

Staffordshire Safeguarding Children Board

Part 27

Abuse of Disabled Children

Abuse of Disabled Children

1. The available UK evidence on the extent of abuse among disabled children suggests that disabled children are amongst the most vulnerable in society and at increased risk of abuse, and that the presence of multiple disabilities increases the risk of both abuse and neglect.
2. Disabled children may be especially vulnerable to abuse for a number of reasons. Some disabled children may:
 - Have fewer outside contacts than other children;
 - Receive intimate personal care, possibly from a number of carers, which may both increase the risk of exposure to abusive behaviour, and make it more difficult to set and maintain physical boundaries;
 - Have little or no choice about who provides them with intimate care;
 - Have an impaired capacity to resist or avoid abuse;
 - Have communication difficulties which may make it difficult to tell others what is happening;
 - Experience the misuse of manipulation of the method by which they communicate, so that they either cannot express concerns or do not have the opportunity to express concerns;
 - Be worried about complaining because of a fear of losing services;
 - May particularly fear disclosing a perpetrator who is also a carer;
 - Be especially vulnerable in bullying and intimidation;
 - Be more vulnerable than other children to abuse by their peers;
 - Not understand or be aware of what is or is not appropriate behaviour.
3. The mistaken assumption that disability protects children from abuse contributes to the vulnerability of disabled children. Because of increased vulnerability it is particularly important for practitioners to gain a clear perception of the individual child's experience of life and to be mindful not to collude with, or be over sympathetic to, parents/carers.
4. Disabled children may not be believed when they report what has happened to them or may not understand what is and is not acceptable intervention by their carers.
5. Providers of services (statutory and voluntary) must have:
 - An explicit commitment to, understanding of disabled children's needs, safety and a culture openness;
 - Guidelines and training for staff on: good practice in intimate care, working with children of the opposite sex, handling difficult behaviour, consent to treatment, anti-bullying strategies, sexuality and sexual behaviour among young people and the vulnerabilities of those living away from home;
 - Have clear guidelines about the administration of drugs and medication.

6. Providers and individual practitioners should always ensure that all disabled children are helped to:

- Make their wishes and feelings known in respect of their care and treatment;
- Receive appropriate personal, health, and social education (including sex education);
- Know how to raise concerns, and give them access to a range of adults with whom they can communicate.

Recognition

7. The indicators for abuse and neglect are the same for disabled children as they are for the wider population however their reaction or response may be less overt. Where children are observed to have significant bruising or other injuries it is important to consider all the possibilities and not to assume that it is a result of the disability.

8. Similarly when disabled children display behaviours that would cause concern in other children it is important not to make assumptions about its connection with the disability.

9. Where a child is unable to tell someone of her/his abuse s/he may convey anxiety or distress in some other way, eg behaviour or symptoms. Carers and staff must be alert to this and be aware of the possibility that challenging behaviour may be caused by something other than the disability.

10. Sex offenders may target disabled children in the belief that they are less likely to be detected. There may be more opportunities to groom disabled children and a belief that any subsequent behaviour will not be seen as an indicator of abuse but as linked to their disability.

11. Examples of the abuse of disabled children may include:

- Force feeding
- Unjustified or excessive physical restraint or rough handling
- Extreme behaviour modification including the deprivation of liquid, medication, food or clothing
- Misuse of medication, sedation, heavy tranquilisation
- Invasive procedures against the child's will
- Deliberate failure to follow medically recommended regimes
- Misapplication of programmes or regimes
- Ill fitting or poorly maintained equipment which may cause injury or pain, inappropriate splinting
- Not having their holistic developmental needs as children recognised or met due to excessive focus on disability.

12. Safeguards for disabled children are essentially the same as for non-disabled children. Where there are concerns about the welfare of a disabled child, their emerging vulnerabilities and needs should be assessed and met in the same way as with any other child.
13. Where a disabled child has communication impairments or learning disabilities, special attention should be paid to communication needs, and to ascertaining the child's perception of events, his or her wishes and feelings. All agencies involved should be aware that children with disabilities may need additional time and specific arrangements to express their wishes, feelings and concerns; account of this should be taken in the operation of timescales in the safeguarding process.
14. Many disabled children will be known to specialist services (eg health and education) and may already be receiving services as a child in need. However, there will be children and families who have not previously accessed services but whose vulnerabilities and needs become more pressing as the child becomes older and/or their condition becomes more difficult to manage.
15. When plans are being made to undertake an assessment of a disabled child it is important to identify someone who can communicate with the specific child to ensure that their wishes and feelings are heard.
16. The Common Assessment Framework (CAF) may be used by any agency as a means of working with the child, family and other service providers to identify and meet needs which could enable the child to achieve a satisfactory level of health and/or development.

Referral to Children's Social Care

17. Some disabled children will have more complex needs. Children who are unlikely to reach or maintain a satisfactory level of health or development are entitled to receive services as a child in need.
18. They will carry out an initial assessment to determine whether the child is in need, the nature of any services required, and whether a further, more detailed core assessment should be undertaken.
19. If at any point a practitioner becomes concerned that a disabled child is at risk of significant harm they should consult with their designated lead for child protection and make a referral to Children's Social Care via First Response Service.
20. Expertise in both safeguarding children and promoting the welfare of the disabled child must be brought together to ensure that disabled children receive the same levels of protection from harm as other children.

21. Possible indicators of abuse or significant harm may prove difficult to separate from the effects of a child's impairment, therefore a multi-agency approach involving all practitioners who work with the child is essential.
22. It is usual for a practitioner from the Children's Disability social work teams to take the lead in any S47 enquiry involving a child already known to them.
23. Where the child is not known to the Children's Disability social work team, case management rests with the relevant safeguarding manager unless a decision is made to transfer the case to the disabled children's service.
24. Where the concern is about abuse or neglect within the child's home all other children in the household should also be subject to enquiry in the normal way. Sometimes the same social worker will undertake the enquiry about all children though they will need to liaise closely with other practitioners involved with the family. Most usually the needs of the family will be better met with a specialist worker and a safeguarding worker undertaking the enquiry together.
25. There may be an increased role for practitioners from disabled children's service, health and education services because of their relationship with a child and/or family.
26. The nominated health practitioner may be able to provide useful information prior to any investigation and other key practitioners who are familiar with the child's disability and communications method may be able to assist, directly or indirectly, with the investigation.

Strategy Discussion

27. Where there are concerns that a disabled child may be or is likely to suffer significant harm the Team Manager will convene a strategy discussion/meeting in consultation with the other relevant practitioners.
28. In addition to considering the threshold for S47 enquiries, a strategy discussion may also look at appropriate multi-agency interventions early in the process and seek to minimise risk.
29. The strategy discussion/meeting should give particular consideration to:
 - Ensure that there is sufficient information about the impact and the context of the specific disability on the child;
 - Enabling the child to communicate effectively, sometimes this will require someone who knows the child and their specific communication needs. They will advise whether the usual method of communication can be used;

- Whether specialist advice should be sought, who should undertake the investigation, where and how it will take place.
30. Given the potentially complex nature of S47 enquiries it may be appropriate to hold additional strategy discussions to ensure that informed decisions are made and timescales are kept.

The Court Process

31. Agencies should not make assumptions about the ability of a disabled child to give credible evidence, or to withstand the rigours of the court process. Each child should be assessed carefully, and be helped and supported to participate in the criminal justice process when this is in the child's best interest and the interests of justice.
32. In criminal proceedings aged under 17 are automatically eligible for assistance with giving their evidence. The special measures they may be provided with include: screens around the witness box so they do not see the defendant; video recorded evidence in chief and live video links so that they may not have to go into the courtroom at all, and intermediaries and aids to communication to facilitate good communication. Achieving Best Evidence in Criminal Proceedings (2002) - includes comprehensive guidance on planning and conducting interviews with children and a specific section about interviewing disabled children.