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SAFEGUARDING POLICY AND PROCEDURE

for Vulnerable Adults and Children

This policy statement aims to protect vulnerable adults and children who access counselling through Ian Cartwright Compassion-Focused Therapy, referred to in the remainder of this document as Ian Cartwright CFT.
Ian Cartwright receives professional supervision and has the appropriate qualifications. Ian Cartwright can also provide evidence of his insurance, a DBS check, membership in a governing body, and recent safeguarding training.

All new clients undergo an initial phone call and complete a referral form. Part of this initial phone call is an assessment of risk. If, at the assessment, we think that there is a high risk of suicide, the client may well not be suitable for private practice and will be advised to contact their GP, or the police may be contacted depending on the level of risk.

Once the assessment is completed, we assume the client's clinical responsibility, including safeguarding. In the case of children, the assessment telephone call is usually made with the parent who is seeking therapy for their child.

Whistleblowing

Ian Cartwright CFT has an open culture where people feel able, positively supported, and encouraged to raise their concerns, even when they relate to the practice

Responding to concerns and disclosure

The safeguarding procedures are publicly available on the website so that potential and current clients are aware of them.

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Safeguarding Lead

Ian Cartwright is the safeguarding lead for adults and children, who will deal with any concerns arising during the initial assessment stage.

Safeguarding Lead:	Ian Cartwright
Phone number:	07794377321
Email	ian@iancartwrightcft.co.uk

The appendix, which ends this document, provides contact numbers and a procedural form for gathering information.

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SAFEGUARDING POLICY STATEMENT – VULNERABLE ADULTS

1) Policy Statement

The policy ensures that Ian Cartwright CFT implements appropriate arrangements, systems, and procedures to ensure the organisation has the right skills, means, and resources to protect and safeguard adults.

Ian Cartwright Compassion-Focused Therapy recognises safeguarding means protecting an adult's right to live in safety, free from abuse and neglect.

2) Aim

The Care Act 2014 provides a definition and framework for Safeguarding Adults.

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It involves people and organisations working together to prevent and stop the risks and experiences of abuse or neglect while promoting the adult's well-being. Where appropriate, this includes considering the adult's views, wishes, feelings, and beliefs when deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear, or unrealistic about their personal circumstances.

The aims of adult safeguarding are to:

- Stop abuse or neglect wherever possible.
- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs.
- Safeguard adults in a way that supports them in making choices and having control about how they want to live.
- Promote an approach that concentrates on improving life for the adults concerned.
- Raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect.
- Provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult.
- Address what has caused the abuse or neglect.

3) Legislation - The Care Act

2014 Safeguarding Duties

The **Care Act 2014** introduced statutory safeguarding duties. The safeguarding duties apply to an adult who:

(a) Has needs for care and support (whether or not the authority is meeting any of those needs).

(b) Is experiencing, or is at risk of, abuse or neglect.

(c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

4) Key Principles for adult safeguarding

In the safeguarding of adults Ian Cartwright CFT is guided by the principles set out in The Care Act 2014 (See Appendix Two) and aims to demonstrate and promote these principles in our work

- **Empowerment** – People being supported and encouraged to make their own decisions and informed consent.
- **Prevention** – It is better to take action before harm occurs.
- **Proportionality** – The least intrusive response appropriate to the risk presented.
- **Protection** – Support and representation for those in greatest need.
- **Partnership** – Local solutions through services working with their communities.
- Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** – Accountability and transparency in delivering safeguarding.

Factors which may mean that an individual is deemed a vulnerable adult: -

(a) Being **elderly and frail**. This may be due to physical disability, cognitive impairment, general ill health or advanced age.
(b) **Learning disabilities** especially those individuals who are assessed as having significant learning disabilities.
(c) **Physical disabilities**. Specifically, those individuals whose disability impacts their ability to affectively care for themselves.
(d) **Mental illness**. Individuals who live with a serious mental health condition

5) Recognising the signs of abuse

Therapists may be particularly well-placed to spot abuse and neglect, the adult may say or do things that hint that all is not well. It may come in the form of a complaint or an expression of concern. Everyone within the organisation should understand what to do, and where to go locally to get help, support and advice. It is vital that everyone within the organisation is vigilant on behalf of those unable to protect themselves, including:

- Knowing about different types of abuse and neglect and their signs
- Supporting adults to keep safe
- Knowing who to tell about suspected abuse or neglect and
- Supporting adults to think and weigh up the risks and benefits of different options when exercising choice and control.

The Care Act 2014 defines the following areas of abuse and neglect; they are not exhaustive but guide behavior that may lead to a safeguarding enquiry. This includes:

Physical abuse

The physical mistreatment of one person by another, which may or may not result in physical injury, may include slapping, burning, punching, unreasonable confinement, pinching, force-feeding, misuse of medication, shaking, inappropriate moving and handling.

Signs and indicators -

Over- or underuse of medication, burns in unusual places, such as hands or feet; sudden incontinence; bruising at various healing stages; bite marks, disclosure, or bruising in the shape of objects; unexplained injuries or those that go untreated; and reluctance to uncover parts of the body.

Sexual abuse

Any form of sexual activity that the adult does not want and or have not considered, a sexual relationship instigated by those in a position of trust, rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Signs and indicators

Signs of being abused may include recoiling from physical contact, genital discharge, fear of males or females, inappropriate sexual behaviour in the presence of others, bruising to thighs, disclosure, and pregnancy. Abusers may take longer with personal care tasks, use offensive language, work alone with clients, or show favoritism to clients.

Financial or material abuse

Financial or material abuse – including theft, fraud, internet scamming, coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits

Signs and indicators

This may include not allowing a person to access to their money, not spending allocated allowance on the individual, denying access to their money, theft from the individual, theft of property, misuse of benefits. There may be an over protection of money, money not available, forged signatures, disclosure, inability to pay bills, lack of money after payments of benefits or other, unexplained withdrawals. An abuser may be evasive when discussing finances, goods purchased may be in the possession of the abuser, there may be an over keenness in participating in activities involving individuals' money

Psychological and/or Emotional abuse

This abuse may involve the use of intimidation, indifference, hostility, rejection, threats of harm or abandonment, humiliation, verbal abuse such as shouting, swearing or the use of discriminatory and or oppressive language. A deprivation of contact, blaming, controlling, coercion, harassment, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks. There may be a restriction of freedom, access to personal hygiene restricted, name calling, threat to withdraw care or support, threat of institutional care, use of bribes or threats or choice being neglected

Signs and indicators

Stress and or anxiety in response to certain people, disclosure, compulsive behavior, reduction in skills and concentration, lack of trust, lack of self-esteem, someone may be frightened of other individuals, there may be changes in sleep patterns

Neglect and acts of omission

Behavior by carers that results in the persistent or severe failure to meet the physical and or psychological needs of an individual in their care. This may include ignoring medical, emotional or physical care needs, failure to provide access to appropriate healthcare and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating, willful failure to intervene or failing to consider the implications of non-intervention in behaviors which are dangerous to them or others, failure to use agreed risk management procedures, inadequate care in residential setting, withholding affection or communication, denying access to services

Signs and indicators

There may be disclosure. Someone being abused may have low self-esteem, deterioration, depression, isolation, continence problems, sleep disturbances, pressure ulcers. There may be seemingly uncertain attitude and cold detachment from a carer, denying individuals request, lack of consideration to the individuals request, denying others access to the individual health care professionals

Self-neglect

This covers a wide range of behaviours, including neglecting one's personal hygiene, health, or surroundings and hoarding.

Discriminatory Abuse

This includes forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation, and religion or health status and may be the motivating factor in other forms of abuse. It can be personal, a hate crime or institutional.

Signs and indicators

There may be a withdrawal or rejection of culturally inappropriate services e.g. food, mixed gender groups or activities. Individual may simply agree with the abuser for an easier life, there may be disclosure, or someone may display low self-esteem. An abuser may react by saying "I treat everyone the same", have inappropriate nick names, be uncooperative, use derogatory language, or deny someone social and cultural contact.

Institutional or Organisational Abuse

Neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one's own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

Signs and indicators

This may include a system that condones poor practice, deprived environment, lack of procedures for staff, one commode used for several people, no or little evidence of training, lack of staff support/supervision, lack of privacy or environment, manager implicated in poor practice. There may be a lack of personal clothing, no support plan, lack of stimulation, repeated falls, repeated infections, unexplained bruises/burns, pressure ulcers, unauthorised deprivation of liberty. Abusers may have a lack of understanding of a person's disability, misuse medication, use illegal controls and restraints, display undue/inappropriate physical intervention, and inappropriately use power/control.

Domestic abuse

The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:

- Psychological
- Sexual
- Financial
- Emotional

A new offence of coercive and controlling behaviour in intimate and familial relationships was introduced into the **Serious Crime Act 2015**. The offence will impose a maximum 5 years imprisonment, a fine or both.

Signs and indicators

May include many of those indicators listed under previous categories in this document, including unexplained bruising, withdrawal from activities, work or volunteering, not being in control of finances, or decision makin personal care, repeated unaddressed incidents of poor practice, lack of homely

Modern slavery

Encompasses slavery, human trafficking, and forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

Signs and indicators

There may be signs of physical or psychological abuse, victims may look malnourished or unkempt, or appear withdrawn. Victims may rarely be allowed to travel on their own, seem under the control, influence of others, rarely interact or appear unfamiliar with their neighbourhood or where they work. They may be living in dirty, cramped or overcrowded accommodation, and / or living and working at the same address. Victims may have no identification documents, have few personal possessions and always wear the same clothes

day in day out. What clothes they do wear may not be suitable for their work. People may have little opportunity to move freely and may have had their travel documents retained, e.g. passports. They may be dropped off / collected for work on a regular basis either very early or late at night. Victims may avoid eye contact, appear frightened or hesitant to talk to strangers and fear law enforcers for many reasons, such as not knowing who to trust or where to get help, fear of deportation, fear of violence to them or their family.

Radicalisation to terrorism

The Government through it's PREVENT programme has highlighted how some adults may be vulnerable to radicalisation and involvement in terrorism. This can include the exploitation of vulnerable people and involve them in extremist activity**.** Radicalisation can be described as a process, by which a person to an increasing extent accepts the use of undemocratic or violent means, including terrorism, in an attempt to reach a specific political/ideological objective. Vulnerable individuals being targeted for radicalisation/recruitment into violent extremism is viewed as a safeguarding issue**.**

Signs and indicators

May include being in contact with extremist recruiters. Articulating support for violent extremist causes or leaders. Accessing violent extremist websites, especially those with a social networking element. Possessing violent extremist literature. Using extremist narratives to explain personal disadvantage. Justifying the use of violence to solve societal issues. Joining extremist organisations. Significant changes to appearance and/or behaviour.

Who might abuse?

Abuse of adults at risk, may be perpetrated by a wide range of people including relatives, family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people and strangers.

Incidents of abuse may be one-off or multiple, and affect one person or more. Professionals and others should look beyond single incidents or individuals to identify patterns of harm.

Patterns of abuse vary and include:

- Serial abusing in which the perpetrator seeks out and 'grooms' individuals. Sexual abuse sometimes falls into this pattern as do some forms of financial abuse;
- Long-term abuse in the context of an ongoing family relationship such as domestic violence between spouses or generations or persistent psychological abuse;
- Or opportunistic abuse such as theft occurring because money or jewellery has been left lying aroud.

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6.1) Promoting Adult Safeguarding within Ian Cartwright Compassion Focused Therapy

Prevention of abuse

- Ensuring every. One involved with the practice has received up to date safeguarding training when they start working at Ian Cartwright CFT and are expected to update their safe guarding training.
- Internal guidelines for staff in the form of Safeguarding policies

THERAPISTS PROCEDURES

The therapists' procedures outline what therapists need to do in a range of situations in order to best protect the client within the therapeutic setting.

As with all these procedures, the first step at a general level is **Supervision**.

Supervision's major focus is to help the therapist to provide their best services for the client. It is in supervision that the therapist brings their anxieties, worries and concerns to the supervisor.

If the client discloses that they are being abused, harming themselves or have been abused in the past:

* The first port of call is to gently enquire and check out what you have heard to make sure you understand correctly – this is not an interrogation – though you have to be specific to ensure the facts. This needs to be done in a relational manner.

* Remember that the information you will be hearing in this context will be very difficult for them to talk about, and it will have taken a lot of courage for them to disclose at this level, so you must treat the person in an empathic manner with a great sense of integrity, authenticity and respect.

* It is imperative that you do not lead the client to the conclusion that they are being, or were, abused. For example, do not put thoughts into the client's head.

* If there is a risk to the person, or you are not sure if there is a risk to the person, it is imperative you speak to a personal supervisor as soon as possible to discuss the situation fully. And the situation needs to be recorded in your own notes.

* If there is a risk you may need to disclose – dependent on level of risk, ie if you

think they are of harm to themselves or other people, you will need to disclose this immediately. If there is no immediate risk, then discuss it at your next scheduled personal supervision.

* In your personal notes, vis a vis your client, this must be recorded as said above, even if you choose not to take this to your supervisor. However, it is highly recommended that you do take all considerations to your supervisor.

* You must note all actions you have taken in your client records, and you must tell your supervisor about them, providing dates and times for each action.

If the client discloses, they are abusing:

* You should gently check what you have heard to ensure you have understood it correctly, and you should remind them of the contracting about confidentiality and its limits.

* Try to get them to take the appropriate action, for example, with your support contacting the police.

* You must disclose the information being given to you and make this clear to your client.

* If the risk is significant and imminent, you must immediately disclose it to social services or the police.

* Offer to continue to support the client through the ongoing therapy if appropriate and safe to do so.

* If you no longer feel safe working with the client, seek advice from your supervisor.

* Please make sure that you take notes of all appropriate actions and discussions with your client, supervisor, and safeguarding lead.

If the client discloses that a Third Party is Abusing:

* First, gently check what you have heard to ensure you understand correctly.

* Try to get them to take appropriate action.

* If they are prepared to take appropriate action speak to your supervisor as soon as possible.

* In your client notes, you need to record all discussions with the client, supervisor

SUICIDE AND SELF HARM FRAMEWORK

This document has been informed by the BACP Information Sheet P7 Working With Suicidal Clients.

When working with clients who present with a wide variety of issues, such as depression, anxiety, stress, repression of feelings, hopelessness, and a feeling of helplessness in the world and indeed in their levels of functioning, you may well find as the therapeutic sessions evolve that sitting underneath these presenting issues the client may report feelings/thoughts of suicide/suicidal idealisation.

Suicidal Idealisation

This is when clients may have fantasies, dreams or even imaginations of the ideas of what it's like to take their own life and indeed may have whole thought processes on how their suicide may impact other people around them. More often than not, when people report suicidal idealisation, it does not mean that they are then going to go and take their life. However, reporting of this to yourself is important and must be taken extremely seriously by yourself. This is where supervision is imperative.

The Threshold Model

The threshold model shows how different types of risk and protective factors interact to produce a threshold for suicidal behaviour for the individual. The different types of factors are:

1. **Long-term predisposing risk factors**

That can be present at birth or soon after birth identify people in risk groups.

Genetic or Biological Influences:

(a) Family history of suicide or attempted suicide

(b) Family history of depression

(c) Family history of alcohol or other substance misuse

2. **Personality Traits**

Rigid thinking characterized by patterns of thought that are difficult to change.

Black and white thinking or “nothing thinking”

Excessive perfectionism, where high standards are causing distress to the person or others.

Hopelessness with bleak and pessimistic views of the future

Impulsivity, tending to do things on the spur of the moment

Low self esteem with feelings of worthlessness

3. **Short Term Risk Factors**

Environmental Factors:

(a) Divorced, separated of widowed

(b) Being older and/or retired

(c) Having few social supports

(d) Being unemployed

Psychiatric Diagnosis

The three psychiatric disorders most strongly correlated with suicide are:

* depression
* Substance misuse (including alcohol)
* Schizophrenia

4. Precipitating Factors

These are events that may tip the balance when a person is at risk. They include:

* High stress/life crises
* Divorce
* Imprisonment or threat of imprisonment
* Recent job loss
* Recent house move
* Recent loss or separation
* Unwanted pregnancy
* Interpersonal problems

Managing Suicide Risk

Managing suicide risk in many ways comes with the territory of risk assessment and management techniques will differ depending on the assessed level of risk. For example, if your risk assessment is low then the management techniques will differ from working with a high assessment risk.

Low Risk to High Risk (in Ascendency with 1 being Low risk and 7 being High risk):

1. If a risk is low, maintain usual contact/sessional arrangements.
2. A therapeutic approach is useful in promoting contact and encouraging the client to take a shared responsibility for their future care and safety.
3. If you are concerned or anxious talk to your Supervisor (do not wait necessarily for your next booked supervision session).
4. Use the person's existing support system by encouraging them to engage with their contact/friends/family.
5. As said earlier, if you believe the risk is more urgent contact your Supervisor as soon as possible
6. If they are the high end of suicide risk contact the Supervisor immediately to work out an action plan with regards to future sessions.

7. The same as above – immediate contact with your Supervisor and immediate plans may need to be implemented, such as an urgent mental health assessment or even a 999 call.

Conclusion

(a) Always be aware of suicide risk.

(b) It is vital to keep good and accurate records.

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Part 2

SAFEGUARDING POLICY STATEMENT – CHILDREN

This safeguarding policy was drawn upon the basis of legislation, policy and guidance that seeks to protect children and young people in England. A summary of the key legislation and guidance is available from: **nspcc.org.uk/childprotection**

The purpose of this policy statement is to protect children and young people who access therapy at Ian Cartwright CFT.

We believe that:

* children and young people should never experience abuse of any kind.
* we have a responsibility to promote the welfare of all children and young people to keep them safe, and to practice in a way that protects them.

We recognise that:

* the welfare of the child is paramount.
* all children, regardless of age, disability, gender reassignment, race, religion or belief, sex, or sexual orientation, have a right to equal protection from all types of harm or abuse.
* some children are additionally vulnerable because of the impact of previous experiences, their level of dependency, communication needs or other issues.
* working in partnership with children, young people, their parents, carers and other agencies is essential in promoting young people's welfare.

We will seek to keep children and young people safe by:

* valuing, listening and respecting them.
* appointing the appropriate child protection/safeguarding lead.
* Sharing and developing child protection and safeguarding policies to reflect best practice.
* using our safeguarding procedures to share concerns/relevant information with agencies who need to know. Involving children and young people, parents and carers, appropriately.

* Using our procedures to manage any allegations appropriately.
* Ensuring that we have effective complaint policies in place.
* Ensuring that we provide a safe physical environment for our children, young people, and therapists, by applying health and safety measures in accordance with the law and regulatory guidance.
* Recording and storing information professionally and securely.

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Appendix

Abuse is always wrong; reporting it is always right.

Who to contact: Safeguarding in York

For safeguarding concerns with adults:

The City of York Council has an excellent website.

https://www.safeguardingadultsyork.org.uk/

CITY OF YORK Safeguarding Adults Board

If you would prefer to speak to someone or report information **anonymously,** you can:

Contact the City of York Adult Social Care,

- Telephone: 01904 555111, Monday to Friday, 8.30am to 5.00pm
- Text telephone: 07534 437804 if you're hearing impaired
- Telephone: 0300 131 2131 for out of hours help

For safeguarding concerns with a child:-

https://www.york.gov.uk/ChildProtection

Child protection and safeguarding
The Multi-Agency Safeguarding Hub (MASH) is a single point of contact for all concerns about children and ensures that children receive the right level of support.

Reporting child abuse
If you're concerned about a child or young person, you must contact the MASH team. If there are immediate concerns about the safety of a child, you should contact North Yorkshire Police on 999

Contact MASH Monday to Friday, 8.30am to 5.00pm:

- telephone: 01904 551900
- email: **mash@york.gov.uk**

Contact MASH Early Help Team to make an early help referral or access advice:

- telephone: 01904 551900
- email: **earlyhelp@york.gov.uk**

Outside office hours, at weekends and on public holidays, contact the Emergency Duty Team

- telephone: 0300 131 2131
- email: **edt@northyorks.gov.uk**

City of York Safeguarding Children Partnership

The City of York Council has pulled together a partnership of professionals to safeguard children and young people. https://www.saferchildrenyork.org.uk/

Police	**National** Non – emergency 101 Emergency 999 Ask for Child Protection Unit – 24 hours
NSPCC Help line	Tel: 0800 800 500 – 24 hours, Freephone
Child Line (NI)	Tel: 0800 1111 - Freephone

PROCEDURE FOR REPORTING ALLEGATIONS OR SUSPICIONS OF ABUSE with children and/or vulnerable adults

Any information that is written on to a disclosure form should be:

- Factual and not opinion based.
- Legible.
- Accurate.
- Signed and dated.

The person completing the form should remember that it may be used as evidence if the report results in a criminal trial or the removal of a child from their family.

In any case where an allegation is made a record should be made.

Details must include, as far as practical:

- Name of child/young person /vulnerable adult
- Age
- Home Address (if known)
- Address where the incident took place
- When the abuse occurred
- Date of Birth (if known)
- Name/s and Address of parent/s or person/s with parental responsibility
- Telephone numbers if available
- Is the person making the report expressing their own concerns, or passing on those of somebody else? If so, record details
- What has prompted the concerns?
  Include dates and times of any specific incidents
- Has the client been spoken to?
  If so, what was said?
- Has anybody been alleged to be the abuser?
  If so, record details

- Who has this been passed on to, in order that appropriate action is taken? e.g. school, designated officer, social services etc

- Has anyone else been consulted?

  If so, record details

  Name of person making the report ……

  Dated ……..

ACTION TAKEN

Supporting Guidelines when reporting a concern

These guidelines refer to working with a child but may also be applicable if the concern is regarding a vulnerable adult.

It is important to ensure that any information given by a child is recorded in their own words, exactly as it was said at the time. The information should also contain details about what was happening at the time of the disclosure, where the disclosure took place and if there was anything happening prior to the disclosure that may be relevant.

If possible, particular details about when abuse has taken place should be recorded if this information has been given. For example, was it a one-off incident that took place in a public area or was it in the home of the child or the home of the alleged abuser?

Other useful information to record includes when the alleged abuse occurred, for Example: was it during the day, at night-time, yesterday, a week ago, or months ago? As well as this, a child may disclose if they were alone with the alleged abuser or if they were with other people; any information like this should be noted as part of the report.

Children may mention that they have already told someone else about what happened, and that person may or may not have taken action to make a report. Regardless of whether someone else has reported the information though, the person listening to the disclosure should always take action themselves because the more evidence that can be given about the incident, the more likely that the best outcome in terms of what to do in response can be achieved.

Any information a child gives should be of their own volition, and the person hearing the disclosure should never press the child for more information or ask questions that could lead to exaggerated or false information.

Body Maps

A body map is used to record information about any kinds of physical injuries that a child has sustained as a result of abuse. The map acts as a visual record and help professionals and agencies to work together in determining whether or not there is a safeguarding concern

Any person who completes a body map should remember that it is not a replacement for a medical assessment. If there is any concern about the physical injuries that are recorded on the body map, the child must be attended to by a medical professional.

Details that should be recorded on a body map include:

- Information about the person who noticed the injuries on the child, when they noted them and what their relationship is to the child in question.
- Details of specific injuries – where they are, what they look like, their colour, shape, size and condition.
- Whether the injury seems to be healing or getting worse.
- Whether the child is showing distress about the injury.
- Information about how the injury was sustained.
- Information about what a child or their parent says about the injury.

Information on a body map, just like with a disclosure report form, should be factual and accurate and the information should be signed and dated by the person who has completed it.

See sample body map below