

National Guideline for The Management of Child Abuse and Neglect

A Multi-Sectoral Approach





Ministry of Health
Ministry of Education
Ministry of Justice
Ministry of Child Development and Women's Affairs
Attorney Generals Department
Children and Women's Bureau of Sri Lanka Police



Sri Lanka College of
Paediatricians



College of Forensic
Pathologists of
Sri Lanka



Sri Lanka College of
Psychiatrists
of Forensic Pathologists
of Sri Lanka



Medico-Legal Society of
Sri Lanka



Plan Sri Lanka

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STATEMENT OF INTENT

The intention of developing the National Guideline for the Management of Child abuse and Neglect, is to provide a more systematic, well integrated and well directed management and follow up plan for the victims of child abuse and neglect in Sri Lanka. Ultimate expectation is to minimise the short term and long term, physical, psychological and social adverse effects of child abuse and neglect. This guideline is not intended to be construed (understood) or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data for an individual case and are subject to change as scientific knowledge and technology advance and the patterns evolve.

These parameters of practice should be considered recommendations only. Adherence to them will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same result. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor in light of the clinical data presented by the patient and the diagnostic and treatment options available.

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Message from the Hon. Minister of Health

Sri Lanka has achieved significant progress in the Human Development indices and is in the leading position in the Asian region. The rapid development led by the health sector together with progress of education, social welfare, economy and infra-structure facilities have contributed towards this position. The benefits of this development have reached all social strata including men, women and children even in remote communities.

Due to the complexity and rapid changes in the socio-economic and cultural processes, unfortunately we have to witness the incidents of harassment and violence against women and children. It is the duty of all the responsible citizens to prevent and support those who have experienced such unfortunate incidents.

I am glad to forward a message for the National Guideline for the Child Abuse and Neglect which has been compiled to achieve the objectives of better management of abuse and neglect against children. I appreciate the key role played by the professional bodies of the Sri Lanka College of Pediatricians, forensic pathologists, psychiatrists and the Medico-Legal society in this valuable endeavor.

It is obvious that the Ministry of Child Development and Women's Affairs and its subordinate agencies of the Department of probation and Child Care Services and the National Child Protection Authority, Ministries of Justice and Education, Departments of the Attorney General and Sri Lanka Police have collaboratively worked under the guidance of respective ministers, secretaries and departmental heads.

All the stakeholders have gone through a comprehensive discourse on Multi-Sectoral Management to ensure the best interests of the children. The significance observed is that everybody has agreed upon common process and procedures in dealing with the issues of victimized Children, their rehabilitation and re-integrating.

I appreciate the coordination made by College of Pediatricians and Plan Sri Lanka in producing this valuable document.

I wish all the best for the successful implementation of the guideline with a high level of coordination, mutual understanding and commitment of all the relevant stakeholders to ensure a better future for the Sri Lankan Children.

Maithripala Sirisena,
Minister of Health
September 2014

Message from Secretary Ministry of Justice

I take much pleasure in congratulating all the senior professionals and professional organizations which have collaborated with the Ministries of Health, Education, Justice and Child Development & Women's Affairs to produce these Multi-Sectoral Guideline for the Management of Child Abuse and Neglect.

The essential focus of this challenging exercise is to give priority to the needs of child victims through an orderly and principled process. The protracted journey that they must now take from police stations to hospitals, magistrate's courts and remand homes involves many service providers having different levels of competencies. Marshalling the resources available for responding to the most important needs of children requires both leadership and a change of perspective to see things through the eyes of these children.

The common duty imposed on all professionals attending to these children is laid down clearly in sec. 5(2) of the ICCPR Act No. 56 of 2007 and it deserves repetition here:

In all matters concerning children, whether undertaken by public or private social welfare institutions, courts, administrative authorities or legislative bodies, the best interests of the child shall be of paramount importance.

This section controls the interpretation of all powers and duties exercised by any of the above-named functionaries to cast their work in a new light. In the case of caring and helping professionals like doctors and counselors providing therapeutic support there is no question at all as to their prime objective. This is the best interests of the child. It is when understanding the ambit of duties of officers of state who investigate facts, prosecute and judge cases of child abuse within the criminal justice system that this section directs that those duties cannot cut across the interests of the child who is the subject of those proceedings. In this way the law has recognized the dangers of secondary victimization, and safeguarded children against it, once they are removed into the care of the State. This harmonizes the special interests of the state in the development of the child with the specific objectives of the criminal justice system as far as the administration of justice is concerned. This common principle provides the legal foundation for multi-sectoral work relating to child victims of abuse and neglect today. It is my sincere wish that all professionals will work to build on it and strengthen the care and protection that is due to these children.

Kamalini De Silva
Secretary
Ministry of Justice

Message from the Secretary of the Ministry of Child Development & Women's Affairs

At the very beginning let me thank the Sri Lanka College of Paediatricians and Plan Sri Lanka for paving way to this important forum where arrogance of individual institution is suppressed for a better integrated institution arrangement with proper coordination for the management of child abuse and neglect. I think this approach itself is a good practice for many other fields of activities. Multi-sectoral management is the key word here. This word itself is an achievement. In many fields we fail as a result of our institutional subjective attitudes towards the real problems of people.

Here this College, a centre of excellence, which is no doubt an Academy with world class consultants, with their modern knowledge, is essential to overcome our social problems, has come forward to cultivate the seeds of corporative and participatory multi-sectoral institutional and organizational culture.

I think the social problem, whether they are abuses or other various crimes, poverty, inequality, marginalization etc. are bigger than individual institutions or individual disciplines. That is why we need a multi-sectoral approach through which many partners overcoming their institutional limitations can come forward for the benefit of the victims of various social ills. In terms of modern or post-modern philosophy of humanities, an institution itself is a power relation and it extends power over people. The famous French thinker, Michel Foucault in his landmark works, i.e. *The Birth of Clinic, Discipline and punishment* and also *Madness and Civilization* said that “discipline victimized people even by treatment”. There is a carceral role to every institution, which creates its own limitations. Therefore, multi-sectoral approach is needed to avoid people from victimization and re-victimization in the process of treatment and care.

Western Musicology and Aesthetics give the best example for the multi-sectoral behaviour. Western music is basically polyphonic. There each musician in the orchestra plays his or her own musical line and in the end it creates a beautiful polyphonic musical achievement. In literature also we find polyphonic and the existence of many voices, especially in the novels of Dostoevsky. There in the characters have their own individual voices but they are culminated as a common voice of the novel.

Therefore, today you are here with the participation of the representatives from many sectors including Justice, Medicine, Child Development and Protection, Probation, Education, Social Activism etc. are launching a very important discipline, which will be an effective medicine for our chronic institutional illnesses where human subjects are being victimized and re-victimized as a result of our own limitations.

With the collaboration contribution for the preparation of guideline and implementation of them on a pilot basis in the beginning will be able to serve for the real needs of the children who are abused and neglected.

Eric Illayapparachchi

Secretary, Ministry of Child Development & Women's Affairs

Message from the Country Director of Plan Sri Lanka

It gives me great pleasure in saying a few words about the National Guideline for The Management of Child Abuse and Neglect that has been developed to support better child protection systems and structures in the country so that children can enjoy a safe and productive life ahead. I am particularly happy that as a child centered international development organization Plan Sri Lanka, was able to work closely with the Ministry of Child Development and Women's Affairs, Sri Lanka Colleague of Pediatricians, and the relevant stakeholders in child protection and development in the country to adopt and mainstream a multi-sectoral approach to dealing with cases of child abuse and neglect.

In 2012, Plan Sri Lanka started working with the medical authorities, practitioners and community to strengthen a management process that ensures all responsible stakeholders are working together so that children subject to abuse are properly care for, and are adequately prepared for return to their homes and communities. The process is designed to reduce to a minimum mental scars caused by the abuse.

In this respect, Plan Sri Lanka and the Sri Lanka College of Pediatricians facilitated extensive discussions around strengthening multi-sectoral management of child abuse and neglect. This was followed by a multi stakeholder forum organized with representatives from the Ministries of Health, Education, Child Development and Women's Affairs, and the Sri Lanka Police along with Plan Sri Lanka, to discuss prevention and response issues in detail and agree upon concrete actions. This National guideline is indeed the results of the joint work.

Plan Sri Lanka with its 33 year long history in working with the most remote and marginalized communities in the country has implemented and facilitated processes, systems and projects that ensure the safety of children in their homes, community and the school. Plan's work has benefited hundreds of parents, care givers, officers that work on child protection. It has further reminded and refreshed the important role of the family in protecting their children, while working hand in hand with the national and provincial governments to facilitate systems, policies and best practices that continue to keep the safety of children at the centre.

I once again appreciate all the hard work put in by the team of authors, the support received from the respective ministries and departments, and my colleagues in Plan that work tirelessly in supporting this initiative.

Supriyanto
Country Director, Plan Sri Lanka

Message from the President Sri Lanka College of Paediatricians

Child abuse and neglect are issues facing children the world over. Sri Lankan children are no exception. Reported cases are increasing but are often handled in a less than appropriate way.

At present, there is no official guide to help health care workers and other professionals involved, to manage a suspected victim efficiently, within the correct medico-legal framework. Hence this initiative is timely. This guideline which will be available in all 3 languages will definitely improve handling of suspected victims.

I congratulate Prof. Asvini Fernando and the members of the Child Protection Committee for initiating the excellent project titled 'Creating Safe Communities for Children'. What constitutes child abuse is debated even among parents and teachers. Children also need to be made aware of their rights. The preventative aspect of this project will ensure more awareness of this problem amongst both these groups. The Guideline will, undoubtedly, strengthen the second arm of the project, which is the better management of the victims.

On behalf of the Sri Lanka College of Paediatricians I wish to thank all the representatives of the guideline development committee from the different sectors – The Sri Lanka College of Psychiatrists, College of Forensic Pathologists of Sri Lanka, the Medico-legal Society of Sri Lanka, Ministries of Child Development and Women's Affairs, Health, Justice and Education and the Attorney General's Department and the Women's and Children's Bureau of the Sri Lanka Police. I would also like to extend my sincere thanks to Plan Sri Lanka for collaborating with the Sri Lanka College of Paediatricians in this timely project and for their generous funding.

Prof Dulanie Gunasekera
President
Sri Lanka College of Paediatricians

Preface

There has been an increase in the number of reported cases of child abuse and neglect in the country over the past few years. This may be a true increase in incidence or a reflection of increasing awareness of the problem amongst the general public. It is heartening to note that more child victims are now being presented to the system for appropriate intervention. All stakeholders involved in the management of these victims need to make a concerted effort to sustain the present trend in reporting and to improve the management of the victims of abuse.

Taking these facts into consideration the child protection committee of the Sri Lanka College of Paediatricians decided that it had an important role to play in protecting the rights children throughout the country. The committee ventured on a project titled 'Creating Safe Communities for Children.' This project had two main objectives: prevention of child abuse and neglect and the better management of victims. In keeping with second objective the members of the child protection committee together with Plan Sri Lanka commenced a journey to develop a nationally accepted guideline for the management of child abuse and neglect. The intention of the guideline was to provide a more systematic, well integrated and well directed management and follow up plan for the victims of child abuse and neglect in Sri Lanka. Ultimate expectation is to minimise the short term and long term, physical, psychological and social adverse effects of child abuse and neglect.

A child victim presenting to the system in any part of the country, should receive a holistic management package unlike the rather ad-hoc management that occurs at present. Being cognizant of the multidisciplinary nature of the management of the problem in the health sector a workshop titled Strengthening the Multidisciplinary Management of Child Abuse & Neglect was held at the Annual Sessions of the Sri Lanka College of Paediatricians in 2012. Members of the other three main professional bodies involved with the management of victims in the health sector - Sri Lanka College of Psychiatrists, College of Forensic Pathologists of Sri Lanka and the Medico-legal Society of Sri Lanka were invited for the workshop. The roles of each of the health specialties were defined and co-ordination between specialties was strengthened.

The management in the health sector needed to be integrated with the other professionals involved in management of victims. The second step was to invite all other sectors to a workshop on the Multi-sectoral Management of Child Abuse and Neglect. This was held in November 2012. In addition to the members of the four professional bodies the Ministries of Child Development and Women's Affairs, Health, Justice and Education and the Attorney General's Department and the Women's and Children's Bureau of the Sri Lanka Police participated. A guideline development committee was formed with representatives from all the sectors and several meetings and discussions followed.

The result of this venture blossomed into the document titled – ‘National Guideline for the management of child abuse and neglect – a multi-sectoral approach.’ The Guideline was launched on 4 December, 2013 by the Honourable Minister of Health, Maithripala Sirisena. It has now been formatted and re-printed in a more user friendly manner and will be released at the launch of the pilot project of Creating Safe Communities for Children in the Gampaha District.

A task such as this is enormous due to the several sectors that come into play in the management. However, due to the ready, unstinted cooperation and enthusiasm rendered by all sectors and unifying commitment by all to the well being and the welfare of the children of this land, this task was made easier than anticipated. Each and everyone contributed wholeheartedly towards the cause.

I wish to acknowledge with thanks the contribution by all involved in the process and Plan Sri Lanka for the collaboration and funding of the project. The dream of the child protection committee became a reality due to these efforts. The book will be available in all three languages and it is hoped that this Guideline will be followed by all sectors for the integrated management of victims.

Attainment of our common goal will be judged with time. Let’s hope that the venture will make a difference towards making a better tomorrow for the child victims of Sri Lanka.

Prof. Asvini D Fernando
Chairperson, Child Protection Committee
Sri Lanka College of Paediatricians
September 2014

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CHAPTER

01

INTRODUCTION

A child is defined as a person less than 18 years according to the United Nations Convention on the Rights of the Child (See annexure 1). The Sri Lankan Government ratified the convention in 1991, thus affirming its commitment towards promoting wellbeing of the children of our country.

Children need to be loved, nurtured and protected at all times, to achieve their full growth and developmental potential. If children are subjected to abuse and neglect, they will bear long lasting physical and psychological scars. It will undermine their development and prevent them achieving their true potential.

THE ISSUE

Children may be abused by acts of commission or of omissions of caretakers leading to exposure to unnecessary suffering and actual or potential damage to their health and development.

According to the World Health Organisation (WHO), Child abuse and

neglect or Maltreatment constitutes all forms of physical and/or emotional ill treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in a context of a relationship of responsibility, trust or power (1999).

Several different types of child abuse and neglect are recognized,

» Physical	
» Sexual	
» Emotional	
» Neglect	
» Exploitation	<ul style="list-style-type: none"> • Child labour • Child trafficking • Intentional drugging and poisoning • Munchausen syndrome by proxy • Conscription of children to armies

Types of Child Abuse

Physical Abuse

Physical abuse maybe the result of:

- » a deliberate attempt to hurt the child or
- » an attempt to discipline the child

Examples for the modes of physical abuse includes hitting, beating, kicking, shaking, biting, slapping, kneeing, drowning, burning, exposure to electrical shock etc.

Sexual abuse

Sexual abuse is defined as, involvement of dependent, developmentally immature children & adolescents in sexual activities:

- » that they do not truly understand,
- » to which they cannot give informed consent
- » which violate accepted social norms and family roles
- » which are against the law

Child sexual abuse can be divided into categories based on,

- » Physical activity (touch)
 - e.g.:** asking or pressurizing a child to engage in sexual activities, physical contact with the child's genitals, breasts or mouth, actual sexual act with a child
- » No actual physical activity (non-touch)
 - e.g.:** viewing of the child's genitalia without physical contact, indecent exposure of the adult's genitals, using a child to produce child pornography, selling sexual services of children, displaying pornography/pornographic videos

Emotional abuse

Emotional abuse is the failure to provide a developmentally appropriate, supportive environment to a child.

Emotional abuse includes constant belittling & blaming, shaming, routine labeling and humiliating a child, calling names and making negative comparisons to others, telling a child that he or she is “no good”, “worthless”, “bad” or “a mistake”, frequent yelling, threatening or bullying, inappropriate or excessive demand, e.g. “You have to become the 1st in class this term”, Ignoring or rejecting a child as punishment and withholding communication, limited physical contact with the child – no hugs, kisses or other signs of affection, exposing the child to violence or the abuse of others, whether it is the abuse of a parent, a sibling or destruction of personal belongings.

Neglect

Neglect is the failure to provide for the development of the child in all spheres: health, education, emotional development, nutrition, shelter, and safe living conditions, in the context of resources being reasonably available to the family or caretakers and causes or has a high probability of causing harm to the child's health or physical, mental, spiritual, moral or social development.

Exploitation

Commercial or other exploitation of a child refers to use of the child in work or other activities for the benefit of others. This includes child labour, child prostitution, child trafficking, intentional drugging and poisoning, Munchausen syndrome by proxy, conscription of children to armies.

Child labour: defined as work that deprives children of their childhood, their potential and their dignity, and that is harmful to physical and mental development. It refers to work that is mentally, physically, socially or morally dangerous and harmful to children and interferes with their schooling by:

- » depriving them of the opportunity to attend school
- » making them leave school prematurely
- » requiring them to attempt to combine school attendance with excessively long and heavy work

Child trafficking: ‘Acts’ of recruitment, transportation, transfer, harbouring or receipt of - a person under the age of 18 years, whether by force or not, by a third person or group. The third person or group organizes the recruitment

and/or these other acts for exploitative purposes;

Movement may not be a constituent element for trafficking in so far as law enforcement and prosecution is concerned. However, an element of movement within a country or across borders is needed - even if minimal - in order to distinguish trafficking from other forms of slavery and slave-like practices.

Munchausen syndrome by proxy

Munchausen syndrome by proxy is a behavior pattern in which a caregiver fabricates, exaggerates, or induces health problems in those who are in their care. With deception at its core, this behavior is an elusive, potentially lethal, and frequently misunderstood form of child abuse or medical neglect that has been difficult to define, detect, and confirm.

The caretaker of a child, usually a mother, either makes up false symptoms or causes real symptoms to make it look like the child is sick. The mother can do extreme things to falsify symptoms of illness in her child. For example, she may:

- » Add blood to the child's urine or stool
- » Withhold food so the child looks like they can't gain weight
- » Heat up thermometers so it looks like the child has a fever
- » Make up lab results
- » Give the child drugs to make the child vomit or have diarrhea
- » Infect an intravenous line (IV) to make the child sick

Signs in the mother

- » The mother often works in health care and knows a lot about medical care. She can describe the child's symptoms in great medical detail. She likes to be very involved with the health care team and is liked by the staff for the care she gives her child.
- » These mothers are really involved with their children. They seem devoted to the child. This makes it hard for health professionals to see a diagnosis of Munchausen syndrome by proxy.

Signs in the child

- » Frequent hospital visits.
- » Often has had many tests, surgeries, or other procedures.
- » Has strange symptoms that don't quite fit any disease. The symptoms do not match the test results.
- » Symptoms are reported by the mother, but are never seen by health care professionals. The symptoms are gone in the hospital, but start again when the child goes home.
- » Drugs or chemicals are found in the child's urine, blood, or stool.

Recognition of the issue

The most important first step in the management of child abuse & neglect is a high degree of suspicion and prompt recognition. There are warning signs in the history and examination of such victims. All professionals dealing with children should be conversant in detecting these signs.

Warning signs in the history

Nature of presentation		<ul style="list-style-type: none"> a) Delayed presentation for medical treatment. b) History incompatible with the injuries seen. c) History incompatible with the developmental age of the child. d) Changing history from time to time.
Symptom pattern	Somatic	<ul style="list-style-type: none"> a) Vaginal discharge especially if blood stained or purulent. b) Assumed menarche without secondary sexual characteristics. c) Painful defecation with or without bleeding per rectum. d) Skin lesions in the perineum and or peri-anal region. e) Somatization phenomena such as headache, abdominal pain, pseudo- seizures etc.
	Behavioural/ psychological	<ul style="list-style-type: none"> a) Deteriorating school performance or school refusal. b) Sudden onset unusual behaviours. c) Attempted suicide or deliberate self-harm. d) Sexualized behaviour. e) Avoiding certain places and / or persons. f) Children with sexually inappropriate behaviours e.g. being unusually friendly with certain adults.

Social issues

- a) Dysfunctional home environment
 - e.g.** Fractured families, parent/s employed abroad, substance abuse among family members
- b) Children without adult supervision

Warning signs in the examination

Physical	<ul style="list-style-type: none"> a) Evidence of neglect e.g. Poor grooming, unkempt, malnutrition etc. b) Multiple injuries of different stages of healing c) Unusual skeletal injuries* <ul style="list-style-type: none"> i. Long bone fractures in infants (spiral fractures are very suspicious) ii. Metaphyseal fractures – chip and bucket handle fracture iii. Posterior rib fractures d) Bite marks.* e) Burns and scalds eg. Cigarette and fire brand injuries, incense stick burns, peri-oral scalds, immersion injuries due to hot water f) Association of retinal haemorrhages and finger-tip bruises on the chest in. shaken baby syndrome* g) Foreign body in the vagina h) Multiple anal fissures or patulous anus, skin lesions in perineum/ peri-anal region e.g. viral warts due to genital Herpes Simplex i) Ulcerations in oral cavity and torn frenulum*
Psychological	<ul style="list-style-type: none"> a) Depressed mood and other unusual emotional responses b) Poor eye to eye contact c) Aggressive behaviour d) Unusual or unexplainable attachment patterns with carers
Any other physical or psychological findings which may arouse suspicion	

* See annexure 02

CHAPTER

02

MANAGEMENT

This guideline outlines the multi-sectoral management of child abuse and neglect. The initial management is a hospital based one as the medical issues need to be addressed and medical institutions are accepted as places of safety. It is expected that the guideline will be implemented in Base, District, Provincial and Teaching hospitals where key specialties are available. In all other situations the child should be transferred or referred to the nearest Base, District, Provincial or Teaching hospital. General Practitioners should seek advice from Paediatricians. Referral should be made to a Paediatrician or a Specialist in Forensic Medicine.

Patients seen in the private sector, who need medico-legal examination, should be referred to the Specialist in Forensic Medicine at the closest Government hospital.

The management of child abuse and neglect is essentially multi-sectoral.

Objectives of Multi-Sectoral Management

1. Provide immediate medical care in a secure environment
2. Reduce re-traumatization
3. Psycho-social rehabilitation and reintegration
4. Assess other children who may be at risk
5. Work towards holistic recovery
6. Prevent further abuse
7. Assist legal processes for justice

The sectors involved are

Medical	b) Preventative – Medical Officer of Health (MOH) and all categories of primary health care workers for <ol style="list-style-type: none"> 1. primary prevention 2. prevention of further abuse and follow up a) Curative- all categories of medical and nursing staff in health institutions in the country
Legal	a) Police b) The Attorney General's Department
Social	The Ministry of Child Development & Women's Affairs (Department of Probation & Child Care, National Child Protection Authority) and The Ministry of Education
See Annexure 3, for a representative diagram of the Ministerial structure in relevance to the sectors involved in the management	

Procedure in the management

Provide immediate medical care in a secure environment -

Initial encounter by medical personnel

At the first encounter when a child presents with suspected abuse, it is very important for the doctor to establish a trusting relationship with the child and caregivers. The following steps would help in establishing such relationship.

1. Indicate your willingness to listen and help
2. Listen and show you understand their concerns
3. Clearly communicate with them about your suspicions of abuse in a gentle and subtle way
4. Emphasize the need to provide absolute protection from further abuse
5. Discuss options for providing safety

Reasons for admission to a hospital

1. Medical/surgical/psychological treatment that cannot be provided as an outpatient.
2. To provide a place of safety
e.g. Alleged/ suspected perpetrator living in the same environment as the child victim

All admissions should be to the Paediatric Wards. A victim with a surgical problem should be managed in a surgical ward initially and transferred to a Paediatric Ward for further management. A pregnant teenager should be managed in the Obstetric and Gynaecology ward.

Once wards for victims of child abuse and neglect (Lama Piyasa) are established in health institutions child victims should be admitted to these wards (Annexure 4).

If parents/guardians refuse admission, Medical Officer OPD should inform the Specialist in Forensic Medicine immediately to obtain a court order through the police irrespective of the time of day.

Procedure for medical officers admitting victims

At the Out- Patient Department (OPD)

1. Should ensure safety and privacy of all parties concerned.
2. Should speak very gently to the child and SHOULD NOT ask any details of the incident from the child at any stage.

3. Should take details with regard to the date and time of the incident and a very brief account of the incident from the police or the guardian (preferably having kept the child away in a safe place).
4. No other members of the staff should speak to the child with regard to the problem.
5. The Medical Officer of the OPD should take all possible precautions to make sure that all parties concerned are not embarrassed, criticized or accused.

A brief examination including vital signs should be carried out to establish that the child is clinically stable. If any serious or life threatening situations are suspected, inform relevant specialties immediately over the phone and take all other necessary action as for any other OPD admission (ETU care etc.) Documentation at the OPD to ensure confidentiality and other legal implications should include the following;

- » Date and time of the incident
- » “Admitted due to child protection concerns” to be stated without mentioning the exact incident (i.e. sexual abuse, rape etc.)

Procedure to be followed in the Paediatric Ward

1. The child should be spoken to by the member of the staff who has been appointed to deal with children with child protection issues (Consultant/ Senior Registrar/ Registrar/SHO/ HO/Nurse).

2. Comfort the victim and reassure his/her safety.
3. At this stage the victim should not be questioned about the incident. This is the duty of the medico-legal team.
4. A relevant history should be obtained from the Guardian or the Police by a designated Medical Officer in the ward. A relevant Paediatric examination should be carried out with a view to manage immediate medical concerns.
5. Inform the Specialist Paediatrician, irrespective of the time of day or night.
6. If the case is an acute abuse, inform the Specialist in Forensic Medicine, Senior Registrar, Registrar, Postgraduate trainee, MO- Medico-legal on call, over the telephone, irrespective of the time of day or night.
7. The Specialist Paediatrician/senior member of the Paediatric team will explain to the child regarding the Forensic Medicine examination whilst providing comfort and reassurance. Maximum effort should be taken for a designated member of the Paediatric team to accompany the child for the Medico-Legal examination.
8. Pages of the BHT should be numbered as it is an important legal document and each entry should carry the date, time and the full signature of the person making the documentation.
9. The recordings in the BHT should be legible and reflect the management of the case in a chronological order.
10. The BHT should be kept under lock and key to be taken out as and when necessary. This should be the responsibility of the Sister / Nurse-In-Charge.
11. If the history changes from time to time, document the different versions separately on the BHT & exchange the information among / with other specialties.
12. The essential needs of the child should be met. e.g. when clothes are taken for medico-legal purposes, child may be in need of clothes.
13. The Paediatric team also should look into the victim's nutrition/ immunization/ other medical/ surgical issues etc.
14. Safety of the other children at home needs to be discussed with the mother or the caregiver when necessary.
15. The designated Medical Officer should inform the Medical Administrator of the Institution regarding the admission. Sister / Nurse-In-Charge should take necessary steps for provision of essentials to the caregivers in special cases.
16. While the child is in the ward it is essential to ensure safety. Increasing awareness amongst the medical and nursing staff of the wards used as places of safety is important. Otherwise the child victim becomes victimized again by inquisitive members of staff of the hospital.
17. Inform the ward staff to note the relationship between the mother/ guardian and the child.

Video recording of evidence of the victim

Video recording of evidence in a child victim of abuse is acceptable in a court of law in Sri Lanka.

Whenever possible recording of video

evidence should be instituted as this reduces re-traumatization of the child. The facility is now available at the National Child Protection Authority. It is anticipated that this facility would be incorporated into the “Lama Piyasa” in the future.

Ensuring strict confidentiality of these children is a responsibility of all designated staff members of the ward.

Medico-legal Examination

1. The detailed history will be obtained by the representative of the Medico-legal unit. He/she will perform the examination, obtain necessary samples for evidential purposes and refer to relevant specialists under the supervision of the Specialist in Forensic Medicine.
2. Subsequent to the Medico- Legal examination, the Specialist in Forensic Medicine, Specialist Paediatrician and the Specialist Psychiatrist will have an informal discussion about the details of the incident in order to optimize the care of the victim.
3. It is recommended to use medico-legal examination and reporting guidelines of sexually abused survivors and Examination and reporting guidelines on child abuse of the College of Forensic Pathologists of Sri Lanka to improve the standard and uniformity in the examinations.

Psychological assessment by psychiatrist

The focus would be on the following aspects.

- » Assessment
- » Writing a report. For content of the report please see Annexure 5.

Assessment

The psychiatrist will undertake to assess a child following abuse when;

- » referred by the specialist in Forensic Medicine/ Senior Registrar/ Registrar/ Postgraduate trainee or MO-medico-legal for a report on psychological impact of the abuse experience
- » referred by the Paediatrician for psychological assessment
- » abuse is disclosed directly to the psychiatrist or identified in the course of routine mental health assessment.

The assessment should focus on the following

1. The presence of emotional and behavioural changes related to the abuse experience. Presence of certain specific features such as sexualized behaviour, fear and anxiety in specific circumstances, will also serve as confirmatory evidence of abuse.
2. Use other tools of assessment such as drawings, storylines, and anatomically correct dolls to obtain information.
3. It is important to be mindful of inconsistencies in giving information and false memories especially in a young child.
4. The presence of risk factors for abuse in terms of vulnerabilities in the child and the environment.
5. Mental state examination to elicit behaviour, emotions, thought content, Perceptual abnormalities and other features related to abuse experience and its consequences.
6. Cognitive assessment will help in eliciting risk factors such as intellectual impairment.
7. Social circumstance and support available to ensure safety of the child, prevent further abuse and to minimize disruption to normal daily routines.
8. Impact of the child's experience on the rest of the family and their coping ability.
9. Obtain collateral information as far as possible without compromising privacy and confidentiality.

10. The assessment techniques used will depend on the developmental age of the child.

Investigations

- » Physical abuse (where relevant)

- i. Skeletal survey

- ii. Clotting profile

- iii. Imaging

Obtain a written report from the Radiologist regarding the skeletal survey and imaging studies.

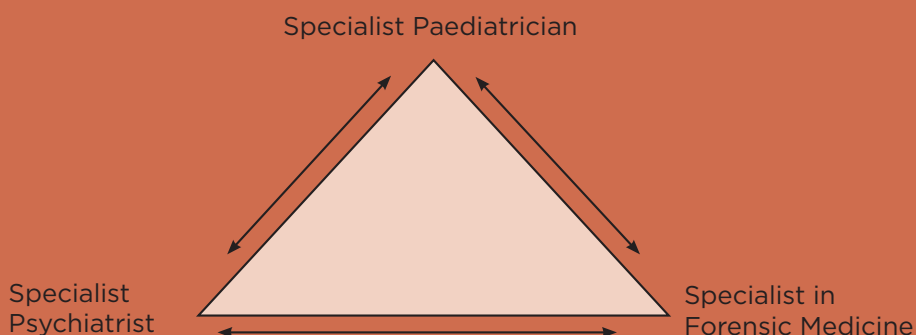
- » Sexual abuse will be dealt with by the Medico-Legal team. However, in instances where a Medico-Legal on-call system is not in operation, the ward medical officer shall obtain necessary trace material/swabs with the concurrence of the relevant Specialist in Forensic Medicine or MO Medico-Legal. The specimens should be labelled appropriately and handed over to the Medico-Legal unit while maintaining the chain of custody.
- » Depending on the Last Regular Menstrual Period (LRMP) consider pregnancy testing. Offer emergency contraception in consultation with the Obstetrician.
- » Screen for sexually transmitted infections and liaise with the Specialist Venereologist.

CHAPTER

03

THE CLINICAL CASE
CONFERENCE

A Clinical Case Conference (CCC) will be held within 24 hours of the child first presenting to the hospital. The participants of the Clinical Case Conference will be the Specialist in Forensic Medicine, Specialist Psychiatrist, Specialist Paediatrician and any other relevant clinician. The Clinical Case Conference will be chaired by the Specialist in Forensic Medicine.



A child may be admitted to a ward other than to a Paediatric/ Psychiatric ward depending on the clinical situation and age. They may be admitted to Medical wards, General Surgical/ Surgical Subspecialty wards or to Obstetrics/ Gynaecology wards. They should be referred to the Medico-Legal Unit soon after admission so that the Clinical Case Conference can be arranged within 24 hours for all child victims under 18 years of age. It is anticipated that there would be participation by the relevant Medical/ Surgical/ Obstetrics/ Gynecology team at the Clinical Case Conference.

Some cases may not need admission. However, a similar Clinical Case Conference should be arranged as soon as possible with the concurrence of the clinicians.

Objectives of the Clinical Case Conference:

1. To prevent re-victimization by attempting to obtain the history at different times by different specialties
 2. To inform other specialties about the victim.
 3. To plan further management
- » Date, time and chair for the Institutional Case Conference will be decided

Special notes

In cases of suspected abuse where the Paediatrician/ Psychiatrist is uncertain about the abuse they will refer to the Specialist in Forensic Medicine for a 2nd opinion prior to issuing a MLEF. If the Specialist in Forensic Medicine decides that it is a case of child abuse a MLEF will be issued and a Clinical Case Conference will be arranged.

The Procedure of the Clinical Case Conference

- » The Specialist in Forensic Medicine is responsible for coordinating the Clinical Case Conference.
- » The decisions will be documented in the BHT

CHAPTER 04

INSTITUTIONAL CASE CONFERENCE

Once the child has been seen by all the relevant medical specialists the institutional case conference (ICC) should be convened. The Institutional Case Conference is the link to the Multi-Sectoral Management.

Objectives

1. Ensure that further victimization does not take place
2. Prevent stigmatization
3. Ensure safety of child and family
4. Ensure that the child continues his/her education without interruption
5. Ensure a process of psychosocial rehabilitation and re-integration
6. Ensure legal justice with minimal delay

The Procedure

The date and time will be decided at the Clinical Case Conference. The Institutional Case Conference will be held at the hospital premises. The venue will be decided by the Chairperson. When the “Lama Piyasa” is established it is anticipated that there will be a room dedicated for this purpose. The Chairperson of the conference will be either the Paediatrician or the Psychiatrist. The Medical Administrator will be a co-opted member of the Institutional Case Conference.

The Chairperson of the Clinical Case Conference will inform:

1. the Child Rights Promotion Officer designated to the hospital, to inform the Chief Probation Officer (CPO) to designate a Case Manager (Probation Officer) for the child.
2. the National Child Protection Authority psychosocial officer designated to the hospital, to inform the Police of the date and time of the Institutional Case Conference.

The Probation Officer will receive authority from the Chief Probation Officer to deal with the particular case and the Probation Officer should collect relevant details of the child prior to attending Institutional Case Conference when indicated.

The participants at the Institutional Case Conference

(Chair - Paediatrician/Psychiatrist as decided at the CCC).

1. Medical administrator (Co-opted member).
2. Paediatrician.

3. Psychiatrist.
4. Specialist in Forensic Medicine.
5. Relevant medical and nursing Officers from the Paediatric ward
6. Child Probation officer designated as the case manager.
7. Police officer from the Women's and Children's desk of the Police Station of the area of residence of the victim. The ASP/ OIC should nominate an officer from the Women's and Children's desk to attend the case conference. This should be an officer other than the investigating officer in each case. The offer should be given a briefing by the OIC, Prior to ICC.
8. Medical Officer of Health (MOH), Public Health Nurse (PHN)/ Public Health Midwife (PHN) of the relevant area.
9. Child Rights Promotion Officer attached to the health institution.
10. Psychosocial officer of the National Child Protection Authority attached to the health institution.
11. The victim.
12. Parents/guardian of the child and any other relatives when indicated should be present at the time of the case conference.
13. Others who may be invited depending on the case.
 - » Orthopaedic/General Surgeons
 - » Obstetricians
 - » Zonal Officer of Education
 - » Principal/School Teacher
 - » Any other relevant person

12. The child and the relatives should be invited after the preparatory discussion has been done.
13. A representative of the Paediatric/ Psychiatric/ Medico-Legal team should make a brief presentation regarding the victim and the incident.

All members who attend the Institutional case conference will be expected to sign a confidentiality clause (Annexure 06)

Decisions and Recommendations of the Institutional Case Conference

The decisions and recommendations of the Institutional Case Conference should include the following aspects.

1. Placement
2. Medical Management
3. Psychosocial rehabilitation & re-integration
4. School / vocational training
5. Follow up plan

These decisions and recommendations will be included in the 'Recommendations for Facilitating

Psychosocial Rehabilitation & Re-integration of Child' form which will be filled for the purpose of referral for follow-up the victim by all sectors. (Annexure 06)

The decisions and recommendations will be included in the Social Inquiry Report compiled by the Probation Officer as the case manager. This will be the process by which the decisions and recommendations made at the Institutional Case Conference will be communicated to the Magistrate.

01. Placement

The following points should be clearly explained to the parents or guardian;

- » The importance of protecting the child from further abuse or neglect
- » The importance of re-integrating the child back to the society
- » The need to address the issues regarding the psychosocial wellbeing of the child
- » That alternate placement will be considered if the above is not adhered to by the parents/ guardian
- » The importance of adhering to follow up in the hospital

Can the child be sent back to the environment that he/she came from?	
If yes	<p>A follow up plan should be implemented</p> <ul style="list-style-type: none"> » Follow up should be done in the community by the Probation Officer and the Child Rights Promotion Officer in discussion with the Public Health Midwife (other community based officers eg. Grama Niladari, Family Health Officers when necessary). » Follow up in the hospital should be done by the Paediatrician and the Psychiatrist in the hospital.
If no	<ul style="list-style-type: none"> » Always consider extended family as a priority. Child can be sent to a relative capable of taking the responsibility for the child. The Probation Officer will do a background check on the proposed guardian. If the person seems to be a fit person, the members of institutional case conference will recommend obtaining the guardianship. » When the Institutional Case Conference decisions are conveyed to courts, a court order will have to be obtained to appoint the guardianship to the extended family member. If in case the guardian is unable to financially support the child, the Institutional Case Conference will explore the possibilities to obtain financial assistance and submit this information to the courts through PO. » This guardianship may be for a limited period of time. <p><i>If no suitable guardian is available, the child may be sent to a Child Development Centre. The permanent placement will be decided with the help of the PO.</i></p>

02. Medical Management

A follow up plan for any acute or chronic medical or surgical problems should be made. The Paediatrician and the Psychiatrist will follow up the child in hospital to ensure psychosocial wellbeing and re-integration. Overall medical management will be coordinated in the Paediatric clinic or “Lama Piyasa”.

03. Psychosocial Rehabilitation & Re-integration

The Psychiatrist will follow up the child in hospital.

The Probation Officer appointed as the case manager for the child should

follow up the continuing wellbeing of the child. He/she will facilitate the medical and psychiatric follow up at Paediatric and Psychiatric clinics. When health sector “Lama Piyasa” is in place in health institutions the institutional follow up will take place in these centres. (See Annexure 4)

The Psycho-social Coordinator of the National Child Protection Authority, Child Rights Promotion Officer, the Counselling Officer attached to the Divisional Secretariats (DS) offices and the Public Health Midwife will ensure follow up of the child in the community.

A computerized data base should be maintained at the “Lama Piyasa”.

04. School / vocational training

- a) The child should continue his/her education in the same school. All sectors should ensure the child's education is not interrupted due to the incident.
- b) If it is impossible for the child to continue the education in the same school, a transfer to another school should be arranged in a confidential manner.
- c) The principal should issue a non-problematic leaving certificate for the child to go to another school when necessary.
- d) The relevant education officers should provide an appropriate school to such children without delay.
- e) Trained Student Counsellors should have regular sessions with the child and if there are any concerns ask for help from the medical professionals.
- f) The child's performance in school should be monitored.
- g) Depending on the age of the child and if there is a history of not attending school for a long period

of time vocational training should be arranged.

05. Follow up plan

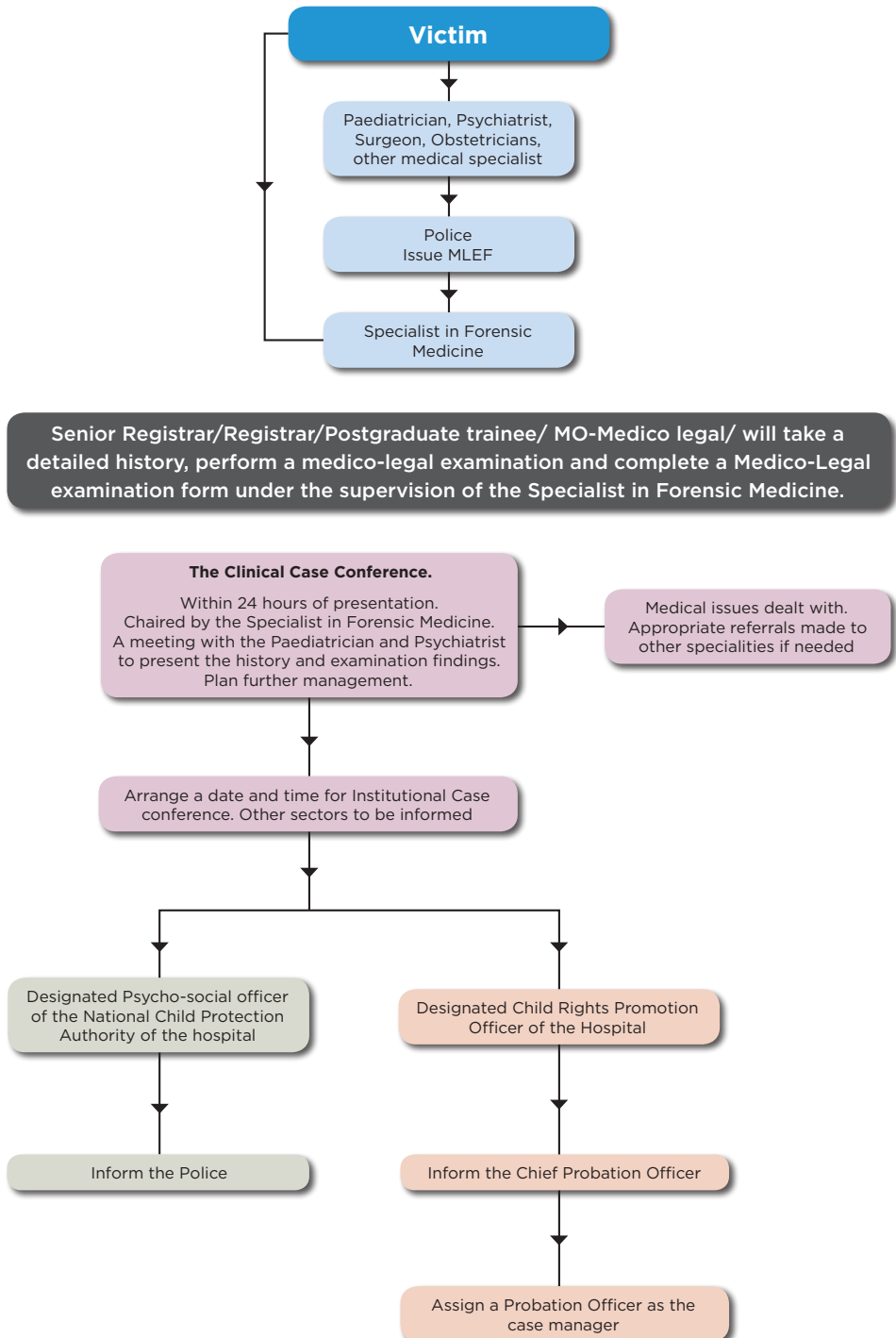
To ensure proper psychosocial rehabilitation and re-integration a follow-up plan should be drawn up for the child. Community follow-up by social workers and hospital based follow-up by the Psychiatrist and the Paediatrician should be documented.

The follow up files of these victims will be maintained confidentially at the Lama Piyasa in a computerized database.

Follow up meeting

Every 3 months the Paediatrician and the Psychiatrist will meet the Probation Officers (Case Managers) of the area to discuss the situation of each child who has been in need of care and protection in the area. This will include children sent back to the family, extended family or to a child development center. When all the parties agree that no further follow up is necessary the child may be discharged. The venue will be the Lama Piyasa or probation office.

FLOW OF CLINICAL CASE CONFERENCE



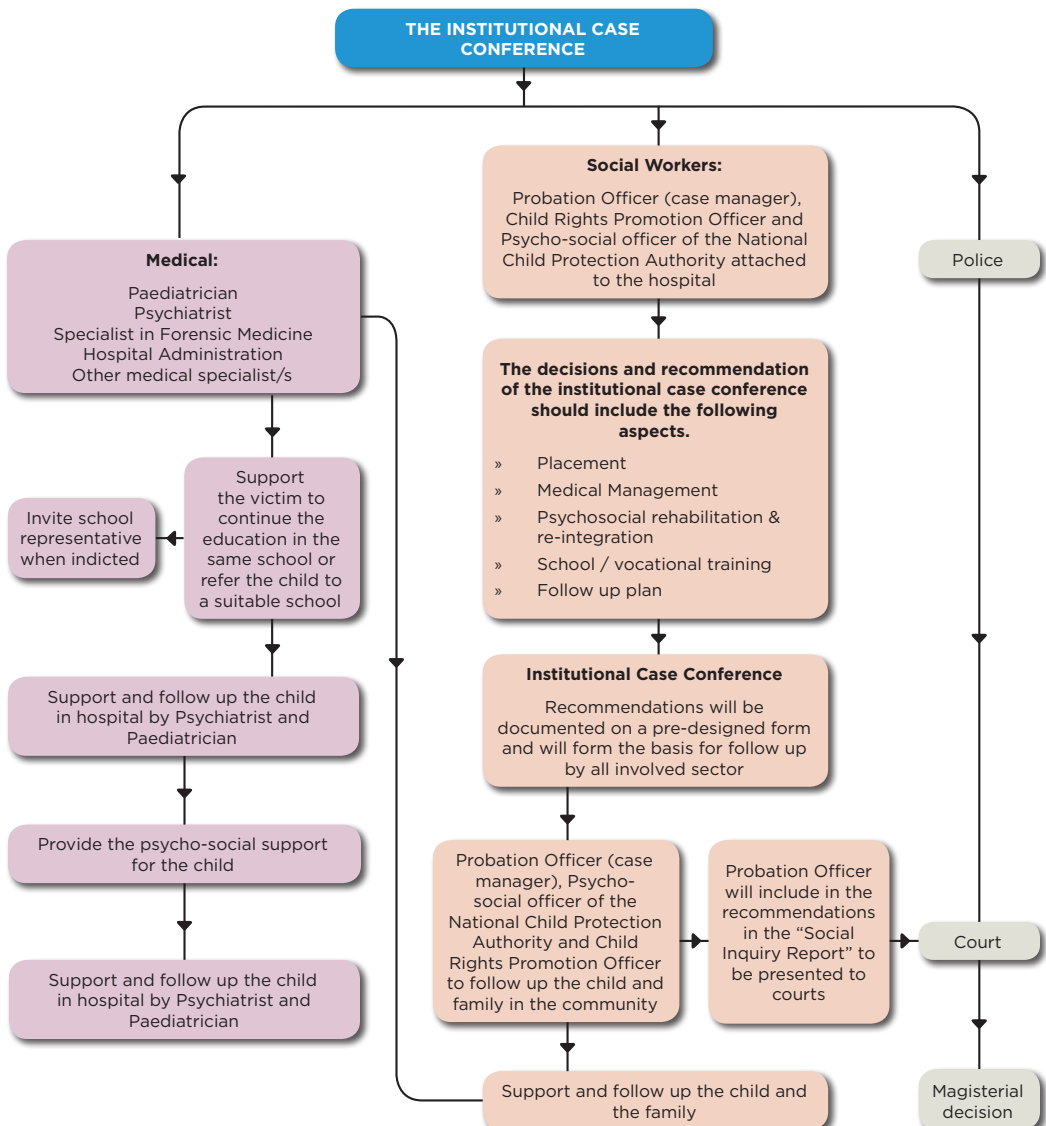
FLOW OF INSTITUTIONAL CASE CONFERENCE

OBJECTIVES OF INSTITUTIONAL CASE CONFERENCE

- » Ensure that further victimization does not take place - safe placement of the child
- » Prevent stigmatization
- » Ensure safety of child and family
- » Ensure that the child continues his/her Education without interruption
- » Ensure a process of psycho-social rehabilitation and re-integration
- » Ensure legal justice with minimal delay

THE KEY MEMBERS INSTITUTIONAL CASE CONFERENCE

- » Consultant Paediatrician
- » Consultant Psychiatrist
- » Specialist in Forensic Medicine
- » Police
- » Probation Officer (PO)
- » Child Rights Promotion Officer



CHAPTER

05

ROLES AND
RESPONSIBILITIES
OF THE DIFFERENT
STAKEHOLDERS

MEDICAL

Designation	Role
Medical Administrator	a) Co-opted member of the institutional case conference.
MO-OPD	a) Identify victims. b) Refer for immediate medical care in a secure environment c) Inform Specialist in Forensic Medicine if guardians refuse admission. d) Take a brief history. e) Inform Paediatrician.
Specialist in Forensic Medicine / MO- Medico Legal	a) Detailed history taking. b) Medico-legal examination. c) Coordinate clinical case conference. d) Participate as the Chairperson of clinical case conference e) Participate at institutional case conference. f) Finalize the Medico-Legal Report within three weeks and make arrangements to send to the Attorney General's Department directly or through the relevant Police officer.
Consultant Paediatrician	a) Identify victims b) Treat immediate medical problems. c) Ensure strict confidentiality in Paediatric ward/Lama Piyasa d) Participate in clinical case conference. e) Participate in institutional case conference, he/she may be the Chairperson of institutional case conference. f) Coordinate overall management. g) Initiate psychosocial rehabilitation and re-integration together with the Psychiatrist. h) Follow up and ensure that the recommendations of the institutional case conference are being complied with for the wellbeing of the child. i) Every 3 months the Paediatrician will meet the Psychiatrist and the Probation Officers of the area to discuss the situation of each child who has been in need of care and protection in the area.

Consultant Psychiatrist	<ul style="list-style-type: none"> a) Identify victims. b) Psychological assessment. c) Ensure psychological wellbeing and re-integration. d) Participate in clinical case conference. e) Participate in institutional case conference. He/she may be the chairperson of institutional case conference. <p>Follow up of victims</p> <ul style="list-style-type: none"> f) Every 3 months the Psychiatrist will meet the Paediatrician and the Probation Officers of the area to discuss the situation of each child who has been in need of care and protection in the area. g) Follow up and ensure that the recommendations of the institutional case conference are being complied with for the wellbeing of the child.
VP, Surgeon, VOG, Orthopedic Surgeon	<ul style="list-style-type: none"> a) Identify victims. b) Treat immediate medical Surgical problems. c) Refer to the Specialist in Forensic Medicine soon after admission. d) Participate at Clinical Case Conference.
Venereologist	<ul style="list-style-type: none"> a) Identify victims and refer to the medico-legal unit. b) Screen victims of child sexual abuse for sexually transmitted infections when referred. c) Attend the clinical case conference when indicated.
Sister / Nurse in - charge	<ul style="list-style-type: none"> a) Safety of BHT should be assured. b) Comfort the victims and ensure safety while in the ward. c) Take necessary steps for provision of essentials to the care givers in special cases. d) In cases of issues of safety inform hospital police post.
MOH/PHM	<ul style="list-style-type: none"> a) Should attend institutional case conference. b) After child has been sent to the community, follow up should be done to ensure continuing wellbeing of the child, in conjunction with Probation Officer, Child Rights Promotion Officer and Psycho-social officer of the National Child Protection Authority.

LEGAL

Designation	Role
Police	<ul style="list-style-type: none"> a) Women and Children`s desks at police stations should be child friendly. If possible W&C desks should be considered a separate unit within the police station. b) Ensure that the Women`s and Children`s Desks are manned by trained WPCs during the day and night. Taking of statements of child victims overnight should be a regularized procedure. c) Repetition of obtaining the information regarding the incident from the child by different officers manning the Women`s & Children`s Desk should be avoided. d) Take appropriate action when a complaint is made in the best interests of the child. e) Immediately inform to the relevant probation officer according to the provision of section 17 of the Children and Young Person's Ordinance (CYPO) and the circular 2539/2012 titled Monthly coordination meetings between Police and Probation issued by the Inspector General of Police (See Annexure 7). f) Take the necessary steps to arrest the perpetrator. g) It is recommended that police officers use civilian clothing whenever they visit the children in hospitals, schools or at home. However, they should carry their official identity card with them. h) Means of transporting the child to courts should be a non-official vehicle. i) Keeping the child in a prison cell / under custody before producing to court should be avoided. Child should be taken directly to courts from the hospital ward/Lama Piyasa. Under no circumstances should a child be kept in remand prison. j) Provide a police matron to stay with the child when necessary. k) The Police officers should maintain strict confidentiality. l) The police officer should liaise with the hospital police post regarding the on-call medical officer of the Forensic unit/ specialist in Forensic Medicine especially if the child is produced after routine working hours.

	<p>m) The police officer should make arrangements to obtain the police copy of the MLEF and the Medico-Legal Report from the examining doctor.</p> <p>n) It is the duty of the investigating officer to obtain the Case number (B number) and inform the specialist in Forensic medicine who is supervising the case. He also should coordinate with the specialist in Forensic medicine regarding sending the report to the Attorney General's Department.</p> <p>o) After the child has been sent to the community, support the Clinicians, Probation Officer, Child Rights Promotion Officer, Psycho-social officer of the National Child Protection Authority to follow up the continuing wellbeing of the child.</p> <p>p) In situations where the child victim/family is threatened by the perpetrator/anyone else on his/her behalf the Police should take steps to protect the child and family.</p> <p>q) ASP/ OIC should nominate an officer from the women's and children's desk to attend the case conference. This should be an officer other than investigating officer in each case. The nominated should be given a briefing about the case officer by the OIC prior to ICC.</p>
Attorney General's department	<p>a) Whenever possible Video Evidence should be encouraged.</p> <p>b) The child should not be called to lead evidence facing the alleged perpetrator in open court. The evidence should be led from a separate room with CCTV facilities when available.</p> <p>c) Fast tracking of the court cases should be considered priority.</p>
Department of Prisons	<p>a) It is preferable if prison officers use civilian clothing whenever they visit the child. However, they should carry their official identity card with them.</p> <p>b) Means of transporting the child to courts should be a non-official vehicle. If using a non-official vehicle, Police would have to provide security.</p> <p>c) Keeping the child in a prison cell before producing to court should be avoided at all times. Child should be taken directly to courts from the hospital ward/safe house. Under no circumstances should a child be kept in remand prison.</p>

SOCIAL

Probation Officer	<ul style="list-style-type: none"> a) The Probation Officer (PO) will receive authority from the Chief Probation Officer (CPO) appointing him/her as the Case Manager for the particular child. b) The Probation Officer should have a sensitive approach to interviewing child and family and should maintain strict confidentiality. c) The PO should attend the Institutional Case Conference. d) Decisions made at the institutional case conference should be included in the Social Inquiry Report which is submitted to Courts. e) If the child cannot be sent back to the environment he/she came from, Probation Officer will do a background check on the proposed guardian. f) The completed 'Recommendations for Facilitating Psychological Rehabilitation and Re-integration of Child' (Annexure 6) which will be completed at the institutional case conference should be filed as a guideline for future follow up of the child. g) The Probation Officer should follow up the child and ensure continuing wellbeing of the child. h) Every 3 months a follow up meeting will be held. The PO will chair the meeting. The Psychiatrist and Paediatrician will meet the PO to discuss the situation of each child who has been in need of care and protection in the area.
Child Rights Promotion Officer	<ul style="list-style-type: none"> a) After receiving information from the chairperson of the institutional case conference the Child Rights Promotion Officer (CRPO) attached to the hospital should inform the Chief Probation Officer to designate a case manager (probation officer) for the child. b) The (CRPO) should attend institutional case conference. c) The (CRPO) should maintain strict confidentiality.
	<ul style="list-style-type: none"> d) After child has been sent to the community, follow up should be done to ensure continuing wellbeing of the child, together with the Probation Officer, Psycho-social officer of the National Child Protection Authority and the area Public Health Midwife (PHM). e) The follow up should be based on the information in the form completed at the institutional case conference.

Psycho-social officer of the National Child Protection Authority psychosocial officer	<ul style="list-style-type: none"> a) After receiving information from the Chairperson of the institutional case conference the Psycho-social officer of the National Child Protection Authority (NCPA) attached to the hospital should inform the Police the date and time of the institutional case conference. b) Psycho-social officer of the (NCPA) should attend institutional case conference. c) Sharing information with the area PHM who is an important care provider for the family should be ensured while taking steps to maintain confidentiality. d) The Psycho-social officer of the (NCPA) should maintain strict confidentiality e) After child has been sent to the community follow up should be done to ensure continuing wellbeing of the child. f) In issues relating to the security of the child in the community e.g. threats received by perpetrator/ relatives the Psycho-social officer of the (NCPA) should coordinate activities with the police to ensure security for the child and family. g) The follow up should be based on the information in the form completed at the institutional case conference.
Department of Social Services	<ul style="list-style-type: none"> a) Provide social environment with necessary economic opportunities to child victim/family, if it is at all necessary to prevent further abuse. b) Provide individual consultancy services to drug addicted persons, family consultancy services and awareness programs to perpetrator/victim's family as necessary.

Principal/ Student Counsellor	<ul style="list-style-type: none"> a) The Principal should ensure the victim continues his/her education in the same school. b) Confidentiality should be maintained. c) The Principal should ensure that the child does not get stigmatized in the school, due to the incident. d) If it is impossible for the child to continue the education in the same school, a transfer to another school should be arranged in a confidential manner. e) The Principal should issue a non-problematic leaving certificate for the child to go to another school when necessary. f) The Principal should liaise with the relevant education officer to provide an appropriate school to such children without delay. g) Trained Student Counselors should have regular sessions with the child and if there are any concerns ask for help from the medical professionals. h) The child's performance in school should be monitored. i) Discourage corporal punishment in schools. (Circular No. 2005/17) Teachers should be trained on the alternative methods of dispelling. (Annexure 9)
Zonal/Divisional Education Director	<ul style="list-style-type: none"> a) Ensure the child's education is not interrupted due to the incident and the child should continue his/her education in the same school. b) Depending on the age of the child and if there is a history of not attending school for a long period of time vocational training should be arranged. c) Discourage corporal punishment in schools (Circular No.2005/17) Teachers should be trained on the alternative methods of disciplining. (Annexure 9)
Media	<ul style="list-style-type: none"> a) Publishing or broadcasting about the incidences of the child abuse and neglect is strictly prohibited. Please refer the Guideline issued by the Child protection Authority regarding the Media reporting of these cases. (See Annexure 8)

ANNEXURE 1-9

ANNEXURES 01-09

UN Convention on the Rights of the Child (UN CRC)

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| <p>Article 1 Everyone under 18 has these rights.</p> <p>Article 2 All children have these rights, no matter who they are, where they live, what their parents do, what language they speak, what their religion is, whether they are a boy or girl, what their culture is, whether they have a disability, whether they are rich or poor. No child should be treated unfairly on any basis.</p> <p>Article 3 All adults should do what is best for children. When adults make decisions, they should think about how their decisions will affect children.</p> <p>Article 4 The Government has a responsibility to make sure child rights are protected. They must help child's family to protect child rights and create an environment where child you can grow and reach their potential.</p> <p>Article 5 Families have the responsibility to help the children learn to exercise their rights, and to ensure that their rights are protected.</p> <p>Article 6 Children have the right to be alive.</p> | <p>Article 7 Children have the right to a name, and this should be officially recognized by the government. Children have the right to a nationality (to belong to a country).</p> <p>Article 8 Children have the right to an identity – an official record of who they are. No one should take this away from them.</p> <p>Article 9 Children have the right to live with their parent(s), unless it is bad for them. Children have the right to live with a family who cares for them.</p> <p>Article 10 If children live in a different country than their parents do, children have the right to be together in the same place.</p> <p>Article 11 Children have the right to be protected from kidnapping.</p> <p>Article 12 Children have the right to give their opinion, and for adults to listen and take it seriously.</p> <p>Article 13 Children have the right to find out things and share what they think with others, by talking, drawing, writing or in any other way unless it harms or offends other people.</p> |
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Article 14 Children have the right to choose their own religion and beliefs. Their parents should help them decide what is right and wrong, and what is best for them.

Article 15 Children have the right to choose their own friends and join or set up groups, as long as it isn't harmful to others.

Article 16 Children have the right to privacy.

Article 17 Children have the right to get information that is important to their well-being, from radio, newspaper, books, computers and other sources. Adults should make sure that the information children are getting is not harmful, and help them find and understand the information they need.

Article 18 Children have the right to be raised by their parent(s) if possible.

Article 19 Children have the right to be protected from being hurt and mistreated, in body or mind.

Article 20 Children have the right to special care and help if they cannot live with their parents.

Article 21 Children have the right to care and protection if they are adopted or in foster care.

Article 22 Children have the right to special protection and help if they are refugees (if they have been forced to leave their home and live in another country), as well as all the rights in this Convention.

Article 23 Children have the right to special education and care if they have a disability, as well as all the rights in this Convention, so that they can live a full life.

Article 24 Children have the right to the best health care possible, safe water to drink, nutritious food, a clean and safe environment, and information to help them stay well.

Article 25 If children live in care or in other situations away from home, they have the right to have these living arrangements looked at regularly to see if they are the most appropriate.

Article 26 Children have the right to help from the government if they are poor or in need.

Article 27 Children have the right to food, clothing, a safe place to live and to have their basic needs met. Children should not be disadvantaged so that they can't do many of the things other kids can do.

Article 28 Children have the right to a good quality education. Children should be encouraged to go to school to the highest level they can

Article 29 Their education should help children use and develop their talents and abilities. It should also help them learn to live peacefully, protect the environment and respect other people.

Article 30 Children have the right to practice their own culture, language and religion - or any they choose. Minority and indigenous groups need special protection of this right.

Article 31 Children have the right to play and rest.

Article 32 Children have the right to protection from work that harms them, and is bad for their health and education. If children work, they have the right to be safe and paid fairly.

Article 33 Children have the right to protection from harmful drugs and from the drug trade.

Article 34 Children have the right to be free from sexual abuse.

Article 35 No one is allowed to kidnap or sell them.

Article 36 Children have the right to protection from any kind of exploitation (being taken advantage of).

Article 37 No one is allowed to punish children in a cruel or harmful way.

Article 38 Children have the right to protection and freedom from war. Children under 15 cannot be forced to go into the army or take part in war.

Article 39 Children have the right to help if they've been hurt, neglected or badly treated.

Article 40 Children have the right to legal help and fair treatment in the justice system that respects their rights.

Article 41 If the laws of their country provide better protection of their rights than the articles in this Convention, those laws should apply.

Article 42 Children have the right to know their rights! Adults should know about these rights and help the child learn about them, too.

Articles 43 to 54

These articles explain how governments and international organizations like UNICEF will work to ensure children are protected with their rights.

SOFT TISSUE INJURIES



Cigarette burn¹



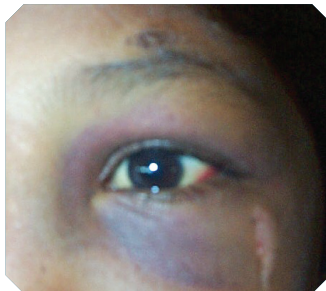
Slap mark on the face¹



Bite marks on the back of the chest²



Incense stick burns³



Peri-orbital haematoma due to blunt trauma to face³



Abraded contusion due to pinching of earlobe³



Injuries of different stages of healing in the same child caused by beating with a cylindrical object consistently over a period of time³



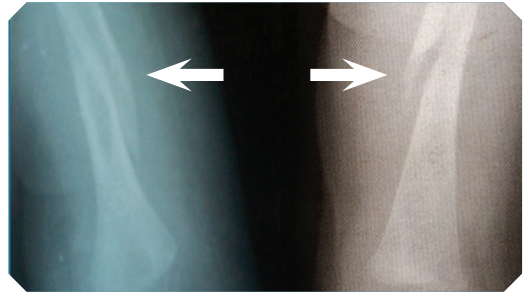
Blunt trauma to mouth⁴



Immersion burn of hand⁴

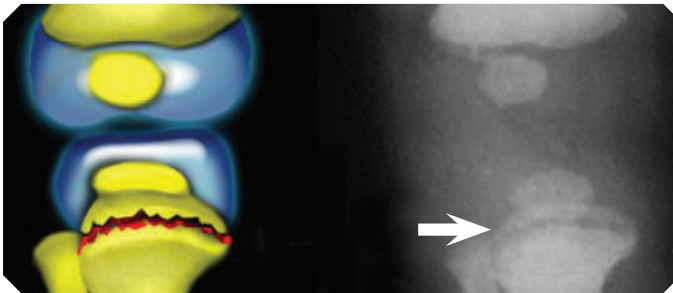
SKELETAL INJURIES

Diaphyseal Fractures

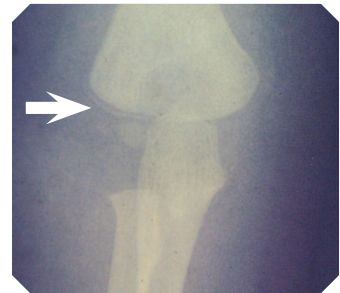


Spiral Fractures in long bones of infants³

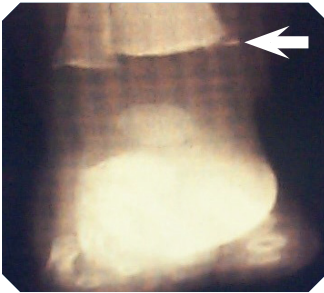
Metaphyseal Fractures



Bucket Handle fracture⁵



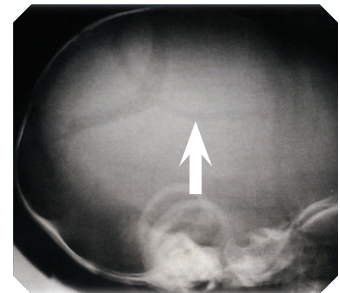
Bucket Handle fracture¹



Corner/Chip fracture¹

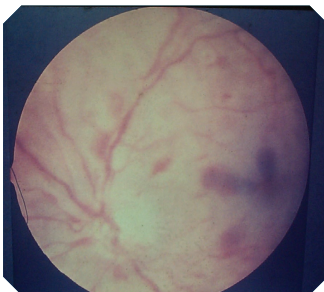


Sub-periosteal reaction in a healing fracture. Delayed presentation for medical attention⁴



Skull Fracture³

Visceral Injuries



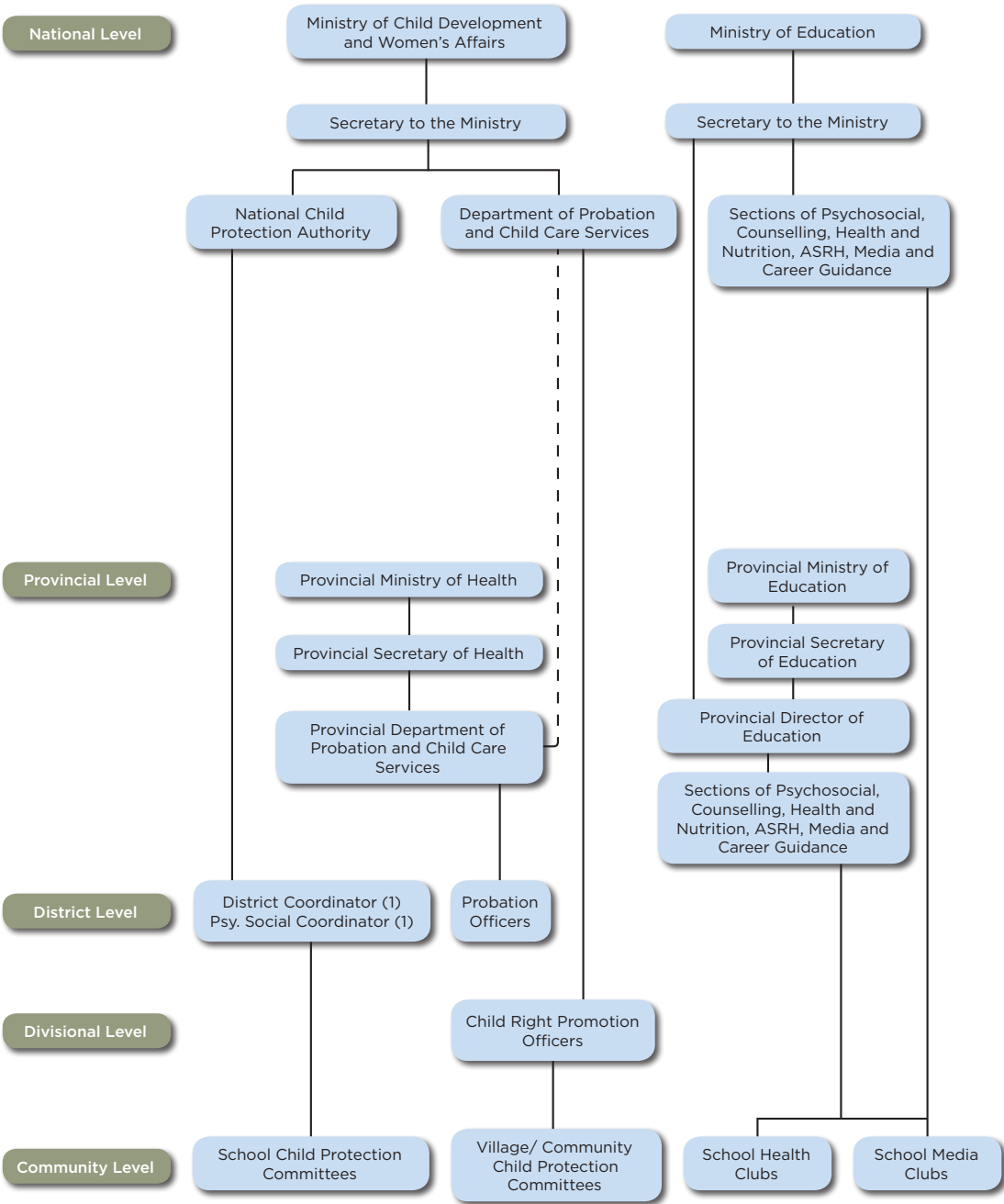
Retinal Haemorrhages in shaken baby syndrome¹

Photo courtesy/Source:

1. Christopher J. Hobbs, Physical Signs of Child Abuse: A Colour Atlas, 2nd Edition.
2. Dr. Deepal Fernando, MO medico-legal, Teaching Hospital, Ragama
3. Professor Asvini D. Fernando, Department of Paediatrics, Faculty of Medicine, Ragama.
4. Dr. Anuruddhi Edirisinghe, Department of Forensic Medicine, Faculty of Medicine, Ragama
5. www.radiologyassistant.nl

MULTI-SECTORAL STRUCTURE FOR WELLBEING

SOCIAL



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graph TD
    subgraph LEGAL
        MD[Ministry of Defence] --> SM[Secretary to the Ministry]
        SM --> IG[Inspector General of Police]
        IG --> DIG[Deputy Inspector General for Children and Women's Bureau]
        DIG --> NLB[National Level Bureau for Children and Women]
        MD --> SDIG[Senior Deputy Inspector General for the Province]
        SDIG --> DIG2[Deputy Inspector General for the District]
        DIG2 --> DLB[District Level Bureau for Children and Women]
        DLB --> CWD[Children and Women's Desk]
        CWD --> CDC[Civil Defence Committees]
        JSC[Judiciary Service Commission] --> SC[Supreme Court]
        JSC --> AC[Appeal Court]
        JSC --> JC[Juvenile Court]
        JSC --> PC[Provincial Courts]
        PC --> DC[District Courts]
        DC --> MC[Magistrate Courts]
        MC --> MB[Mediation Boards]
        AGD[Attorney General's Department] --> SG[Solicitor General]
        SG --> ASG[Additional Solicitor General]
        ASG --> DSG[Deputy Solicitor General]
        DSG --> SSC[Senior State Councillors]
        SSC --> SC2[State Councillors]
    end

    subgraph MEDICAL
        MJ[Ministry of Justice] --> LDD[Legal Draftsman Department]
        MJ --> PMO[Medical Officers of Health]
        PMO --> PHIP[Public Health Inspectors]
        PMO --> PHM[Public Health Midwife]
        PMO --> PHN[Public Health Nurse]
        MH[Ministry of Health] --> SMH[Secretary to the Ministry]
        SMH --> HEB[Health Education Bureau]
        SMH --> PMH[Provincial Ministry of Health]
        PMH --> PSH[Provincial Secretary of Health]
        PSH --> PDH[Provincial Director of Health]
        PDH --> PPH[Paediatricians, Psychiatrists and Judiciary Medical Officers attached to the Base Hospitals]
        MJ --> PPH2[Paediatricians, Psychiatrists and Judiciary Medical Officers attached to the Teaching and General Hospitals]
    end

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The organizational chart is divided into two main sections: LEGAL and MEDICAL. The LEGAL section includes the Ministry of Defence, Judiciary Service Commission, Attorney General's Department, and Ministry of Justice. The MEDICAL section includes the Ministry of Health and Ministry of Justice. The chart shows the hierarchy of various departments and offices, including the Inspector General of Police, Deputy Inspector General for Children and Women's Bureau, National Level Bureau for Children and Women, Senior Deputy Inspector General for the Province, Deputy Inspector General for the District, District Level Bureau for Children and Women, Children and Women's Desk, Civil Defence Committees, Provincial Courts, District Courts, Magistrate Courts, Mediation Boards, Solicitor General, Additional Solicitor General, Deputy Solicitor General, Senior State Councillors, State Councillors, Legal Draftsman Department, Health Education Bureau, Provincial Ministry of Health, Provincial Secretary of Health, Provincial Director of Health, Paediatricians, Psychiatrists and Judiciary Medical Officers attached to the Teaching and General Hospitals, Paediatricians, Psychiatrists and Judiciary Medical Officers attached to the Base Hospitals, and Medical Officers of Health.

Ward for victims of child abuse in Health Institutions

“Lama Piyasa”

“A place where abuse ends and healing begins”.



The Ministry of Health has accepted this concept to accommodate child victims (up to 18 years) of abuse and neglect in Health Institutions.

Aim: To provide a comprehensive care for victims of abuse in a secure, homely environment.

Comprehensive care includes;

- » Management of medical / legal issues
- » Management of psychological sequelae of abuse
- » Assessment and provision of psycho- social needs of the victims of abuse in liaison with the relevant agencies.

It is anticipated that at least one Lama Piyasa in a Province will have facilities for recording of video evidence from child victims.

All sectors involved will have access to the facility.

- » Medical specialties Forensic, Paediatrics, Psychiatry, Surgical specialties, Obstetrics and Gynaecology and any other medical specialty that may be involved in the management of a particular victim.
- » Nursing staff – as appointed by the Medical administrator of the

hospital

- » Non Health Sector - Probation officers, Child Rights Promotion Officers (CRPOs), Psycho-social officer of the National Child Protection Authority and Police officers.
- » Confidentiality and empathic care is of vital importance

Location: Within the hospital premises

Admission/Management & Discharge Policies:

Admission : An admission plan to be instituted in consulting with the medical administrator and the medical specialists.

Management: Essentially multi-sectoral based on a care plan with a good understanding among the team members about respective ideas to facilitate the psycho-social rehabilitation

Discharge: Procedure to be decided upon the decision of the case conference.

Psychiatrist report

Content of the Report

The report will be important in supporting the findings by the Specialist in Forensic Medicine and will help the supportive services such as Probation and Child Care or Social Services towards making effective decision in providing the relevant care for the child. Therefore, the report should be relevant to the context and focused. Duplicating information already known and unnecessary details that would mask the important issues are better avoided.

Salient points of the report include;

1. Who made the referral and for what reason.
2. Who was interviewed – child alone, child with mother, aunt etc.
3. Findings of the assessment
 - » History and mental state
 - » Highlight specific emotional and behavioural features elicited in the assessment that indicate the nature of abuse and its psychological impact
 - » Psychiatric diagnosis if relevant
 - » Specific vulnerabilities and persistent risks in the child and environment that would compromise the safety of the child
4. Conclusions drawn from the assessment
5. Recommendations about
 - » Ensuring safety
 - » Appropriate placement that

would meet the mental health needs of the child

- » Need for psychological therapy and where such service could be accessed

A sample report written by a Specialist in Psychiatric

23.4.2013.

Re: Mas S.... (12 years, DOB-31/12/2000)

Thank you for referring the above named child for assessment. For the purpose of assessment and provision of this report, the following persons were interviewed to obtain information.

1. S was assessed at the Lady Ridgeway Hospital on 9. 4.2013. and 19.4.2013.
2. S's paternal grandmother (Ms. D P) on 10.4.2013.
3. S's paternal uncle (Mr. U A) on 10.4.2013.
4. Ms. I, the warden of the Maakola Detention Centre on 10.4.2013.

Background

S's paternal grandmother was his main care giver since the age of one year. His mother apparently left the family when S was one year old and his father re-married when he was 10 years old.

The grandmother could not give details of S's inherent temperamental traits but she remembered that S had always been restless and over active from a young age. According to grandmother, S was impulsive and prone to get physically

injured from jumping off heights and by attempting to play with fire. There were many complaints about S from school for being inattentive, restless and being disruptive by running out of classroom. He was uncooperative with the teachers and apparently made inappropriate comments. He often picked fights with peers and was physically aggressive towards them. He is known to steal money and lie about it when confronted. He had short-lasting friendships mostly with boys older than him. S likes his pets but also tends to harass them. More lately, S had gone missing from home and school and grandmother did not know his whereabouts. He had gone missing for several days and was brought back home by the police after being found wandering in Colombo City.

Two years ago, S disclosed to his grandmother that he was sexually abused by 4 older peers. The alleged abuse had taken place in the school premises. The boys had apparently took S to an unoccupied hall and forced him to have oral sex with them.

S was 9 ½ years of age at the time. The grandmother claimed that she informed the school authorities about the incidence and soon after that, she presented the child to the LRH Child Psychiatry Unit for assessment. However no written records were found. S was seen again in the LRH Child Psychiatry unit one year later in February 2011,

and was given the diagnosis of conduct disorder and hyperactivity. He was given medication but defaulted treatment. Subsequently, S disclosed

to his grandmother that he had sexual encounters with many persons, mostly with his consent. Sometimes he received financial benefits from the perpetrators which he spent to play video games.

About a month ago, S claims that he was abducted by a man he met during the Veil Festival in Wellawatta. S was allegedly exposed to pornographic movies by this man. S fell asleep after drinking a glass of milk given to him by this man. He woke up later with pain in the anal and genital areas. Since then this man took S to various locations and sexually abused S several times. S stayed with this man for nearly two weeks. S claims he ran away from the man as he felt that he may not be able to return home. Maradana Police found him wandering in the streets and returned him home. However, grandmother felt that she no longer could provide safety due to S's tendency to frequently run away. He was produced in Court and placed in Makola Detention Centre.

Mental State Examination:

S was well groomed, dressed in clean clothing. He has many scars on his body. He was calm and composed and did not display any anxiety, low mood or restlessness throughout the assessment. He was reasonably cheerful, given the circumstance of an unfamiliar setting and did not appear worried about the fact that he had been repeatedly questioned about his experiences. S did not express any specific preoccupations, wishes or immediate plans for himself.

Cognitive Assessment:**Intelligence Quotient (IQ) Test**

IQ was measured using the Test of Non-Verbal Intelligence (TONI-3). This assesses aptitude, intelligence, abstract reasoning, and problem solving in a completely language-free format. S showed average intellectual ability. He was able to understand the test format and content well. He initially cooperated well with the testing but later seemed to lose interest.

Assessment of Executive Function using Trail Making Test

S took longer than average time to complete the test. However he did not make any mistakes while doing the test. There was inattention and easy distractibility.

Mathematical Ability

Mathematical ability was poor. He had trouble with multiplication and division. He is not up to the standard of a twelve year old.

Reading and Writing

S refused to cooperate in writing initially but later copied a sentence. He wrote legibly and clearly. He read at age appropriate level clearly and confidently.

Opinion

S is an intellectually normal child with good educational potential. However, from the history obtained from persons who know him, S prefers to do things on his terms and as he wishes rather than comply with adults. He had learnt to have a life for himself by repeatedly absconding from home. He does not seem to understand social risks and boundaries and puts himself repeatedly at risk of exploitation. He also does not understand the gravity and implications of his behaviour. Therefore, his safety and educational requirements can only be met through institutional care.

Recommendations for Facilitating Psychosocial Rehabilitation & Reintegration of Child

A. Serial number:

B. Hospital :

C. Ward Number :

D. Bed Head Ticket No. :

E. Court :

F. Date of Trial :

I. Reference details :

a. MLEF number :

b. Date of issue :

c. Police station/Court :

J. Identification

Full name :

Date of birth :

Age :

If date of birth is not known estimated age :

Sex:

Address:

K. Preliminary details

Place of the case conference :

Date and time of the case conference :

L. Case summary and conclusions:

M. Recommendations :

- » Placement
- » Medical Management
- » Psychosocial rehabilitation & re-integration
- » School / vocational training
- » Follow up plan

Participants at the Institutional Case Conference

- » Confidentiality Clause

I hereby certify that I will hold all information divulged and generated during the case conference of _____ (name of the child) on _____ (date) at _____ (place) strictly confidential.

These five recommendations will be included in Social Inquiry Report compiled by the Probation Officer. This will be the means of communicating the recommendations of the Institutional Case Conference to Courts.

Name	Designation	Signature

CYPO section 17 and IG circular on Police Probation Coordination

17. (1) Where a child or young person is to be brought before a Magistrate's Court or before a Juvenile Court in respect of an offence alleged to have been committed by him, or as being in need of care or protection, the officer in charge of the police station to which the child or young person is taken shall forthwith notify the day and hour when and the nature of the charge or other grounds on which, the child or young person is to be brought before the court, to the probation officer, or one of the probation officers, for the area within the jurisdiction of such court.
- (2) A probation officer who has received a notification under the last foregoing subsection shall make such investigations and render available to the court such information as to the home surroundings, school record, health, and character of the child or young person as appear to him to be likely to assist the court.

Reporting on Child Abuse

(Handbook for Journalists - National Child Protection Authority)

Journalism is not just a profession or an industry. Journalists can readily be described as a group of unofficial public servants. Newspapers, radio, television, and the internet have created the idea of a global village. The media takes selected events and reports the facts, interprets them, and even provides opinions in some cases. All these can be seen in how the media handles child abuse cases.

However, it is the media's responsibility to be very careful in such cases as it deals with the country's future generation.

What journalists need to remember when reporting on cases of child abuse:

- » Don't reveal names of victims In reporting cases of child abuse, there have been occasions where journalists have reported personal details of the victims, such as name, age, village, and school. Such details should never be revealed in cases of child abuse.
- » Don't publish photographs or air video of victims Some media institutions have been guilty of publishing photographs or airing video of victims. If photographs and video are being published or aired, it is the responsibility of the media institution to do so in such a way that the victims cannot be identified. Ex: If publishing/airing photographs or video of a child who has been

subjected to physical abuse, media can show the areas of the body that had been subjected to abuse (such as arms or legs). If the victim is being photographed or videoed, the permission should always be obtained from both the victim and their families or guardians. Obtain the permission of the Child or their families or guardians before using him/her for commercials.

- » Report such incidents in a manner that does not encourage sexual perversions and violence.
- » Be mindful not to publish false information. All the facts need to be fully verified when reporting such incidents. During the course of its investigations into certain incidents of this nature, the National Child Protection Authority has found that the media has sometimes published false information relating to a case.
- » Do not report speculations relating to cases.
- » Do not offend people's sensitivities and violate ethics. Some journalists have reported such cases in ways that have not only offended sensitivities of the public, but have also crossed ethical boundaries. This must not happen and responsible reporting needs to be practiced.
- » The behavior of those reporting on these cases should be respectful to the victims.
- » The production of cartoons aiming children should be done in a way which is free from indicating violence.

- » The media should not simply report these incidents, but do so in a manner that creates awareness among the public so that such incidents aren't repeated.
- » The media has a responsibility towards fostering the subject of child protection among people's attitudes through their reporting.
- » The child should not be reabused when it comes to the reportings of these cases.
- » Journalists should practice in-depth investigative journalism when reporting on such cases.
- » Media institutions should make more efforts to produce programmes that are aimed at preventing child abuses in society.
- » Journalists should always protect the identity of sources that provide them with information regarding child abuses cases.
- » Journalists should be considerate of their social responsibilities when reporting on these

Law & Child Abuse

According to Sri Lankan Law:

1. The legal age for consent for sex is 16 years.
2. The legal age of marriage for children in Sri Lanka is 18 years.

❖ Regulations issued by the Commissioner of Labour, Sri Lanka:

- » Employment of a child under the age of 14yrs is prohibited in Sri Lanka, They can be employed only before and after school time by his /her parents for their agricultural or gardening activities.
- » Children under 14yrs cannot be employed in domestic labour.
- » Children under 14yrs can participate only in vocational training programs conducted by the state or recommended technical colleges.
- » Children under 14yrs should not be allowed to participate in public performances where tickets are being sold. They may however, be allowed to participate in charitable events organized by school or drama society or however tickets are not being sold.
- » Children under the age of 16yrs should not be engaged in performances of a dangerous nature.
- » Children less than 16yrs of age should not be engaged in any performances endangering his/her life or limbs.

Circular on Corporal Punishment

Corporal punishment in schools is prohibited by the Circular Number 2005/17, titled “Maintaining Discipline in School” issued by the Ministry of Education on 11.05.2005. Alternative ways of disciplining children are also described in the circular mentioned above.

Alternative Ways of Disciplining Children

- » Organize curricular and extra-curricular activities in schools to prevent students engaging in bad behaviours in school, teach them about the rules and regulations prevalent in schools. Do not allow and accept wrong act.
- » Be an example of good behaviour and let them learn by good adult models.
- » If he/she does a very wrong act, a decision regarding the punitive action to be taken should be made by a panel. The panel should include the principal. A child can be suspended for a maximum period of 2 weeks. The decision should be conveyed to the parents.
- » If the act is very wrong, depending on the seriousness of the act, the child can be transferred to another school, to the same grade with the approval of the Zonal/Provincial Director of Education. Every single act against the student should be recorded and kept in the school. This information should not be publicized in the school or outside the school.

Members of the Child Protection Committee of Sri Lanka College of Paediatricians

Prof. Asvini D Fernando (Chairperson)	Dr. Samantha Waidyanatha
Prof. Harendra de Silva	Dr. Shanthini Ganeshan
Dr. Kalyani Guruge	Dr. Srian Fernando
Prof. Wasantha Karunasekera	Dr. Nishadie Ranasinghe
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Dr. Lilanthi de Silva	Dr. Ranmali Rodrigo

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NOTES

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



Creating Safe communities For Children

A Project for the Protection of Children from
Abuse, Exploitation, Violence and Neglect

www.protectingthechild.org

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