

REPORTING OF ABUSE OR DELIBERATE NEGLECT OF CHILD
(Regulation 33)
[SECTION 110 OF THE CHILDREN'S ACT 38 OF 2005]

**REPORTING OF ABUSE TO PROVINCIAL DEPARTMENT OF SOCIAL DEVELOPMENT,
DESIGNATED CHILD PROTECTION ORGANISATION OR POLICE OFFICIAL**

NOTE: A SEPARATE FORM MUST BE COMPLETED FOR EACH CHILD

TO: The Head of the Department

Pursuant to section 110 of the Children's Act, 2005, and for purposes of section 114(1)(a) of the Act, you are hereby advised that a child has been abused in a manner causing physical injury/ sexually abused/ deliberately neglected or is in need of care and protection.

Source of report (do not identify person)				<input type="checkbox"/> Victim	<input type="checkbox"/> Relative	<input type="checkbox"/> Parent	
<input type="checkbox"/> Neighbour				<input type="checkbox"/> friend			<input type="checkbox"/> Professional (specify)
<input type="checkbox"/> Other (specify)							
Date Reported to child protection organisation:				DD	MM	CCYY	
1. INFORMANT: (DETAILS OF PERSON WHO REPORTS ALLEGED ABUSE)							
Surname			Full name(s)				
Gender:	M	F	Date of Birth:	DD	MM	CCYY	
Age / Estimated Age:			Relationship to Child:				
* ID no:			* Passport no:				
Contact no:							
2. CHILD: (COMPLETE PER CHILD)							
Surname			Full name(s)				
Gender:	M	F	Date of Birth:	DD	MM	CCYY	
School Name:			Grade:	Age / Estimated Age:			
* ID no:			* Passport no:				
Contact no:							
3. CATEGORY OF CHILD IN NEED OF CARE AND PROTECTION							
<input type="checkbox"/> Child abuse		<input type="checkbox"/> Child labour		<input type="checkbox"/> Child trafficking		<input type="checkbox"/> Street child	
<input type="checkbox"/> Commercial sexual exploitation			<input type="checkbox"/> Exploited children		<input type="checkbox"/> Child abduction		

4. OTHER INTERVENTION – CONTACT PERSON TRUSTED BY CHILD	
Surname:	Name:
Physical address:	Telephone number:
Other children interviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No Number :	

5. CAREGIVER INFORMATION (If not same as trusted person or parent(s) of child)	
Surname:	Name:
Physical Address:	Postal address
Relationship to child:	
Telephone number:	Mobile:

6. ALLEGED ABUSER						
5.1) Surname				Full Name(s)		
Date of Birth:	DD	MM	CCYY	Gender:	M	F
ID No:	Age:					
* Passport No:	* Drivers license number:					
Also known as:	Relationship to child:					
Street Address (include postal code):	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Grandfather <input type="checkbox"/> Grandmother <input type="checkbox"/> Step father <input type="checkbox"/> Step mother <input type="checkbox"/> Foster father <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Foster mother <input type="checkbox"/> Sibling <input type="checkbox"/> Caregiver <input type="checkbox"/> Professional: social worker/police officer/teacher/caregiver/priest/dr/volunteer <input type="checkbox"/> Other (specify) Other (specify)					
	Postal Code:					
5.2) WHEREABOUTS OF ALLEGED PERPETRATOR:						
<input type="checkbox"/> Section 153 (Request for removal by SAPS) <input type="checkbox"/> Still in home <input type="checkbox"/> In hospital (Name/Place.....) <input type="checkbox"/> In detention (Name/Place.....)						

Living somewhere else (Address.....)

Whereabouts unknown Un-identified

6. PARENTS OF CHILD (If other than above)						
Surname: Father / Step-father				Full name(s)		
Date of Birth:	DD	MM	CCYY	Gender:	M	F
ID number:				Age:		
Surname: Mother / Step-mother				Full name(s)		
Date of Birth:	DD	MM	CCYY	Gender:	M	F
ID number:				Age:		
Names and ages of siblings or other children if helpful for tracking						
Surname		Full names			Age/Date of birth	
Street Address (include postal code):					Postal Code:	

7. ABUSE								
Date of Incident:			If date unknown (mark with X here):	Episodic		Reported to CPR:		
DD	MM	CCYY		Yes	No	DD	MM	CCYY
Place of incident: <input type="checkbox"/> Child's home <input type="checkbox"/> Field <input type="checkbox"/> Tavern <input type="checkbox"/> School <input type="checkbox"/> Friend's place <input type="checkbox"/> After school centre <input type="checkbox"/> ECD Centre <input type="checkbox"/> Neighbour <input type="checkbox"/> Private hostel <input type="checkbox"/> Child and youth care centre <input type="checkbox"/> Foster home <input type="checkbox"/> Temporary safe care <input type="checkbox"/> temporary respite care <input type="checkbox"/> Other (specify)								
7.1) TYPE OF ABUSE (Tick only the one that indicates the key motive of intent)								
Physical			Emotional		Sexual		Deliberate neglect	
7.2) INDICATORS (Check any that apply)								
<u>PHYSICAL:</u> <input type="checkbox"/> Abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Burns/Scalding <input type="checkbox"/> Fractures <input type="checkbox"/> Other physical illness <input type="checkbox"/> Cuts <input type="checkbox"/> Welts								

<input type="checkbox"/> Repeated injuries <input type="checkbox"/> Fatal injury (date of death)			
<input type="checkbox"/> Injury to internal organs		<input type="checkbox"/> Head injuries	
<input type="checkbox"/> Poisoning (specify)		<input type="checkbox"/> No visible injuries (elaborate)	
<input type="checkbox"/> Other Behavioral or physical (specify)			
<u>EMOTIONAL:</u> <input type="checkbox"/> Withdrawal <input type="checkbox"/> Depression <input type="checkbox"/> Self destructive aggressive behaviour			
<input type="checkbox"/> Corruption through exposure to illegal activities		<input type="checkbox"/> Deprivation of affection	
<input type="checkbox"/> Exposure to anti-social activities		<input type="checkbox"/> Exposure to family violence	
<input type="checkbox"/> Parent or care giver negative mental condition		<input type="checkbox"/> Inappropriate and continued criticism	
<input type="checkbox"/> Humiliation	<input type="checkbox"/> Isolation	<input type="checkbox"/> Threats	<input type="checkbox"/> Development Delays
<input type="checkbox"/> Rejection	<input type="checkbox"/> Accusations	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Lack of cognitive stimulation
<input type="checkbox"/> Mental, emotional or developmental condition requiring treatment (specify)			
<u>SEXUAL:</u> <input type="checkbox"/> Contact abuse <input type="checkbox"/> Rape <input type="checkbox"/> Sodomy			
<input type="checkbox"/> Masturbation	<input type="checkbox"/> Oral sex area	<input type="checkbox"/> Molestation	
<input type="checkbox"/> Non contact abuse (flashing, peeping)		<input type="checkbox"/> Irritation, pain, injury to genital	
<input type="checkbox"/> Other indicators of sexual molestation or exploitation (specify)			
<u>DELIBERATE NEGLECT:</u> <input type="checkbox"/> Malnutrition <input type="checkbox"/> Medical <input type="checkbox"/> Physical <input type="checkbox"/> Educational			
<input type="checkbox"/> Refusal to assume parental responsibility		<input type="checkbox"/> Neglectful supervision	<input type="checkbox"/> Abandonment
7.3) Indicate overall degree of risk to child:			
<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Unknown
7.4) Where applicable, tick the secondary type of abuse or multiple abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Sexual	Physical	Emotional	Deliberate Neglect
Brief explanation of occurrence(s) (including a statement describing frequency and duration)			
8. MEDICAL INTERVENTION (*)			
Examined by:	Treatment received:	Where (name of hospital, clinic, private doctor):	Hospitalised:
<input type="checkbox"/> Doctor	<input type="checkbox"/> Yes		<input type="checkbox"/> For assessment
<input type="checkbox"/> Reg. Nurse	<input type="checkbox"/> No		<input type="checkbox"/> For treatment

			<input type="checkbox"/> As temporary safe care (place of safety)
Contact person:	Contact person:	Contact person:	Contact person:
Telephone No:	Telephone No:	Telephone No:	Telephone No:

9. CHILDREN'S COURT INTERVENTION (*)			
Removal of child to temporary safe care (Section 152):		Date	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	MM	DD
		CCYY	

10. SAPS: (ACTION RELATED TO ALLEGED ABUSER(S)) - (*)				
Reported to SAPS:		Charges laid:		Date
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	DD
				MM
				CCYY
CASE NR		Police Station		Telephone Nr
Name of Police Officer			Rank of Police Officer	

11. CHILD KNOWN TO DESIGNATED CHILD PROTECTION ORGANISATION (DCPO)/ SOCIAL DEVELOPMENT (DSD)?		
11.1) Child known to DCPO/DSD ?:		
		<input type="checkbox"/> Yes
		<input type="checkbox"/> No
Name of DCPO/DSD Office:	Contact number	Reference number

12. DETAILS OF PERSON WHO REPORTS ALLEGED ABUSE (Refers to a professional or mandatory obliged to report child abuse in terms of Section 110(1))		
Surname:	Name:	Name of employer:
CAPACITY		
Employer Address	Work Telephone Nr	Fax Number
Email Address		

(*) = Complete if information is available or applicable

I declare that the particulars set out in the above mentioned statement are true and correct to the best of my knowledge.

Signature of official: _____

Date: _____

