**Child Abuse linked to Faith or belief (CALFB)**

**1.** **1 Introduction**

The belief in “possession or “witchcraft” is widespread. It is not confined to particular countries, cultures or religions, nor is it confined to new immigrant communities in this country.

The definition which is commonly accepted across faith–based organisations, non-governmental organisations and the public sector is the term ‘possession by evil spirits’ or ‘witchcraft’.

Any concerns about a child which arise in this context must be taken seriously.

**2.** **1 The Child**

The number of known cases of child abuse linked to accusations of “possession” or “witchcraft” is small, but children involved can suffer damage to their physical and mental health, their capacity to learn, their ability to form relationships and to their self-esteem.

Such abuse generally occurs when a carer views a child as being “different”, attributes this difference to the child being “possessed” or involved in “witchcraft” and attempts to exorcise him or her.

A child could be viewed as “different” for a variety of reasons such as, disobedience; independence; bed-wetting; nightmares; illness; or disability. There is often a weak bond of attachment between the carer and the child.

There are various social reasons that make a child more vulnerable to an accusation of “possession” or “witchcraft”. These include family stress and/or a change in the family structure.

The attempt to “exorcise” may involve severe beating, burning, starvation, cutting or stabbing and isolation, and usually occurs in the household where the child lives.

Any siblings or other children in the household may be well cared for with all their needs met by the parents and carers. The other children may have been drawn in by the adults to view the child as “different” and may have been encouraged to participate in the adult activities.

**3.1** **Concerns**

Concerns reported in the cases known from research usually involve children aged 2 to 14, both boys and girls, and have generally been reported through schools or non-governmental organisations. The referrals usually take place at a point when the situation has escalated and become visible outside the family.

Note: This means that the child may have been subjected to serious harm for a period of time already.

The initial concerns referred have been about:

* Issues of neglect such as not being fed properly or being ‘fasted’, not being clothed, washed properly etc. but left to fend for themselves especially compared to the other children in the household;
* Often the carer is not the natural parent and the family structure can be complex;
* Children often appear distressed and withdrawn;
* The child is seen as the scapegoat for a change in family circumstances for the worse;
* In a group of children it may be the child who is relatively powerless vis-a-vis the parents/carers, maybe a child with no essential role in the family;
* The child is seen as someone who violates the family norms by being physically different perhaps because of illness, disability or, in some cases, a suspicion by the father of adultery by the mother.

All agencies should be alert to the indicators above and should be able to identify children at risk of this type of abuse and intervene to prevent it by using the procedures for Referrals, and, when appropriate, Strategy Discussions/Meetings.

A child at risk of or suffering abuse linked to spiritual and religious beliefs may also be at risk of honour based abuse. Extreme caution should be taken in sharing information with any family members or those with influence within the community as this may alert them to your concerns and may place the child in danger.

If you have concerns that a child is at risk you should contact Children’s Services and/or West Yorkshire Police without delay:

Children’s Services:  01484 456848   
West Yorkshire Police: 101 or in urgent cases dial 999

**4.** **Assessments**

All referrals must be responded by Children’s Social Care Services with a thorough Assessment and, depending on the seriousness of the referral information, a Strategy Discussion which takes into account the dimension of the beliefs expressed by the child and family. The assessment should involve the particular faith group or person performing or advising the family about the child in order to establish the facts i.e. what is happening to the child.

Careful assessment at all stages is needed with close communications, which include key people in the community especially when working with new immigrant communities and with all the various faith groups, are essential.

In view of the nature of the risks, a full health assessment of the child should take place to establish the overall health of the child, the medical history and current circumstances.

Any suggestions that the parent or carers will take the child out of the country must be taken seriously and legal advice sought regarding possible prevention.

The child must be seen and spoken to on his or her own. The child’s bedroom or sleeping arrangements must be inspected.

Although research has found a number of parents and carers to have some form of mental health problem, this must not distract from the child’s situation nor be seen as a factor to explain away the potential risks to the child.

In assessing the risks to the child, the siblings or any other children in the household must also be considered as they may have witnessed or been forced to participate in abusive or frightening activities.

Further contacts for advice can be found from the local representatives for some faiths, from organisations such as the [Churches’ Child Protection Advisory Service (CCPAS)](http://trixresources.proceduresonline.com/nat_cont/contacts/ccpas.html) who provide information about exorcism and others.

This protocol requires any professional who considers that a child is at risk of abuse linked to faith or belief (CALFB) to make a referral to Children's Social Care.

3.2 The referrer should treat Children's Social Care as the first point of contact. They have a 24/7 service that deals with all requests for a Children's Social Care service.

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|  | **Kirklees Children’s Social Care – Tel: 01484 414960**  **Kirklees Children’s Social Care – out of hours Tel: 01484 414933**  **Other area contact details here** |
| 3.3 | **Informing the Parents/Carers and Obtaining Consent**  It would be expected that, in most cases, the professional will inform parents/carers of their intention to make a referral and obtain their consent to do so. However, in judging whether or not to inform the parent/carer that a referral is to be made, the professional who has identified the suspected abuse must consider the possibility that to do so may increase the level of risk to the child. In this instance the professional does not need to obtain consent to make a referral.  If the professional concludes that informing the parent/carer may increase the level of risk to the child, they should consult with Children's Social Care or the child’s allocated Social Worker before speaking to the parent in order to obtain advice.  **In all cases, Children's Social Care should be advised if the parents or carers are aware of the referral.** |
| 3.4 | Prior to making the referral, the professional should ensure that they have sufficient information. This includes basic details such as name, date of birth, address, contact telephone number etc. as well as details of parents/carers/siblings and any other relevant background information that is known at the time.  Upon identifying a concern, there should be no delay in making a referral to Children's Social Care. |
| **4** | **Action to be taken by Children’s Social Care** |
| 4.1 | Referrals made to Children's Social Care under this protocol will always be deemed to be **high priority** due to the vulnerability of the child concerned. |
| 4.2 | Where a referral is made to Children's Social Care they will first check existing records to ascertain if the family is currently in receipt of a service. If this is found to be the case, the information will be recorded in detail on the electronic system and passed **immediately** to the responsible Social Worker or Team Manager, unless the referral is made out of hours, in which case the out of hours duty Social Worker will make an immediate assessment of risk. |
| 4.3 | If the child or family are **not** already in receipt of a service, Children’s Social Care will follow safeguarding children procedures and record the information as a **high priority** referral. This referral will then be transferred to the appropriate team for a multi-agency investigation. |
| 4.4 | In all cases, Children's Social Care must confirm that the information/referral has been received by either the allocated Social Worker or Team Manager. This will require direct communication, and **is to ensure that there is no delay in the information or referral being actioned**. If neither is able to confirm receipt of the referral, Children's Social Care should liaise with another Team Manager to ensure that the referral is received and responded to. |
| 4.5 | Following receipt of a referral under this protocol a strategy meeting /discussion must be held with Children’s Social Care the Police Safeguarding Unit and a Health professional in order to consult and plan any future assessment. Confirmed cases of CALFB made under this protocol must progress to an Enquiry under S47 Children Act 1989. This will determine whether the child has suffered or is likely to suffer significant harm. Multi-agency safeguarding procedures must be followed from the point of referral. |
|  | **West Yorkshire Consortium Safeguarding Children Procedures in relation to Strategy Meetings and Discussions can be found at:**  [West Yorkshire Consortium Safeguarding Children Procedures](http://www.proceduresonline.com/westyorkscb) |
| 4.7 | Strategy Meetings / Discussions should also involve any other agency that may hold information about the family, as far as is practicable given the time of the referral. |
| **5** | **Referrals Made Outside Office Hours – the role of Children’s Social Care** |
| 5.1 | In cases where information is received outside normal office hours, Children's Social Care will be required to begin the process of a conducting **a strategy discussion**, regardless of whether the child or family has an allocated Social Worker already.  **It is not acceptable to allow the matter to wait until normal office hours have resumed.** |
| 5.2 | In cases where Children's Social Care commences a Section 47 Enquiry, this will transfer to the appropriate team who will undertake multi-agency information gathering when normal office hours have resumed. The transfer will involve direct communication between Children's Social Care and Social Worker or Team Manager, and will require full records to be entered onto the electronic system by Children’s Social Care without delay. |
| **6** | **West Yorkshire Police** |
| 6.1 | Where information relating to a suspected or actual CALFB is received by West Yorkshire Police from another source, Child Safeguarding officers will themselves refer the matter to the Children’s Social Care and participate in a Strategy Meeting /Discussion. |
| 6.2 | On the basis of this Strategy Meeting / Discussion, a plan for the investigation of the suspected abuse will be developed jointly, in line with the West Yorkshire Consortium Safeguarding Children Procedures |
| **7** | **The Paediatric Assessment** |
| 7.1 | The examining Paediatrician will participate in all Strategy Meetings /Discussions that are initiated in line with this Protocol. |
| 7.2 | Where information relating to actual or suspected CALFB is received by a member of the Paediatric team they will themselves refer the matter to Children's Social Care and participate in a Strategy Meeting / Discussion, along with the Police. |
| 7.3 | All children referred to Children's Social Care under this protocol **must have a medical assessment**. The medical assessment should be carried out by a Paediatrician with the appropriate training, competencies, and supervision as per *Safeguarding Children and Young People: Roles and Competencies for Health Care* *Staff (RCPCH 2014).* |
| 7.4 | The Paediatrician should arrange for additional medical investigations if the circumstances warrant this. The Paediatrician will provide a verbal opinion at the time of the medical assessment, which will be followed up in writing within 72 hours, unless it has agreed that it will be sooner. If the social worker, upon receipt of the report, is unclear about the medical opinion, they must contact the Paediatrician to clarify this. |
| 7.5 | Wherever possible, a member of Children’s Social Care staff should attend the examination. If the family is already known to social care then a worker who is familiar with the family should ideally attend. However in cases where this is not possible e.g. with a family who are not previously known to Children's Social Care, the worker(s) attending with the family should be familiar with the referral that has been made and the nature of the suspected abuse etc. |
| **8** |  |
| 8.1 | The key principle of this protocol is that when a child has suffered abuse as outlined in this document, decisions should **not** be made by a single agency. As a minimum, decisions should be made by a group consisting of **Social Worker, Police Officer and Paediatrician or appropriate Health Care Professional.**  This protocol does not seek to remove or undermine professional judgement, but rather to support it (and encourage professional challenge where appropriate) in a multi-agency environment to ensure the best outcomes for children and families. |
| 8.2 | At the close of the Section 47 Enquiry, Children's Social Care should have made an assessment in relation to whether the child has suffered or is likely to suffer significant harm. This assessment should have been developed in full consultation with all relevant partner agencies. |
| 8.3 | In some cases, the outcomes of the Section 47 Enquiry may not be clear for example, the findings of the Paediatric medical assessment may be inconclusive or agencies may hold differing views about the level of risk. In such cases a further Strategy Meeting / Discussion should be convened and chaired by a Team Manager or Advanced Practitioner from Children's Social Care in line with West Yorkshire Consortium Safeguarding Procedures. The process of bringing the relevant professionals together to discuss the case may contribute to better assessment and outcomes. |
| 8.4 | This assessment will inform the action to be taken by Children's Social Care and/or West Yorkshire Police. |
| 8.5 | Where there is professional disagreement the case should be referred to relevant managers or equivalent for resolution in line with [West Yorkshire Consortium Procedure for Resolving Professional Disagreements or your local escalation procedures.](http://westyorkscb.proceduresonline.com/chapters/p_res_profdisag.html) |
| 8.6 | Children's Social Care should also ensure that the outcomes of the Section 47 Enquiry are shared with the family (unless to do so would place the child at increased risk) and all relevant partners. |
| 8.7 | In all agencies, the outcomes of the **strategy discussion and or** Section 47 Enquiry should be recorded in detail. This is particularly important where a decision is taken that no further action is required to protect the child. |
| **9** | **Timescales** |
| 9.1 | It is expected that all referrals under this protocol will be responded to, and assessment commenced on the same day that the referral is received. If this is not possible, then arrangements should be made for assessment to commence at the start of the following day at the latest. **In all cases, a Strategy Meeting / Discussion and Paediatric Medical Assessment should have been undertaken within 24 hours of receipt of the referral.** |