National Guidance for Child Protection in Scotland (2014)

Additional Notes for Practitioners: Protecting Disabled Children from Abuse and Neglect

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1. Introduction

These additional practice notes have been designed to be read in conjunction with local single and inter-agency child protection procedures and the *National Guidance for Child Protection in Scotland* which was refreshed in 2014, particularly Part 4, "Child Protection in Specific Circumstances". Other relevant legislation, guidance and policy specifically relating to disabled children can be found at Appendix 1.

Child protection must be seen in the context of the wider Getting it right for every child (GIRFEC) approach, the Early Years Framework (2009), Article 12 of the UN Convention on the Rights of the Child (1989) and Article 12 of the UN Convention on the Rights of Persons with Disabilities 2007. All children and young people have the right; to be cared for; to be protected from harm and abuse; and to grow up in a safe environment in which their rights are respected and their needs met. Children and young people should get the help they need when they need it; and their safety and wellbeing is always paramount.

Disabled children and young people are children/young people first and foremost and their wellbeing and protection should be considered in relation to the individual child's circumstances.

Whilst disabled children are likely to suffer much the same abuse as other children, research suggests that disabled children are 3.4 times more likely to be abused than non-disabled children (Sullivan & Knutson, 2000). Research has also shown that children with communication impairments, behavioural disorders, learning disabilities and sensory impairments are particularly vulnerable (Stalker *et al*, 2010),(Spencer *et al* 2005). The most common forms of abuse experienced by disabled children are neglect and emotional abuse, although they may experience multiple abuses. Disclosing abuse can be more difficult for children who have a wide range of communication styles, and this can be more problematic if a perpetrator is also in a trusted role (Hershkowitz *et al*, 2007).

Ensuring disabled children's wellbeing is everybody's responsibility and an awareness of what constitutes best practice is essential. It is critical that all practitioners are aware of the potential vulnerability of disabled children and of what constitutes best practice in protecting them from the risk of abuse and neglect.

This document will provide a summary to support the identification of abuse and harm and practice considerations to support the protection of disabled children.

2. Definition

The definition of "disabled" comes from the Equality Act 2010: a person, including a child, is considered to be disabled if they have a physical or mental impairment and the impairment has a substantial and long-term adverse effect on their ability to perform normal day-to-day activities. It includes children and young people with a comprehensive range of physical, emotional, developmental, learning, communication and health care needs. Disabled children are defined as "a child in need" under section 93(4) of the Children (Scotland) Act 1995.

This Guidance uses the social model of disability, which, rather than focusing on medical problems or physical deficits, explores the social and environmental barriers, cultural processes and policy frameworks that disable children with an impairment. (Watson, 2004).

3. Scope and Purpose

These additional practice notes are for **all** practitioners including those working in: children and family social work teams; health; education; schools; residential care; early years; youth services; the youth justice system; the police; independent and third sector; and for adult services who might be supporting parents with disabled children or involved in the transition between these child and adult services.

It aims to raise practitioners' awareness of the increased vulnerability of disabled children and ensure that practitioners take this into account in their involvement with disabled children and their families.

4. Why disabled children and young people may be at greater risk

Disabled children are at greater risk of harm partly from the effects of their disability and their environment; partly because of the response of practitioners.

The list below details some of the risks from the effects of their **disability and environment** – it is by no means exhaustive and is supported by additional reading and resources identified in Appendix 2.

- Many disabled children are at increased likelihood of being socially isolated with fewer outside contacts than non-disabled children. They may particularly lack the support of peers in whom they can confide.
- They may not know they are being abused or neglected because they lack the life experience to make that judgement.
- Their dependency on parents, carers and service providers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour.
- They may be reluctant to share worries or concerns, for fear of getting familiar adults into trouble, or may not have access to someone they can trust to disclose that they have been abused.
- There may be established practices within the family which minimise or hide risk factors or actual abuse.
- They may have an impaired capacity to resist or avoid abuse.
- They may have speech, language and communication needs which may make it difficult to tell others what is happening.
- They are especially vulnerable to bullying and intimidation.
- Looked after disabled children are also vulnerable to the same issues that exist for all children living away from home e.g foster/kinship care. They are particularly susceptible to abuse due to their additional dependency on residential and hospital staff for their day to day physical and other care and support needs as they may not have the vigilance of family members to be alert to such abuse.
- They may lack self-worth and feel that the abuse is their fault, even be desensitised to abuse.
- They are less likely to know about/understand their rights.

- There is an even greater power imbalance between disabled children and other non-disabled children and adults.
- They are less likely to have had sex education.
- They may not have the communication aids which allow them to describe body parts and abuse.
- They may have less choice, be used to obeying/complying to survive, lack belief they can control things in their lives.

The **response of practitioners** can also contribute to the vulnerability of disabled children in respect of the risk of abuse and harm. Practitioners from all agencies/disciplines must be aware of the values, attitudes and beliefs that lead to denial or minimisation of the impact of abuse and neglect in relation to a disabled child, as this can lead to a failure to respond and/or report abuse or neglect.

Practitioners may find it more difficult to attribute indicators of abuse or neglect, or may be reluctant to act on concerns in relation to disabled children due to a number of factors which they may not be consciously aware of.

These could include:

- The belief that disabled children are not abused; or are not at risk of certain types of abuse and harm i.e. child sexual exploitation; cyberbullying; forced marriage.
- Assuming that an investigation cannot take place without a disclosure of abuse.
- Beliefs that minimise the impact of abuse on disabled children, e.g. that due to their impairment they are less likely to remember or be adversely affected by an abusive incident.
- Workers feeling overwhelmed by the child's disability.
- A lack of knowledge about the child, e.g. not knowing the child's usual behaviour or the impact of disability on the child.
- Not being able to understand the child's method of communication, therefore not seeking their views.
- Assumptions being made about the impairment rather than the needs of and risks to the child i.e. accepting a parent or carers explanation that an injury or behaviour is the result of the impairment rather than considering other possible causes.
- Being uncomfortable with or in denial of the child's stages of sexual development and sexuality.
- Lack of understanding of a disabled child's health care needs. Medication being delayed by one hour can cause significant risk of life threatening seizures which is not the case with typically developing children.
- Not considering behaviour, including harmful sexual behaviour or self-injury, which may be indicative of abuse.
- Not being aware of how certain health/medical complications may influence the way symptoms present or are interpreted i.e. some conditions cause spontaneous bruising or fragile bones potentially resulting in more frequent fractures.
- Assessments which focus on needs relating to impairment rather than general wellbeing.
- A lack of time for thorough assessment which considers family history, chronologies, concerns about or actual harm to other children within the family group.
- Making assumptions that disabled children who can communicate will disclose abuse – an assumption not made for other children.
- Not being alert to the possibility of abuse by professionals caring for disabled children

5. Recognising indicators of possible abuse and neglect

Significant harm caused by abuse and neglect may be the result of a specific incident, or more likely, an accumulation of concerns over time. Assessment must include analysis of accurate recordings, comprehensive chronologies and relevant information regarding significant events/concerns in relation to the disabled child **and their siblings**. This along with the timeous sharing of relevant information can increase the identification of and inquiries into possible abuse and neglect.

The National Guidance for Child Protection in Scotland (Scottish Government, 2014) defines different types of abuse and neglect and outlines indicators of abuse and neglect that can affect any child. Disabled children experience the same sort of abuse as other children: neglect, physical abuse, sexual abuse (including exploitation) and emotional abuse. Neglect seems particularly prevalent.

In addition to this there are some **features of abuse particular to disabled children**:

- Missing medical appointments, misuse of medication, failure to provide treatment or providing inappropriate or unnecessary invasive procedures carried out against the child's will.
- Using ill-fitting equipment or not allowing adaptations a child might need such as, callipers, safe space, inappropriate splinting or inappropriate physical confinement.
- Threats of abandonment/exclusion and/or depriving access to visitors.
- Exclusion: from family events, overuse of 'respite', unnecessary schooling away from home.
- Not feeding the child enough in order to keep them light for lifting, or over-feeding.
- A disregard for a child's right to privacy i.e. poor toileting arrangements.
- Fear of carers.
- Inappropriate use of physical restraint.
- Rough handling, extreme behaviour modification.
- Lack of communication or stimulation; unwillingness to try to learn a child's means of communication or withholding a child's means of communication.
- Teasing, bullying or blaming because of their impairment.
- Verbal abuse; achievements ridiculed or ignored.
- Punitive responses to behaviour.
- Having too high/low expectations of child.
- Over protection.
- Misappropriation of a child's finances.

Some of the above behaviours can constitute criminal offences. Similarly, inappropriate restraint, sanctions, humiliation, intimidation, verbal abuse, and having needs ignored; depending on the circumstances, may also be criminal offences, acts of gross misconduct and reportable to Police Scotland and relevant professional regulatory bodies.

It is crucial when considering whether a disabled child has been/or is at risk of abuse and/or neglect that the disability does not mask or deter appropriate investigation of child protection concerns. Any concerns for the safety and wellbeing of a disabled child should be acted upon timeously as directed by the National Guidance for Child Protection in Scotland (Scottish Government, 2014) and local inter-agency guidance. *There should be no distinction made in acting on concerns where a child is disabled.*

6. Barriers to communicating abuse

Communicating abuse is difficult for any child, they may be confused, fearful, traumatised and uncertain about what has happened and what might happen in the future. The recognition of concerns in relation to the protection of children and young people from abuse and harm cannot be determined by disclosure alone. Not every child will disclose abuse or harm and there should be no greater expectation that disabled children will disclose more readily than any other children.

For a disabled child it may be especially difficult, as they may not have the means to communicate about their abuse experience(s). For some disabled children with speech, language and communication needs, making known that they have been subject to abuse, neglect or ill treatment is dependent on the ability of practitioners to recognise and respond appropriately to a range of verbal and non-verbal cues. It may be necessary to seek support and advice from practitioners with specialist skills who are most familiar with the child and their means of communication, for example Picture Exchange Communication System (PECS).

The Scottish Government (2011) Guidance on Joint Investigative Interviewing of Child Witnesses in Scotland and West Dunbartonshire Council (2009) Helping Children & Young People to have their say practice guideline provide helpful information on supporting children and young people to share their story.

7. Working with family members and carers of disabled children

Most parents and carers of disabled children provide safe and loving homes. However, there must be awareness that this is not always the case: some fail to offer acceptable care, overwhelmed by the pressures upon them and their family or receiving inadequate support from services and some do deliberately harm their children.

As in all cases of suspected child abuse, it is important to develop cooperative working relationships as far as possible with the families and carers of disabled children. This is challenging when the parents and carers are themselves under suspicion as set out in the National Guidance and particularly difficult with some parents and carers who are very hostile or superficially cooperative. Some parents and carers of disabled children may exhibit similar behaviour and the possibility that threatening and hostile behaviour towards workers may indicate similar behaviour towards the children must always be considered; where parents are apparently compliant, the advice to maintain healthy scepticism is just as relevant. There should also be awareness that families with disabled children may also have issues about the misuse of alcohol and drugs, mental health, domestic abuse just as in other families. Additionally, the parent or carer may be disabled and not receiving the support they require to meet the additional demands of being a parent.

There are also **some particular issues which may apply** when a child is disabled:

- Some parents and carers are reluctant to seek help from professionals, particularly those in statutory services, when under pressure as they are afraid of being labelled as unable to cope and harbour a fear that if they do seek help their children will be removed from their care. Early intervention with these families can be, therefore, more difficult.
- Often parents and carers feel they have not had sufficient help and support with their disabled child and describe having to fight for any services they have received. Not surprisingly, then, some families are particularly hostile to intervention – especially when they perceive this as the blame being put on them by services who have previously failed them.
- Services for disabled children are encouraged to work with parents and carers as partners and, in reality, parents usually understand the needs of their disabled child best. This can, though, create complexity when there are suspicions of abuse. The parents and carers may be seen as part of the team around the child by those professionals who have been working with them and there can be resistance to re-assessing a situation which shows them in a different light. Sometimes parents will actively try to enlist the help and support of these professionals and dealing with these issues can divert focus away from the central issue of the welfare and safety of the child.
- There is a general difficulty for all who work with families of disabled children of over identifying with the parents' situation. This is particularly the case for professionals who may have been working with the family for sometime but it can affect all who come into contact with the family. Workers may feel sorry for parents struggling to cope, or indeed to view them as "heroic carers". The child becomes seen as a passive recipient of parental care, which is disempowering and may divert attention away from the parenting needs of the children. This is significant in a child protection context, where a risk assessment must include consideration of the adequacy or safety of parenting, as opposed to the provision of care.
- Parents and carers may feel that only they are able to understand their child and be able to interpret their wishes. This may lead to an oversight of the child's wishes.

Opportunities to reflect, discuss and challenge thinking in respect of these issues must therefore be made available to ensure the provision of child centred, ethical and disability aware practice in a child protection context.

8. Reporting and investigating child protection concerns

Initial referral

Where a practitioner has concerns that a disabled child may be being abused or neglected, they should follow their own agency and local child protection committee policy and procedures for passing on a concern to statutory child protection services. Concerns should be shared at the first opportunity either with an appropriate manager or with the designated member of staff who has responsibility for child protection in the agency/service provider, so that a referral can be made promptly.

Under GIRFEC, we all have a responsibility to pass on concerns if we have reason to believe that any child is at risk of, or has suffered significant harm because of, abuse and/or neglect. Local authorities have a duty to make initial enquiries and investigate child protection referrals. The Childrens Hearings (Scotland) Act 2011(section 37-54) sets out the duties and powers of local authorities where there is an immediate level of concern for a child.

Specific aspects to consider in making a child protection referral, or raising a concern, in respect of a disabled child may include the following. However, this should not prohibit a timeous referral to the local child protection team or service.

The referrer should:

- In line with any referral of a child protection concern, state specifically what the concern is, include recent changes in behaviour, responses to individuals in additional to other indicators of concerns or descriptions of incidents.
- State the child's diagnosis (if known), the main difficulties affecting day to day functioning and avoid describing solely in broad terms such as learning disability.
- State the child's medical conditions, associated treatments and how they are managed.
- Describe how the child communicates (thoughts, behaviours, feelings and wishes) and what aids to support communication are used, e.g. symbols/picture communication symbols, Makaton.
- Describe how the child expresses distress.
- In the absence of direct substantiation of a concern (e.g. a disclosure), state a hypothesis based on professional judgement (the person raising concern is likely to be someone who knows the child/family more than others so his/her judgement is valid).
- Detail the other agencies/services that are involved and what their specific role/ service is (e.g. support, respite care), including those supporting adult carers.
- Detail child's network - family members, friends, neighbours. Specifically identify those who provide care and/or support.
- Not delay passing on a concern and/or making a referral because of lack of any of the above information.
- Accurately record concerns and actions taken.

As with non-disabled children, it is not always obvious from an initial referral that there is a child protection issue to be considered. Practitioners, the family, the child and others may emphasise other problems or difficulties and the need for protection from harm may not always be obvious. Thus, the practitioner receiving the referral should systematically

seek information about the identified needs and circumstances that have prompted the referral.

Acting on the referral/concern

- Ask for information in relation to all the referral points above.
- Cross-reference to other family members including siblings/check with other agencies (e.g. the child/young person's main carer may have indicated to another service, e.g. family GP, that she/he isn't coping, or that there are other issues that might be affecting the safety of the child).
- Confirm whether the child and their parents/carers are aware that this referral has been made.
- Have initial discussions with line manager following the referral. This is particularly important given the complexities often around for disabled children/young people and extra resources may be necessary, especially where a child has speech, language and communication needs, in order to ensure that an appropriate assessment can be undertaken.

It is important that, where possible, as much accurate information is gathered, in order to fully understand the context and assess the likelihood of harm to the child. It may be necessary to obtain an accurate assessment of the child's understanding and language abilities from their parent, teacher, speech and language therapist or advocacy support and then take advice on communicating or working with the assistance of someone who knows the child well.

In addition, the following questions should be considered and asked when a referral is received concerning a disabled child:

- What is the nature of the child's disability? Ask for a description of the child's impairment rather than just using generic terms, for example, 'learning disability' could mean many things and does not tell you much about the child or their needs.
- If you do not know how to spell a word that describes an impairment or condition ask how it is spelt. This will be important if further enquiries are required about how the condition might be expected to affect the child.
- How does the child's 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?
- Has the impairment or condition been medically assessed and/or diagnosed?
- What type of assessment was carried out, when and has it been reviewed?
- Is there someone who can support the child's communication, e.g. a speech and language therapist or teacher?

Investigation of allegations of abuse involving disabled children

Local procedures and National Guidance must be followed where there is reasonable cause to believe that any child, is suffering, or is at risk of suffering, significant harm. The first responsibility, as with any investigation into allegations of abuse and/or neglect is to **ensure that the child is safe** including when the child is living away from home in foster, residential, secure or hospital care. Consideration also needs to be given to the **wellbeing and protection needs of any siblings** living in the family home. As with all enquiries, the need for accurate, detailed, contemporaneous recording of information is essential.

Some additional considerations in relation to disability are outlined below.

- Any enquiries planned or undertaken should be carried out with sensitivity and an informed understanding of a disabled child's needs and impairment. This includes taking into consideration matters such as the venue for the interview/s; the care needs of the disabled child; whether additional equipment or facilities are required; who should conduct the interview; who should be present at the interview and whether someone with specialist skills in the child's preferred method of communication needs to be involved.
- Throughout the process, all service providers must ensure that they take time to communicate clearly and objectively the relevant information, with the disabled child and family, and with one another, as there is likely to be a greater number of practitioners involved with a disabled child than with a non-disabled child. This should be co-ordinated through the lead professional as consideration should be given to impact of information sharing on any criminal investigations.
- The disabled child's preferred communication method for understanding and expressing themselves needs to be given the utmost priority, and where a child has speech, language and communication needs, including those with non-verbal means of communication and deaf children, arrangements will need to be made to ensure that the child can communicate about any abuse or neglect she/he is experiencing and their views and feelings can be made obtained.
- When assessing/considering the child's needs, the focus should always be: "what are their abilities?" Even if the child cannot communicate through the usual communication media, this should not prevent investigative agencies from attempting to obtain their account.
- Some disabled children may not be able to state dates/times when particular events (such as an abusive experience) occurred but may be able to describe an event as before or after some other event e.g. at mealtime.
- The collation of medical information concerning the health needs of the child is important as it may be have a bearing on the outcome of any enquiry/investigation. Consider and identify who may have the best knowledge about the child's medical condition, for example, paediatrician; school doctor or school nurse. Where there is a need for a medical examination, consideration needs to be given to the most appropriate medical professional who should undertake the examination, the venue, timing and the child's ability to understand the purpose of the medical procedure.
- The number of carers involved with the child should be established as well as where the care is provided and when. A disabled child's network of carers could include short break foster carers, befrienders, sitters, personal assistants, community support workers, residential care staff, independent visitors and learning support assistants.

- Do not underestimate the important information that others can provide (including, for example, transport drivers/escorts).
- Where there is to be a police investigation into allegations of abuse or neglect of a disabled child, those undertaking such investigations should not make presumptions about the ability of the child to give credible evidence. All such investigations should be undertaken in accordance with Guidance on Joint Investigative Interviewing of Child Witnesses in Scotland (Scottish Government, 2011) and the use of special measures for vulnerable witnesses with special support needs in the guidance pack on the Vulnerable Witnesses (Scotland) Act 2004 (Scottish Executive, 2006).
- Where there are allegations of abuse and a disabled child is the alleged abuser, investigations need to be handled with sensitivity and a duty of care shown to both the victim and the alleged abuser.
- Where the parents of a disabled child are disabled themselves, arrangements also need to be put in place to accommodate their needs throughout the investigation/assessment process.
- Following any child protection referral and investigation, the need for the disabled child and their family to be provided with on-going support, should be recognised. This is especially important where disabled children have disclosed that they have been abused as the need for therapeutic services for disabled children, following such experiences is not always recognised.
- A very useful question to ask when assessing a disabled child is "Would I consider that option if the child were not disabled?" Clear reasons are necessary if the answer is No. (Assessing Children in Need and their Families: Practice Guidance, Department of Health, 2000 p.80)
- Consider the use of an Independent Advocacy service to support the child or young person to express their views and wishes.
- Ensure ongoing support is put in place throughout the investigation process and beyond to avoid the child/young person not being aware of what is happening and becoming confused/disempowered.

Transition to adult services

The importance of ensuring appropriate planning to support disabled children in the transition from child to adult services is vital. A child may be biologically of an adult age but developmentally much younger. Therefore, local authorities should ensure that there are appropriate operations links between adult and children's services to ensure a careful and planned transfer. The Protection of Vulnerable Groups (Scotland) Act 2007 is of particular relevance here.

9. Key messages for practice

- Essentially, disabled children at risk of or who have experienced abuse should be treated with the same degree of professional concern accorded to non-disabled children.
- Additional resources and time may need to be allocated, if an investigation of potential or alleged abuse is to be meaningful. This is a basic premise and should not be ignored at any stage of the child protection process.
- Basic training and awareness raising of the susceptibility of disabled children to abuse is essential for all those working with disabled children, including ancillary staff such as bus drivers, care assistants, escorts and personal assistants.
- Reporting child protection concerns needs to be encouraged at all levels of professional involvement; and prompt and detailed information sharing is vital.
- The disability with which a child presents should not detract from early multi-agency assessments of need that consider possible underlying causes for concern.
- There should be a clear agreement within the local authority as to who takes the lead role for child protection referrals and investigations and this should be identified in local procedures. Best practice would indicate that child protection teams lead on child protection but do so in consultation with specialist disability teams or the workers involved with child, as there may be other children in family requiring assessment etc. the rationale for this is, not all practitioners working in speciality disability teams are trained to carry out child protection procedures. Similarly, those working in child & families teams may not feel confident about assessing the wellbeing and protection needs of a disabled child. There may also be liaison with adult protection for older young people.
- It is fundamental that all staff working with disabled children or who are likely to receive child protection referrals concerning disabled children, receive appropriate training to equip them with the knowledge and awareness to assess risk of harm to a disabled child and know how best to work together to provide a high quality service to the child.
- Where a criminal offence is alleged, investigation by the police needs to be handled sensitively and in accordance with Vulnerable Witnesses (Scotland) Act (2004).
- Parents and carers need to be made aware (if they are not already) of the vulnerability of their children to abuse or neglect, but also of their potential role in the child protection process.

Appendix 1

LEGISLATION

Equality Act 2010

Children (Scotland) Act 1995

The Childrens Hearings (Scotland) Act 2011

Vulnerable Witnesses (Scotland) Act 2004

Protection of Vulnerable Groups (Scotland) Act 2004

A comprehensive list of legislation can be found in the National Guidance for Child Protection in Scotland 2014.

Appendix 2

REFERENCES

Department of Health (2000). Assessing Children in Need and their Families: Practice Guidance. Department of Health : Page 80
http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4014430.pdf

Herskwowitz, I. Lamb, ME. Horowitz, D (2007). Victimization of children with disabilities. American Journal of Orthopsychology. 77 (4): 629-35. DOI 10.1037/0002-9432.77.4.629

Scottish Executive (2006). Guidance pack on the Vulnerable Witnesses (Scotland) Act 2004. Scottish Executive
http://www.scotland.gov.uk/Publications/2008/04/21142140/3

Scottish Government (2009). Early Years Framework. Scottish Government
http://www.scotland.gov.uk/Resource/Doc/257007/0076309.pdf

Scottish Government (2010). National Guidance for Child Protection in Scotland. Scottish Government
http://www.scotland.gov.uk/Resource/Doc/334290/0109279.pdf

Scottish Government (2011). Guidance on Joint Investigative Interviewing of child Witnesses in Scotland. Scottish Government
http://www.scotland.gov.uk/Resource/Doc/365398/0124263.pdf

Spencer, N. Devereux, E. Wallace, A. Sundrum, R. Shenay, M. Bacchus, C. Logan, S. (2005) Disability Conditions and Registration for Child Abuse and Neglect: A Population Study. Pediatrics. Doi 10.1542

Stalker, K. Green-Lister, P. Lerpiniere, J. McArthur, K. (2010). Child Protection and the needs and rights of disabled children and young people: a scoping study. Strathclyde University http://strathprints.strath.ac.uk/27036/1/child_protection_abridged_report.pdf

Stalker, K. and McArthur, K. (2010) 'Child abuse, child protection and disabled children: a review of recent research'. Child Abuse Review, n/a. doi: 10.1002/car.1154

Sullivan,PM. Knutson, JF. (2000). Maltreatment and disabilities: a population based study. Child Abuse and Neglect. 24 (10) : 1257-73

Watson, N. (2004). How Disability Theory Can Help Our Understanding of the Lives of Disabled Children. Strathclyde University
http://www.strath.ac.uk/media/faculties/hass/appliedsocialsciences/socialwork/esrcseminar/Disability_theory_Watson_N.pdf

West Dunbartonshire (2009). Helping Children and Young People to have their say. West Dunbartonshire Council. Available online:

Assessment in Child Care, Russell House Publishing, Dorset
http://www.russellhouse.co.uk/pdfs/assinchildcare.pdf

Kennedy, M. and Wonnacott, J. (2005) 'Neglect of disabled children'. In J. Taylor and B. Daniel (eds) Child Neglect. Practice Issues for Health and Social Care, pp.228 -248. London: Jessica Kingsley Publishers

The Victoria Climbié Inquiry: report of an inquiry by Lord Laming, Publisher Stationery Office
http://www.publications.parliament.uk/pa/cm200203/cmselect/cmhealth/570/570.pdf

Serious Case Review - Ricky Neave, 1997, Bridge Childcare Development Service, (Cambridgeshire Safeguarding Board)

Stalker K and McArthur K (2012)) 'Disabled Children and Child Protection: A Literature Review' Child Abuse Review 21, 1, 24-40

Support and Aspiration: A New Approach to Special Educational Needs and Disability. A consultation. Department for Education (2011) London: Department for Education.
http://webarchive.nationalarchives.gov.uk/20130401151715/https:/www.education.gov.uk/publications/standard/publicationDetail/Page1/CM%208027

Support and Aspiration: A New Approach to Special Educational Needs and Disability. A consultation. Department for Education (2011) London: Department for Education.
http://webarchive.nationalarchives.gov.uk/20130401151715/https:/www.education.gov.uk/publications/standard/publicationDetail/Page1/CM%208027

Miller, D. and Raymond, A. (2008) 'Safeguarding disabled children.' In Baginsky, M. Safeguarding Children and Schools. London: Jessica Kingsley Publishers

Murray, M. and Osborne, C. (2009) Safeguarding Disabled Children. Practice Guidance. London: Department for Children, Schools and Families
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/190544/00374-2009DOM-EN.pdf

Vaccari, C. and Marschark, M. (1997) 'Communication between parents and deaf children: Implications for socio--emotional development'. Journal of Child Psychology and Psychiatry **38(7)** 793--801
http://www.ncbi.nlm.nih.gov/pubmed/9363578