Safeguarding Disabled Children

For additional guidance, please see **Safeguarding Disabled Children: Practice Guidance** (DCSF 2009).

Contents

AMENDMENT

In November 2019, this chapter was updated throughout and should be re-read.

1. Introduction and Legislation

Safeguards for disabled children are essentially the same as all other children, however safeguarding disabled children demands a greater awareness of their vulnerability, individuality and needs.

The Children Act 1989 s17(1) creates a general duty on children's services authorities to safeguard and promote the welfare of children within their area who are 'in need'. So far as is consistent with this duty, children's services authorities must promote the upbringing of such children by their families.

The definition of ‘children in need’ is to be found at CA 1989 s17(10), which provides that a child is to be taken as ‘in need’ if:.

(c) he is disabled.

‘Social model’ of Disability

It is important that workers understand the’ social model’ of disability. Many of the problems that disabled children face are not caused by their disability or condition but by social values, service structure and adult behaviour. There is an increased risk that behavioural changes and physical injuries are attributed to disability, so abuse may be sustained for long periods of time.

2. Definition

Under the Equality Act 2010 a child or young person is disabled if they have a physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on their ability to do normal daily activities.

Children with a disability are children first and foremost and deserving of the same rights and protection as other children. By definition, any child with a disability should also be considered as a child in need. A child can be considered to be disabled if he or she has significant problems with communication, comprehension, vision, hearing or physical functioning .

3. Reporting Concerns

Concerns about the welfare of a disabled child should be acted upon in the same way as any other child in accordance with the **Referrals Procedure**. The same thresholds for action apply.

Disabled children should not be left in situations where there is a high level of neglect or other forms of abuse, because a professional feels the parent, carer or service is 'doing their best'.

Where there are communication impairments or learning difficulties, attention should be paid to the communications needs of the child to ascertain the child’s perception of events and his or her wishes and feelings. Disabled Children may be unable to tell someone of the abuse they may convey anxiety or distress in some other way, e.g. behaviour or indicators and carers and staff must be alert to this.

Throughout any assessment process, including a Section 47 Enquiry, all service providers must ensure that they communicate clearly with the disabled child and the family and with one another as there is likely to be a greater number of services and staff involved than for a

non-disabled child. All steps must be taken to avoid confusion so that the welfare and protection of the child remains the focus.

4. Risks

People caring for and working with disabled children need to be alert to the signs and indicators of abuse.

Many factors can make a disabled child more vulnerable to abuse than a non-disabled child of the same age. Safeguarding disabled children demands a greater awareness of their vulnerability, individuality and needs.

Disabled children should not be left in situations where there is a high level of neglect or other forms of abuse, because a professional feels the parent, carer or service is 'doing their best'.

Disabled children may be especially vulnerable to abuse for several reasons. Some disabled children may:

- Have fewer outside contacts than other children;
- Receive intimate care from carers, which may increase the risk of exposure to abusive behaviour and make it more difficult to set and maintain physical boundaries;
- Have an impaired capacity to resist or avoid abuse;
- Have communication difficulties that may make it difficult to tell others what is happening;
- Be inhibited about complaining, fearing a loss of services;
- Be especially vulnerable to bullying and intimidation (see **Bullying Guidance**);
- Be more vulnerable than other children to abuse by their peers.

Additional factors may be:

- The child's dependence on carers could result in the child having a problem in recognising what is abuse. The child may have little privacy, a poor body image or low self-esteem;
- Carers and staff may lack the ability to communicate adequately with the child;
- A lack of continuity in care leading to an increased risk that behavioural changes may go unnoticed;

- Lack of access to 'keep safe' strategies available to others;
- Disabled children living away from home in poorly managed settings are particularly vulnerable to over medication, poor feeding and toileting arrangements, issues around control of challenging behaviour, lack of stimulations and emotional support (see **Children Living Away from Home with Other Families (including Private Fostering) Procedure**);
- Parents'/carers' own needs and ways of coping may conflict with the needs of the child;
- Some adult abusers may target disabled children in the belief that they are less likely to be detected;
- Signs and indicators can be inappropriately attributed to disability;
- Disabled children are less likely to be consulted in matters affecting them and as a result may feel they have no choice about whether to accept or reject sexual advances.

5. Indicators

In addition to the universal indicators of abuse/neglect listed in the **Responding to Abuse and Neglect Procedure**, the following abusive behaviours and their impact must be considered:

- Force feeding;
- Unjustified or excessive physical restraint;
- Rough handling;
- Extreme behaviour modification including the deprivation of liquid, medication, food or clothing;
- Misuse of prescribed and non-prescribed medication including sedation, heavy tranquilisation;
- Use of illicit drugs and alcohol;
- Invasive procedures against the child's will;
- Failure to accept child's disability which impacts of the child's health and wellbeing;
- Non-compliance with programmes, regimes or medical/health treatment;

- Failure to address ill-fitting equipment e.g. callipers, sleep boards which may cause injury or pain, inappropriate splinting;
- Misappropriation/misuse of a child's finances;
- Over protective parenting; impacting on the child's social, emotional and physical health and wellbeing;
- Fabricating or inducing illness – see **Fabricated or Induced Illness Procedure**;
- Female genital mutilation in the UK and overseas (up to the age of 18) see **Female Genital Mutilation (FGM) Procedure**;
- Male Circumcision and adverse impact of the child or young person;
- Any of the following situations involving disabled children/young people:
    - **Children and Young People who go Missing from Home or Care Procedure**;
    - **Children from Abroad, including Victims of Modern Slavery, Trafficking and Exploitation Procedure**;
    - **Child Sexual Exploitation Procedure**.
- Failure to address the harmful impact of family domestic abuse:
    - **Domestic Abuse/Violence Procedure**;
    - **Forced Marriage Procedure**.

IF YOU HAVE CONCERNS REGARDING ANY OF THE ABOVE – SEEK ADVICE

6. Protection

Safeguards for disabled children are essentially the same as all other children, however safeguarding disabled children demands a greater awareness of their vulnerability, individuality and needs.

Paediatric Safeguarding Medicals should always be considered necessary where there has been a disclosure or there is a suspicion of any form of abuse to a child.

Measures should:

- Make it common practice to enable disabled children to make their wishes and feelings known in respect of their care and treatment;

- Ensure that disabled children receive appropriate personal, health and social education (including sex education);
- Make sure that all disabled children know how to raise concerns and give them access to a range of adults with whom they can communicate. This could mean using interpreters and facilitators who are skilled in using the child's preferred method of communication;
- Recognise and utilise key sources of support including staff in schools such as support workers, friends and family members where appropriate;
- Ensure that there is an explicit commitment to and understanding of disabled children's safety and welfare among all providers of services used by disabled children;
- Develop the safe support services that families want, and a culture of openness and joint working with parents and carers on the part of services;
- Provide guidelines and training for staff on good practice in intimate care; working with children of the opposite sex; managing behaviour that challenges families and services; issues around consent to treatment; anti-bullying and inclusion strategies; sexuality and safe sexual behaviour among young people; monitoring and challenging placement arrangements for young people living away from home.

7. Communication and Participation

All Agencies should be aware of non-verbal communication systems and should know how to contact suitable interpreters and facilitators.

Agencies must not make assumptions about the inability of a disabled child to provide consent and must follow Gillick Competence Principles, for more information see **NSPCC Factsheet** and **Appendix 1: Assessing Competence**.

Carers are relied upon (whether family or paid carers) as a source of information about disabled children and to interpret and explain behaviour or symptoms.

Carer will need to be challenged in the same way as carers of non-disabled children.

Professional staff can potentially feel out of their depth in terms of knowledge of a disabled child's impairment, where the familiar developmental milestones may not apply.

Agencies must not make assumptions about the inability of a disabled child to give credible evidence, or to withstand the rigours of the Court process.

Each child should be assessed carefully and supported where relevant to participate in the criminal justice system when this is in their interests as set out in **Achieving Best Evidence** which includes comprehensive guidance on planning and conducting interviews with children and a specific section about interviewing disabled children.

Participation in all forms of meetings such as Child Protection Conferences and Core Groups must be encouraged and facilitated and take into account any issues about access.

8. Allegation of Abuse carried out by an Employee, Agency Worker, Volunteer or Student against a Disabled Child or Young Person

Disabled children come into contact with a wide range of carers, it is important that all staff are clear about the process they should follow if they become aware a person working with children has:

- Behaved in a way which has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Where such concerns are identified they should be discussed with the **Local Authority Designated Officer (LADO)**.

9. Useful Links

Council for Disabled Children

Department for Works and Pensions DWP

Personal Independence Payments (PIP)

Disability Living Allowance

Deprivation of liberty (invoked from the age of 16), see **LLR Safeguarding Adults Board Mental Capacity and Deprivation of Liberty Safeguards**

My Adult Still my Child

10. Related Chapters

Referrals Procedure

Section 47 Enquiries Procedure

Neglect Guidance

Fabricated or Induced Illness Procedure

Assessment Protocol

Thresholds for Access to Services for Children and Families in Leicester, Leicestershire and Rutland Children's Social Care

Appendix 1: Assessing Competence

Gillick Competence and Mental Capacity Act 2005 Concepts and Language

Gillick competence applies to children under the age of 16 where the Mental Capacity Act does not yet apply. It is most commonly used in Adult Care and Support when a child under 16 begins the transition process to adults at an early stage.

Gillick is a test to reach a judgement about the child's capabilities to understand something in order to give consent to it. Gillick can be applied to a range of matters, including medical treatment and consent to an assessment.

Further guidance to support practitioners assessing competence was set out in the case Re S [2017] EWHC 2729 (Fam). Even though this case was in the context of a child parent's ability to give consent to an adoption order, the judgement has implications for all assessments of competency (including consent to a Deprivation of Liberty).

The judgement stated that even though the Mental Capacity Act 2005 does not apply 'there is an advantage in applying relevant concepts and language (of the Mental Capacity Act 2005) to the determination of competence to the under-16s'.

Specifically:

- The determination of a child's competence must be decision-specific and child-specific;
- Just because the child lacks competence in one context does not mean they lack it in another;
- The assessment of competence must be made on the current evidence;
- The child should be of sufficient intelligence and maturity to:
    - Understand the nature and implications of the decision and the process of implementing that decision;
    - Understand the implications of not pursuing the decision;
    - Retain the information long enough for the decision-making process to take place;
    - Weigh up the information and arrive at a decision;
    - Communicate that decision.

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Appendix 2: Intimate Care Good Practice Guidelines

It is recommended that where children require intimate care, good practice guidelines are drawn up within the establishment and disseminated to all staff. Parents / carers should also be made aware of how intimate care for their child will be managed. These guidelines should be viewed as expectations upon staff, which are designed to protect both children and staff alike. In situations where a member of staff potentially breaches these expectations, other staff should be able to question this in a constructive manner.

Staff should be advised that if they are not comfortable with any aspect of the agreed guidelines, they should seek advice within the establishment. For example, if they do not wish to conduct intimate care on a 1 to 1 basis, this should be discussed, and alternative arrangements considered. For example, it may be possible to have a second member of staff in an adjoining room or nearby so that they are close to hand but do not compromise the child's sense of privacy.

The following is an example of good practice guidelines from Chailey Heritage, a nationally recognised centre for the education, assessment, treatment and support of children with physical and multiple disabilities. They are reproduced here with additions relating specifically to Leicester City LSCB and Leicestershire and Rutland Local Safeguarding Children Board. Whilst these are considered to be "best practice", individual establishments may wish to adapt them to suit their particular circumstances.

Guidelines for good practice (adapted from the Chailey Heritage Centre)

See Chailey Heritage Centre website

1. Treat every child with dignity and respect and ensure privacy appropriate to the child's age and the situation. Privacy is an important issue. Much intimate care is carried out by one staff member alone with one child. Leicester City LSCB and Leicestershire and Rutland Local Safeguarding Children Board believe this practice should be actively supported, unless the task requires two people. Having people working alone does increase the opportunity for possible abuse. However, this is balanced by the loss of privacy and lack of trust implied if two people have to be present - quite apart from the practical difficulties. It should also be noted that the presence of two people does not guarantee the safety of the child or young person - organised abuse by several perpetrators can, and does, take place. Therefore, staff should be supported in carrying out the intimate care of children alone unless the task requires the presence of two people. Leicester City LSCB and Leicestershire and Rutland Local Safeguarding Children Board recognise that there are partner agencies that recommend two carers in specific circumstances. Where possible, the member of staff carrying out intimate care should be someone chosen by the child or young person. For

older children it is preferable if the member of staff is the same gender as the young person. However, this is not always possible in practice.

Agencies should consider the implications of using a single named member of staff for intimate care or a rota system in terms of risks of abuse. Managers of individual establishments should make such decisions based on their knowledge of the child and their staff. Staff may also, at times, wish to give intimate care with a colleague.

2. Involve the child as far as possible in his or her own intimate care. Try to avoid doing things for a child that s/he can do alone, and if a child is able to help ensure that s/he is given the chance to do so. This is as important for tasks such as removing underclothes as it is for washing the private parts of a child's body. Support children in doing all that they can themselves. If a child is fully dependent on you, talk with her or him about what you are doing and give choices where possible.

3. Be responsive to a child's reactions. It is appropriate to "check" your practice by asking the child - particularly a child you have not previously cared for - "Is it OK to do it this way?"; "Can you wash there?; "How does mummy do that?". If a child expresses dislike of a certain person carrying out her or his intimate care, try and find out why. Conversely, if a child has a "grudge" against you or dislikes you for some reason, ensure your line manager is aware of this.

4. Make sure practice in intimate care is as consistent as possible. Line managers have a responsibility for ensuring their staff have a consistent approach. This does not mean that everyone has to do things in an identical fashion, but it is important that approaches to intimate care are not markedly different between individuals. For example, do you use a flannel to wash a child's private parts rather than bare hands? Do you pull back a child's foreskin as part of daily washing? Is care during menstruation consistent across different staff?

5. Never do something unless you know how to do it. If you are not sure how to do something, ask. If you need to be shown more than once, ask again. Certain intimate care or treatment procedures, such as rectal examinations, must only be carried out by nursing or medical staff. Other procedures, such as giving rectal valium, suppositories or intermittent catheterisation, must only be carried out by staff who have been formally trained and assessed as competent.

6. If you are concerned that during the intimate care of a child:

•You accidentally hurt the child;

•The child seems sore or unusually tender in the genital area;

•The child appears to be sexually aroused by your actions;

•The child misunderstands or misinterprets something;

•The child has a very emotional reaction without apparent cause (sudden crying or shouting).

Report any such incident as soon as possible to another person working with you and make a brief written note of it. This is for two reasons: first, because some of these could be cause for concern, and secondly, because the child or another adult might possibly misconstrue something you have done.

Additionally, if you are a member of staff who has noticed that a child's demeanour has changed directly following intimate care, e.g. sudden distress or withdrawal, this should be noted in writing and discussed with your lead professional, who may then seek advice from the named or designated professionals.

7. Encourage the child to have a positive image of her or his own body. Confident, assertive children who feel their body belongs to them are less vulnerable to abuse. As well as the basics like privacy, the approach you take to a child's intimate care can convey lots of messages about what her or his body is "worth". Your attitude to the child's intimate care is important. As far as appropriate and keeping in mind the child's age, routine care of a child should be enjoyable, relaxed and fun.

Intimate care is to some extent individually defined, and varies according to personal experience, cultural expectations and gender. Leicester City LSCB and Leicestershire and Rutland Local Safeguarding Children Board recognises that children who experience intimate care may be more vulnerable to abuse:-

•Children with additional needs are sometimes taught to do as they are told to a greater degree than other children. This can continue into later years. Children who are dependent or over-protected may have fewer opportunities to take decisions for themselves and may have limited choices. The child may come to believe they are passive and powerless;

•Increased numbers of adult carers may increase the vulnerability of the child, either by increasing the possibility of a carer harming them, or by adding to their sense of lack of attachment to a trusted adult (see also Section 1 above);

•Physical dependency in basic core needs, for example toileting, bathing, dressing, may increase the accessibility and opportunity for some carers to exploit being alone with and justify touching the child inappropriately;

•Repeated “invasion” of body space for physical or medical care may result in the child feeling ownership of their bodies has been taken from them;

•Children with additional needs can be isolated from knowledge and information about alternative sources of care and residence. This means, for example, that a child who is

physically dependent on daily care may be more reluctant to disclose abuse, since they fear the loss of these needs being met. Their fear may also include who might replace their abusive carer.

The above is taken largely from the publication 'Abuse and children who are disabled: a training and resource pack for trainers in child protection and disability, 1993'.