Safeguarding Disabled Children
Practice Guidance October 2020

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1. Definitions

The Disability Discrimination Act 2005 (DDA) defines a disabled person as someone who has *"a physical or mental impairment which has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities".* According to the DDA 'substantial' means *'more than minor or trivial'* and 'long-term' means that it *'has lasted or is likely to last more than a year'.* However, the 'social model' of disability uses the term disability not to refer to an impairment or functional limitation, but rather to describe the effects of prejudice and discrimination. These are the social factors that create barriers, deny opportunities and dis-able people. Children's impairments can of course create genuine difficulties in their lives. However many of the problems faced by disabled children are not caused by their conditions or impairments but by negative attitudes, prejudice and unequal access to the things necessary for a good quality of life.

Sadly, disabled children are likely to have poorer outcomes across a range of indicators compared to their non-disabled peers, including lower educational attainment, poorer access to health services, poorer health outcomes and more difficult transitions to adulthood. They are more likely to suffer from family break up and are significantly overrepresented in the populations of looked after children and young offenders. Families with disabled children are more likely to experience poverty and pupils with Special Educational Needs are more likely to be excluded from school.

2. Why are disabled children more vulnerable to abuse?

Research indicates that disabled children face an increased risk of abuse or neglect, yet they are underrepresented in safeguarding systems. Below are some of the factors that may help account for this.

Increased vulnerability:

- A disabled child's dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour;
- Parents do not always fully understand the nature or impact of their child's disability e.g. they can interpret their child's behaviour as innate or wilful, rather than related to their disability;
- Disabled children often spend greater periods of time away from home, which is a risk factor of abuse, particularly when children are in residential settings;
- Disabled children are especially vulnerable to bullying and intimidation;
- Disabled children can be put at additional risk due to cultural perceptions of disability e.g. that disability is a punishment from god, or that symptoms of a child's disability are the result of spirit possession or witchcraft. The word autism in particular is not well understood in many communities and often leads to confusion and misinterpretation. In some cultures there is no word for autism and the closest definition is 'brain dead.' Parents who do not fully understand their disabled child's needs can look for alternative treatments and 'cures', either online or abroad, sometimes at great expense, which can increase the risk of harmful practices. For example, there are websites that advertise cures for autism including bleach, restricting children's food intake or feeding them camel milk.
- The stigma attached to disability in some communities can result in a child and their caregivers feeling isolated. Some single mothers have reported that their child's father has blamed them for the child's disability, which increases their sense of isolation and can compromise their emotional well-being.
- Parents worried about the well-being of their disabled child and overwhelmed by the additional day-to-day tasks that caring for them can suffer from increased anxiety levels and poor mental health.
- Disabled children are generally entitled to enhanced financial support to help them access activities of daily living alongside their non-disabled peers through DLA e.g. by funding taxis to get them to and from extra-curricular activities. However, there is scope for parents/caregivers to misuse these funds.

Reduced detection:

- Behaviours that indicate that a child is being abused can be misinterpreted as symptoms of a child's disability;
- A disabled child may have speech, language and communication needs which makes it more difficult to tell others what is happening to them;
- Practitioners can over identify with the child's parents/carers and be reluctant to accept that abuse or neglect is taking or has taken place, or see it as being attributable to the stress and difficulties of caring for a disabled child.
- Practitioners who see parents as 'doing their best' and have no intention of harming their children may be reluctant to appear critical of them and inadvertently accept lower standards of care for disabled children;
- Many disabled children are at an increased likelihood of being socially isolated, with fewer outside contacts than non disabled children, so less opportunity to 'tell';

- During child protection investigations it can be assumed that disabled children will not be able to give credible evidence and therefore joint investigations with police are not pursued;
- The number of agencies working in families where the child has complex support needs can overwhelm families and complicate information sharing.

Some of these factors can compound professional reluctance to report safeguarding concerns, due to issues that are common to all children:

- Concerns about breaching confidentiality;
- Fear of losing a positive relationship with a family;
- Discomfort of disbelieving, thinking ill of, or suspecting or wrongly blaming a parent or carer;
- Worry about losing control over the child protection process and doubts about its benefits;
- Concerns about the repercussions of a referral e.g. around personal safety and fear of complaints.

3. Practice Principles

1. Disabled children must receive **at least** the same levels of protection from harm as non-disabled children. Often **higher levels of protection** are required, given their additional vulnerabilities.
2. The participation of children and young people in decision making about their own welfare and in the services they receive is a legal requirement. **All children can communicate preferences if they are asked in the right way by people who understand their needs and have the skills to listen to them.** It is **never** acceptable to say or write that a disabled child is *'unable to communicate their views'*.
3. A disabled child's preferred communication method for understanding and expressing themselves needs to be given the utmost priority. Where a child has speech, language and communication needs, adequate arrangements must be made to ensure that their views and feelings can be obtained.
4. **Where there is a safeguarding concern related to the child's home environment, the child should be seen away from their parents, outside of the home, with a professional (e.g. their teacher or a speech and language therapist) who is familiar with their preferred communication method**. For disabled children subject to CIN or CP Plans, these arrangements should be made on an ongoing basis and at a minimum of every 8 weeks for CP cases and 3 months for CIN cases.
5. A detailed understanding of the impact of the disability on the child and the child's usual behaviour is a prerequisite in any safeguarding assessment. It is crucial that through the course of the assessment professionals develop a shared understanding of the nature of the child's disabilities, the services the family is receiving and the risk of harm. Multi-agency Strategy Discussions where the threshold of significant harm is a possibility are an important tool in this process, as are professionals' meetings.
6. Assessments must consider all the needs of the child and their family, not just those related to the child's disability.

7. **It should never be assumed that a behaviour of concern is a symptom of a child's disability**. Where this is suggested or suspected, this must be explicitly explored with the child's professional network. Practitioners must remain mindful that *all children communicate through their actions*: distressed or disruptive behaviour should not automatically be attributed to the disability.
8. Where disabled children experience barriers to communication and have complex presenting needs, safeguarding investigations may be more likely to conclude with some uncertainty about what a child has experienced. Where multiple possibilities remain as there is insufficient evidence to come to a definitive conclusion to a child protection investigation, practitioners need to continue to hold a position of 'respectful uncertainty'. The child's plan should include actions that address dual hypotheses, so that these are kept in mind e.g. both offer additional support to a family to manage a child's complex needs ***AND*** remain alert to the possibility that the child's behaviour could be a symptom of abuse.

4. Helpful questions to consider:

- What is the disability, special need or impairment that affects the child?
- How does the disability or impairment affect the child on a day-to-day basis?
- How does the child communicate? If someone says the child can't communicate, simply ask the question: "How does the child indicate s/he wants something?"
- How does s/he show s/he is happy or unhappy?
- Are there or have there in the past been concerns about parenting or abuse?
- Are there any concerns about the parenting of non disabled children in the family?
- How are the 'problems' in this family being framed? What is being located in the disabled child, as opposed to the systems around them?
- What support for the child and the family that is in place? What is working well and what interventions or support has been tried in the past that has proved to be less helpful and why might that be?
- What resources are available to support the disabled child from within their own family network? Have both parents and/or anyone with Parental Responsibility been engaged in the assessment and/or intervention? Has a Family Group Conference been considered?
- Have I reviewed the Local Offer for children with additional needs (https://www.hackneylocaloffer.co.uk/kb5/hackney/localoffer/home.page) and/or consulted with the Disabled Children's Service to ensure the child is accessing all the services he or she is entitled e.g. Short Breaks?
- Are there differences of opinion about the experiences of the child in the professional network and if so, what may this be about?
- Where there are multiple hypotheses about what might be happening for a child, does my plan reflect this and work to address all possible scenarios of concern?
- Would I consider the same safeguarding options if the child was not disabled?

5. Possible indicators of abuse or neglect for a disabled child

The following are some indicators of possible abuse or neglect for a disabled child:

- A bruise in a site that might not be of concern on an ambulant child, such as the shin, might be of concern on a non-mobile child;
- Not getting enough help with feeding leading to malnourishment;
- Poor toileting arrangements;
- Lack of stimulation;
- Unjustified and/or excessive use of restraint;
- Rough handling, extreme behaviour modification e.g. deprivation of liquid, medication, food or clothing;
- Unwillingness to try to learn a child's means of communication;
- Ill-fitting equipment e.g. calipers, sleep boards, inappropriate splinting;
- Misappropriation of a child's finances;
- Invasive procedures which are unnecessary or are carried out against the child's will;
- Inappropriate feeding methods for children who have difficulty swallowing, leading to risk of aspiration.

6. Sexualised behaviour

Research suggests disabled children are three times more likely to be subject to sexual abuse than their non-disabled peers. However, making an assessment about the risk of sexual abuse is always complex.

Practitioners should remain mindful that for a disabled child there are multiple possible explanations for sexualised behaviour, including:

- That it is an indicator of sexual abuse;
- That is is an indicator of other form of abuse or trauma;
- That it is a function of the child's disability e.g. sensory seeking behaviour.

It is important to note that research suggests most children displaying sexualised behaviour have not suffered sexual abuse.

Where a disabled child is displaying sexualised behaviour and there is a concern about possible sexual abuse:

- Read the Hackney CFS Practice Guidance Working with the risk of inter-familial sexual abuse;
- Consider what direct work can be undertaken with the child to increase potentially safety e.g. thinking about good and bad secrets, boundaries and privacy in their family life and safe touching. Where a disabled child has additional needs around communication, it will be important to consult with a professional familiar with their preferred method of communication to plan this work;
- Consult with your Unit's link clinician. The Clinical Service can offer advice and guidance around undertaking risk and protective capacity assessments and direct work with children;

- Where children are less able to disclose what may be happening to them due to communication difficulties, it is important to think about potential opportunities for abuse e.g. to think through a timetable of their day and week and consider who spends time with them on a one-to-one basis, considering everyone in the family network (including siblings) as well as all professional carers.
- If a disabled child is displaying harmful sexual behaviour, refer to the Hackney CFS Practice Guidance on Working with harmful sexual behaviour.

7. The roles and responsibilities of the Disabled Children's Service

While many of Hackney's disabled children are known to the Disabled Children's Service, often safeguarding issues regarding disabled children are responded to by other parts of Children and Families Services. For more information on the remit of the Disabled Children's Service, please see an overview of the Disabled Children's Service.

8. Partnership Working

Understanding and addressing concerns for disabled children and young people is difficult without the involvement of the network around the child or young person. Early help, assessment and intervention are important because incidents of neglect and abuse within this cohort are on a continuum and situations where abuse is developing can, at times, be resolved by multi-agency preventative services outside the child protection procedures.

City and Hackney Safeguarding Children Partnership's Escalation Policy supports practitioners to resolve professional difference with partners. Occasionally situations arise when workers within one agency feel that the actions, inaction or decisions of another agency do not adequately safeguard a disabled child. This interagency policy defines the process for resolving such professional differences and should be read alongside the London Child Protection Procedures and relevant internal policies on escalating matters of concern.

Watch out for The City & Hackney Safeguarding Children Partnership training on Safeguarding Children with Disabilities/ SEND.

8. Further resources

1. Hackney's Local Offer: Services for 0-25 with SEN, disabilities or additional needs
2. Department for Children, Schools and Families, Safeguarding Disabled Children
3. NSPCC, *Deaf and Disabled Children: Learning from Serious Case Reviews*
4. Working with the risk of inter-familial sexual abuse: Practice Guidance
5. Working Together Guidance sets out how we work in partnership with other professionals to respond to the needs of children and families.
6. Protecting Disabled Children from Sexual Abuse Podcase https://learning.nspcc.org.uk/news/2019/november/podcast-preventing-the-sexual-abuse-of-disabled-children.