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Safeguarding Disabled Children

Factors Potentially Increasing Vulnerability

Discrimination & Assumptions	Communication	Impairment-related factors	More time away from home	Lack of choice / participation	Bullying & Harassment	Isolation	Criminal Justice Systems	Parents / Carers	Dependency
- Impact of double-discrimination e.g. race & disablity or parents / carers with a physical / learning disability -Disability protects e.g. no-one would stoop so low -More likely to make false allegations	-Adults do not understand child's means of communication - Augmentative systems or tools such as word boards may not include words relating to abuse -May be unable (children) or unwilling (parents / carers) to complain because of fear of losing services -Insufficient co-ordination or sharing of expertise	-Impaired capacity to resist or avoid abuse - Behaviours such as self-harming or repetitive behaviours may be misconstrued and associated with impairment as opposed to abuse	-A third of disabled children in residential care found to be isolated from parents -Poor track record of residential establishments in responding to complaints	-Lack of access to 'keeping safe' strategies and education (adult, child and peers) - Lack of consultation & / or action following - Assumptions around asexuality limit education and blur boundaries around sexual abuse in particular[1]	-Evidence of increased victimization of disabled children / those with visible medical Conditions -Particular vulnerability to peer abuse	- From other children & adults may make abuse and neglect remain hidden for longer -Fewer 'outside' contacts or access to independent facilitators / advocates -Increased pressure on parents / carers	-Concerns about 'evidence' may result in a lack of action to safeguard -Fear of impediment or lack of skills / training may cause practitioners to fail to listen properly or to check-out concerns	-Too much focus on needs and support at the expense of risk i.e. danger of collusion e.g. Fabricated or Induced Illness, forced marriage, Female Genital Mutilation[2] -Complexity / co-morbidity e.g. learning disability, drugs, alcohol, dv, MH issues	-Multiple carers blurs boundaries and affords access to more adults -Basic & intimate care needs / possible dependence on abuser -Child may come to 'accept' what is inappropriate / abusive

[1] Research indicates that around 1/6 of child sexual abuse is perpetrated by adolescents with a learning disability and it is estimated that 1 in 30 cases of sexual abuse involving disabled people is reported, compared with 1 in 5 of the non-disabled population.

[2] Research has shown, for example, that disabled children are particularly vulnerable to forced marriage &, by definition, 'disability' may be a central issue in cases where Fabricated or Induced Illness is suspected.

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Avoid Assumptions	**Communicate Effectively**	**Recognize Abuse**	**Empower**	**Counter Bullying**	**Be Inclusive**	**Clarify Roles**	**Be Child-Centred**	**Draw Boundaries**
-Do we understand & embrace a social model of disability? -Does everyone accept that disabled children are particularly vulnerable to all forms of abuse & neglect & is the possibility always considered, however remote or unpalatable? -Do we actively counter the possibility & / or impact of double-discrimination?	-How do we communicate effectively with *individual* young people? -Do any alternative and augmentative systems provide a sufficiently wide 'vocabulary'? -Are links and transition arrangements between safeguarding / CWD & children's/ adult services clear? -Are we trained to & clear about how we should listen to & *hear* disabled children?	- Are staff trained to recognize signs and symptoms of abuse[3] ? -What might that behavior mean? Who knows what is 'normal' for this child, here & now? -Do we understand specific issues such as FII, honour-based violence, forced marriage etc? -Do we have are systems in place for reporting & recording any changes, events & welfare concerns which map & build 'pictures' chronologically?	-Help children to establish a positive self-identity as a disabled child -Committed, creative and flexible approach to raising awareness among disabled children - Are strategies to empower & encourage participation tailored to meet individuals skills, needs & abilities?	- Unequivocal anti-bullying policies and procedures in place e.g. what bullying behavior might consist of -How do we raise awareness, draw boundaries & consult with children, parents & carers? -Do we consult on & audit what we do? How does this shape future practice?	-Awareness-raising & education for adults (including non-professionals) & peers -Do we appoint / use independent advocates and visitors? -Do parents, carers & children have access to appropriate complaints and whistle-blowing procedures? -What does 'assessment' mean for this child / family?	-Are investigative processes left to investigative agencies & professionals? - From whom would we seek advice in any case where doubt or a lack of clarity remained? -Do we consult with others who have specific training, skills & knowledge? -Do the *right people* conduct assessments at the *right time* & with access to the *right information*? Do we assess *with*?	- -What would this child say / think / feel? -How do we strike appropriate balances between partnership / empathy / support and a willingness to question & challenge -How will we know that this child is safe? -What do SCRs tell us & how do we take account of them?[4]	-Is the number of carers kept to a minimum? - Are staff provided with induction training around safe & acceptable practice e.g. behavior management, intimate care, whistle-blowing & allegations? -Is there an ongoing culture of vigilance? -Are whistle-blowing & managing allegations procedures in place & known by all?

[3] Research indicates that the identification of the abuse of disabled children is most likely to come from observations of physical signs, behaviour or mood changes (DCSF, 2009, para.4.16, page 54).

[4] Serious Case Reviews: www.dcsf.gov.uk/research (see DCSF-RR129 for example).

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