1.1.4 Definition and Recognition of Significant Harm (Abuse and Neglect)

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1. Concept and Definition of Significant Harm

1.1 Some children are In Need because they are suffering, or likely to suffer, Significant Harm.

1.2 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 children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, Significant Harm.

Under Section 31(9) of the Children Act 1989, as amended by the Adoption and Children Act 2002:

'Harm' means ill-treatment or the impairment of health or development, including for example impairment suffered from seeing or hearing the ill-treatment of another;

'Development' means physical, intellectual, emotional, social or behavioural development;

'Health' means physical or mental health; and

'Ill-treatment' includes Sexual Abuse and forms of ill-treatment that are not physical.

1.3 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 of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements as well as the

protective factors in the child's life that may promote their resilience to adverse factors.

1.4 Each of these elements has been associated with more severe effects on the child, and / or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment.

1.5 Sometimes, a single traumatic event may constitute Significant Harm (e.g. a violent assault, suffocation or poisoning). More often, Significant Harm is a compilation of significant events, both acute and long-standing, which interrupt, change or damage the child's physical and psychological development.

1.6 Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term neglect, emotional, physical or sexual abuse that causes impairment to the extent of constituting Significant Harm.

1.7 To understand and identify Significant Harm, it is necessary to consider:

- The nature of harm, in terms of maltreatment or failure to provide adequate care
- The impact on the child's health and development
- The child's development within the context of their family and wider family environment
- Any special needs, such as medical condition, communication impairment or disability, that may affect the child's development and care within the family
- The capacity of the parents to meet adequately the child's needs
- The wider and environmental family factors
- The resilient factors in both the child, their relationships and their environment

1.8 For these reasons, each child's experience within a potentially abusive situation will be different and must be separately assessed.

2. What is Abuse and Neglect?

Abuse and Neglect are forms of maltreatment of a child. Somebody may abuse or Neglect a child by inflicting harm, or by failing to act to prevent harm.

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. They may be abused by an adult or adults, or another child or children.

It is important to remember that child Abuse and Neglect occurs across the social spectrum and that abuse of a child is considered to be a criminal offence.

The following definitions are taken from Working Together to Safeguard Children, 2006.

2.1 Physical Abuse

2.1.1 Physical Abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child.

2.2 Emotional Abuse

Emotional Abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent effects on the child's emotional development.

2.2.1

- It may involve conveying to children 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. These may include:
  - Interactions that are beyond the child's developmental capability,
  - Overprotection and limitation of exploration and learning,
  - Preventing the child participating in normal social interaction;
- It may involve seeing or hearing the ill-treatment of another;
- It may involve serious bullying, causing children frequently to feel frightened or in danger, or the exploitation or corruption of children;

2.2.2 Some level of Emotional Abuse is involved in all types of maltreatment of a child, though it may occur alone.

2.3 Sexual Abuse

2.3.1 Sexual Abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, sexual online images, watching sexual activities or encouraging children to behave in sexually inappropriate ways

2.3.2 Sexual abuse includes abuse of children through sexual exploitation. Penetrative sex where one of the partners is under the age of 16 is illegal, although prosecution of similar age, consenting partners is not usual. However, where a child is under the age of 13 it is classified as rape under Section 5 of the Sexual Offences Act 2003. For further guidance refer to Guidance for Professionals Working with Sexually Active Young People under 18 years.

2.4 Neglect

2.4.1 Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.

2.4.2 Neglect may occur during pregnancy as a result of maternal substance abuse.

2.4.3 Once a child is born, neglect may involve a parent failing to:

- Provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- Protect a child from physical and emotional harm or danger;
- Ensure adequate supervision (including the use of inadequate care-givers);
- Ensure access to appropriate medical care or treatment.

2.4.4 It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

3. Recognition of Physical Abuse

As with all forms of abuse, physical abuse - inflicted injury to a child- often occurs against a background of other family problems. It is linked, in particular, with neglect and often injuries may be a mixture of direct abuse and accidents due to lack of safe parenting.

Most Physical Abuse occurs in families under stress, including the stresses of child rearing, and results from a loss of control. It may be a "one-off" incident or become a habitual response. The misuse of alcohol and certain substances are a recognized contributory factor to Physical Abuse as well as to other forms of abuse. Repeated incidents of Physical Abuse are likely to be emotionally damaging even where there is no serious physical harm.

Physical Abuse of the child should always be considered as a possibility where there is known to be domestic abuse against a parent. The child may be inadvertently caught up in violence between adults. For further guidance on this issue, see Domestic Abuse Procedure.

Similarly, where there is known mistreatment of animals, the risk of child abuse increases.

Seemingly trivial injuries should not be ignored because abuse can and does escalate against a child if it goes unchecked. In terms of physical danger, babies and young children are at greatest risk. Further incidents may result in serious physical harm or be fatal.

Suspicion that an injury may be have been inflicted should be raised by a combination of medical and social factors, which, taken together, arouse concern. Commonly these are:

- Vague, unwitnessed, inconsistent, discrepant history
- Injury at an unusual site
- Inconsistency between the explanation and the injury observed (for example, multiple bruising from a simple fall);
- Accounts which differ between parent and child, or which change over time;

- Explanations which do not fit the age and developmental level of the child, particularly when the child is said to have caused the injury himself;
- Incidental discovery of an unreported serious injury;
- Evidence that an implement has been used;
- Where the pattern of injuries itself raises concern;
- Injuries of different ages
- History of inappropriate child response (e.g. didn't cry, felt no pain).
- History of inappropriate parents'/carers' response (e.g. time delay without appropriate explanation, unconcerned or aggressive carers);
- Age of child - infants who are immobile rarely have accidental injuries
- Direct allegation from the child
- Child/family known to Children's Social Care/ subject to a Child Protection Plan/previous concerns about child care for this or another child in the family
- Previous history of unusual injury
- Repeated attendance at emergency care services may be due to Neglect or abuse

3.1 Bruising

3.1.1 What we know about bruising:

- Bruising is strongly related to mobility.
- Once children are mobile they sustain bruises from everyday activities and accidents.
- Bruising in a baby who is not yet crawling, and therefore has no independent mobility, is very unusual.
- Only one in five infants who has starting to walk by holding onto the furniture has bruises.
- Most children who are able to walk independently have bruises
- Bruises usually happen when children fall over or bump into objects in their way
- Children have more bruises during the summer months

3.1.2 Accidental injuries predominately affect bony prominences and the front of the body, although no site itself is pathognomonic, and therefore a careful history should be taken in all cases.

3.1.3 Patterns of bruising that may mean Physical Abuse has taken place:

- Abusive bruises often occur on soft spots of the body, e.g. cheeks, abdomen, back and buttocks
- The head is by far the commonest site of bruising in child abuse
- Clusters of bruising are a common feature in abused children - these are often on the upper arm, outside of the thigh, or on the body
- As a result of defending themselves, abused children may have bruising on the forearm, face, ears, abdomen, hip, upper arm, back of leg, hands or feet
- Abusive bruises can often carry the imprint of the implement used or the hand
- Non-accidental head injury or fractures can occur without bruising

3.1.4 Bruising that suggests the possibility of Physical Abuse includes:

- Bruising in children who are not independently mobile
- Bruising in babies
- Bruises that are seen away from bony prominences
- Bruises to the face, back, abdomen, arms, buttocks, ears and hands
- Multiple bruises in clusters
- Multiple bruises of uniform shape
- Bruises that carry an imprint - of an implement or cord

3.1.5 A bruise should never be interpreted in isolation, no matter what the age of the child, and must always be assessed in the context of the child's medical and social history, developmental stage and explanation given.

3.2 Bites

3.2.1 Bites are always inflicted injuries. They can be animal or human - adult or child. Bite marks are made by teeth either acting alone or in combination with other mouth parts. 'Love bites' are suction marks caused by the mouth with or without teeth marks, and can appear as petechial haemorrhages.

Adult or child?

3.2.2 Human bites are mostly paired crescent shaped arches of bruises. In the most aggressive bites the skin may be broken. Individual teeth marks may be seen. The marks may be distorted by the contours of the area bitten.

The differences between adult and child bites are subtle. For example, the inter-canine distance (measurement across the mouth between the third teeth on each side) is more than 3 cm in the adult and less than 3 cm in the young child with primary teeth. It may be possible to distinguish between a bite mark made by a child and one made by an adult. Where there is any doubt over the origin of the bite, a medical opinion should be sought.

3.3 Thermal injury

3.3.1 Burns and scalds to children are common. The majority of burn or scald injuries result from non-intentional injury, which involves varying degrees of parental inattention, but also include some cases of neglect. A smaller number involve deliberate abuse.

3.3.2 Most accidental burns and scalds in childhood occur in pre-school children and should be preventable.

3.3.3

Features of childhood thermal injury

Accidents follow brief lapses in protection, Neglect is part of a pattern of inadequate parenting, and abuse occurs when injury is deliberately inflicted.

When burns are old or become infected they are difficult to differentiate from a primary infected lesion.

Common patterns of abusive burn and scald injuries:

3.3.4

- Contact burns - clearly outlined marks from contact with hot objects
- Deep, cratered, circular burns from cigarettes, which heal to leave scars
- Immersion scalds most usually from hot water:
  - Sometimes there are glove and stocking circumferential scalds of limbs/parts of limbs/buttocks from forced immersion.
  - Clear waterlines may be visible where the child has been held in the water.
  - Splash marks may be absent.
- Scalds from poured or thrown liquids
- Friction or carpet burns e.g. from dragging child across the floor

Common sites of non-accidental thermal injury:

3.3.5

- Feet and hands especially the back of hands
- Legs and buttocks
- Face

3.4 Fractures

3.4.1 Fractures in very young children may present with non-specific symptoms and may only be revealed by X-ray or other radiological tests. Fractures may not be obvious even on X-ray immediately after an injury; they are easier to identify once the bones show some sign of healing

3.4.2 A fracture, like any other injury, should never be interpreted in isolation. It must always be assessed in the context of the child's medical and social history, developmental stage and explanation given. Any child with unexplained signs of pain or illness should be seen promptly by a doctor.

3.5 Injuries to "non-mobile" infants (non-mobile relates to infants who are unable to walk, crawl, bottom shuffle, pull to stand).

3.5.1 Infants are most at risk of serious deliberate harm and as such require careful consideration. Following the recommendation from a Serious Case Review, it has been decided that in the following situations, referral to a clinician with paediatric experience should be AUTOMATIC:

Any evidence of physical injury in a non-mobile infant, for example: bruise, thermal injury, clinical or radiological evidence of a fracture etc. (this does not include minor scratches).

3.5.2 In these situations the professional will contact the Emergency Medicine Consultant on call at Salford Royal Hospital who will arrange for the infant to be medically examined (see the Referrals Procedure for the detailed process.

3.5.3 Remember: an older child with any of the above findings would also warrant careful consideration.

3.5.4 Where it is suspected that the injury is non-accidental, a referral to Children's Social Care should be made in accordance with the Referrals Procedure.

4. Recognition of Emotional Abuse

4.1 Emotional Abuse may be difficult to recognise, as the signs are usually behavioural rather than physical. In most instances, concern about Emotional Abuse will develop, based upon observation of the relationship between a parent and child.

4.2 The difficulty most often experienced by those with concerns is that each individual incident may appear insignificant and "a matter of individual judgement" about how to respond to the child. It is often helpful to cluster together those interactions which have caused concern, and also those which have been positive, in order to form an overall picture.

4.3 What makes the parental behaviour abusive is that it typifies their relationship with the child. It is likely to be recognized by what is observed over time this involves making judgements about how a parent/carer should manage a child's behaviour, and clarity about what puts this parental behaviour beyond an acceptable threshold.

4.4 Key questions will be:

- How persistent is this way of treating the child?
- How severe/inappropriate is it?

Children at risk of Emotional Abuse may be:

4.5

- The wrong sex, unwanted, disabled, abused as child, rejected
- Seen as ill or difficult
- Born into difficult situations - martial difficulty, separation, violence
- Born to vulnerable parents - alcohol or drug abuse, depressed, mentally or otherwise ill.

Indicators of Emotional Abuse

The indicators of Emotional Abuse are often also associated with other forms of abuse. Professionals should therefore be aware that Emotional Abuse might also indicate the presence of other kinds of abuse.

Suggested indications of Emotional Abuse include:

4.6

- Developmental delay;
- Abnormal attachment between a child and parent (e.g. anxious, indiscriminate or no attachment);
- Aggressive behaviour towards others;
- Appeasing behaviour towards others;
- Scapegoated within the family;
- Frozen watchfulness, particularly in preschool children;
- Low self esteem and lack of confidence;
- Withdrawn or seen as a 'loner' - having difficulty relating to others

5. Recognition of Sexual Abuse

5.1 Sexual Abuse can be very difficult to recognise and reporting Sexual Abuse can be an extremely traumatic experience for a child. Therefore both identification and disclosure rates are deceptively low.

5.2 Boys and girls of all ages may be sexually abused and are frequently scared to say anything due to guilt and/or fear.

5.3 If a child makes an allegation of Sexual Abuse, it is very important that they are taken seriously. Allegations can often initially be indirect as the child tests the professional's response. There may be no physical signs and indications are likely to be emotional/behavioural.

5.4 Behavioural indicators which may help professionals identify the Sexual Abuse of a child include:

- Inappropriate sexualised conduct;
- Sexually explicit behaviour, play or conversation, inappropriate to the child's age;
- Contact or non-contact sexually harmful behaviour;
- Continual and inappropriate or excessive masturbation;
- Self-harm (including eating disorder), self mutilation and suicide attempts;
- Involvement in sexual exploitation or indiscriminate choice of sexual partners;
- An anxious unwillingness to remove clothes for e.g. sports events (but this may be related to cultural norms or physical difficulties).

5.5 Physical indicators associated with Sexual Abuse include:

- Pain or itching of genital area;
- Blood on underclothes;
- Pregnancy in a child;
- Physical symptoms such as injuries to the genital or anal area, bruising to buttocks, abdomen and thighs, sexually transmitted disease, presence of semen on vagina, anus, external genitalia or clothing.

5.6 Sex offenders have no common profile, and it is important for professionals to avoid attaching any significance to stereotypes around their background or behaviour.

5.7 While media interest often focuses on 'stranger danger', research indicates that as much as 80 per cent of sexual offending occurs in the context of a known relationship, either family, acquaintance or colleague.

6. Recognition of Neglect

6.1 It is rare that an isolated incident will lead to agencies becoming involved with a neglectful family. Evidence of Neglect is built up over a period of time. Professionals should therefore compile a Chronology and discuss concerns with any other agencies which may be involved with the family, to establish, jointly, whether seemingly minor incidents are in fact part of a wider pattern of neglectful parenting.

6.2 In working with families where there is evidence of neglect it is expected that the Graded Care Profile (GCP) should be completed so that in addition to parenting strengths, areas of concern are identified as early as possible. Professionals can then work with the family on improving those areas of parenting. Should there be no improvement a completed GCP will inform workers when to refer to Children's Social Care.

6.3 When working in areas where poverty and deprivation are commonplace professionals may become desensitised to some of the indicators of neglect. These include:

- Failure by parents or carers to meet essential physical needs (e.g. adequate or appropriate food, clothes, warmth, hygiene and medical or dental care)
- Failure by parents or carers to meet essential emotional needs (e.g. to feel loved and valued, to live in a safe, predictable home environment)
- A child seen to be listless, apathetic and unresponsive with no apparent medical cause
- Failure of child to grow within normal expected pattern, with accompanying weight loss
- A child thriving away from his or her home environment
- A child frequently absent from school
- A child left with inappropriate carers (e.g. too young, complete strangers)
- A child left with adults who are intoxicated or violent
- A child abandoned or left alone for excessive periods

7. Potential Risk of Harm to an Unborn Child

7.1 In some circumstances, agencies or individuals are able to anticipate the likelihood of Significant Harm with regard to an expected baby (e.g. domestic abuse, parental substance abuse or mental ill health).

7.2 There is an expectation that the agency identifying these concerns would have undertaken their own assessment to determine the potential impact that the issues identified may have on the parent's ability to provide a safe level of care.

7.3 These concerns should be addressed as early as possible before the birth, so that a full assessment can be undertaken and support offered to enable the parent/s (wherever possible) to provide safe care.

7.4 See also:

Section 13, Pre-birth referral of the Referral Procedure

Section 13, Pre-birth conference of the Child Protection Conference Procedure

8. Responsibilities of all Practitioners Working with Children and Families

8.1 Professionals in all agencies who come into contact with children, who work with adults who are parents or who gain knowledge about children through working with adults, should:

- Be alert to potential indicators of abuse or neglect;
- Be alert to the risks which individual abusers or potential abusers, may pose to children;
- Remember that an allegation of child abuse or Neglect may lead to a criminal investigation, so don't do anything that may jeopardise a Police investigation, such as asking a child a leading question or attempting to investigate the allegations of abuse;
- If you are responsible for making referrals, know who to contact in the Police and/or Children's Social Care to express concerns about a child - see the Referrals Procedure;
- Refer any concerns about child abuse or Neglect to Children's Social Care or the Police; if you make a referral by telephone, confirm it in writing using the multi-agency referral form within 48 hours - see the Referrals Procedure;
- Have an understanding of the Common Assessment Framework and the Graded Care Profile which underpins the processes of assessing needs;
- Discuss your concerns with your Manager, named or designated Child Protection lead, depending on your organisational setting;
- Record in writing all concerns, discussions about the child, decisions made, and the reasons for those decisions; the child's record should include an up-to-date Chronology and details of the lead worker in the relevant agency.