Appendix 1

Gloucestershire
Safeguarding Children
Board

What to do if you have concerns about the welfare of a child....

As professionals working with children, young people and families you should ensure you understand how to seek advice or make a referral to Gloucestershire County Councils children's social care and what to expect as a response.

When faced with child welfare concerns that might result in the impairment of a child's health and development or the possibility a child is suffering or likely to suffer significant harm:-

- Discuss your concerns with the child's parents and explain you will be seeking advice or making a referral from Children's Social Care- unless you judge to do so would put the child at risk;
- Discuss your concerns with your supervisor or designated safeguarding officer to decide whether to seek advice from, or make a referral to, children's social care;
- To seek advice or make a referral to children's social care contact the children's helpdesk on **01452 426565.**

Seeking advice from children's social care:-

- If you have concerns but are unsure how to proceed tell the Children's Helpdesk you are seeking advice about a child welfare matter and you will be put through to the appropriate social work team, determined by where the child lives;
- You can discuss your concerns in principle with a social worker or social work manager without the issue being recorded on the social work database;
- During this discussion you should be clear about the nature of the concerns and any history of concern held by yourself or your agency;
- Alternative ways of addressing your concerns will be discussed and these could include the provision of extra support on a single agency basis, initiating multi agency support through a CAF as well as the appropriateness of making a referral.
- In cases where the concerns do amount to possible impairment to a child's health and development or the possibility a child is suffering, or likely to suffer significant harm, you will be advised that a referral is appropriate and necessary and you will be asked to make that referral and details will be recorded on the social work database (see below);
- the responsibility for making a referral remains with you and if after seeking advice you feel your concerns do amount to possible impairment to a child's health and development, or the possibility a child is suffering or likely to suffer significant harm, you should make that referral.

Making a referral to Children's Social Care:-

- When making a referral you will be asked by the Children's Helpdesk to complete a Multi-Agency Referral Form, which will include personal information about the family and child, the nature and degree of your concerns (including any previous concerns held by you or your agency) as well as contact details about yourself;
- These details will be passed to the appropriate social work team, determined on where the child lives , a social worker will contact you and discuss your concerns within the next 24 hours;
- In circumstances where there is immediate risk you will be put through to the social work team to discuss the next steps.
- Your discussion with the social work team should include what action is appropriate in the light of the information supplied by you and any information held by the social work team including whether there are alternatives to a referral, if a referral is not appropriate;
- The social work team may need to conduct further enquiries before making a decision about whether to accept the referral; this decision will be fed back to you.

If you are left worried that your concerns are not being addressed:-

- Use the new "resolution of professional disagreements in work relating to the safety of children (escalation policy)" which is available through SW child protection procedures, which can be accessed via www.gscb.org.uk.

For further information please contact the Safeguarding Children Service on:
Tel: 01452 583629 Email: gscb@gloucestershire.gov.uk Website: www.gscb.org.uk

Appendix 2

Allegations Management

Safeguarding Children (Child Protection) In Gloucestershire

Allegations Management

(Handling concerns about your staff)

The allegations management procedures should be used in all cases where it is alleged that a person who works with children has:-

1. **Behaved in a way that has harmed or may have harmed a child.**
2. **Possibly committed a criminal offence against, or related to, a child.**
3. **Behaved towards a child or children in a way that indicates s/he is unsuitable to work with children**

What to do

- Take all safeguarding concerns seriously
- Report to the most senior person not implicated in the allegation. This may be the designated lead for safeguarding within the workplace.
- Get advice early-on from the Local Authority Designated Officer (LADO).
- Don't start an investigation by yourself- this might interfere with a police or social care investigation.

Employers will be involved in any investigation or may be asked to carry out their own depending on the seriousness of the allegation.

For help and advice:

Local Authority Designated Officer (LADO)	**01452 426994**
Children and Families Helpdesk	**01452 426565**
Childline	**0800 1111**
Police Child Abuse investigation Team	**01242 261112**
Safeguarding Children Business Unit	**01452 583629**

For further information please contact the Safeguarding Children Service on:

Tel: 01452 583629 Email: gscb@gloucestershire.gov.uk Website: www.gscb.org.uk

Gloucestershire Safeguarding Children Board

Signs and Symptoms of Abuse

Physical Abuse

Bruises

All children, especially toddlers, are injured from time to time, and the vast majority of those injuries are accidental, even those which are unexplained. Some features should alert one to the possibility of non- accidental injury:

• There may be a delay in seeking medical help or such help may not have been sought at all.

• The account of the accident may be vague or may vary from one telling to another. Parents reliving a genuine accident will usually tell a detailed vivid story.

• The parents may be more concerned about their own problems than about the child's injuries, and they may be hostile and leave before the discussion is finished.

• The interaction between child and parents may be abnormal and the child may be sad, afraid or even withdrawn. Classic "frozen watchfulness" is a late stage resulting from repeated physical and emotional abuse. It should be noted, however, that some physically abused children may relate to their parents remarkably well.

• If children think they are going home with their parents, they may be unwilling to say what has happened while the adults are present . Given a safe environment the child may well give an accurate account of the incidents of abuse.

There may be discrepancies between the injuries and the story given, or the explanation may even be impossible, for example a four-week-old baby with facial bruising could not have been injured whilst falling over because they are unable to sit up in the first place, or alternatively, a child with bruises of different ages could not have sustained them all in a single incident . (Workers should be aware, however, that the ageing of bruises is not an exact science; as they age, bruises change colour from red to blue and through brown to
yellow, but the timing of these changes varies from one individual to another and from one site to another.)

There may be a series of different marks or bruises suggesting repeated injuries. The greater the number of incidents, the less likely it is that they have been accidental.

• The pattern of bruises may suggest a particular cause: slap marks, fingertip bruises and the imprint of weapons are commonly seen. Large areas of

petechial haemorrhages, often with parallel dense lines within them, occur after hard slaps, particularly on the buttocks and cheeks. The left cheek is most commonly affected since the right-handed adult, facing the child, slaps the left cheek. Fingertip bruises on the upper arms or chest wall may suggest that the child has been held tightly and then shaken. In this situation, the fragile blood vessels in the eyes and on the surface of the brain may be torn. Examination by a paediatrician may then reveal retinal haemorrhages, rib fractures and subdural haematomas. This constitutes a medical emergency.

- The site of bruising may give cause for concern. Accidental bruises commonly occur over bony prominences; bruising on other sites is more suspicious. Certain injuries are inherently suspicious. Bruising to the outer ear may happen when the ear is "boxed" or compressed against the side of the skull by a blow or when the margin of the ear is pinched. Fresh or healed tears of the frenulum of the upper lip are caused by a blow to the mouth or by a feeding bottle being forced into the mouth. Such injuries seldom occur accidentally.

Burns and scalds

These are particularly difficult to handle because of the emotional connotations. Neglected children are more prone to accidental burns whereas abused children may be deliberately burned. The principles applied to bruises are relevant - the injuries seen should be compared with the story given.
Scalds are burns caused by hot liquids. Blistering often occurs and the skin may be pale and soggy and peel off in sheets. The injuries tend to be variable in depth but demonstrate characteristic drip, pour and splash patterns. Children whose hands or feet have been dipped in scalding water show a "glove or stocking" pattern.

Contact burns from a hot dry surface are often uniform in density and may follow the shape of the branding object .

Cigarette burns, typically, deliberately inflicted cigarette burns form a circular lesion with a crater. Skin infections can leave almost identical marks.

Parents of accidentally burned children are often defensive and guilty but show appropriate concern for the child.

Fractures

In young children these should give cause for concern in that it has been suggested that as many as half of all fractures under the age of two years are non-accidental. Spiral fractures of long bones in babies are especially suspicious as are rib fractures. Spiral fracture suggest a pulling and twisting force which would be an unusual mechanism in an accident to a non-mobile infant . Older children, however, may suffer spiral fractures accidentally. Rib fractures are unusual in accidentally injured babies and toddlers but multiple bilateral rib fractures occur when a young child's chest wall is violently squeezed.

Such fractures are often difficult to detect in the early stages, both clinically and radiologically, and may be found only when healing occurs and callus is seen on X-

ray. Metaphyseal fractures, chips of bone pulled from the ends of long bones, are highly suggestive of abuse. Subperiosteal haemorrhage occurs when the lining membrane is stripped from the developing long bone during incidents in which the arms or legs are grabbed and twisted or pulled. Again, such injuries may only become evident after 10 to 14 days when healing and calcification are seen on X-ray.

Single linear skull fractures may occur after apparently minor head injuries and may present after one or two days with a localised swelling. Most such injuries do not result in serious injury, however. In one study, babies failing from a height of less than one metre, even onto a hard floor, had only a one per cent chance of suffering a skull fracture, and 80 per cent suffered no injury whatever. Even in fails from a greater height , any fractures were single and linear, and serious intracranial injury was uncommon. Extensive or
branched fractures are less likely to be accidental and serious intracranial damage suggests the more severe force associated with non-accidental injury. Fractures of the humorous or clavicle may occur in birth injury, particularly after breech delivery, and may not be clinically evident . By the age of two weeks, however, X-rays will show evidence of healing.

A skeletal survey, usually performed in young children where serious abuse is suspected, may show fractures of different ages and in suspicious sites.

Differential diagnosis

There are various diseases, both acute and chronic, which cause easy bruising, and which may lead to the suspicion of non-accidental injury. These include such conditions as idiopathic thrombocytopenic Purpura (ITP), and Haemophilia, which should be considered if a child has extensive unexplained bruising.

Osteogenesis imperfecta (brittle bone disease) is a condition, inherited as an autosomal dominant, in which bones break with even minor trauma. Usually sufferers will have blue sclerae (the whites of the eyes), and there will often be a family history of the disorder.

The diagnosis of non- accidental injury, which is often not easy, should take account of the whole picture of the injuries seen and the story given. In view of the possible pitfalls, the diagnosis of child abuse requires the help of an experienced paediatrician.

Fabricated or Induced Illness by carers
(previously known as Munchausen's Syndrome by Proxy)

This describes a situation where parents or carers fabricate or cause illness in their child. There are three main types of fabricated illness: verbal fabrication; tampering with charts and specimens and producing physical signs to suggest illness. Boys and girls are equally affected. By the time of diagnosis the child's apparent ill health may have been a problem for months or years.

The features are those of persistent or recurrent illness with a discrepancy between the child's apparently good health and a story of serious symptoms.

Some of the more typical symptoms are seizures, spontaneous bleeding, stopping breathing, diarrhoea and fever.

Mothers are the carers most likely to perpetrate the deception and they typically are very attentive to the needs their child. Untreated the problem leads to serious effects on the emotional health of the child in addition to physical effects if fabrication involves the production of physical symptoms.
Often these children will be taken to different hospitals and doctors and bringing together the complete story is one of the steps in achieving a diagnosis. Communication between professionals who have contact with the child is therefore very important .

Sexual Abuse

Presentation of Sexual Abuse

1. Statement of the Child
The abuse is rarely disclosed at the time. Children only talk about the trauma of sexual abuse after much thought. They also choose the person to talk to very carefully. This might be a teacher or leader of a children's group whom they feel that they can trust, although in the majority of cases a child will make an initial disclosure to a peer of a member of their family.

2. Symptoms due to local trauma or infection: perineal soreness, vaginal discharge, urinary tract infection, anal pain or bleeding are non-specific symptoms which may be indicative of sexual abuse. Bruising, lacerations, burns, bites or scratches on the inner thighs, breast , genital or anal region should be thoroughly investigated and deserve a full explanation.

3. Symptoms attributable to emotional effects: loss of concentration, enuresis (1. Primary enuresis refers to children who have never been successfully trained to control urination. This represents a fixation. 2. Secondary enuresis refers to children who have been successfully trained but revert to wetting in a response to some sort of stressful situation. This represents a regression.), encopresis (involuntary faecal soiling in adults and children who have usually already been toilet trained. The estimated prevalence of encopresis in four-year-olds is between one and three percent. The disorder is thought to be more common in males than females, by a factor of 6 to 1), and anorexia may be related to various emotional factors but sexual abuse should be considered.

4. Self harm: many victims of sexual abuse will in some way act out their distress. Common amongst adolescent behaviour is drug abuse, alcohol abuse and prostitution. Attempts at suicide are often of self-loathing and the inability to betray the abuser who may be quite close. Self-mutilation can be a symptom of sexual abuse. Victims may burn or scar themselves or make themselves ill.

5. Sexualised conduct or inappropriate sexual knowledge of young children: such conduct or knowledge may be acquired by observing others or pornographic videos/literature. Children who have been sexually abused may describe pain or

other features, such as the quality of semen, which cannot be acquired by observation only.

6. Sexually transmitted disease: a small proportion of sexually abused children may have sexually transmitted disease (STD). STD after infancy in children and adolescents who are not sexually active is strongly suggestive but not proof of sexual abuse. Gonorrhoea, syphilis, venereal warts, genital herpes, chlamydia, trachomatous and HIV infection are all primarily sexually transmitted conditions and so are matters for clinical diagnosis followed by multidisciplinary consideration.

7. Pregnancy: a girl who seems lost to explain her pregnancy, or who refuses to identify the father, may have been abused by a member of the family.

Signs of Sexual Abuse

A substantial proportion of sexually abused children show no abnormal physical findings. In girls the hymenal orifice dimension is not a reliable indicator of sexual abuse, although a hymenal diameter exceeding 1cm in a pre-pubertal girl occurs more commonly in abused girls.

In penetrating sexual abuse lacerations or scars in the hymen or attenuation of the hymen with loss of hymenal tissue may be noted. Supportive findings of sexual abuse which are not diagnostic are notches in the hymenal edge associated with scarring or bumps on the hymen with some disruption. Recent abuse may cause bruising, redness, splitting and bleeding to the genital area.

Signs of anal abuse are likely to be most prominent in young children, but in many cases there are no abnormal signs.

Fissures, scars and skin tags around the anal verge may be indicative of sexual abuse in the absence of an alternative explanation. Perianal bruising or bleeding without reasonable explanation raises substantial suspicion. Other findings such as anal laxity may be supportive of sexual abuse but are not diagnostic and it is always important to consider clinical findings in the context of the medical history, as the presence of constipation or other medical conditions may affect clinical findings.

In boys the genitalia should be examined by a medical professional; bruising or trauma to the penis or scrotum may occur in sexual abuse. Medical examinations are an integral part of the investigation of sexual abuse. However, child protection decisions should not rely solely on medical evidence or opinion. Whilst these form a vital part of the decision- making process, the totality of background information should be considered.

A substantial proportion of sexually abused children show no abnormal physical findings.

Emotional Abuse

Components of Emotional Abuse

1. Rejecting the child - The adult refuses to acknowledge the child's worth and the legitimacy of their needs.

2. Isolating the child - The adult cuts the child off from normal social experiences and contacts and prevents them from making friendships, thus making them believe they are alone in the world.

3. Terrorising the child - The adult verbally abuses the child, creating a climate of fear. The child is bullied and frightened and is made to believe that the world is capricious and hostile.

4. Ignoring the child - The adult deprives the child of essential stimulation and responsiveness, stifling emotional growth and intellectual development.

5. Corrupting the child - The adult mis-socialises the child, for example stimulating them to engage in anti-social behaviour, reinforcing that deviance and making them unfit for normal social experiences.

There is a tremendous variation in the delivery of care and parenting. The most important aspects of emotional abuse are the effects on children and the consequences for them. Those effects and consequences are diverse and vary significantly with age.

Infants

Lack of encouragement shown towards infants can result in the impairment of social and psychomotor skills; infants can appear withdrawn with developmental delay. Infants may indulge in acts of self-stimulation (banging of the head or rocking movements); there may be a noted lack of social responsiveness.

Pre-school children

At the age where language development is at its most sensitive, emotional abuse can result in significant delay in language acquisition and, in severe cases, the child may be effectively mute. Behavioural problems are also common, and may be manifested as a reduced attention span, which often goes along with hyperactivity. Emotionally abused children may show significant growth retardation. Children may be aggressive, especially towards their peers, and may at other times be significantly withdrawn. A lack of selective attachment is quite frequently seen, and inappropriate physical contacts to strangers, even in the presence of the main carer, is common.

School-age children

Learning difficulties are a manifestation of emotional abuse in this age group, with poor concentration and significant over-activity. Such children may be

disruptive in schools, and may also show behavioural abnormalities such as aggression, or inappropriate or unusual patterns of defecation or urination. These children often have low self-esteem, which in its mildest form shows very poor social interaction and may result in other behaviour patterns, such as repetitive rocking, self mutilation or masturbation. As with neglect , if the abuse is substituted by sensitive care and displays of appropriate emotions (usually in an alternative environment), there is a rapid and dramatic improvement in growth, developmental attainment, behaviour and social and emotional adjustment.

Neglect

Neglect is difficult to diagnose because by definition it has to be present for a period of time. All age groups can be affected by neglect but the pre-school child is the most vulnerable.

The diagnosis is made by collecting vital pieces of the jigsaw. A child is neglected if its basic needs are unmet. Manifestations of this are when the child is:

1. Malnourished, ill-clad, dirty, without proper shelter or sleeping arrangements
2. Without supervision, unattended.
3. Ill and lacking essential medical care
4. Denied normal experiences that produce feelings of being loved, wanted, secure and worthy (emotional neglect)
5. Failing to attend school regularly.

The issue of standards of parental care and behaviour is a major problem in proving neglect . The lack of clear definitions makes it problematic to prove, particularly in a court of law. General neglect may be difficult to prove but 'failure to thrive' a specific type of neglect , is easier to define.

Failure to thrive

'Failure to thrive' is a term applied to babies and toddlers whose growth rate, particularly in weight but also in length, is exceptionally poor. It is important to realise that there are many medical reasons for failure to thrive, such as chronic infection, failure to absorb food because of cystic fibrosis or coeliac disease, major congenital heart disease and many others. Nevertheless, about three-quarters of all infants seen by hospital paediatricians with failure to thrive are growing poorly for non-organic reasons. Whether through ignorance or neglect they lack the necessary elements of care, food, attention and love, which promote normal growth.

At the extreme, failure to thrive is easily detected. The infant is obviously undernourished, thin with wasted buttocks and prominent folds of skin. It is important to remember that the pads of fat in the cheeks, which are essential if an infant is to suck effectively, are preserved even when the rest of the baby's fat stores have disappeared. Thus the clothed infant may appear to be well nourished when in fact gaining weight poorly.
Serious growth failure in the first two years of life has irreversible long-term effects on body size and health and one would like therefore to diagnose failure to

thrive before it is obvious on examination. This is achieved by weighing all babies regularly and plotting the weights on a standard growth chart , often called a centile chart . These charts have been produced by analysing growth data from thousands of normal children and then drawing
centile lines on a graph. Growth charts now have 9 centile lines although some are still in use with 7 centile lines. The lines on the 9 centile charts correspond to the 99.6th, 98th, 91st , 75th, 50th, 25th, 9th,2nd and 0.4th growth lines. Basically, 50% of normal individuals fall below the 50th centile
for the particular characteristic such as weight , length or head circumference. Only 2% of the population will fall below the 2nd centile but this will include children who are genetically small and whose growth is appropriate. Only one child in 250 will fall below the 0.4th line and children whose growth is below this line need assessment. Two further features of the centile charts increase their usefulness. Firstly, the slope of the printed line at a particular point on the chart is an indication of the rate of growth at the particular age; the steeper the slope, the faster the growth rate. The growth rate of a particular child can be compared with normal by plotting serial measurements on the
printed chart and seeing whether the child's growth is "parallel to the centile lines". The weight curve of a child who is failing to thrive for non-organic reasons may accelerate upwards across the centile lines when brought into a more nurturing environment . The child is then said to be showing "catch-up growth". Secondly, the weight centile of a normal child of average build will be the same as the height centile. A baby whose height and weight are both on the third centile is probably adequately nourished but genetically small whereas one whose weight is on the third centile and whose height is on the fiftieth centile is probably failing to thrive. The diagnosis of non-organic failure to thrive needs careful interpretation of growth charts and investigation to rule out medical conditions. It is confirmed by the finding of catch-up growth when the child is moved to a more nurturing environment .

Signs and Symptoms of Abuse

NSPCC Guidance

Signs of abuse

Recognising child abuse is not easy. It is not your responsibility to decide whether or not child abuse has taken place or if a child is at significant risk of harm from someone. You do however, have both a responsibility and duty, as set out in your organisation's child protection procedures, to act in order that the appropriate agencies can investigate and take any necessary action to protect a child.

The following information should help you to be more alert to the signs of possible abuse.

Physical Abuse

Most children will collect cuts and bruises as part of the rough-and-tumble of daily life. Injuries should always be interpreted in light of the child's medical and social history, developmental stage and the explanation given. Most accidental bruises are seen over bony parts of the body, e.g. elbows, knees, shins, and are often on the front of the body.

Some children, however, will have bruising that is more than likely inflicted rather than accidental.

Important indicators of physical abuse are bruises or injuries that are either unexplained or inconsistent with the explanation given, or visible on the 'soft' parts of the body where accidental injuries are unlikely, e g, cheeks, abdomen, back and buttocks. A delay in seeking medical treatment when it is obviously necessary is also a cause for concern, although this can be more complicated with burns, as these are often delayed in presentation due to blistering taking place some time later.

The physical signs of abuse may include:

- unexplained bruising,
- marks or injuries on any part of the body
- multiple bruises- in clusters, often on the upper arm, outside of the thigh
- cigarette burns
- human bite marks
- broken bones
- scalds, with upward splash marks,
- multiple burns with a clearly demarcated edge.

Changes in behaviour that can also indicate physical abuse:

- fear of parents being approached for an explanation
- aggressive behaviour or severe temper outbursts
- flinching when approached or touched
- reluctance to get changed, for example in hot weather
- depression
- withdrawn behaviour
- running away from home.

Emotional Abuse

Emotional abuse can be difficult to measure, as there are often no outward physical signs. There may be a developmental delay due to a failure to thrive and grow, although this will usually only be evident if the child puts on weight in other circumstances, for example when hospitalised or away from their parents' care. Even so, children who appear well-cared for may nevertheless be emotionally abused by being taunted, put down or belittled. They may receive little or no love, affection or attention from their parents or carers. Emotional abuse can also take the form of children not being allowed to mix or play with other children.

Changes in behaviour which can indicate emotional abuse include:

- neurotic behaviour e.g. sulking, hair twisting, rocking
- being unable to play
- fear of making mistakes
- sudden speech disorders

- self-harm
- fear of parent being approached regarding their behaviour
- developmental delay in terms of emotional progress

Sexual Abuse

Adults who use children to meet their own sexual needs abuse both girls and boys of all ages, including infants and toddlers. Usually, in cases of sexual abuse it is the child's behaviour that may cause you to become concerned, although physical signs can also be present. In all cases, children who tell about sexual abuse do so because they want it to stop. It is important, therefore, that they are listened to and taken seriously.
It is also important to remember that it not just adult men who sexually abuse children – there are increasing numbers of allegations of sexual abuse of children against women and sexual abuse can also be perpetrated by other children or young people.

The physical signs of sexual abuse may include:

- pain or itching in the genital area
- bruising or bleeding near genital area
- sexually transmitted disease
- vaginal discharge or infection
- stomach pains
- discomfort when walking or sitting down
- pregnancy

Changes in behaviour which can also indicate sexual abuse include:

- sudden or unexplained changes in behaviour e.g. becoming aggressive or withdrawn
- fear of being left with a specific person or group of people
- having nightmares
- running away from home
- sexual knowledge which is beyond their age, or developmental level sexual drawings or language bedwetting
- eating problems such as overeating or anorexia
- self-harm or mutilation, sometimes leading to suicide attempts
- saying they have secrets they cannot tell anyone about
- substance or drug abuse
- suddenly having unexplained sources of money
- not allowed to have friends (particularly in adolescence)
- acting in a sexually explicit way towards adults

Neglect

Neglect can be a difficult form of abuse to recognise, yet have some of the most lasting and damaging effects on children.

The physical signs of neglect may include:

- constant hunger, sometimes stealing food from other children
- constantly dirty or 'smelly'
- loss of weight, or being constantly underweight
- inappropriate clothing for the conditions

Changes in behaviour which can also indicate neglect may include:

- complaining of being tired all the time
- not requesting medical assistance and/or failing to attend appointments
- having few friends
- mentioning being left alone or unsupervised

These definitions and indicators are not meant to be definitive, but only serve as a guide to assist you. It is important too, to remember that many children may exhibit some of these indicators at some time, and that the presence of one or more should not be taken as proof that abuse is occurring. There may well be other reasons for changes in behaviour such as a death or the birth of a new baby in the family or relationship problems between parents/carers. In assessing whether indicators are related to abuse or not, the authorities will always want to understand them in relation to the child's development and context.

Impact of Abuse on Children

Physical Abuse

Physical abuse can lead directly to neurological damage, physical injuries, disability or, at the extreme, death. Harm may be caused to children both by the abuse itself and by the abuse taking place in a wider family or institutional context of conflict and aggression, including inappropriate or inexpert use of physical restraint.

Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems and educational difficulties. Violence is pervasive and the physical abuse of children frequently coexists with domestic violence.

Sexual Abuse

Disturbed behaviour – including self-harm, inappropriate sexualised behaviour, sexually abusive behaviour, depression and a loss of self-esteem – has been linked to sexual abuse. Its adverse effects may endure into adulthood. The severity of impact on a child is believed to increase the longer the abuse continues, the more extensive the abuse, and the older the child. A number of features of sexual abuse have also been linked with severity of impact, including the relationship of the abuser to the child, the extent of premeditation, the degree of threat and coercion, sadism, and bizarre or unusual elements. A child's ability to cope with the experience of sexual abuse, once recognised or disclosed, is strengthened by the support of a non-abusive adult carer who believes the child, helps the child understand the abuse, and is able to offer help and protection.

The reactions of practitioners also have an impact on the child's ability to cope with what has happened, and on his or her feelings of self worth.

A proportion of adults and children and young people who sexually abuse children have themselves been sexually abused as children. They may also have been exposed as children to domestic violence and discontinuity of care. However, it would be quite wrong to suggest that most children who are sexually abused inevitably go on to become abusers themselves.

Emotional Abuse

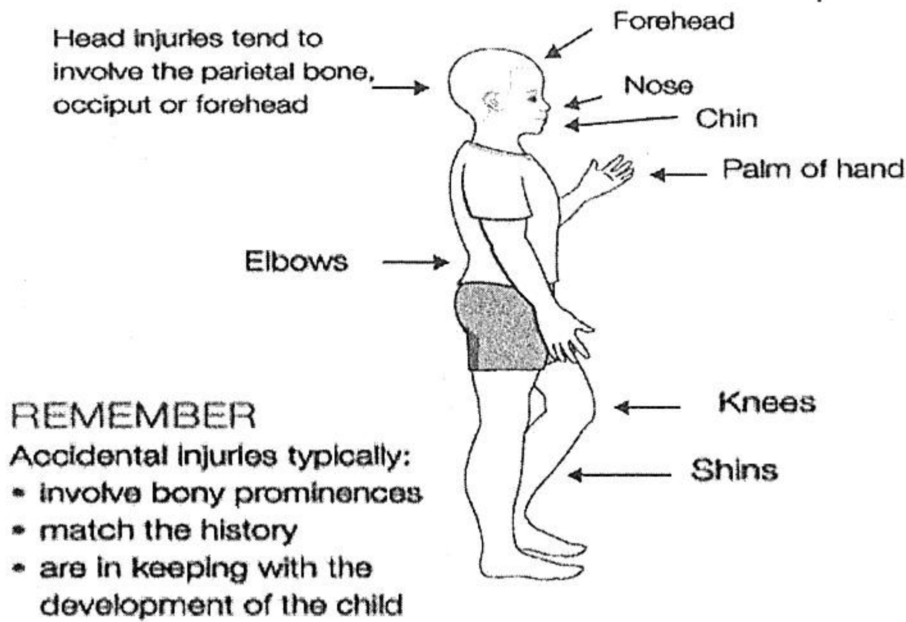
There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse, including the impact of serious bullying[156]. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, as other more visible forms of abuse in terms of its impact on the child.

Domestic violence is abusive in itself. Adult mental health problems and parental substance misuse may be features in families where children are exposed to such abuse.

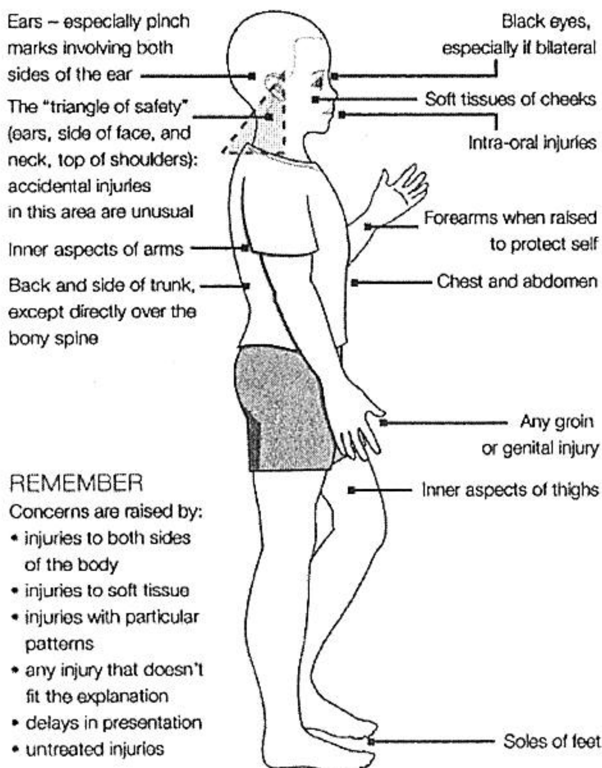
Neglect

Severe neglect of young children has adverse effects on children's ability to form attachments and is associated with major impairment of growth and intellectual development. Persistent neglect can lead to serious impairment of health and development, and long-term difficulties with social functioning, relationships and educational progress. Neglected children may also experience low self-esteem, and feelings of being unloved and isolated. Neglect can also result, in extreme cases, in death. The impact of neglect varies depending on how long children have been neglected, the children's age, and the multiplicity of neglectful behaviours children have been experiencing.

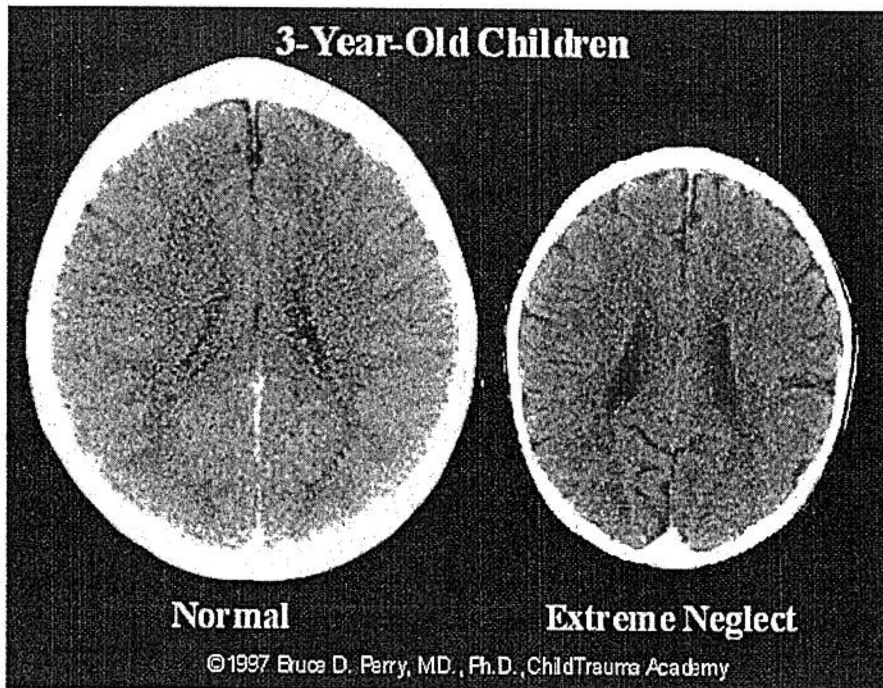
Common Sites of Accidental Injuries



Common Sites of Non-Accidental Injuries



Impact of Neglect



Appendix 4

Glossary

CIN	Children in Need
CP	Child Protection
CRB	Criminal Records Bureau
CWD	Children with Disabilities
CYPD	Children & Young People's Directorate (the combined children's services from the former Social Services and Education)
DARP	Domestic Abuse Referral Process
DCPO	Designated Child Protection Officer
DOE	Department of Education
ESCALATION	Resolution of Professional Differences (Escalation) Policy
GASB	Gloucestershire Adult Safeguarding Board
GPPB	Gloucester Public Protection Bureau
GSCB	Gloucestershire Safeguarding Children Board
ISA	Independent Safeguarding Authority
LA	Local Authority
LADO	Local Authorities Designated Officer
LT	Locality Team (Hub)
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
R&AT	Referral and Assessment Teams
SCR	Single Central Record
SCS	Safeguarding Children Service (Previously known as the Child Protection Unit)

Changes in Terms

Previously:	**Now known as:**
Child Protection Register	Child with a Child protection Plan
Child Protection Unit	Safeguarding Children Service
Area Child Protection Committee	Gloucestershire Safeguarding Children Board
Department for Children, Schools and Families	Department of Education

Do not print this handbook – it will be updated constantly so always use the online version at www.gscb.org.uk/handbook.
You may also like to become part of the GSCB website updates mailing list, by sending an e-mail to updates@gscb.org.uk with the subject heading "subscribe".

Appendix 5

Appendix 6: Useful Telephone Numbers

Telephone numbers for concerns about the safety of a child.

Social Care

Report concerns to Children and Families Helpdesk Customer Service Operators on:	01452 426565

Referral and Assessment Teams. Children and Families Teams.

Gloucester Referral & Assessment Team	01452 427850
Gloucester Children & Families Team	01452 427827
Forest Referral & Assessment Team	01594 820489
Forest Children & Families Team	01594 820577
Cheltenham & Tewkesbury Referral & Assessment Team	01242 532447
Cheltenham Children & Families Team	01242 532425
Stroud & Cotswolds Referral & Assessment Team	01453 760534
Stroud Children & Families Team	01453 760530
Cotswold Children & Families Team	01285 881029
Tewkesbury Children & Families Team	01452 427533

Safeguarding Children Service	01452 583636
Safeguarding Children Development Officer (education)	01452 426994
Local Authority Designated Officer for Allegations	01452 426994

Police

Police – Child Abuse Investigation Team	**01242 261112**
Gloucestershire Police	101

Health Services

For general enquiries about health services, please contact:

Gloucestershire Health Victoria Warehouse, Gloucester, GL1 2EL	01452 300222
Gloucestershire Partnership NHS Trust Rikenel, Montpellier, Gloucester, GL1 1LY	01452 891000
Safeguarding Children, NHS Gloucestershire Sanger House, 5220 Valiant Court, Gloucester Business Park, Brockworth, Gloucester, GL3 3PX	08454 221500
East Gloucestershire NHS Trust Ambulance Control & HQ Horton Road, Gloucester, GL1 3PX	01452 395050

Housing Services

Cheltenham Borough Council Municipal Offices, The Promenade, PO Box 12, Cheltenham, GL50 10PP	01242 262626
Cotswold District Council (area offices) Trinity Road, Cirencester, Glos, GL7 1PX	01608 650881
Forest of Dean District Council The Council Offices, High Street, Coleford, GL16 8HG	01594 810000

Other useful telephone Numbers

Citizens Advice Bureau (Cheltenham)	01242 522491
Citizens Advice Bureau (Gloucester)	01452 527202
Cheltenham General Hospital (switchboard)	08454 224438
Gloucester Royal Hospital (switchboard)	08454 228394
NSPCC Gloucester	0808 8005000
Rape Crisis	01452 526770
Childline	0800 1111
Samaritans	08457 90 90 90
SHARE – Young Peoples Counselling Service	01452 500300

Gloucestershire's Child Protection Procedures can be found on the Gloucestershire Safeguarding Children Board website at:
http://www.swcpp.org.uk/swcpp/swcpp_procedures.htm
All those working with children should be made aware of these procedures and should know where to find them.