

FEEDBACK REPORT: FORM 23

REPORTING OF ABUSE OR DELIBERATE NEGLECT OF CHILD TO DIRECTOR-GENERAL

(Regulation 33)

[SECTION 110(5) OF THE CHILDREN'S ACT 38 OF 2005]

REPORTING OF ABUSE TO DIRECTOR-GENERAL

**NOTE: A SEPARATE FORM MUST BE COMPLETED FOR EACH CHILD**

TO: The Director-General

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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 we have received a report that a child has been abused in a manner causing physical injury/sexually abused/deliberately neglected or is in need of care and protection. \* Kindly include the particulars listed below in Part A of the National Child Protection Register.

Source of report (do not identify person)	<input type="checkbox"/> Victim	<input type="checkbox"/> Relative	Parent <input type="checkbox"/>
<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. 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:						

2. DISABILITY (*)	
Disability:	Nature
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Blind <input type="checkbox"/> Deaf <input type="checkbox"/> Hard of hearing <input type="checkbox"/> Physical disability <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Mental disability: <input type="checkbox"/> Developmental <input type="checkbox"/> Psychiatric <input type="checkbox"/> Other(specify)

3. CHRONIC ILLNESS (*)	
Chronic illness:	Nature
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Diabetic <input type="checkbox"/> Cancer <input type="checkbox"/> Liver <input type="checkbox"/> HIV/ Aids <input type="checkbox"/> Epileptic <input type="checkbox"/> Tuberculoses <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Other(Specify)

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<b>4. CATEGORY OF CHILD IN NEED OF CARE AND PROTECTION</b>	
<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
<b>5. OTHER INTERVENTION – CONTACT PERSON TRUSTED BY CHILD</b>	
Surname:	Name:
Address:	Telephone number:
Other children interviewed: <input type="checkbox"/> Yes <input type="checkbox"/> No Number :	
<b>6. CAREGIVER INFORMATION ( If not same as trusted person or parent(s) of child)</b>	
Surname:	Name:
Physical Address:	Postal address
Relationship to child:	
Telephone number:	Mobile:
<b>7. ALLEGED ABUSER</b>	
7.1) Surname	Full Name(s)
Date of Birth: DD MM CCYY	Gender: M F
ID No:	Age:
* Passport No:	* Drivers license:
Also known as:	Relationship to child: <input type="checkbox"/> Father <input type="checkbox"/> Mother
Street Address (include postal code):	<input type="checkbox"/> Grandfather <input type="checkbox"/> Grandmother <input type="checkbox"/> Step father
Postal Code:	<input type="checkbox"/> Step mother <input type="checkbox"/> Foster father <input type="checkbox"/> Uncle <input type="checkbox"/> Aunt
	<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)
<b>7.2) WHEREABOUTS OF ALLEGED ABUSER:</b>	

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Section 153 (Request for removal by SAPS)       Still in home  
 In hospital (Name/Place.....)  
 In detention (Place.....)  
 Living somewhere else       Whereabouts unknown       Unidentified

7.3 ABUSE HAS BEEN CONFIRMED: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date	DD	MM	CCYY
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Type:     Physical     Emotional     Sexual     Deliberate Neglect

**8. PARENTS OF CHILD (if other than above)**

Surname: Father / Step-father				Full name(s)			
Date of Birth:	DD	MM	CCYY	Gender:	M	F	
ID no:				Age:			
Surname: Mother / Step-mother				Full name(s)			
Date of Birth:	DD	MM	CCYY	Gender:	M	F	
ID no:				Age:			
Also known as:							
Names and ages of siblings or other children if helpful for tracking							
Surname		Full named			Age/Date of birth		
Street Address (include postal code):						Postal Code:	

**9. ABUSE**

Date of Incident:			If date unknown(mark with X here):	Episodic/ongoing from (date)			Reported to CPR:		
DD	MM	CCYY		DD	MM	CCYY	DD	MM	CCYY

Place of incident:     Child's home     Field     Tavern       School       Friend's place  
 After school centre     ECD Centre     Neighbour     Private hostel       Foster home  
 Child and youth care centre     Temporary safe care     Other (specify)

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<b>9.1) TYPE OF ABUSE (Tick only the one that indicates the key motive of intent)</b>			
Physical	Emotional	Sexual	Deliberate neglect
<b>9.2) INDICATORS (Check any that apply)</b>			
<b>PHYSICAL:</b> <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"/> No visible injuries (elaborate)		<input type="checkbox"/> Poisoning (specify)	<input type="checkbox"/> Other Behavioral or physical (specify)
<b>EMOTIONAL:</b> <input type="checkbox"/> Withdrawal <input type="checkbox"/> Depression <input type="checkbox"/> Self destructive aggressive behavior			
<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"/> Oppression	<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)		
<b>SEXUAL:</b> <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)			
<b>DELIBERATE NEGLECT:</b> <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
<b>9.3) Indicate overall degree of Risk to child:</b>			
<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> Unknown
<b>9.4) When applicable, tick the secondary type of abuse or multiple abuse:    <input type="checkbox"/> Yes    <input type="checkbox"/> No</b>			
Sexual	Physical	Emotional	Deliberate Neglect
Brief explanation of occurrence(s) (including a statement describing frequency and duration)			

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10. MEDICAL INTERVENTION (*)			
<b>Examined by:</b> <input type="checkbox"/> Doctor  <input type="checkbox"/> Reg. Nurse	<b>Treatment received</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Where (name of hospital, clinic, private doctor)</b>	<b>Hospitalised:</b> <input type="checkbox"/> For assessment <input type="checkbox"/> For treatment <input type="checkbox"/> As place of safety
<b>Contact person</b>	<b>Contact person</b>	<b>Contact person</b>	<b>Contact person</b>
<b>Telephone number</b>			

11. CHILDREN'S COURT INTERVENTION (*)							
<b>Removal of child to temporary safe care (Section 152):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Date</b> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">MM</td> <td style="width: 25%; text-align: center;">DD</td> <td style="width: 25%; text-align: center;">CCYY</td> <td style="width: 25%;"></td> </tr> </table>		MM	DD	CCYY	
MM	DD	CCYY					
<b>Children's Court Opening:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>Name of Court</b>	<b>Reference Number</b>	<b>Date</b>					
		DD	MM CCYY				
<b>Movement of children placed in alternative care:</b>							
- Child absconding from Alternative Care ( Section 170) <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>Date</b>		<b>Where to (place)</b>					
DD	MM	CCYY					
-Removal of child already in alternative care (Section 173): <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>Date</b>		<b>Where to (place)</b>					
DD	MM	CCYY					
- Provisional transfer from alternative Care (Section 174) : <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>Date</b>		<b>Where to (place)</b>					
DD	MM	CCYY					
<b>Other (specify):</b>							

12. SAPS: (ACTION RELATED TO ALLEGED ABUSER(S)) - (*)							
<b>Reported to SAPS:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Charges laid:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					
		<b>Date</b> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 25%; text-align: center;">DD</td> <td style="width: 25%; text-align: center;">MM</td> <td style="width: 25%; text-align: center;">CCYY</td> <td style="width: 25%;"></td> </tr> </table>		DD	MM	CCYY	
DD	MM	CCYY					

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<b>CASE NR</b>	<b>Police Station</b>	<b>Telephone Nr</b>
<b>Name of Police Officer</b>		<b>Rank of Police Officer</b>
<b>12.1) Police intervention:</b> <input type="checkbox"/> None <input type="checkbox"/> Joint intervention <input type="checkbox"/> Informal contact <input type="checkbox"/> Charges laid <input type="checkbox"/> Police investigation		<b>11.2) Offender guilty of previous abuse:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If Yes, Type of conviction:</b>  <b>Date:</b> DD      MM      CCYY

<b>13. TYPE OF FACILITY</b> (If child is placed as a preventative measure or statutory placed – SECTION 191(2))	
<b>Name:</b>	<b>Street address (include postal code):</b>
	<b>Postal code</b>
<b>Type:</b> <input type="checkbox"/> Reception and temporary safe care <input type="checkbox"/> Reception, and care of street children <input type="checkbox"/> Reception, development and secure care <input type="checkbox"/> Reception, care and development of children on a shared basis	

<b>14. CURRENT FUNCTIONING OF THE FAMILY:</b>							
<b>CAUSATIVE FACTORS</b>	<b>Complete if not known to a welfare organisation : Current Situation</b>		<b>If known to organisation/ department</b>				
			<b>Deterioration ( To be completed on subsequent assessment)</b>		<b>Improvement (To be completed on subsequent assessment)</b>		<b>Unchanged (To be completed on subsequent assessment)</b>
<b>14.1) Parents</b>	<b>Yes</b>	<b>No</b>	<b>Slight</b>	<b>Significant</b>	<b>Slight</b>	<b>Significant</b>	
<input type="checkbox"/> Heavy child care responsibilities							
<input type="checkbox"/> lack of support system							
<input type="checkbox"/> marital difficulties							
<input type="checkbox"/> lack of knowledge of child care / development							
<input type="checkbox"/> physical violence/ corporal punishment acceptable							
<input type="checkbox"/> different cultural/ sub-cultural/ religious norms							

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<input type="checkbox"/> alcohol/drug abuse							
<input type="checkbox"/> physical illness							
<input type="checkbox"/> mental illness							
<input type="checkbox"/> personality disorder							
<input type="checkbox"/> intellectual limitation							
<input type="checkbox"/> abused in childhood							
14.2) Child	If child is known to Child Protection Organization						
	Current situation		Deterioration		Improvement		Unchanged
	Yes	No	Slight	Significant	Slight	Significant	
<input type="checkbox"/> unwanted							
<input type="checkbox"/> premature							
<input type="checkbox"/> disabled							
<input type="checkbox"/> behaviour problem/ provocative							
<input type="checkbox"/> other							

14.3) Environment	If child is known to Child Protection Organization						
	Current situation		Deterioration		Improvement		Unchanged
	Yes	No	Slight	Significant	Slight	Significant	
<input type="checkbox"/> unemployment							
<input type="checkbox"/> social isolation	Yes	No					
<input type="checkbox"/> housing: I = Informal F = Formal	I	F					
<input type="checkbox"/> finances: U = unemployed E = employed	U	E					
<input type="checkbox"/> other							

14.4) Services provided	By (Name of service provide)	Date: From-to
<input type="checkbox"/> psychiatric/psychological assessment		
<input type="checkbox"/> psychiatric treatment		
<input type="checkbox"/> counseling		
<input type="checkbox"/> medical treatment		
<input type="checkbox"/> health care workers		
<input type="checkbox"/> parent education courses		

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<input type="checkbox"/> parents/ self help group		
<input type="checkbox"/> volunteer support		
<input type="checkbox"/> home community base care		
<input type="checkbox"/> child and youth care worker		
<input type="checkbox"/> foster care		
<input type="checkbox"/> day care		
<input type="checkbox"/> substance abuse treatment		
<input type="checkbox"/> material needs/ financial assistance		
<input type="checkbox"/> housing		
<input type="checkbox"/> employment		
<input type="checkbox"/> child taken into care		
<input type="checkbox"/> other		
<input type="checkbox"/> none (give reasons)		

**14.5) Evaluation of case**

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**14.6) Planning for family and child at risk**

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**14.7) Recommendation**

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Investigation conducted by: (Name of Organisation):	Date		
	DD	MM	CCYY
Reporting person:			
Caseworker(s) (please print):	Signature:		

**15. PERSON(S) WITH WHOM IS CHILD LIVING AT TIME OR AFTER AN INCIDENT**  
(If other than above)

Surname		Full Name(s)	
Gender	M	F	Age:



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<b>Also known as:</b>	<b>Relationship to child:</b>	<b>Street Address (include postal code)</b>  <b>Postal code</b>
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<b>16. INVESTIGATING DESIGNATED SOCIAL WORKER</b>		
<b>Name of Social Worker</b>	<b>Employer</b>	
<b>Employer Address</b>	<b>Work Telephone Number</b>	<b>Fax Number</b>
<b>Email Address</b>	<b>Reference Number</b>	

(\* = Complete if information is available, applicable or information has changed

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

Signature of investigating designated social worker: \_\_\_\_\_

Date: \_\_\_\_\_

<p><b>Official Stamp of Department/Child Protection Organisation</b></p>
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