of children caught up in, or witnessing situations of domestic abuse. Domestic abuse is often a long term situation and it is well known that long term exposure to domestic abuse can have a profound effect on the development of a child.

Not only is it essential that we do all in our power to protect the victims of abuse, but it is equally important to take in a bigger picture and recognise that there may be more than one victim in the long term.

Staff should consider very carefully in situations where children are caught up in, or witness, domestic violence whether it is in their best interest that they be referred to the relevant Children's Social Care.

Ambulance staff, amongst many other professionals can find themselves in a unique position whereby they have the real ability to save a child from a lifetime of abuse, and in doing so potentially promote their long term development and help towards securing a better future into adulthood for them.

Sharing Information or Referring

By definition there will be many occasions when we are at a location where domestic abuse and / or violence may have taken place alongside our colleagues from the police. It is important in these situations that we act unilaterally in referring any concerns that we may have to the relevant Children's Social Care department. Relying on each other to take the initiative can, and has lead in the past to nothing happening.

Likewise, and in keeping with making referrals in general the same applies when taking victims of domestic abuse to an A&E Department. Regardless of whether the hospital staff make their own referral ambulance staff should still follow the Trust referral pathway.

Domestic abuse is no different to any other form of abuse in that it is totally unacceptable. If staff have a concern that domestic abuse has occurred they should follow the normal Trust pathways.

3.5 Emotional or Psychological Abuse

Emotional / psychological abuse is the persistent emotional ill-treatment of a person such as to cause severe and persistent adverse effects on their emotional development or wellbeing. It may involve conveying to them 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. It may involve causing the person frequently to feel frightened or in danger, or the exploitation or corruption of the person. There may be threats of harm or abandonment, deprivation of contact, humiliating, blaming, controlling, intimidating or coercive behaviours, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

If someone is always telling a child that they're ugly, stupid and worthless or that the adult wished the child had never been born - that's emotional abuse. It's wrong, even if they are not doing it on purpose. The effects can make the child feel scared, sad and upset.

It is emotional abuse when someone is:

- Calling a child names or shouts down at them
- Putting the child down or saying the child isn't good enough
- Ignoring a child or leaving a child out of things/family/activities

- Saying or do things that make the child feel bad about themselves
- Pushing a child away or makes the child feel like the adult doesn't belong in the family
- Making a child do things that are not appropriate to the child's age or development; like caring for siblings
- Trying to control the child or push the child too hard
- Treating the child differently from siblings
- Putting the child in dangerous situations
- Making the child see things that are distressing, like domestic violence
- Stopping the child from having friends

Emotional damage occurs as a result of all forms of abuse, but emotional abuse alone can be difficult to recognise as the person may be physically well cared-for and the living environment in good condition. Some factors which may indicate emotional abuse are:

If the child

- is constantly denigrated before others
- is constantly given the impression that the parents are disappointed in them
- is blamed for things that go wrong or is told that they may be unloved/sent away
- is either bullying others or being bullied him/herself

If the parent

- does not offer any love or attention, e.g. leaves them alone for a long time
- is obsessive about cleanliness, tidiness etc.
- has unrealistic expectations of the child, e.g. educational achievement/toilet training

Children can be at risk of emotional abuse because of the circumstances of adults in their immediate surroundings, e.g. if there is an atmosphere of domestic violence, adults with mental health problems or a history of drug or alcohol abuse. It cannot be assumed that a child is safe in a care setting, as children in this environment can be subject to exploitation e.g. for prostitution.

3.6 Fabricated Induced Illness

Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes ill-health, to a vulnerable person they are looking after. Common description terms used are Fabricated or Induced Illness (FII), 'factitious illness by proxy' or 'Munchausen's syndrome by proxy'.

The following list is of behaviours exhibited by carers who may be associated with fabricating or inducing illness in a child. This list is not exhaustive and should be interpreted with an awareness of cultural behaviours and practices which can be mistakenly construed as abnormal behaviours:

- Deliberately inducing symptoms in children by administering medication or other substances, by means of intentional transient airway obstruction or by interfering with the child's body so as to cause physical signs.
- Interfering with treatments by over dosing with medication, not administering them or interfering with medical equipment such as infusion lines;
- Claiming the child has symptoms which are unverifiable unless observed directly, such as pain, frequency of passing urine, vomiting or fits. These claims result in unnecessary investigations and treatments which may cause secondary physical problems;

- Exaggerating symptoms which are unverifiable unless observed directly, causing professionals to undertake investigations and treatments which may be invasive, are unnecessary and therefore are harmful and possibly dangerous;
- Obtaining specialist treatments or equipment for children who do not require them;
- Alleging psychological illness in a child.

Concerns may arise about possible fabricated or induced illness when:

- Reported symptoms and signs found on examination are not explained by any medical condition from which the child may be suffering; or
- Physical examination and results of medical investigations do not explain reported symptoms and signs; or
- There is an inexplicably poor response to prescribed medication and other treatment; or
- New symptoms are reported on resolution of previous ones; or
- Reported symptoms and found signs are not seen to begin in the absence of the carer; or
- Over time the child is repeatedly presented with a range of signs and symptoms; or
- The child's normal, daily life activities are being curtailed, for example school attendance,
- Beyond that which might be expected for any medical disorder from which the child is known to suffer.

3.7 Female Genital Mutilation

Female Genital Mutilation (FGM) is child abuse and a form of violence against women and children, and therefore should be dealt with as part of existing child and adult safeguarding/protection structures, policies and procedures.

FGM is a collective term for procedures which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons (WT2010).

In the UK FGM is a criminal offence (*Prohibition of Female Circumcision Act 2003*) and equally the act makes it an offence for UK residents or nationals to carry it out, or knowingly allow it to happen abroad – even in countries where it is legal.

FGM has potentially serious health implications, is unnecessary and can be extremely painful, both at the time and later on in life. It is typically carried out between the ages of 4 and 13. It remains relatively common across the world. It is estimated that approximately 103,000 women aged 15-49 and approximately 24,00 women aged 50 and over who have migrated to the England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM. (Multi –Agency Practice Guidelines: Female Genital Mutilation 2014)

3.8 Financial or Material Abuse

Financial recorded abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse also occurring. Although this is not always the case, everyone should be aware of this possibility. This includes theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangement including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Potential indicators of financial abuse include:

- Change in living conditions;

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- Lack of heating. Clothing or food;
- Inability to pay bills/unexplained shortage of money;
- Unexplained withdrawals from an account;
- Unexplained loss/misplacement of financial documents;
- The recent addition of authorised signers on client or donor's signature card; or
- Sudden or unexpected changes in a will or other financial documents.

This is not an exhaustive list, nor do these examples prove that there is actual abuse occurring. However, they do indicate that a closer look and possible investigation may be needed.

3.9 Forced Marriage

Introduction

A marriage must be entered into with the full and free consent of **both** people. Everyone involved should feel that they have a choice. An arranged marriage is not the same as a forced marriage. In arranged marriages the families take a leading role in choosing the marriage partner. The marriage is entered into freely by both people.

However, in some cases, one or both people are **forced** into a marriage their families want. A forced marriage is a marriage conducted without the valid consent of both people, where pressure or abuse is used. The victims are put under both physical pressure (harm / injury may be threatened or inflicted), or emotional pressure (they may be made to feel that they are bringing shame on their family) to get married.

Hundreds of young people (particularly girls and young women) are forced into marriage each year. Some are taken overseas to marry whilst others may be married in the UK. Forced marriage can involve child abuse, including abduction, violence, rape, enforced pregnancy and enforced abortion. Refusing to marry can place a young person at risk of murder, sometimes also known as "honour killing".

A forced marriage is not sanctioned within any culture or religion.

The majority of cases reported in the UK involve South Asian families, but also families from East Asia, the Middle East, Europe and Africa.

In some cases people are taken abroad without knowing they are to be married. Children and young adults may only be aware they are going on holiday or to learn their cultural / ethnic culture. When they arrive in the country their passports may be taken by their family to stop them from returning home.

Forced marriage is an abuse of human rights, and a form of domestic violence, hate / discriminatory crime, honour crime, sexual assault / rape, migrant / human trafficking and child abuse.

Children as young as 7 or 8 can be victims of forced marriage.

There are many cases that don't get reported, but of those that do it is known that around 85% of cases involve women and 15% involve men.

Reasons for Forced Marriage

There are well documented reasons for forced marriages which include:

- Controlling unwanted behaviour and sexuality (including perceived promiscuity, or being gay, lesbian, bisexual or transgender) – and particularly the behaviour and sexuality of women.
- Protecting 'family honour'
- Responding to peer group or family pressure

- Attempting to strengthen family links
- Ensuring land, property and wealth remain within the family
- Protecting perceived cultural ideals
- Protecting perceived religious ideals which are misguided
- Preventing 'unsuitable' relationships e.g. outside the ethnic, cultural, religious or caste group
- Assisting claims for residence and citizenship
- Long-standing family commitments
- Arrangements for the marriage can be made very early on in the child's life, including pre-birth.
-

General Information

A forced marriage will be valid unless and until it is set aside by a divorce or annulment in a civil court. Women forced to marry may find it very difficult to initiate any action to bring the marriage to an end and may be subjected to repeated rape (sometimes until they become pregnant) and on-going domestic abuse within the marriage.

Women under threat of forced marriage may appear anxious, depressed and emotionally withdrawn with low self-esteem. They may come to the attention of health professionals for a variety of reasons such as unexplained injuries or mental health, self-harming, eating disorders or challenging behaviour disorders but they are unlikely to disclose forced marriage. Others may come to the attention of health professionals, for example through pregnancy.

Other warning signs may include a family history of older siblings marrying early. In these cases their parents may feel that it is their duty to ensure that children are married soon after puberty in order to protect them from sex outside marriage.

Women with physical or learning disabilities may be withdrawn from their social networks or day care and kept at home. However, there have been occasions when women have presented with less common warning signs such as cutting or shaving of a woman's hair as a form of punishment for disobeying or perhaps 'dishonouring' her family.

In some cases a girl may report that she has been taken to the doctors to be examined to see if she is a virgin. There have been reports of women presenting with symptoms associated with poisoning, or burning themselves by setting light to their hair.

Some people may feel that running away is their only option. For many people, especially women from ethnic minority communities, leaving their family can be especially hard. They may have no experience of life outside the family. In addition, leaving their family (or accusing them of a crime or simply approaching statutory agencies for help) may be seen as bringing shame on their honour and on the honour of their family in the eyes of the community. This may lead to social ostracism and harassment from the family and community. For many, this is simply not a price they are prepared to pay.

For people with mental and physical disabilities, their impairment and care needs may prevent them from leaving and make them completely reliant on the family.

Those who do leave often live in fear of their own families who will go to considerable lengths to find them and ensure their return. Families may solicit the help of others to find their runaways, or involve the police by reporting them missing or falsely accusing the woman of a crime.

Some families have traced women through medical and dental records, bounty hunters, private investigators, local taxi drivers, members of the community and shopkeepers or

through National Insurance numbers, benefit records, school and college records. Sometimes having traced them, the family may murder them (so-called “honour killing”).

Health professionals should be alert to potential warning signs and consider that forced marriage could be the reason. However, they should be careful not to assume that forced marriage is an issue simply on the basis that a woman presents with any of these problems. Of course, some of these warning signs could be indicative of other forms of abuse.

Forced marriage is recognised in the UK as a form of domestic abuse and as serious abuse of human rights. The Department of Health has joined forces with the Forced Marriage Unit to raise awareness of the problem.

3.10 Migrant Abuse and Human Trafficking

There are no exact estimates of the numbers of trafficked children at this time. However, one estimate suggests that 50 per cent of trafficking victims worldwide are children. There are many reasons for imprecise data on child trafficking. Trafficking is a criminal act, shrouded in secrecy. Victims are often afraid to come forward, making it difficult to get accurate numbers. In addition, there is no common methodology to count trafficking victims. Consistent criteria to define a trafficked person in accordance with the international legal definition are often not used.

Statistics may exclude those trafficked within national borders and often do not disaggregate trafficking victims by age and sex.

Despite the absence of an exact count of trafficked children, the numbers are enormous, and the trend is on the rise.

Children are trafficked into a range of exploitative practices that include:

Labour exploitation: Children may be trafficked to work on plantations, in mines or in other hazardous conditions, such as handling chemicals and pesticides or operating dangerous machinery. They are often kept isolated within destination countries and are fearful of reporting the abusive work conditions to authorities.

In certain cases, children are trafficked into bonded labour. The family typically receives an advance payment, often structured so that ‘expenses’ or ‘interest’ are deducted from a child’s earnings in such amounts that it is nearly impossible to repay the debt or ‘buy back’ the child.

Domestic work: The International Labour Organization (ILO) estimates that the majority of child domestics are girls. Parents and children are often lured by promises of education or a good job. Once trafficked, they may find themselves stripped of their identification papers and lacking any support network. They are dependent on their exploiters for safety, food and shelter, and most endure harsh working conditions.

Sexual exploitation: Children, especially girls, are trafficked to work in brothels, massage parlours, prostitution rings or strip clubs, or used to produce pornographic materials. Though it is difficult to determine precisely, ILO global child labour figures for the year 2000 estimate that 1.8 million children are exploited in the commercial sex industry, suffering extreme physical, sexual and psychological violence and abuse by traffickers, pimps and ‘customers’.

Marriage: Girls are trafficked as brides for various reasons. When poverty is acute, a girl may be regarded as an economic burden for her family and her marriage to an older man may be seen as a family survival strategy.

Sometimes, the arrangements made by male migrants to find wives from their home regions result in the trafficking of child brides. There is a growing demand by older men for a young

virgin bride, particularly in places where the fear and risk of HIV/AIDS infection is high. Sometimes families may encourage their daughters to marry early because they mistakenly believe that it will protect their girls from HIV. Early marriage is common in Central and Western Africa, where 40 per cent and 49 per cent, respectively, of girls under the age of 19 are affected.

Illicit adoption: An increase in demand for adoption has helped to propel the unlawful trafficking of babies and young children. Sometimes mothers from developing countries sell their baby or young child, at other times the infant is stolen and mothers are told the baby was stillborn.

Sport: Children, particularly young boys, have been trafficked as camel jockeys. The sport is a lucrative industry, and children are especially appealing for this purpose because of their small size. The use of children as jockeys in camel racing is extremely dangerous and can result in serious injury and even death. Boys who lose races are often brutalised by their exploiters, deprived of their salary and food, and mentally and physically abused.

Begging: Children may be recruited and trafficked to earn money for others by begging or selling goods on the street. In some cases, child beggars are maimed by their captors to engender sympathy and greater charity.

Organs: Organ trafficking is specifically included in the Palermo Protocol. Although this horrific practice is nearly impossible to monitor or detect, it nonetheless is reported.

Child trafficking victims are subjugated and physically abused by the perpetrators: traffickers, employers, pimps, madams, and 'customers'. Trafficked children are often beaten and abused, and the violence occurs at all stages of the trafficking cycle.

Emotional impact: Children who have been trafficked have reported feelings of shame, guilt and low self-esteem and are frequently stigmatized. They often feel betrayed, especially if the perpetrator was someone they had trusted. These factors as well as the experience itself can cause nightmares, sleeplessness, feelings of hopelessness and depression. Some children who have been trafficked turn to substance abuse to numb their psychic pain, and others have attempted suicide.

Physical impact: Children trafficked into the sex industry are susceptible to contracting sexually transmitted infections, including HIV/AIDS. The dangerous and mistaken belief in some countries that sex with a virgin can cure HIV/AIDS has led to even higher demand for young girls. Many women and girls report that 'customers' pay more for sex without a condom, and they – especially girls – are rarely in a position to insist upon condom use. Domestic workers, street children, child labourers and children in detention are vulnerable to rape and sexual exploitation, and are at high risk of contracting HIV/AIDS.

Psychosocial impact: Children who are trafficked typically suffer adverse effects to their social and educational development. Many have no family life and are forced to work at young ages. Without access to school or family support, and cut off from normal social activities, they fail to develop their potential. Also, under constant surveillance and restriction, they have little contact with the outside world and often do not have the possibility to seek help. When they are victims of physical and emotional violence and abuse, the effects may be life-threatening and long term. Coordinated efforts are needed to stop and prevent child trafficking. Through specific steps to advance public policy, awareness and response, it is possible to end the scourge of child trafficking, to hold perpetrators of crimes of trafficking of children accountable, and to build a protective environment to keep children safe from harm.

Trafficking victims often come from poor families and lack economic opportunities. Children who have minimal education, lack vocational skills or have few prospects for job opportunities are most at risk. These factors, when compounded by gender, racial or ethnic discrimination, or insecurity caused by armed conflict and civil strife, create the ideal environment for trafficking networks to thrive. Unless these underlying causes are addressed, the more direct measures to stop trafficking will have limited success. Some of the main areas in which members of parliament can take action are described below.

Poverty: Poverty heightens children's vulnerability to traffickers. One of the most obvious ways material poverty leads to exploitation and abuse is through child labour. Poverty frequently forces vulnerable children to turn to hazardous work. Those who attempt to sell children into slavery or sexual exploitation do not seek their prey in comfortable suburbs; they look in the poorest shanty towns or the most underprivileged rural areas, where grinding poverty can heighten children's vulnerability to protection abuses.

With promises of employment opportunities abroad, families in extreme poverty may send their children away to work. Not all poor children are trafficked. They are most vulnerable, but vulnerability increases through a confluence of such factors gender and ethnic discrimination. Those who are most at risk are also in close proximity to an environment where trafficking is pervasive.

Inequality of women and girls: The legal and social inequality of women and girls is a breeding ground for trafficking. Where women and girls are objectified and seen as commodities, a climate is created in which girls can be bought and sold. Far too often girls are denied the opportunity to go to school and instead are forced to stay at home to perform household chores. They remain unskilled and uneducated. Girls are frequently abused within their families, making the lure of traffickers seem like an escape from domestic exploitation and violence. For many, migrating or seeking jobs outside their community is not just an economic decision; it may be a quest to find personal freedom, better living conditions or a means to support their families.

Low school enrolment: Children who are not in school can easily fall prey to traffickers. The estimated global number of children not attending school is 121 million girls. School enrolment is a critical factor in the fight against trafficking. Uneducated children have few opportunities for their future, and are therefore more vulnerable to traffickers' promises of money and a 'better life'. Additionally, most prevention messages are aimed to children who can read, placing illiterate children at a disadvantage. School can also provide a haven to keep children off the streets.

Children without caregivers: Children who are without caregivers are extremely vulnerable to trafficking and exploitation. Parents provide an essential safety net for their offspring. Children without parental protection, or those placed in institutions, are targets for traffickers. Children who grow up in institutions often lack ties to community as well as opportunities and so may be more at risk. Assessments by the International Labour Organisation have found that orphaned children are much more likely than non-orphans to be working in domestic service, commercial sex, commercial agriculture or as street vendors.

Orphans or children separated from their parents due to poverty, armed conflict, violence or migration may live with more distant relatives or a foster family. Without guidance, a sense of belonging or opportunities, they may be at an increased risk of trafficking.

Millions of children in Africa are orphaned by HIV/AIDS, and in Asia and Eastern Europe the threat of HIV/AIDS is on the rise. When caregivers become sick or die, older children may be removed from school to take care of their siblings. Family members who cannot work and who need expensive medications put a financial burden on the family. Children may be forced to supplement the family's income and thus be more vulnerable to traffickers. Combating HIV/AIDS would have the additional effect of reducing child trafficking.

Lack of birth registration: Children who are not registered are more susceptible to trafficking. It is estimated that 41 per cent of the children born in 2000 were not registered at birth. When children are without a legal identity it is easier for traffickers to 'hide' them. It is also more difficult to trace and monitor disappearances. In addition, without a birth certificate, it is difficult to confirm the child's age and hold traffickers accountable. Lack of identification may mean that children who are trafficked between countries cannot be traced to their country of origin and are thus not easily returned to their communities.

Humanitarian disasters and armed conflict: During conflicts, children may be abducted by armed groups and forced to participate in hostilities. They may be sexually abused or raped. Conflicts contribute to porous borders, increasing traffickers' ability to transport people. Finally, the influx of international workers may increase sexual exploitation and trafficking. There is increasing evidence documenting sexual exploitation by humanitarian workers and the arrival of peacekeeping troops has been correlated with escalating child prostitution.

Such catastrophic disasters as protracted armed conflict and the tsunami that struck South East Asia at the end of 2004 often leave children unaccompanied. Cataclysmic events that disrupt livelihoods or result in the death of one or both parents make children vulnerable to trafficking. These crises create chaos and a breakdown of law enforcement, which decreases the likelihood of traffickers facing legal consequences.

Demand for exploitative sex and cheap labour: Trafficking and the skyrocketing demand for exploitative labour and sexual services are inexorably linked. The drive for rising profits too often trumps ethics, resulting in children being exploited in factories and sweatshops. Underlying attitudes about male entitlement can foster a perverse notion that it is acceptable for men to sexually exploit children and women. These attitudes are reinforced when men are allowed to sexually exploit without facing any repercussions or punishment.

Traditions and cultural values: Trafficking of children intersects the traditional role of extended families as caregivers and an early integration of children into the labour force. The 'traditional placements' of children in families of distant relatives or friends have mutated into a system motivated by economic objectives.

3.11 Neglect and Acts of Omission

Neglect is the persistent failure to meet a child or young person's basic physical and/or psychological needs, likely to result in the serious impairment of their health or development. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect the person from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to a child or young person's basic emotional needs.

Children need adequate food, water, shelter, warmth, protection and health care. They also need their caregivers to be attentive, dependable and kind. Children are neglected if these essential needs – the things they need to develop and grow – are persistently not met.

There are many signs that may indicate neglect; if your common sense and instincts tell you that something is wrong then you should take action.

Children may be neglected because they come from disadvantaged backgrounds, although most children from such backgrounds are well-cared for. A child's circumstances may also make them more vulnerable to neglect, such as children who are in care or seeking asylum.

Some adults find it difficult to organise their lives, which can lead to a chaotic home life for children. Some adults simply do not understand the needs of their children, possibly because they did not experience adequate parenting themselves. These adults sometimes neglect their children's physical needs.

Other adults find it difficult to show their feelings. This difficulty can cause them to neglect their children's emotional needs. For example, a parent may give gifts to their child as a substitute for feelings they are unable to express.

Mental health problems, domestic abuse, and drug or alcohol misuse, may also affect a parent's ability to meet their children's needs.

Neglect can have a debilitating and long-lasting effect on a child's physical wellbeing, and on their mental, emotional and behavioural development. In some cases the effects can cause permanent disabilities and, in severe cases, death. The effects of physical neglect may include:

- poor muscle tone/prominent joints
- poor skin: sores, rashes, flea bites
- thin or swollen tummy
- poor hygiene, like being dirty or smelly
- untreated health problems, such as bad teeth
- unwashed clothing
- inadequate clothing, like not having a coat in winter

The effects of neglecting a child's mental development may include:

- difficulties with school work
- missing school

The effects of neglecting a child's emotional development may include:

- being anxious about, or avoiding, people
- difficulty in making friends
- being withdrawn

The effects of neglecting a child's behavioural development may include:

- anti-social behaviour
- early sexual activity
- drug or alcohol misuse

The effects may last into adulthood and may cause a person to neglect their own children later in life.

An inadequate home environment may suggest that a parent cannot cope and can be a sign that children are being neglected; as are adults who leave their children alone for long periods, persistently ignore them, or fail to properly supervise or protect them from danger. And where adults have mental health problems, suffer violence in the home, or have a drug or alcohol addiction, it is possible that the children in their care may be neglected.

Poor appearance and delayed development (see Effects) are also common signs that may indicate a child is being neglected. A child taking on the role of carer of other family members, in the absence of a parent, is another sign.

Neglect and Acts of omission in relation to adults includes ignoring their medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

Self-Neglect: This covers a wide range of behaviours neglecting to care for one's personal hygiene, health or surroundings and includes behaviours such as hoarding.

3.12 Organisational (Institutional) Abuse

Children can be subject to living within an institutional setting, often not as in such high numbers as found within adults, however those that live within institutional settings can be subject to abuse while at the liberty of the adult caring/supervising them.

Examples of institutions for children can be:

- Residential schools and collages
- Children's Hospitals
- Rest bite care facilities
- Foster Care
- Interim Care facilities
- Young Person detention facilities
- Clubs and organisations for children
- Schools

The risk factors increase when the child remains within the institution over night or for extended periods of time as they can be groomed and accessed more readily by the perpetrator.

With regards to adults Organisational abuse includes neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

As well as a focus on catching a perpetrator from abusing children or adults, organisational abuse also focuses on collective failure of the organisation to provide an appropriate and professional service. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping.

It includes a failure to ensure the necessary safeguards are in place to protect children and vulnerable adults and maintain good standards of care in accordance with individual needs, including training of staff, supervision and management, record keeping and liaising with other providers of care. In these cases the Police should be notified to ensure that a criminal investigation is undertaken.

3.13 Physical Abuse

Physical abuse is when someone deliberately hurts or injures a child. Physical abuse can include hitting, kicking, hair pulling, beating with objects, throwing and shaking and can cause pain, cuts, bruising, broken bones and sometimes even death. No person has the right to hurt another person in this way. Physical abuse can happen as a single event or over a longer period of time.

Methods of perpetration can include:

- Hitting and smacking
- Slapping
- Punching
- Pinching
- Kicking
- Shaking or suffocating you
- Scalding or burning you
- Hair pulling

How physical abuse can make you feel

Experiencing physical abuse can leave you feeling:

- Fearful
- Anxious
- Lonely and isolated
- Depressed and sad
- Worthless with low self-esteem
- Like you want to self-harm
- Like you want to run away

Unable to concentrate at school, eat or sleep properly.

Who could physically abuse?

Physical abuse can be carried out by adults including your mum and dad as well as by other young people such as brothers, sisters, boyfriends, or girlfriends. Bullying can often involve hitting, kicking and hurting and this is also a form of physical abuse.

How common is physical abuse?

Worryingly, lots of children and young people experience abuse. In the last year almost 30,000 young people contacted ChildLine about physical abuse (April 2011 – March 2012). However, there are people out there who care and can help put a stop to it.

Physical abuse of adults includes assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

3.14 Sexual Abuse / Sexual Exploitation

Sexual abuse involves forcing or enticing a person to take part in sexual activities, whether or not the person is aware of what is happening. The activities may involve rape, physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving the child or young person looking at, or in the production of indecent material or watching sexual activities, or encouraging them to behave in sexualised ways far beyond the child/young person's age of development.

What is sexual abuse? How are children affected? What can we do about it?

An introduction to the subject of child sexual abuse, what we know about it and what we can do to prevent it happening.

Child sexual abuse remains a challenging topic which can be difficult to talk about. There is still a lot we don't know about the extent of sexual abuse, the long-term impacts and the effectiveness of treatment and prevention. These pages aim to provide an introduction to the subject and a guide to the policy, practice and research as well as useful resources for anyone working with children or with an interest in child protection.

What is child sexual abuse?

Child 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, and whether or not the child is aware of what is happening (HM Government, 2013).

Child sexual abuse includes:

- assault by penetration, including rape or penetration of the mouth with an object or part of the body
- sexual touching of any part of the body, clothed or unclothed, including using an object
- encouraging a child to engage in sexual activity, including sexual acts with someone else, or making a child strip or masturbate
- intentionally engaging in sexual activity in front of a child or not taking proper measures to prevent a child being exposed to sexual activity by others
- meeting a child following sexual 'grooming', or preparation, with the intention of abusing them
- taking, making, permitting to take, distributing, showing or advertising indecent images of children
- paying for the sexual services of a child or encouraging them into prostitution or pornography
- showing a child images of sexual activity including photographs, videos or via webcams.

How much child sexual abuse is there?

In 2000 the NSPCC published the first comprehensive study into the prevalence of child abuse in the UK. A further prevalence study was then published in 2011, during which, interviews with young adults, children and parents revealed that nearly a quarter of young adults experienced sexual abuse during childhood.

The Radford study also found that more than one in three children aged 11-17 (34%) who experienced contact sexual abuse by an adult did not tell anyone else about it, and, that four out of five children aged 11-17 (82.7%) who experienced contact sexual abuse from a peer did not tell anyone else about it.

Such low levels of disclosure and, that child sexual abuse is a crime that is usually only witnessed by the abuser and the victim, means that most sexual abuse goes unreported, undetected and unprosecuted.

Official statistics are published annually and tell us the amount of abuse that is recorded by the authorities during the year. This is the level of incidence of recorded abuse. 17,186 sexual crimes against children under 16 were recorded in England and Wales in 2011/12.

These statistics on child sexual abuse should be regarded as significant underestimates because of the extent to which child sexual abuse is not disclosed and/or reported. The most popular analogy used for child sexual abuse is that of an iceberg, where only a portion of the whole is visible. In the UK and elsewhere across the world we are faced with the visible peak of a much larger problem.

What are the signs and symptoms of child sexual abuse?

Sexual abuse can be very difficult to identify. Children who have been sexually abused may show a variety of signs and symptoms, including:

- becoming withdrawn, anxious or clingy
- depression
- aggressive behaviour
- obsessive behaviours, eating disorders
- sleep problems, bed-wetting or soiling
- problems with school work or missing school
- risk taking behaviour during adolescence
- alcohol and substance misuse

- becoming sexually active at a young age
- promiscuity

For a few children these effects may be relatively short-term, depending on the individual child, the nature of the abuse and the help they receive. However, for many the effects can last into adulthood and cause a long list of problems, especially mental health problems and drug or alcohol misuse.

Other warning signs include a child who:

- suddenly starts to behave differently
- thinks badly, or does not look after, him or herself
- displays sexually inappropriate behaviour, including use of sexual language and sexual information which you would not expect them to know
- has physical symptoms that suggest sexual abuse – these can include anal or vaginal soreness or an unusual discharge, and pregnancy
- avoids being alone with a particular family member
- fears an adult or is reluctant to socialise with them
- tries to tell you about abuse indirectly, through hints or clues
- behaviour by an adult that suggests they are being 'groomed' for future abuse.

Parents should also be alert to any adults who pay an unusual amount of attention to their child, for example:

- giving their child gifts, toys or favours
- offering to take their child on trips, outings and holidays
- seeking opportunities to be alone with their child

What are the causes of child sexual abuse?

The causes of sexually abusive behaviour towards children are complex and not fully understood. As well as the abusers' sexual urges and willingness to act upon those urges, other factors may be involved: power and control issues, traumatic childhood experiences, and troubled families. Child sexual abuse can also be motivated by money, as it is in the case of child prostitution and pornography.

Factors contributing to child sexual abuse can be broadly categorised as:

- biological - sexual drive is a deep seated and basic human urge alongside, for example, the desire to eat
- developmental - a disrupted attachment to a primary care giver is often evident with child sex offenders
- systemic - family and community norms and expectations are a significant influence, and
- situational - even with all the other factors present, unless a potential abuser creates or finds themselves in a situation where they can abuse, they may never move from potential to actual abuse

It's often argued that there is a link between someone being abused and then going on to be an abuser themselves in later life. Whilst some sexual abusers will have been abused as children, current research does not support the contention that being sexually abused increases the chances of someone becoming a perpetrator.

What do we know about the perpetrators of child sexual abuse?

Acts of child sexual abuse are committed by men, women, teenagers, and other children. Sex offenders are found in all areas of society and come from a variety of backgrounds. As so much abuse goes undisclosed and unreported, the majority of perpetrators in our communities are not known to the authorities.

Pedophilia is one facet of child sexual abuse and can be defined as a primary sexual interest in pre-pubescent children. The majority of sex offenders are not pedophiles although this term is used frequently and often inaccurately.

Contrary to the popular image, abusers usually seem quite normal to others; friends, relatives and co-workers often find it hard to believe that someone they know has abused children. They are more likely to be someone that the child knows, like a relative, family friend or person in a position of trust, rather than a stranger. About 80% of offences take place in the home of either the perpetrator or the victim.

Research suggests that the majority of child sexual abuse is perpetrated by men. However, the actual prevalence of abuse by females is not accurately known and such abuse is almost certainly under-reported. Females could be responsible for up to 5% of sexual offences committed against children but research into female offenders has been hindered by a belief that women do not behave this way towards children.

Research also found that 65.9% of contact sexual abuse reported by children up to the age of 18 years was perpetrated by other children and young people under the age of 18 rather than by adults. The most typical child sexual abuser is likely to be close in age to the victim, for example a boyfriend, friend, fellow student or someone they meet whilst socialising.

The great majority of children and young people with harmful sexual behaviour, with the appropriate support, treatment and guidance, will not develop into adult sex offenders. A key assessment task is to identify that relatively small group of children and young people who represent a higher risk.

Not all perpetrators begin offending against children when they are children or young people, some do but others will start to offend as adults.

What do we know about the victims of child sexual abuse?

Nearly a quarter of young adults have experienced sexual abuse during childhood with teenage girls between 15 and 17 reporting the highest rates. Children from all backgrounds and all communities suffer sexual abuse but there are factors which seem to increase the risk, these include:

- a history of previous sexual abuse
- being disabled
- a disrupted home life, or
- having experienced other forms of abuse such as domestic abuse, neglect, or physical abuse

Very young children and disabled children are particularly vulnerable because they may not have the words or the ability to communicate what is happening to them to someone they trust.

Child sexual abuse is most commonly perpetrated in circumstances where the victim is known and sometimes related to the perpetrator. Research shows that girls are at greater risk than boys of being abused by a family member whilst boys are more likely to be abused by a stranger.

The relationship between abusers and victims tends to fit one of three types:

- inappropriate relationships where the abuser is older than the victim
- the boyfriend model which is common in peer abuse, and
- organised exploitation and trafficking

What is the impact of sexual abuse?

The impact of child sexual abuse on the victim can be long term and devastating. The duration and proximity of the abuse and the abuser, i.e. the relationship of the offender to the victim, are important factors that can influence the extent of the impact.

The abused child may be very confused about their feelings and may rationalise, or be persuaded; that what is happening is 'normal'. They may not say anything because they think it is their fault, that no one will believe them, or that they will be teased or punished. The child may even care for an abusing adult – they will want the abuse to stop, but they may fear the adult will go to prison or that their family will break up.

Child sexual abuse may leave few physical scars and where there is physical injury, this will often heal relatively quickly. Far more enduring are the emotional and psychological impacts on the victim. These can include long-term problems with alcohol and substance misuse, aggressive behaviour, and, an inability to form and maintain consenting and equal adult friendships and relationships. Such behaviours may be driven by on-going feelings of betrayal, stigmatisation and powerlessness.

It is likely that the annual costs of child sexual abuse in our child and adult population run to many millions of pounds a year as a result of the expense of on-going support, poor health and low earnings amongst abuse victims.

What can we do about child sexual abuse?

A number of factors contribute to the development of sexually abusive behaviour. It is not a disease that can be cured and people are not born as child sexual abusers. The emphasis should be on reducing the risk of reoffending, addressing specifically the factors that have contributed to the offending.

Generally, in order for abuse to take place, the abuser has to overcome their own internal inhibitions; they usually know what they are doing is wrong and have to convince themselves through a process of cognitive distortions (rationalisations) that the abuse is not causing harm and that the victim wants the sexual contact.

Because these cognitive and behavioural patterns which precede and inform sexual abuse are relatively predictable, it has been possible to develop treatment programmes which specifically target these patterns.

Treatment of perpetrators focuses on getting them to understand how they actively created situations to abuse and on the addictive and habitual nature of the behaviour. The aim is to help them understand that they can lead fulfilling and abuse free lives. Punishment alone is unlikely to stop perpetrators reoffending as it does not address the behaviour and thinking that leads to abuse.

Sadistic and psychopathic offenders do not go through the same process of cognitive distortions, or it is very truncated. Fortunately, these sorts of (very dangerous) offenders are relatively rare.

Abusers typically look for weak spots in a family, a community or an organisation where they will be able to gain unsupervised access to children and where their chances of not being detected are greatest. As well as targeting potential victims and planning abuse, abusers will also engage in a process of grooming, of the child, the child's family and the child's environment.

'Grooming' can leave the child victim feeling very confused and sometimes culpable. The more they are made to feel in some way to blame for the abuse the more difficult disclosure of the abuse can be. Therefore, understanding the specific ways in which grooming has

taken place and the ways in which the child has been silenced by threats, both implicit and explicit, and by being made to feel in some way to blame for the abuse, is key to designing an effective treatment programme for the child as well as for the abuser.

Treatment of child victims of sexual abuse typically lasts for several months following a period of assessment and is based on a variety of cognitive behavioral and psychodynamic approaches to help them understand how they were tricked, groomed and coerced, and crucially that they are not to blame for what was done to them.

Confronting the alleged abuser may give them the opportunity to silence, confuse or threaten the child about speaking out about the abuse. It may also place the child in danger.

How can we prevent child sexual abuse?

Child sexual abuse is a public health problem that requires a response which addresses: Deterrence treatment, and primary prevention (information and education).

This includes working with children who have been sexually abused to help them overcome their experiences and to keep safe from further abuse.

It involves working with children and young people with harmful sexual behavior to help them break their patterns of behavior before they become adult offenders.

And, it means working with adult sex offenders to understand what motivates them and how they operate so that barriers can be introduced to prevent their offending and keep children safe.

For this work to be effective, it must be multi-agency and multi-disciplinary, with communities placed firmly at the center. Children, young people and adults need to be able to recognise what abuse is and understand how to respond to situations that might put children at risk.

http://www.nspcc.org.uk/Inform/resourcesforprofessionals/sexualabuse/csehomepage_wda97456.html

3.15 Prevent Strategy and Violent Extremism

In May 2008 the government launched its Prevent Strategy with the objective of stopping people becoming terrorists or supporting violent extremism. In the Ministerial Foreword it says, *'This country, like many others, faces a challenge from terrorism and violent extremism. A very small minority seek to harm innocent people in the name of an ideology which causes division, hatred and violence. It is the role of government to take the tough security measures needed to keep people safe. But a security response alone is not enough; as with so many other challenges, a response led and driven by the community is also vital'*.

Prevent is just one strand of a larger strategy known as CONTEST. This anti-terrorism strategy promotes collaboration and co-operation between public service organisations. The Health Service has a key role to play in the Prevent strategy by recognising and stopping people – many of whom are vulnerable – becoming terrorists or supporting violent extremism.

One of its primary objectives is to support individuals who are vulnerable to recruitment or have already been recruited by violent extremists. As a result all local authorities should have in place a process for safeguarding vulnerable children, young people and adults susceptible to violent extremism.

Working Together 2013 says, *'Experience suggests that young people from their teenage years onwards can be particularly vulnerable to getting involved with radical groups through direct contact with members, or increasingly, through the internet. This can put a young person at risk of being drawn into criminal activity and has the potential to cause significant harm'*.

It is an important assumption that the intention is not to put through the criminal justice system those who are vulnerable to, or are being drawn into, violent extremism unless they have clearly committed an offence. It is vital that individuals and communities understand this and have the confidence to use the support structures.

As health professionals' staff should be aware of the potential risks in their area. Staff should be aware that if they have a concern that a child or vulnerable person is potentially involved with activities or acts in a way that is of concern to the professional in relation to violent extremism, that they should share that information as appropriate.

3.16 Dangerous Dogs

The NSPCC document, **Understanding the links; Information for professionals; child abuse, animal abuse and domestic violence** says, *'There is increasing research and clinical evidence which suggests that there are sometimes inter-relationships, commonly referred to as 'links', between the abuse of children, vulnerable adults and animals. A better understanding of these links can help to protect victims, both human and animal, and promote their welfare'*.

There have been a number of profile attacks on young children in the last few years which have resulted in serious injury and even deaths of children. Some known dangerous dogs are banned in the UK but many are kept covertly and often trained in connection with dog fighting which has been illegal in this country since 1835.

Dangerous dogs can be considered in two contexts, firstly dogs that come under the Dangerous Dogs Act 1991 and are a banned dog as per the act. These are;

- Pit Bull Terrier
- Japanese Tosa
- Dogo Argentino
- Fila Brasileiro
- Cross bred pit bulls

The second group relates to dogs that are dangerous, or perceived to be. When you attend an incident or come into contact with family that has a dog you need to consider whether or not the dog poses any threat to the child's health, development or safety. This could be any dog of any breed. Considerations might be for example:

- Is it a large dog in a small flat?
- Is the dog left alone with the child?
- Is the dog looked after properly (does it look healthy)?
- Is the dog being maltreated or abused by anybody there?
- Does it appear that more money is spent on the dog compared to the child?

It is obvious that very few people would be able to recognise dogs in the first group as defined by the Dangerous Dogs Act 1991, and this document does not require that staff become canine experts. Many professionals have difficulty in recognising dangerous dogs, particularly the 'pit bull' family of dogs.

Remember that dogs are often protective towards their home and family members, particularly when strangers are invited into the home. A sensible approach should be adopted as often dogs will act to protect that environment and the people well known to them.

Remember equally that dogs can become jealous of children and babies, and particularly when babies are newly introduced into the family and are small and immobile.

In the context of safeguarding in the event that you are not sure about the dog you should, if appropriate share your concerns with the family. In the event that you feel unable to do this you should discuss the issue, in the first place, with your manager.

If you believe there is a safeguarding risk to children in the house you should make a referral to Social Care using the Trust referral pathway.

In extreme circumstances, or when you suspect that the dog is one of the breeds mentioned above or is a serious risk to the child, you should contact the police immediately.

4 Recognition of Abuse

Introduction

All children deserve the opportunity to achieve their full potential. They should be enabled to;

- be as physically and mentally healthy as possible; and
- receive maximum benefit from educational opportunities; and
- live in a safe environment; and
- experience emotional well-being; and
- feel loved and valued; and
- become competent in looking after themselves; and
- have a positive image of themselves; and
- have opportunities to develop good interpersonal skills and confidence.

Section 10(2) of the Children Act 2004 underpins these ideals and additionally sets out five outcomes for improving the wellbeing of children, namely:

- Physical and mental health and emotional wellbeing (**stay safe**)
- Protection from harm and neglect (**be healthy**)
- Education, training and recreation (**enjoy and achieve**)
- **Making a positive contribution to society**; and
- **Social and economic wellbeing**

Significant Harm

The Children Act (1989) introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of the children. The local authority is under a duty to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or likely to suffer, significant harm (*section 47; Children Act 1989*).

There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency and of abuse, the extent of premeditation and the degree of threat and/or coercion.

Some children may be suffering, or at risk of suffering significant harm, either as a result of a deliberate act, or a failure on the part of the parent or carer to act to provide proper care of the child being beyond parental control, or all of these factors. These children need to be made safe from harm as well as their other needs being met.

Children may be abused in a family or in an institutional or community setting; by those known to them or more rarely, by a stranger.

Who is vulnerable to abuse?

Although any child can be perpetrated on by an abuser there are some groups of children who may be particularly vulnerable. These include children with learning disabilities, severe physical illness or sensory impairments. Sources of stress within families may have a negative impact on a child's health, development or well-being, either directly or because they affect the capacity of parents to respond to their child's needs.

Sources of stress may include poverty, social exclusion, domestic violence, the unstable mental illness of parent or carer, or drug and alcohol misuse. Parents who appear over-anxious about their child when there are signs of illness or injury may be displaying signs of an inability to cope.

Children with learning difficulties and / or special needs have particular needs because of a psychological or medical difficulty. For example, deaf or autistic children may demonstrate

challenging behaviour, which may or may not be as a result of abuse. Children with special needs are more likely to be abused.

Allegation of abuse by the child

Any allegation of abuse by a child is an important indicator and should always be taken seriously. It is important to note that children may only tell a small part of their experience initially. Adult responses can influence how able a child feels about revealing the full extent of the abuse. If abuse is alleged, the adult being told about the abuse must be careful not to ask leading questions.

If someone tells you they have been abused

Move them to a private place if possible. Let them tell you what happened in their own words. Reassure them that they have done the right thing in telling you about the abuse. Do not ask leading questions as this might affect a subsequent police enquiry.

Never promise to keep a secret. Tell them as soon as possible that you will have to report to at least one other person, as it is your duty to do this.

Do not talk to anyone who does not need to know about the allegation or suspicion of abuse, not even the witnesses if there were any. By inadvertently telling the alleged abuser for example, you may be later accused of "corrupting evidence" or "alerting."

Sharing and Referring (Reporting) Concerns

Any allegation or suspicion of abuse must be taken seriously and acted on immediately. Any staff member of the East of England Ambulance Service NHS Trust, or voluntary members of the public who help the Trust deliver our service, and who may come into contact with children and young people have a duty to share, and if necessary refer or report concerns regarding suspected abuse.

Failure to act might place the victim at greater risk and they may be discouraged from disclosing the same or further details again as they may feel they were not believed. Failure to report suspected or alleged abuse may also put other people at risk.

Physical signs and symptoms

The following symptoms should give cause for concern and further assessment:

- soreness, discharge or unexplained bleeding in the genital area
- chronic urinary and vaginal infections
- bruising, grazes or bites to the genital or breast area
- sexually transmitted diseases
- pregnancy, especially when the identity of the father is vague
- a change in bowel habit, such as soiling or constipation.

Behavioural and emotional indicators

- inappropriate sexual knowledge for the child's age
- overt sexual approaches to other children or adults
- fear of particular people or situations e.g. bath time or bedtime
- drug and alcohol abuse (older children)
- suicide attempts and self-injury
- running away and fire-setting
- environmental factors and situation of parents (e.g. domestic violence, drug or alcohol abuse, learning disabilities).

Non-accidental injury

For an injury to be accidental it should have a clear, credible and acceptable history and the findings should be consistent with the history and with the development and abilities of the

child. When looking at injuries in children, you should be aware of the possibility of the injury being non-accidental and consider it in every case, even if you promptly dismiss the idea. Examples of abuse indicators may be:

- any injury in a non-mobile baby
- frequent accidents in unlikely places e.g. the buttocks, trunk and inner thighs
- soft tissue injuries under clothing
- bruises of the same age on both sides of the body or of varying ages
- small deep burns in unlikely places or repeated burns and scalds, or 'glove and stocking' burns
- poor state of clothing, cleanliness and/or nutrition
- late reporting of the injury or delay in seeking help.

When assessing an injured child, you should use your judgement regarding what level of accidental injury would be appropriate for their state of development. Although stages of development vary (e.g. children may crawl or walk at different ages), injuries can broadly be divided between mobile and non-mobile children.

Non-mobile babies

Any injury in a non-mobile baby must be considered carefully and have a credible explanation if it is to be considered accidental.

Healthy babies do not bruise or break their bones easily. They do not bruise themselves with their fists or toys, bruise themselves by lying against the bars of a cot, or acquire bruises on their feet when they are held for a nappy change.

Bruising on the ears, face, neck, trunk and buttocks is particularly suspect. Petechial spots (tiny blood spots under the skin) which disappear very rapidly may indicate attempted smothering. A torn frenulum (behind the upper lip) is rarely accidental in babies, and bleeding from the mouth of a baby should always be regarded as suspicious.

Fractures

Fractures in babies are seldom caused by 'rough handling' or putting their legs through the bars of the cot. Babies rarely fracture their skull after a fall from a bed or a chair. After a difficult delivery, the clavicle (collar bone), humerus or femur may be broken and not noticed until a lump appears about 2-3 weeks later. In this case, the baby would require paediatric assessment to confirm any suspicions of non-accidental injury.

Shaking injuries

When small babies are shaken violently their head and limb movements cannot be controlled, and this can result in severe brain damage from haemorrhage inside the skull. It may also cause metaphyseal fractures of the limbs as a result of the rotary movement. Finger bruising on the chest may indicate that a baby has been held tightly and shaken.

Mobile babies and toddlers

A torn frenulum at this age may occur when the child falls flat on a carpet while running, but there are usually friction burns of the nose and chin at the same time. Non-accidental fractures are uncommon after the age of two years. Once the child can talk, he/she is more able to tell how the injury was sustained.

Bruising

Bruises are collections of blood under the skin or in the tissues. They are a bluish-red in the beginning, then turn purple and brown, and finally to yellow. The exact dating of bruising is difficult as it depends on the individual, the depth of the bruise and the tissues affected.

It is normal for toddlers to have accidental bruises on the shins, elbows and forehead. They usually fall forward, so bruises on the back or buttocks are suspect. They do not bruise both sides of the body at the same time, and the bruise cannot be round a curved surface.

Two black eyes may appear 2-3 days after an accidental blow in the middle of the forehead when the bruise begins to resolve. This sign is significant however if it occurs without forehead swelling.

Bruising caused by a hand slap leaves a characteristic pattern of 'stripes' representing the imprint of fingers. Forceful gripping leaves small round bruises corresponding to the position of the fingertips. 'Tramline' bruising is caused by a belt or stick and shows as lines of bruising with a white patch in between. Bites result in small bruises forming part or all of a circle.

Burns and scalds

Burns are caused by the application to the skin of dry heat and the depth of the burn will depend on the temperature of the object and the length of time it is in contact with the skin.

Abusive burns are frequently small and deep, and may show the outline of the object, whereas accidental burns rarely do so because the child will pull away. For example, a burn reflecting the shape of the soleplate of an iron cannot be accidentally caused.

Flame burns are usually less deep, have a less defined outline and may be fan-shaped. Friction burns may look similar to a flame burn and are usually seen on the prominent areas of the body such as the nose and chin, the heels or the shoulders.

Cigarette burns are not common. They are round, deep and have a red flare round a flat brown crust. The burns usually leave a scar and should not be confused with chickenpox scabs or impetigo.

Scalds are caused by steam or hot liquids. Accidental scalds may be extensive but show splash marks, unlike the sharp edges of damage done when the child is dunked in hot water (although splash marks may also feature in a non-accidental burn, indicating that the child had tried to escape hot water). The head, face, neck, shoulders and front of the chest are the areas affected when a child pulls over a kettle. If the child turns on the hot water in the bath, the soles of the feet are in contact with the bath and will be less affected than the top of the feet.

Fractures

Children's bones bend and splinter rather than break, and require considerable force to be damaged. There are various kinds of fractures, depending on the direction and strength of the force which caused the injury.

Greenstick

The bones bend rather than break. This is a very common accidental injury in children.

Transverse

The break goes across the bone and occurs when there is a direct blow or a direct force on the end of the bone, e.g. a fall on the hand will break the forearm bones or the lower end of the humerus.

Spiral or Oblique

A fracture line which goes right around the bone or obliquely across it is due to a twisting force, which is often a feature in non-accidental injuries.

Metaphyseal

Occur at the extreme ends of the bone and are not seen accidentally. They are usually caused by a strong twisting force.

Skull fractures

These must be consistent with the history and explanation given, as babies and small children do not fracture their skulls from falls of only a few feet. Complex (branched), depressed or fractures at the back of the skull are suspect.

Rib fractures

These do not occur accidentally, except in a severe crushing injury. Any other cause is highly suspicious of non-accidental injury.

Deliberate poisoning and attempted suffocation

These are very difficult to assess and may need a period of close observation in hospital. Deliberate poisoning, such as might be found in a case of a child in whom **Fabricated or Induced Illness (FII)** is induced by carers with parenting responsibilities (formally known as Munchausen syndrome by proxy), may be suspected when a child has repeated puzzling illnesses, usually of sudden onset. The signs include unusual drowsiness, apnoeic attacks, vomiting, diarrhoea and fits.

Older children and adolescents

If the injury is accidental, older children will give a very clear and detailed account of how it happened. The detail will be missing if they have been told what to say.

Overdosing and other self-harm injuries must be taken seriously in this age-group, as they may indicate sexual or other abuse (such as exploitation).

5 Parental Engagement

Parental Engagement

Parent – or carer – child interactions alerting features that should prompt you to child maltreatment:

Consider emotional abuse if there is concern that parent– or carer –child interactions may be harmful. Examples include:

- Negativity or hostility towards a child or young person.
- Rejection or scapegoating of a child or young person.
- Developmentally inappropriate expectations of or interactions with a child, including inappropriate threats or methods of disciplining.
- Exposure to frightening or traumatic experiences, including domestic abuse.
- Using the child for the fulfilment of the adult's needs (for example, children being used in marital disputes).
- Failure to promote the child's appropriate socialisation (for example, involving children in unlawful activities, isolation, not providing stimulation or education).
- Suspect emotional abuse when persistent harmful parent– or carer –child interactions are observed or reported.

Consider child maltreatment if parents or carers are seen or reported to punish a child for wetting despite professional advice that the symptom is involuntary.

Consider emotional neglect if there is emotional unavailability and unresponsiveness from the parent or carer towards a child and in particular towards an infant.

Suspect emotional neglect if there is persistent emotional unavailability and unresponsiveness from the parent or carer towards a child and in particular towards an infant.

Consider child maltreatment if a parent or carer refuses to allow a child or young person to speak to a healthcare professional on their own when it is necessary for the assessment of the child or young person.

Emotional, behavioural, interpersonal and social functioning alerting features that should prompt you to CONSIDER child maltreatment:

Any behaviour or emotional state in a child if it is inconsistent with their age and developmental stage or there is no medical explanation (including a neurodevelopmental disorder, for example, ADHD or autism spectrum disorders) or other stressful situation unrelated to maltreatment (for example, bereavement or parental separation). Behaviour or emotional states that may fit this description include:

- Fearful or withdrawn emotional state
- Low self-esteem
- Aggressive or oppositional behaviour
- Habitual body rocking
- Indiscriminate contact or affection-seeking
- Over-friendliness to strangers
- Excessive clinginess
- Persistently resorting to gaining attention
- Demonstrating excessively 'good' behaviour to prevent parental or carer disapproval
- Failing to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed
- Coercive controlling behaviour towards parents or carers

- Very young children showing excessive comforting behaviours when witnessing parental or carer distress
- Child or young person regularly has responsibilities that interfere with essential normal daily activities (for example, school attendance).

Marked change in behaviour or emotional state not expected for the child or young person's age and developmental stage (for example, recurrent nightmares with similar themes, extreme distress, becoming withdrawn, markedly oppositional behaviour or withdrawal of communication) in the absence of a medical explanation or known stressful situation unrelated to maltreatment.

Repeated, extreme or sustained emotional responses shown by a child that are out of proportion to a situation and are not expected for the child's age and developmental stage (for example, frequent rages at minor provocation, anger or frustration expressed as a temper tantrum in a school-aged child or distress expressed as inconsolable crying) in the absence of a medical explanation, neurodevelopmental disorder (for example, ADHD or autism spectrum disorders) or bipolar disorder when the effects of any known past maltreatment have been explored.

Dissociation (transient episodes of detachment that are outside the child's control and that are different from daydreaming, seizures or deliberate avoidance of interaction) displayed by a child, not explained by a known traumatic event that is unrelated to maltreatment.

5.1 Toxic Trio

In their review of Serious Case Reviews Ofsted noted that:

'The most common issues [relating to the children's families] were domestic violence, mental ill-health and drug and alcohol misuse. These issues rarely exist in isolation; there is often a complex interaction between the three issues'.

In one situation domestic violence may be the result of women who use drugs being more likely to be in relationships with volatile men. In another situation maternal drug misuse may be a consequence of their experience of domestic violence.

Maternal mental ill health may be a result of violence or abuse that they have experienced or depression may lead a parent to misuse drugs or alcohol.

Definitions

Domestic violence:

Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.

Mental ill-health:

Depression and anxiety, and psychotic illnesses such as schizophrenia or bipolar disorder. Mental illness may also be associated with alcohol or drug use, personality disorder and significant physical illness

Substance misuse:

Intoxication by – or regular excessive consumption of and/or dependence on – psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances).

5.2 Parental Mental Health

What we're dealing with

Parents with mental health problems and their children are a group with complex needs. Not all parents and children will need the support of health and social care services but those that do can find it difficult to get support that is acceptable, accessible and effective for the whole family.

Parents with mental health problems need support and recognition of their responsibilities as parents. Their children's needs must also be addressed. Research and government reports have highlighted the extent of the problem:

- An estimated one-third to two-thirds of children whose parents have mental health problems will experience difficulties themselves. Of the 175,000 young carers identified in the 2001 census, 29 per cent – or just over 50,000 – are estimated to care for a family member with mental health problems.
- Parental mental health is also a significant factor for children entering the care system. Childcare social workers estimate that 50–90 per cent of parents on their caseload have mental health problems, alcohol or substance misuse issues.
- In a class of 26 primary school children, it is estimated that six or seven children are living with a mother with mental health difficulties.

There are important public health implications of not addressing the needs of these families, as parental mental health problems can have an impact on parenting and on the child over time and across generations:

- Between one in four and one in five adults will experience a mental illness during their lifetime.
- At the time of their illness, at least a quarter to a half of these will be parents.
- Their children have an increased rate of mental health problems, indicating a strong link between adult and child mental health.
- Parental mental illness has an adverse effect on child mental health and development, while child psychological and psychiatric disorders and the stress of parenting can impinge on adult mental health.
- The mental health of children is a strong predictor of their mental health in adulthood.
- The two per cent of families who suffer the combined effect of parental illness, low income, educational attainment and poor housing are among the most vulnerable in society.

The Family Model

The Crossing Bridges Family Model is a useful conceptual framework that can help staff to consider the parent, the child and the family as a whole when assessing the needs of the families with a parent suffering from a mental health problem.

The model illustrates how the mental health and wellbeing of the children and adults in a family where a parent is mentally ill are intimately linked in at least three ways:

- Parental mental health problems can adversely affect the development, and in some cases the safety, of children.
- Growing up with a mentally ill parent can have a negative impact on a person's adjustment in adulthood, including their transition to parenthood.
- Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill health in their parents/carers.

The model also identifies that there are risks, stressors and vulnerability factors increasing the likelihood of a poor outcome, as well as strengths, resources and protective factors that enable families to overcome adversity.

Risks, stressors and vulnerability factors

Individual risk or stress factors, on their own, do not necessarily have a serious effect on an adult's parenting capacity or their children's mental health. However, some parents with mental health problems will face multiple adversities.

Risk factors are also cumulative: the presence of more than one increases the likelihood that the problems experienced and impact on the child and parent will be more serious.

It is when three or more environmental and/or personal factors occur in combination that a negative impact on child and/or parental mental health is much more likely.

For example, the presence of **drug** or **alcohol dependency** and **domestic violence**, in addition to mental health problems with little or no family or community support, would indicate an increased likelihood of risk of harm to the child and to parents' mental health and wellbeing.

Frontline practitioner

Practitioners need to remain aware and be prepared to intervene when there is evidence that the child is suffering or is likely to suffer harm.

Ensure a holistic evaluation of the family, environment and relationship and ensure that referrals are made where concerns are highlighted.

Early interventions avoid crises.

As part of the holistic assessment of the family, note stress factors such as drug abuse, alcohol and substance misuse, domestic abuse and unemployment. Consider the impact on the child(ren) in the family.

Consider the impact of the parental behaviour on the mental health of the child.

6 Child Mental Health

It's easy to know when a child has a fever. A child's mental health problem may be harder to identify, but professionals can learn to recognise the symptoms. Pay attention to excessive anger, fear, sadness or anxiety. Sudden changes in a child's behavior can be a tip off to a problem. So too can behaviors like excessive exercising, or hurting or destroying things.

Some common mental health problems in children are:

- Depression
- Anxiety
- Behavioural disorders
- Attention deficit hyperactivity disorder
- Autism
- Bullying
- Eating Disorders
- Obsessive Compulsive Disorders
- Psychotic Disorders
- Substance Abuse

Mental health problems can disrupt daily life at home, at school or in the community. Without help, mental health problems can lead to school failure, alcohol or other drug abuse, family discord, violence or even suicide. Mental health problems affect about one in ten children and young people. They include depression, anxiety and conduct disorder, and are often a direct response to what is happening in their lives.

The emotional well-being of children is just as important as their physical health. Good mental health allows children and young people to develop the resilience to cope with whatever life throws at them and grow into well-rounded, healthy adults. 1 in 10 children and young people aged 5-16 suffer from a diagnosable mental health disorder- that is around three children in every class! Things that can help keep children and young people mentally well include:

- being in good physical health, eating a balanced diet and getting regular exercise
- having time and the freedom to play, indoors and outdoors
- being part of a family that gets along well most of the time
- going to a school that looks after the well-being of all its pupils
- taking part in local activities for young people.

Other factors are also important, including:

- feeling loved, trusted, understood, valued and safe
- being interested in life and having opportunities to enjoy themselves being hopeful and optimistic
- being able to learn and having opportunities to succeed
- accepting who they are and recognising what they are good at
- having a sense of belonging in their family, school and community
- feeling they have some control over their own life
- having the strength to cope when something is wrong (resilience) and the ability to solve problems.

Most children grow up mentally healthy, but surveys suggest that more children and young people have problems with their mental health today than 30 years ago. That's probably because of changes in the way we live now and how that affects the experience of growing up. Half of lifetime mental illness starts by 14 years of age¹

Dealing with change

Mostly things that happen to children don't lead to mental health problems on their own, but traumatic events can trigger problems for children and young people who are already vulnerable.

Changes often act as triggers: moving home or school or the birth of a new brother or sister, for example. Some children who start school feel excited about making new friends and doing new activities, but there may also be some who feel anxious about entering a new environment.

Teenagers often experience emotional turmoil as their minds and bodies develop. An important part of growing up is working out and accepting who you are. Some young people find it hard to make this transition to adulthood and may experiment with alcohol, drugs or other substances that can affect mental health.

Risk factors

There are certain 'risk factors' that make some children and young people more likely to experience problems than other children, but they don't necessarily mean difficulties are bound to come up or are even probable. Some of these factors include:

- having a long-term physical illness
- having a parent who has had mental health problems, problems with alcohol or has been in trouble with the law
- experiencing the death of someone close to them
- having parents who separate or divorce
- having been severely bullied or physically or sexually abused
- living in poverty or being homeless
- experiencing discrimination, perhaps because of their race, sexuality or religion
- acting as a carer for a relative, taking on adult responsibilities
- having long-standing educational difficulties.

How parents/carers can help

If they have a warm, open relationship with their parents/carers, children will usually feel able to tell them if they are troubled. One of the most important ways parents can help is to listen to them and take their feelings seriously. They may want a hug, they may want you to help them change something or they may want practical help.

Children and young people's negative feelings usually pass. However, it's a good idea to get help if your child is distressed for a long time, if their negative feelings are stopping them from getting on with their lives, their distress is disrupting family life or they are repeatedly behaving in ways you would not expect at their age.

Depression

Depression is a serious medical illness that involves the brain. It's more than just a feeling of being "down in the dumps" or "blue" for a few days. Symptoms can include:

- Sadness
- Loss of interest or pleasure in activities you used to enjoy
- Change in weight
- Difficulty sleeping or oversleeping
- Energy loss
- Feelings of worthlessness
- Thoughts of death or suicide

Depression is a disorder of the brain. There are a variety of causes, including genetic, environmental, psychological, and biochemical factors. Depression usually starts between the ages of 15 and 30, and is much more common in women. Some people get seasonal affective disorder in the winter. Depression is one part of bipolar disorder.

Bipolar disorder is a serious mental illness. People who have it go through unusual mood changes. They go from very happy, "up" (mania) and active to very sad and hopeless, "down" (depression) and inactive, and then back again. They often have normal moods in between.

The causes of bipolar disorder aren't always clear. It runs in families. Abnormal brain structure and function may also play a role. Bipolar disorder often starts in a person's late teen or early adult years. But children and adults can have bipolar disorder too. The illness usually lasts a lifetime.

If not treated, bipolar disorder can lead to damaged relationships, poor job or school performance, and even suicide. However, there are effective treatments to control symptoms: medicine and talk therapy. A combination usually works best. Suicide is one of the three most common causes of death in youth and is now rising: in 2014 there was a 43% rise in the number of young people who admitted attempting suicide, while self-harm and eating disorders are a growing problem.

Anxiety

Fear and anxiety are part of life. You may feel anxious before you take a test or walk down a dark street. This kind of anxiety is useful - it can make you more alert or careful. It usually ends soon after you are out of the situation that caused it. But anxiety can stay with some children and when it does they may develop symptoms such as have chest pains or nightmares. They may even be afraid to leave home. These people have anxiety disorders. Types include:

- Panic disorder
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Phobias
- Generalised anxiety disorder

Treatment can involve medicines, therapy or both.

Behaviour Disorders

All children misbehave at times. And some may have temporary behaviour problems due to stress. For example, the birth of a sibling, a divorce, or a death in the family may cause a child to act out. Behaviour disorders are more serious. They involve a pattern of hostile, aggressive, or disruptive behaviours for more than 6 months. The behaviour is also not appropriate for the child's age. Warning signs can include:

- Harming or threatening themselves, other people or pets
- Damaging or destroying property
- Lying or stealing
- Not doing well in school, skipping school
- Early smoking, drinking or drug use
- Early sexual activity
- Frequent tantrums and arguments
- Consistent hostility towards authority figures

Children who have behaviour problems are at higher risk for school failure, mental health problems, and even suicide. Classes or family therapy may help parents learn to set and enforce limits. Talk therapy and behavior therapy for children can also help. Anti-social behaviour and conduct disorder affect over 5% of children, particularly boys, while anxiety and depression affect 4%.

Attention Deficit Hyperactivity Disorder

Is it hard for the child to sit still? Does the child act without thinking first? Does the child start but not finish things? If so, the child may have attention deficit hyperactivity disorder (ADHD). Nearly everyone shows some of these behaviors at times, but ADHD lasts more than 6 months and causes problems in school, at home and in social situations.

ADHD is more common in boys than girls. The main features of ADHD are:

- Inattention
- Hyperactivity
- Impulsivity

No one knows exactly what causes ADHD. It sometimes runs in families, so genetics may be a factor. There may also be environmental factors.

Treatment may include medicine to control symptoms, therapy, or both. Structure at home and at school is important. Parent training may also help.

Autism

Autism, and the related condition Asperger Syndrome, are disorders affecting social communication. Other skills, such as interaction, language and imagination are often affected to varying degrees.

A frequently used term to describe these conditions is Autism Spectrum Disorders (ASD) - and this emphasises that individuals may be affected in varying degrees and ways by these disorders.

Bullying

Bullying can occur in many forms, comprising behaviours such as name-calling, teasing, excluding and ignoring - through to assaults and other forms of abuse. Bullying may result in intense fear, dread and unhappiness among recipients. Important sources of support include parents, teachers, friends and support groups.

Eating Disorders

Eating disorders include anorexia nervosa, bulimia nervosa, binge-eating and compulsive overeating.

These conditions usually start in the teenage years and can be more common in girls than boys. The number of young people who develop an eating disorder is small. Eating disorders, such as anorexia nervosa and bulimia nervosa can have serious consequences for their physical health and development

Obsessive Compulsive Disorder

Obsessive-compulsive disorder (OCD) is a condition where sufferers experience unwelcome thoughts that repeatedly intrude into their mind (obsessions) and/or repeated unwelcome urges to perform certain actions (compulsions). In both cases, the sufferer has little or no control over these unwelcome thoughts and urges.

Typically, obsessions may involve fears or anxieties about issues such as hygiene (e.g. dirt, contamination, germs etc.) or safety (e.g. door locks, light and power switches, gas controls

etc.), although other issues such as sexual thoughts, blasphemous thoughts and the symmetrical placement of objects may also form the subject matter of obsessions.

Compulsions may also be related to similar issues, and may involve repetitive hand-washing, cleaning, checking (e.g. of light switches, locks etc.), counting, touching and arranging.

Psychosis

Psychosis describes a state where the sufferer, in some way, loses a degree of touch with reality. This tends to express itself in the thoughts or experiences of the individuals.

Typically, this may take the form of experiences whereby the individual has the experience of perceiving a sound (e.g. a voice) or a sight (or sometimes a touch or smell) where, *in actual fact*, no such sound, smell, touch etc. took place. Such an experience is known as a hallucination (e.g. an auditory hallucination = of sound; visual hallucination = of sight; somatic hallucination = of touch; olfactory hallucination = of smell).

Another typical feature of psychosis is the experience of unusual thoughts or beliefs that are usually untrue - although the individual believes them with total and unshakeable conviction (even in the face of what seems to everyone else to be clear evidence to the contrary). Such thoughts and beliefs are known as delusions. A common form of delusion is the belief that 'they are out to get me' (whether *they* refers to aliens, neighbours, the police, MI5, terrorists etc.) - these are termed 'persecutory' delusions.

In addition to hallucinations and delusions, other features of psychosis may occur, such as disorders of the patterns of thinking (which often becomes obvious in a rather muddled or illogical manner of speech) - this is termed 'thought disorder'. Although schizophrenia is the most common illness that causes psychosis, it can occur in a wide range of other conditions, including bipolar affective disorder (sometimes known as 'manic depression'), severe depression, infections, states of extreme stress or anxiety, or as the consequence of the abuse of drugs or alcohol.

Substance Abuse

Substance abuse can take many forms, with the 'substances' in question including alcohol, cannabis, heroin, solvents, ecstasy, amphetamines, LSD, cocaine, crack cocaine, anabolic steroids, cigarettes and a range of medications such as benzodiazepines, pain-killers and stimulants.

What these all have in common, however, is that their abuse is not in the best interests of the individual - with a broad range of adverse consequences including ill health, long-term mental illness (e.g. schizophrenia), dependency, psychosis, cancers and death. Additional consequences are the effects of possible contaminants that may be contained within the drug, potential infections associated with injection (e.g. HIV, Hepatitis C etc.), involvement in crime, withdrawal from other activities (e.g. school, university, work, relationships, family life), trouble with the police, and wasting a lot of money repeatedly purchasing the substance.

7 Sudden Unexpected death in Children

Background

This Trust guidance is based on the 'Sudden unexpected death in infancy' Baroness Helena Kennedy QC report, now known as 'The Kennedy Report'. This document stresses the importance of consistent approach of all services managing sudden death in children and young people.

A child is defined as any person under the age of 18 years; this is set within statute in the Children Act 1989 and Working Together to Safeguard Children 2015.

A sudden unexpected death in childhood is defined as 'death of a child that was not anticipated as a significant possibility 24 hours before the death - or where there was a similarly unexpected collapse leading to, or precipitating the events that led to the death' (Working Together to Safeguard Children 2006).

This guidance is issued to support all staff working with the public who may come into contact with anyone under the age of 18 yrs.

As part of this duty the Trust may be required to transport the body of a child/young person (after death has been confirmed) to the nearest receiving hospital.

If the Trust has attended an incident and has found the child/young person has been dead for some time and the Police have requested the child to be left in situ, Trust staff at the location must then check if they may be needed to transport the child/young person once the Police have complete their investigation.

The attending crew may be asked to stay at the location or if not asked to stay, a crew may be asked, by the Police to return to the location to place the child's body into a body bag and transport to the Hospital identified by the Police. This is not a frequent occurrence but continues to be part of the Trust's statutory obligations for child/young person deaths.

Also covered within this guidance is support information for all Trust staff when attending under 18 year old patients with DNR CPR who may have suffered a sudden or unexpected death.

HEOC / 111 call centres

Trust HEOC and 111 call centres have a critical role in ensuring, at the point of the 999 call, that once the person is identified as under the age of 18, and the clinical triage process indicates the use of the CPR card. In these circumstances the dispatcher/duty manager/team leader must initiate contact with the Police. This is to ensure the Police are aware of the under 18 year old and that they may potentially be dead and to ensure that appropriate legal procedures are initiated at the earliest opportunity.

The police CAD reference number should be noted in the CAD log / 111 case log for the incident and every attempt must be made to obtain an ETA from the Police for their attendance.

The call handler should be supported through the call by the Call Handling Team Leader / 111 peer support or supervisor and any information that could be considered as a safeguarding concern from the 999 / 111 caller must be noted appropriately on the CAD or 111 case log and dispatch as part of the information to notify the Trust staff attending the incident.

It is important for the responding crew to know if the Police will support their attendance on scene. Please clarify if the Police are attending and let the crew know.

Dispatch or the Duty Manager (in ALL events, even if the call has come from 111 NHS pathways triage) should consider contacting with the local DOM / COM or AGM as available to ensure appropriate staff support on these incidents.

In these incidents communication between the 111 call centre manager and the HEOC call centre must be considered to support information sharing and continuity of practice.

All HEOC Managers be aware that the Police or Safeguarding investigation team from the Local Authority may request for an Ambulance to attend the location (if the child/young person's body was not initially transported) to remove the child/young person's body from the location, with Police escort, to the nearest receiving facility.

This is a routine journey and must not be undertaken on blue lights, however this call must be considered as a priority over urgent calls and other non-urgent responses.

It is good practice, where possible to ensure that no child's body is transported across county boundaries.

Responding Trust staff

First and foremost every appropriate action to save life must be made for the child/young person.

When resuscitation is indicated as there is no evidence to suggest that life is extinct, Trust responding staff must immediately start appropriate level of resuscitation either Basic Life Support or Advanced Life Support. Rapid transport must be undertaken to the nearest Accident and Emergency receiving facility. DO NOT wait for the Police if they have not yet arrived, every attempt to save life and transport to receiving Hospital must take priority. Wherever possible and appropriate the parents or carers (and a Police Officer) should accompany the child/young person in the Ambulance.

In situations where the child or young person might be beyond help and life saving measures such as Basic Life support or Advanced Life support are inappropriate, examples of this include where decomposition is evident, severe trauma not compatible with life, extended delays in calling for emergency assistance (this cannot be an exhaustive list, appropriate decisions need to be made by the attending crew). If any attending member of staff is unsure advice from the Clinical Support Line must be obtained.

In these cases the attending crew should remain on scene and with the guidance of the Police Officers, support appropriately any actions required by the Ambulance Service. The attending crew may be requested to undertake transfer of the deceased child or young person to a designated Accident and Emergency unit so that the child's body can be medically examined by a Paediatrician. This will allow for drawing of samples from the child/young person for analysis.

A child or young person's body (Under 18 yrs old) MUST NOT be left in a pre-hospital setting unless expressly designated to do so by a Police Officer (this can often be due to the incident being declared (by the Police) as a scene of crime and the Police have identified the child or young person's body must remain in situ.)

All documentation for the child/young person either transported or left with the Police must contain information regarding the environment, condition of the patient and any other information which is noteworthy, concerning issues.

Be aware that the Police or Safeguarding investigation team from the Local Authority may request for an Ambulance to attend a location (if the child/young person's body was not initially transported from a previous incident) to remove the child/young person's body from the location, with Police escort, to the nearest receiving facility. This is a routine journey and must not be undertaken on blue lights.

It is good practice, where possible to ensure that no child's body is transported across county boundaries.

Please be aware that you may be called to a location to transport a body. You may not have interacted with this incident prior to this call.

Please be mindful of stress and managing your own stress when dealing with these incidents, it is recognised that each of these events, the attendance at a child cardiac arrest or the removal of a child's body from a location can be difficult. If any member of staff involved in the incident needs support, please speak to your DOM/COM/AGM line manager or HR representative.

Do Not Resuscitate Cardio Pulmonary Resuscitation (DNRCPR)

The process of DNRCPR for children and young people can often be difficult to deal with. This guidance offers support in clarifying action and suggests an appropriate response when attending such incidents.

- Unless specific notification from the patient's specialist clinician support or GP (this is often indicated by an update on the DNRCPR)
- If there has been no indication (in writing on the DNRCPR) that the child/young person is likely die within a set 24 hour period, Or
- where the circumstances of the cardiac arrest are not covered by the DNRCPR examples of this can include choking, trauma, drowning (this list cannot be exhaustive).

In the above indicated situations attempts to support the family and child/young person should be made. Where any attending member of staff is unsure Basic Life support must be initiated until further medical support can be gained. Appropriate questioning of people on scene of the incident and checking of the DNRCPR will support attending crews in decision making and identifying actions that need to be taken.

Further medical support should be gained from any of the following Clinical Advice Line, Clinical Support Desk, child/young person's GP, family support palliative care worker, and Hospital specialist.

Police will attend the scene and, as appropriate, further discussion with attending officers should be undertaken. These discussions should include any concerns attending Trust staff may have about the event, environment of others on people that may be on scene.

Supporting Managers DLO/SLM

Guidance should be given to staff to ensure that every appropriate effort to resuscitate should be made.

The environment, situation, other people and safeguarding concerns should be considered in all incidents.

Support for any attending staff to make a safeguarding referral for the safety of other children on scene, coming back to the location or back to the adult's care must be made through to:

SPOC 0845 602 6856

Trust managers must remember that the statutory duty is for all children/young person's body to be transported to Hospital unless expressly asked by a Police officer to leave the body in situ as the incident is a scene of crime.

If the child/young person's body is left the following information must be remembered:

Be aware that the Police or Safeguarding investigation team from the Local Authority

may request for an Ambulance to attend a location (if the child/young person's body was not initially transported from a previous incident) to remove the child/young person's body from the location, with Police escort, to the nearest receiving facility.

This is a routine journey and must not be undertaken on blue lights, however this call must be considered as a priority over urgent calls and other non-urgent responses.

It is good practice, where possible to ensure that no child's body is transported across county boundaries.

Please be mindful of the stress and impact of stress on members of staff after such incidents.

A referral to the Trust **SPOC** referral line **0845 602 6856** must be made after the event. This is to ensure any surviving children are fully supported through the grieving process.

Rapid Response Meetings

As part of the investigation process for the statutory safeguarding responsibilities, the investigation team comprising of a Paediatrician, Senior Detective from Public Protection and the Rapid Response Manager for the Local Authority. These professionals, as part of their investigation will require a full story of events, as part of this process the attending Ambulance staff will be invited to attend a meeting within 48 hrs of the child/young person's death.

The Trust safeguarding team would actively encourage all members of staff to attend as often these meetings can help with closure from the incident. The pathology results are also available to the attending staff and often help to understand the reason why the child/young person died.

The Trust safeguarding team or safeguarding SLM in your area will send you an invitation. It is not mandatory to attend so please do not feel you have to. If you do choose to attend, you must let the safeguarding team or your local Safeguarding SLM know. Uniform in these meetings is optional. However, any member of Trust staff attending must take an ID badge so that they can confirm who you are.

8 Whistleblowing

The Trust and its staff come into contact with a large number of agencies caring for people and a potentially large number of vulnerable people on a daily basis. It is likely during a working shift a member of staff could witness a colleague/care provider abusing a child or young person.

Because abuse is a sensitive and difficult area we can be tempted not to take action when we think it has happened or is occurring within our own environment. This may be particularly true when the abuser is a member of staff. However, ignoring our concerns or keeping them “in house” can risk:

- reinforcing abusive behaviour and perhaps putting others at risk
- no action, including support and protection, for all those in the situation
- further misery because distress is not being fully acknowledged
- vulnerable victims seen as not needing or entitled to care, treatment, support or justice
- Perpetuation of a criminal act by the perpetrator.

The Trust has a 'Whistleblowing Policy' which sets out the policy, roles and responsibilities of staff and processes involved. The policy is available on the Trust Intranet site.