Safeguarding and Child Protection Policy

Whenever we say parents in this document, we mean parents and carers, and whenever we say child, we mean children and young people aged 0 to 19 years old [up to 25 years old for young people with special educational needs and disability (SEND)]. Whenever we say staff, we include all paid employees as well as any volunteers.

Key Contacts:	
Designated Safeguarding Lead (DSL):	Glenys Creese
Designated Safeguarding Deputy:	Pilar Cloud
Lead Trustee for Child Protection:	Carol King
West Sussex Children's Services - Multi-Agency Safeguarding Hub (MASH):	Tel: 01403 229900 (Out of Hours – 0330 222 6664) MASH@westsussex.gcsx.gov.uk

1. Purpose

This policy is in-line with the guidance from the West Sussex Safeguarding Children Board. It includes an explanation of the action to be taken in the event of an allegation being made against a member of staff, and covers the use of mobile phones and cameras in the setting (EYFS Welfare and safeguarding requirements 3:3.4). It also contains an explanation as to the actions staff must take if they have reason to believe that a child or vulnerable adult is being harmed.

The safeguarding of children is everyone's responsibility and something that the Charity takes very seriously.

Annex 1 of this policy gives guidance on when to be concerned that a child is being abused.

The employees along with the trustees takes seriously their responsibility to safeguard and promote the welfare of children in their care; and to work together with other agencies to ensure adequate arrangements within our Charity to identify, assess, and support children who are, or who may be, suffering harm.

We recognise that all adults, including temporary staff, volunteers and trustees, have a full and active part to play in protecting children from harm, and that the child's welfare is our paramount concern.

All staff believe that our Charity should provide a caring, positive safe and stimulating environment that promotes the social, physical and moral development of the individual child and families.

Staff members working with children are advised to maintain an attitude of 'it could happen to a child we know' where safeguarding is concerned. When

concerned about the welfare of a child, staff members should always act in the interests of the child.

This Charity will;

- Support the child's development in ways that will foster security, confidence and independence.
- Provide an environment in which children and young people feel safe, secure, valued, respected, feel confident, and know how to approach adults if they may be worried.
- Provide a systematic means of monitoring children known or thought to be at risk of harm, and ensure we, the Charity, contribute to assessments of need and support packages for those children, if required.
- Emphasise the need for good levels of communication between all members of staff and between other agencies, if the Charity knows that other professionals are working with the family, for example if a family if referred to the Charity through a Portage worker or a Specialist Health Visitor.
- Have and regularly review a structured procedure within the Charity which will be followed by all staff in cases of suspected abuse.
- Develop and promote effective working relationships with other agencies, especially the Police and Children's Social Care.
- Ensure that all adults within our Charity who have substantial access to children have been recruited and checked as to their suitability in accordance with Part Three of Keeping Children Safe in Education (DfE September 2016)1.

2 STATUTORY FRAMEWORK

The Charity will act in accordance with the following government legislation and guidance:

- The Children Act 1989
- The Children Act 2004
- Education Act 2002
- Keeping Children Safe in Education (DfE September 2016): Keeping children safe in education: for schools and colleges

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/550511/Keeping_children_safe_in_education.pdf

- Working Together to Safeguard Children (2015) Working together to safeguard children
- The Education (Child Information) (England) Regulations 2005
- The Counter-Terrorism and Security Act 2015 s. 26

3 CONFIDENTIALITY

As a general principle, all matters relating to child protection are confidential and should only be shared on a 'need-to-know' basis.

The Executive Manager or Head of Service (Designated Safeguarding Lead) will disclose any child protection related information about a child to other members of staff on a need to know basis only.

All staff must be aware that they have a professional responsibility to share information with other agencies in order to safeguard children.

All staff must be aware that they cannot promise a child to keep secrets if doing so might compromise the child's safety or wellbeing.

The intention to refer a child to Children's Social Care will be shared with parents/carers unless to do so could put the child at greater risk of harm, or impede a criminal investigation. If in doubt, advice should be sought from MASH.

4 RESPONSIBILITIES

<u>All staff responsibilities</u>

All staff have an important role to play in supporting vulnerable children and identifying concerns early and providing help. To achieve this they will:

1. Establish and maintain an environment where children feel secure, are encouraged to communicate, and are listened to.

2. Be aware of the signs of abuse and maintain an attitude of "it could happen here" with regards to child protection.

3. Ensure that children know that there are adults in the Charity whom they can approach if they are worried about any problems.

4. Know what to do if a child tells them they are being abused or neglected. Know how and where to record their concerns and report these to the Designated Safeguarding Lead as soon as possible.

5. If a child is in immediate danger, know how to refer the matter to Children's Social Care and/or the Police immediately.

6. If the Charity is aware that a Child attending the Charity has a Child Protection Plan they should support the child in line with their Plan and notify the Designated Safeguarding Lead of any child on a Child Protection Plan who has an unexplained absence.

7. Service staff will actively plan opportunities within the sessions for children to develop the skills they need to assess and manage risk appropriately and keep themselves safe.

8. Be aware of and follow the Sussex Child Protection & Safeguarding Procedures, produced by West Sussex, East Sussex, and Brighton & Hove. This will include the referral process.

9. Must have read and understand Part 1 of Keeping Children Safe in Education September 2016 and be alert to signs of abuse and know to whom they should report any concerns or suspicions.

10. Participate in safeguarding training as part of their induction.

11. Receive safeguarding and child protection updates as required but at least annually, to provide them with relevant skills and knowledge to safeguard children.

12. Ensure that they know who the Designated and Deputy Safeguarding Lead(s) is / are and how to contact them.

13. Refer to the Head of Service or Excusive Manager if they have concerns about another member of staff.

Where the concerns are about the Head of Service or Executive Manager, this should be referred to the Trustee with Safeguarding responsibility.

<u>Special Educational Needs & Disabilities</u>

As a Charity working primarily with children with SEN and disabilities, we are aware that these children can face additional safeguarding challenges and expect all staff to recognise and challenge where appropriate;

- Assumptions that can be made that indicators of possible abuse such as behaviour, mood and injury relate to the child's disability and not identified as potential signs of abuse;

- The potential for children with SEN and disabilities being disproportionally impacted by behaviours such as bullying, without showing any signs; and

- The communication barriers for some children with SEN and disabilities.

Responsibilities of the Trustees

The nominated trustee for child protection in this Charity is:

Name: __Carol King_____

The responsibilities placed on trustees and proprietors include:

1. Making sure that the safeguarding policies & procedures in the Charity are effective and comply with the law at all times. This should include a child protection policy (reviewed at least annually and available online); and a staff behaviour policy (sometimes called a code of conduct) which should amongst other things include acceptable use of technologies staff/child relationships and communications including the use of social media.

2. Appointing a Designated Safeguarding Lead who is part of the senior staff team and has this recorded on their job description in line with Annex B of Keeping Children Safe in Education 2016.

3. Ensuring that any safeguarding deficiencies or weaknesses within the Charity are remedied without delay, and informing West Sussex Safeguarding Board about the discharge of duties via the safeguarding audit.

4. Ensuring that there are procedures in place to handle allegations against all staff members.

5. Recognising that neither the trustees, nor an individual trustee, has a role in pursuing or managing the processes associated with individual cases of child protection. Recognising that neither trustees nor an individual trustee has a right to know details of such cases, except when exercising their disciplinary functions in respect of allegations against staff.

6. Making sure all staff have been trained appropriately and that this is updated in line with guidance.

7. Ensuring that the Charity is contributing to inter-agency working, which includes providing a coordinated offer of early help when additional needs of children are identified.

8. For e-learning, making sure that appropriate filters and appropriate monitoring systems are in place, safeguarding against potentially harmful and inappropriate online material.

9. Giving consideration as to how children may be taught about safeguarding, including online, through teaching and learning opportunities, as part of providing a broad and balanced service.

10. Ensuring that the Charity creates a culture of safe recruitment and, as part of that, adopt recruitment procedures that help deter, reject or identify people who might abuse children (Part Three: Safer Recruitment. Keeping Children Safe in Education, September 2016).

    This includes ensuring that we take up references for each shortlisted candidate **before** interview that at least one member of any appointing panel, including shortlisting, will have attended safer recruitment training.

11. The Charity keeps an up to date Single Central Record (SCR) of all staff and volunteers and the dates of all appropriate safeguarding checks.

Responsibilities of Designated Safeguarding Lead (DSL)

In the Charity, any individual can contact the designated safeguarding lead if they have concerns about a child.

The Designated Safeguarding Lead in this Charity is:

NAME: _____Glenys Creese_____Date____30/05/2018

Whilst the activities of the designated safeguarding lead can be delegated to appropriately trained deputies, the ultimate lead responsibility for child protection, as set out above, remains with the designated safeguarding lead; this lead responsibility should not be delegated.

The Designated Safeguarding Lead will:

1. Attend initial training for their role and refresh this every two years. They will keep their knowledge and skills updated at least annually.

2. Ensure that all staff know who the Designated Safeguarding Lead is, their role and how to make contact.

3. Ensure that all staff understand their responsibilities in relation to signs of abuse and responsibility to refer any concerns to the Designated Safeguarding Lead. In addition, the Designated Safeguarding Lead should ensure that all staff read and understand Part One of Keeping Children Safe in Education 2016 and have a record of when this was done.

4. Ensure that new staff participate in safeguarding training as part of their induction, and that all staff receive safeguarding and child protection updates as required but at least annually, to provide them with relevant skills and knowledge to safeguard children.

The designated safeguarding lead is expected to:

1. Refer cases of suspected abuse to the West Sussex MASH. Where a referral is made that notes are completed that same day.

2. Refer cases where a person is dismissed or left due to risk/harm to a child to the Disclosure and Barring Service as required; and

3. Refer cases where a crime may have been committed to the Police as required.

4. Work with Others

4.1. Liaise with the Executive Manager or Head of Service (if different from the DSL) to inform him or her of issues especially ongoing enquiries under section 47 of the Children Act 1989 and police investigations.

4.2. As required, liaise with the case manager and where required, the local authority designated officer, in all cases involving allegations against members of staff (both current and former members of staff).

4.3. Liaise with staff on matters of safety and safeguarding and when deciding whether to make a referral by liaising with relevant agencies. Act as a source of support, advice and expertise for staff.

5. Training

5.1. As well as training all members of staff as above, the DSL should undergo training to provide them with the skills required to carry out the role. This training should be updated at least every two years.

5.2. The designated lead should undertake Prevent awareness training.

6. The safeguarding lead;

6.1. Should be afforded time to allow them to understand and keep up with any developments relevant to their role so they:

6.2. Have a working knowledge of how local authorities conduct a child protection case conference and a child protection review conference and be able to attend and contribute to these effectively when required to do so;

6.3. Ensure each member of staff has access to and understands the Charity's Child Protection Policy and procedures, especially new and part time staff;

6.4. Are alert to the specific needs of children in need, those with special educational needs and young carers;

6.5. Are able to keep detailed, accurate, secure written records of concerns and referrals; separately from the main child'

6.6. Maintain up to date files and use these records to assess the likelihood of risk. The written records should clearly identify details of the concerns and what action was taken. If these are stored electronically, that they are differently password protected from the child's other files, and accessible only by the head teacher/designated leads.

6.7. Understand and support the Charity with regards to the requirements of the Prevent duty and are able to provide advice and support to staff on protecting children from the risk of radicalisation;

6.8. Obtain access to resources and attend any relevant or refresher training courses;

6.9. Encourage a culture of listening to children and taking account of their wishes and feelings, among all staff, in any measures the school or college may put in place to protect them;

6.10. Act as a source of support, advice and expertise to staff on matters of safety and safeguarding and when deciding whether to make a referral by liaising with relevant agencies.

6.11. Ensure the Charity's Child Protection Policy is reviewed annually, the procedures and implementation are updated and reviewed regularly, and work with trustees or the Executive Manager regarding this.

6.12. Be responsible for making the senior leadership team aware of trends in behaviour that may affect child welfare.

5 CHILD PROTECTION PROCEDURES

If any member of staff has concerns about a child (as opposed to a child being in immediate danger[2])

[2] If a child is in immediate danger, then the Police should be contacted immediately.

1. The member of staff will report their concerns to the Designated Safeguarding Lead.

2. The Designated Safeguarding Lead will decide whether the concerns should be referred to Multi-Agency Safeguarding Hub (MASH). If there are grounds for actual or suspected significant harm, then a referral will be made to the MASH via telephone in the first instance. If the Designated Safeguarding Lead is unsure about whether a referral is required, they should contact the MASH for advice.

3. If it is decided to make a referral to the MASH, this will be usually be discussed with the parents, unless to do so would place the child at further risk of harm or could impact on a police investigation (the MASH is able to provide advice on this).

4. The member of staff will make an accurate and detailed recording (which may be used in any subsequent court proceedings) as soon as possible and on the same day. The signed and dated recording must be a clear, precise, factual account of the observations. Do not add comments or opinion although observations about a child's demeanour or emotional state may be recorded.

5. MASH will require a follow up of any phone call in writing from the referrer. The Designated Safeguarding Lead will ensure that any written referrals are made using the request for Support form available here http://www.westsussexscb.org.uk/professionals/contacts-for-referral/ and can also be found on the LSCB website.

If a member of staff has concerns about another staff member

1. An allegation is any information which indicates that a member of staff/volunteer may have:
   I. Behaved in a way that has, or may have harmed a child
   II. Possibly committed a criminal offence against/related to a child
   III. Behaved towards a child or children in a way which indicates s/he would pose a risk of harm if they work regularly or closely with children

2. This applies to any child the member of staff has contact with in their personal, professional or community life.

3. To reduce the risk of allegations, all staff should be aware of safer working practice and the Government document '*Guidance for Safer Working Practice for Adults who work with Children and Young People in Education Settings*'.
http://webarchive.nationalarchives.gov.uk/20100202100434/dcsf.gov.uk/everychildmatters/resources-and-practice/ig00311/

4. If staff have concerns about another staff member, then this should be referred to the Head of Service in the first instance. If the allegation is against the Head of Service the staff member with concerns should talk with either the Executive Manager or the trustee with safeguarding lead responsibilities.

5. The person to whom an allegation is first reported should take the matter seriously and keep an open mind. S/he should not investigate or ask leading questions if seeking clarification. It is important not to make assumptions. Confidentiality should not be promised and the person should be advised that the concern will be shared on a 'need to know' basis only.

6. Actions to be taken include:

   I. Making an immediate written record of the allegation using the informant's words - including time, date and place where the alleged incident took place, brief details of what happened, what was said and who was present.

   II. This record should be signed, dated and immediately passed on to the Head of Service/Executive Manager/Trustee with lead safeguarding responsibilities.

7. If there are concerns that a child is at risk, then the matter must be immediately reported to MASH.

8. **Whistleblowing.**

We will ensure that all staff members are aware of their duty to raise concerns, where they exist, about the actions or attitudes of colleagues. If necessary, the member of staff can speak with the Head of Service, the Executive Manager or the Trustee with Lead Safeguarding responsibilities.

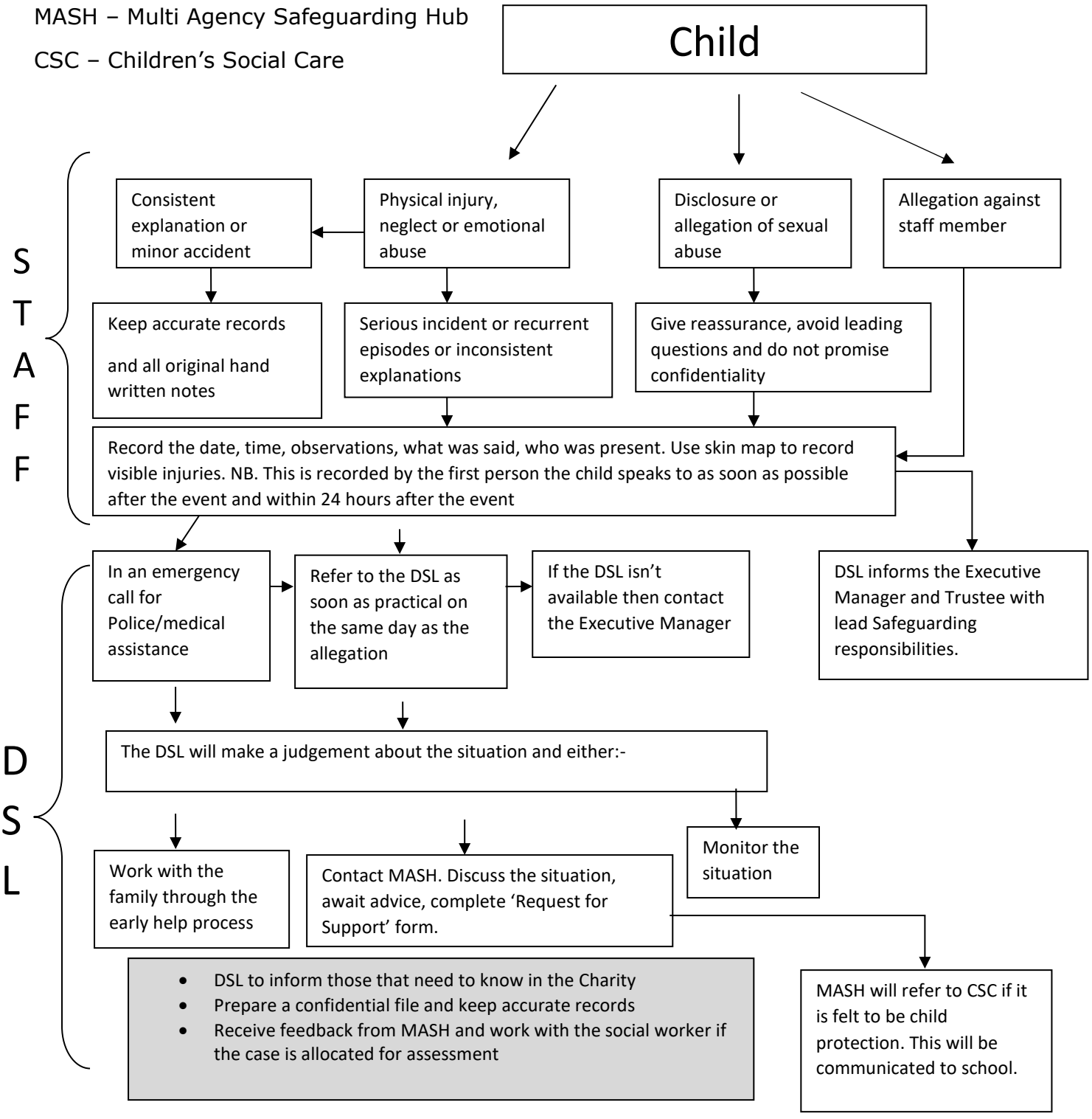
Further assistance for staff to raise concerns can be accessed by calling the NSPCC whistleblowing helpline on 0800 028 0285.

Flowchart for child protection procedures

DSL – Designated Safeguarding Lead

MASH – Multi Agency Safeguarding Hub

CSC – Children's Social Care



6 WHEN TO BE CONCERNED

All staff and volunteers should be aware of the main categories of abuse, which is a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. They may be abused by an adult or adults or another child or children:

- **Physical abuse**:
- A form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

- **Emotional abuse**:
- The persistent emotional maltreatment of a child such as to cause severe and adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental ability as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, although it may occur alone.

- **Sexual abuse**:
- Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images,

watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet) by establishing a close relationship or friendship. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

- **Neglect**:
- The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: provide adequate food, clothing and shelter (including exclusion from home or abandonment); protect a child from physical and emotional harm or danger; ensure adequate supervision (including the use of inadequate care-givers); or ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Other aspects of risk requiring special attention

In addition, the Charity staff should be aware of the specific safeguarding issues listed below. The Charity should ensure that, where such risks may be more likely, that staff are guided on how to understand and act accordingly where there is concern about:

- child missing from education
- child missing from home or care
- child sexual exploitation (CSE)
- bullying including cyberbullying
- domestic violence
- drugs
- fabricated or induced illness
- faith abuse
- female genital mutilation (FGM)
- forced marriage
- gangs and youth violence
- gender-based violence/violence against women and girls (VAWG)
- mental health
- Peer on peer
- private fostering
- preventing radicalisation
- self-harm
- sexting
- teenage relationship abuse
- trafficking

Links to many of these topics can be found in Keeping Children Safe in Education - Keeping children safe in education: for schools and colleges, page 12.

Annex 2 of this policy also considers some specific safeguarding concerns.

ANNEXES

ANNEX 1 – CHILD ABUSE AND INDICATORS OF HARM

PHYSICAL ABUSE

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Indicators in the child

Bruising

It is often possible to differentiate between accidental and inflicted bruises. The following must be considered as non-accidental unless there is evidence or an adequate explanation provided:

- Bruising in or around the mouth
- Two simultaneous bruised eyes, without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive)
- Repeated or multiple bruising on the head or on sites unlikely to be injured accidentally, for example the back, mouth, cheek, ear, stomach, chest, under the arm, neck, genital and rectal areas
- Variation in colour, possibly indicating injuries caused at different times
- The outline of an object used e.g. belt marks, hand prints or a hair brush
- Linear bruising at any site, particularly on the buttocks, back or face

- Bruising or tears around, or behind, the earlobe/s indicating injury by pulling or twisting
- Bruising around the face
- Grasp marks to the upper arms, forearms or leg
- Petechae haemorrhages (pinpoint blood spots under the skin.) Commonly associated with slapping, smothering/suffocation, strangling and squeezing

Fractures

Fractures may cause pain, swelling and discolouration over a bone or joint. It is unlikely that a child will have had a fracture without the carers being aware of the child's distress. If the child is not using a limb, has pain on movement and/or swelling of the limb, there may be a fracture.

There are grounds for concern if:

- The history provided is vague, non-existent or inconsistent
- There are associated old fractures
- Medical attention is sought after a period of delay when the fracture has caused symptoms such as swelling, pain or loss of movement

Rib fractures are only caused in major trauma such as in a road traffic accident, a severe shaking injury or a direct injury such as a kick.

Skull fractures are uncommon in ordinary falls, i.e. from three feet or less. The injury is usually witnessed, the child will cry and if there is a fracture, there is likely to be swelling on the skull developing over 2 to 3 hours. All fractures of the skull should be taken seriously.

Mouth Injuries

Tears to the frenulum (tissue attaching upper lip to gum) often indicates force feeding of a baby or a child with a disability. There is often finger bruising to the cheeks and around the mouth. Rarely, there may also be grazing on the palate.

Poisoning

Ingestion of tablets or domestic poisoning in children under 5 is usually due to the carelessness of a parent or carer, but it may be self-harm even in young children.

Fabricated or Induced Illness

Professionals may be concerned at the possibility of a child suffering significant harm as a result of having illness fabricated or induced by their carer. Possible concerns are:

- Discrepancies between reported and observed medical conditions, such as the incidence of fits
- Attendance at various hospitals, in different geographical areas
- Development of feeding / eating disorders, as a result of unpleasant feeding interactions
- The child developing abnormal attitudes to their own health
- Non organic failure to thrive - a child does not put on weight and grow and there is no underlying medical cause
- Speech, language or motor developmental delays
- Dislike of close physical contact
- Attachment disorders
- Low self esteem
- Poor quality or no relationships with peers because social interactions are restricted
- Poor attendance at school and under-achievement

Bite Marks

Bite marks can leave clear impressions of the teeth when seen shortly after the injury has been inflicted. The shape then becomes a more defused ring bruise or oval or crescent shaped. Those over 3cm in diameter are more likely to have been caused by an adult or older child.

A medical/dental opinion, preferably within the first 24 hours, should be sought where there is any doubt over the origin of the bite.

Burns and Scalds

It can be difficult to distinguish between accidental and non-accidental burns and scalds. Scalds are the most common intentional burn injury recorded.

Any burn with a clear outline may be suspicious e.g. circular burns from cigarettes, linear burns from hot metal rods or electrical fire elements, burns of uniform depth over a large area, scalds that have a line indicating immersion or poured liquid.

Old scars indicating previous burns/scalds which did not have appropriate treatment or adequate explanation. Scalds to the buttocks of a child, particularly in the absence of burns to the feet, are indicative of dipping into a hot liquid or bath.

The following points are also worth remembering:

- A responsible adult checks the temperature of the bath before the child gets in.
- A child is unlikely to sit down voluntarily in a hot bath and cannot accidentally scald its bottom without also scalding his or her feet.
- A child getting into too hot water of his or her own accord will struggle to get out and there will be splash marks

Scars

A large number of scars or scars of different sizes or ages, or on different parts of the body, or unusually shaped, may suggest abuse.

Emotional / behavioural presentation

- Refusal to discuss injuries
- Admission of punishment which appears excessive
- Fear of parents being contacted and fear of returning home
- Withdrawal from physical contact
- Arms and legs kept covered in hot weather
- Fear of medical help
- Aggression towards others
- Frequently absent from school

- An explanation which is inconsistent with an injury
- Several different explanations provided for an injury

Indicators in the parent

- May have injuries themselves that suggest domestic violence
- Not seeking medical help/unexplained delay in seeking treatment
- Reluctant to give information or mention previous injuries
- Absent without good reason when their child is presented for treatment
- Disinterested or undisturbed by accident or injury
- Aggressive towards child or others
- Unauthorised attempts to administer medication
- Tries to draw the child into their own illness.
- Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault
- Parent / carer may be over involved in participating in medical tests, taking temperatures and measuring bodily fluids
- Observed to be intensely involved with their children, never taking a much needed break nor allowing anyone else to undertake their child's care.
- May appear unusually concerned about the results of investigations which may indicate physical illness in the child
- Wider parenting difficulties may (or may not) be associated with this form of abuse.
- Parent / carer has convictions for violent crimes

Indicators in the family/environment

- Marginalised or isolated by the community
- History of mental health, alcohol or drug misuse or domestic violence
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement

EMOTIONAL ABUSE

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional

development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.

It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate.

It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Indicators in the child

- Developmental delay
- Abnormal attachment between a child and parent/carer e.g. anxious, indiscriminate or no attachment
- Aggressive behaviour towards others
- Child scapegoated within the family
- Frozen watchfulness, particularly in pre-school children
- Low self-esteem and lack of confidence
- Withdrawn or seen as a 'loner' - difficulty relating to others
- Over-reaction to mistakes
- Fear of new situations
- Inappropriate emotional responses to painful situations
- Neurotic behaviour (e.g. rocking, hair twisting, thumb sucking)
- Self-harm
- Fear of parents being contacted

- Extremes of passivity or aggression
- Drug/solvent abuse
- Chronic running away
- Compulsive stealing
- Low self-esteem
- Air of detachment – 'don't care' attitude
- Social isolation – does not join in and has few friends
- Depression, withdrawal
- Behavioural problems e.g. aggression, attention seeking, hyperactivity, poor attention
- Low self-esteem, lack of confidence, fearful, distressed, anxious
- Poor peer relationships including withdrawn or isolated behaviour

Indicators in the parent

- Domestic abuse, adult mental health problems and parental substance misuse may be features in families where children are exposed to abuse
- Abnormal attachment to child e.g. overly anxious or disinterest in the child
- Scapegoats one child in the family
- Imposes inappropriate expectations on the child e.g. prevents the child's developmental exploration or learning, or normal social interaction through overprotection
- Wider parenting difficulties may (or may not) be associated with this form of abuse

Indicators of in the family/environment

- Lack of support from family or social network
- Marginalised or isolated by the community
- History of mental health, alcohol or drug misuse or domestic violence
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement

NEGLECT

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's

health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.

Once a child is born, neglect may involve a parent or carer failing to:

- *provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
- *protect a child from physical and emotional harm or danger;*
- *ensure adequate supervision (including the use of inadequate care-givers); or*
- *ensure access to appropriate medical care or treatment.*

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Indicators in the child

Physical presentation

- Failure to thrive or, in older children, short stature
- Underweight
- Frequent hunger
- Dirty, unkempt condition
- Inadequately clothed, clothing in a poor state of repair
- Red/purple mottled skin, particularly on the hands and feet, seen in the winter due to cold
- Swollen limbs with sores that are slow to heal, usually associated with cold injury
- Abnormal voracious appetite
- Dry, sparse hair
- Recurrent / untreated infections or skin conditions e.g. severe nappy rash, eczema or persistent head lice / scabies/ diarrhoea
- Unmanaged / untreated health / medical conditions including poor dental health

- Frequent accidents or injuries

Development

- General delay, especially speech and language delay
- Inadequate social skills and poor socialization

Emotional/behavioural presentation

- Attachment disorders
- Absence of normal social responsiveness
- Indiscriminate behaviour in relationships with adults
- Emotionally needy
- Compulsive stealing
- Constant tiredness
- Frequently absent or late at school
- Poor self esteem
- Destructive tendencies
- Thrives away from home environment
- Aggressive and impulsive behaviour
- Disturbed peer relationships
- Self-harming behaviour

Indicators in the parent

- Dirty, unkempt presentation
- Inadequately clothed
- Inadequate social skills and poor socialisation
- Abnormal attachment to the child .e.g. anxious
- Low self- esteem and lack of confidence
- Failure to meet the basic essential needs e.g. adequate food, clothes, warmth, hygiene
- Failure to meet the child's health and medical needs e.g. poor dental health; failure to attend or keep appointments with health visitor, GP or hospital; lack of GP registration; failure to seek or comply with appropriate medical treatment; failure to address parental substance misuse during pregnancy
- Child left with adults who are intoxicated or violent
- Child abandoned or left alone for excessive periods

- Wider parenting difficulties, may (or may not) be associated with this form of abuse

Indicators in the family/environment

- History of neglect in the family
- Family marginalised or isolated by the community
- Family has history of mental health, alcohol or drug misuse or domestic violence.
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Family has a past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.
- Dangerous or hazardous home environment including failure to use home safety equipment; risk from animals
- Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements, inadequate ventilation (including passive smoking) and lack of adequate heating
- Lack of opportunities for child to play and learn

SEXUAL ABUSE

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening.

The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).

Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Indicators in the child

Physical presentation

- Urinary infections, bleeding or soreness in the genital or anal areas
- Recurrent pain on passing urine or faeces
- Blood on underclothes
- Sexually transmitted infections
- Vaginal soreness or bleeding
- Pregnancy in a younger girl where the identity of the father is not disclosed and/or there is secrecy or vagueness about the identity of the father
- Physical symptoms such as injuries to the genital or anal area, bruising to buttocks, abdomen and thighs, sexually transmitted disease, presence of semen on vagina, anus, external genitalia or clothing

Emotional / behavioural presentation

- Makes a disclosure
- Demonstrates sexual knowledge or behaviour inappropriate to age/stage of development, or that is unusually explicit
- Inexplicable changes in behaviour, such as becoming aggressive or withdrawn
- Self-harm - eating disorders, self-mutilation and suicide attempts
- Poor self-image, self-harm, self-hatred
- Reluctant to undress for PE
- Running away from home
- Poor attention / concentration (world of their own)
- Sudden changes in school work habits, become truant
- Withdrawal, isolation or excessive worrying
- Inappropriate sexualised conduct
- Sexually exploited or indiscriminate choice of sexual partners
- Wetting or other regressive behaviours e.g. thumb sucking
- Draws sexually explicit pictures
- Depression

Indicators in the parents

- Comments made by the parent/carer about the child.
- Lack of sexual boundaries
- Wider parenting difficulties or vulnerabilities
- Grooming behaviour
- Parent is a sex offender

Indicators in the family/environment

- Marginalised or isolated by the community
- History of mental health, alcohol or drug misuse or domestic violence
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement
- Family member is a sex offender

ANNEX 2 – SPECIFIC SAFEGUARDING ISSUES

- **A2.1 Child Sexual Exploitation**

1. Child sexual exploitation (CSE) involves exploitative situations, contexts and relationships where young people receive something (for example food, accommodation, drugs, alcohol, gifts, money or in some cases simply affection) as a result of engaging in sexual activities. Sexual exploitation can take many forms ranging from the seemingly 'consensual' relationship where sex is exchanged for affection or gifts, to serious organised crime by gangs and groups. What marks out exploitation is an imbalance of power in the relationship. The perpetrator always holds some kind of power over the victim which increases as the exploitative relationship develops. Sexual exploitation involves varying degrees of coercion, intimidation or enticement, including unwanted pressure from peers to have sex, sexual bullying including cyberbullying and grooming. However, it also important to recognise that some young people who are being sexually exploited do not exhibit any external signs of this abuse.

2. If you are a professional making a referral for a child or young person who is at risk of CSE, the 'screening tool' Part A would usually be completed:
3. http://www.westsussexscb.org.uk/professionals/helping-you-work/child-sexual-exploitation/
4. Completition of this should not delay you making a referral, however it may assist you in being clear about the key areas of concern and the level of risk.

- **A2.2 Female Genital Mutilation**

1. Female Genital Mutilation (FGM) comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs. It is illegal in the UK and a form of child abuse with long-lasting harmful consequences.

2. Professionals in all agencies, and individuals and groups in relevant communities, need to be alert to the possibility of a girl being at risk of FGM, or already having suffered FGM.

3. From 31st October 2015, regulated health and social care professionals and teachers in England and Wales must report 'known' cases of FGM in under 18's which they identify in the course of their professional work to the police.

4. The Home Office has published procedural information on the duty to help health and social care professionals, teachers and the police understand: the legal requirements placed upon them; a suggested process to follow; and an overview of the action which may be taken if they fail to comply with the duty. it also aims to give the police an understanding of the duty and the next steps upon receiving a report.

- Home Office: Mandatory Reporting of FGM – procedure information
- FGM Mandatory Reporting Fact Sheet
- FGM Reporting Flowchart for under 18's

- **A2.3 Preventing Radicalisation**

1. Protecting children from the risk of radicalisation should be seen as part of the Charity's wider safeguarding duties, and is similar in nature to protecting children from other forms of harm and abuse. During the process of radicalisation it is possible to intervene to prevent vulnerable people being radicalised.

2. Radicalisation refers to the process by which a person comes to support terrorism and forms of extremism[3]. There is no single way of identifying an individual who is likely to be susceptible to an extremist ideology. It can happen in many different ways and settings. Specific background factors may contribute to vulnerability which are often combined with specific influences such as family, friends or online, and with specific needs for which an extremist or terrorist group may appear to provide an answer. The internet and the use of social media in particular has become a major factor in the radicalisation of young people.

3. As with managing other safeguarding risks, staff should be alert to changes in children's behaviour which could indicate that they may be in need of help or protection. School staff should use their professional judgement in identifying children who might be at risk of radicalisation and act proportionately which may include making a referral to the Channel programme.

Prevent

4. From 1 July 2015 specified authorities, including all schools as defined in the summary of this guidance, are subject to a duty under section 26 of the Counter-Terrorism and Security Act 2015 ("the CTSA 2015"), in the

[3] Extremism is vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces, whether in this country or overseas

exercise of their functions, to have "due regard[4] to the need prevent people being drawn into terrorism[5]" must have regard to statutory guidance issued under section 29 of the CTSA 2015 ("the Prevent guidance"). Paragraphs 57-76 of the Prevent guidance are concerned specifically with schools (but also cover childcare, and as such, the Charity has also chosen to follow this guidance). It is anticipated that the duty will come into force for sixth form colleges and FE colleges early in the autumn.

5. The statutory Prevent guidance summarises the requirements on schools in terms of four general themes: risk assessment, working in partnership, staff training and IT policies:

6. Schools are expected to assess the risk of children being drawn into terrorism, including support for extremist ideas that are part of terrorist ideology. This means being able to demonstrate both a general understanding of the risks affecting children and young people in the area and a specific understanding of how to identify individual children who may be at risk of radicalisation and what to do to support them. Schools and colleges should have clear procedures in place for protecting children at risk of radicalisation. These procedures may be set out in existing safeguarding policies. It is not necessary for schools and colleges to have distinct policies on implementing the Prevent duty.
7. The Prevent duty builds on existing local partnership arrangements. For example, governing bodies and proprietors of all schools should ensure that their safeguarding arrangements take into account the policies and procedures of Local Safeguarding Children Boards (LSCBs).
8. The Prevent guidance refers to the importance of Prevent awareness training to equip staff to identify children at risk of being drawn into terrorism and to challenge extremist ideas. Individual schools are best placed to assess the training needs of staff in the light of their assessment of the risk to pupils at the school of being drawn into terrorism. As a minimum, however, schools should ensure that the Designated Safeguarding Lead undertakes Prevent awareness training and is able to provide advice and support to other members of staff on protecting children from the risk of radicalisation.
9. Schools must ensure that children are safe from terrorist and extremist material when accessing the internet in schools. Schools should ensure that suitable filtering is in place. It is also important that schools teach pupils about online safety more generally.

[4] According to the Prevent duty guidance 'having due regard' means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions

[5] "Terrorism" for these purposes has the same meaning as for the Terrorism Act 2000 (section 1(1) to (4) of that Act).

10. The Department for Education has issued advice and social media guidance to schools and childcare providers to help them keep children safe from the risk of radicalisation and extremism.

11. The **prevent duty advice** is for:

a) school leaders, school staff and governing bodies in all local maintained schools, academies and free schools
b) proprietors, governors and staff in all independent schools
c) proprietors, managers and staff in childcare settings
d) It will be of particular interest to safeguarding leads.

12. The **social media guidance** is for:

a) head teachers
b) teachers
c) safeguarding leads

What do I do if I am concerned someone is at risk of radicalisation?

13. School staff should understand when it is appropriate to make a referral to the Channel programme.[6] Channel is a programme which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. It provides a mechanism for schools to make referrals if they are concerned that an individual might be vulnerable to radicalisation. An individual's engagement with the programme is entirely voluntary at all stages.

14. Section 36 of the CTSA 2015 places a duty on local authorities to ensure Channel panels are in place. The panel must be chaired by the local authority and include the police for the relevant local authority area. Following a referral the panel will assess the extent to which identified individuals are vulnerable to being drawn into terrorism, and, where considered appropriate and necessary consent is obtained, arrange for support to be provided to those individuals. Section 38 of the CTSA 2015 requires partners of Channel panels to co-operate with the panel in the carrying out of its functions and with the police in providing information about a referred individual. Schools and colleges which are required to have regard to Keeping Children Safe in Education are listed in the CTSA 2015 as partners required to cooperate with local Channel panels.[7]

[6] Guidance issued under section 36(7) and section 38(6) of the CTSA 2015 in respect of Channel is available at: https://www.gov.uk/government/publications/channel-guidance
[7] Such partners are required to have regard to guidance issued under section 38(6) of the CTSA 2015 when co-operating with the panel and police under section 38 of the CTSA 2015

15. In West Sussex, two panels operate, meeting monthly - one specifically for Crawley, and the other for the rest of West Sussex.

- Prevent and Channel Duty – A Toolkit for Schools
- Channel General Awareness e-learning package
- Making a Channel Referral in West Sussex
- Prevent Channel Referral Form

- **A2.4 Peer on Peer Abuse**

1. The Charity believes that all children have a right to attend and learn in a safe environment. Children should be free from harm by adults in the school and other students

2. We recognise that some children will sometimes negatively affect the learning and wellbeing of others and their behaviour will be dealt with under the Charity's behaviour policy or bullying policy in the first instance.

3. However, we recognise that some allegations may be of such a serious nature that they may raise safeguarding concerns

4. **All staff** should be aware that safeguarding issues can manifest themselves via peer on peer abuse. This may include physical abuse, emotional abuse, sexual abuse and sexual exploitation and may manifest as (though not limited to): bullying (including cyber-bullying), gender based violence/sexual assaults and sexting. Such peer on peer abuse may take many different forms and present in many different ways – see below. **All staff** must be aware that children can be abusers and any concerns should be discussed with the designated safeguarding lead.

5. If Peer on Peer abuse is suspected staff should follow section 8.7 of the West Sussex Child Protection and Safeguarding Procedures - Children who Harm Other Children.

Allegations against other pupils which are safeguarding issues

1. Occasionally, allegations may be made against child by other child in the Charity which are of a safeguarding nature. Safeguarding issues raised in

this way may include physical abuse, emotional abuse, sexual abuse and sexual exploitation.

2. Professionals must decide in the circumstances of each case whether or not behaviour directed at another child should be categorised as abusive or not.
3. <u>It will be helpful to consider the following factors:</u>

1) Relative chronological and developmental age of the two children (the greater the difference, the more likely the behaviour should be defined as abusive)
2) A differential in power or authority (e.g. related to race or physical or intellectual vulnerability of the victim)
3) Actual behaviour (both physical and verbal factors must be considered)
4) Whether the behaviour could be described as age appropriate or involves inappropriate sexual knowledge or motivation
5) Physical aggression, bullying or bribery
6) The victim's experience and perception of the behaviour
7) The possibility the abuser is, or was, also a victim
8) Attempts to ensure secrecy
9) An assessment of the change in the behaviour over time (whether it has become more severe or more frequent)
10) Duration and frequency of behaviour.

<u>Examples of safeguarding issues against a child could include:</u>

Physical abuse

Violence, particularly pre-planned

Forcing others to use drugs or alcohol

Emotional abuse

Blackmail or extortion

Threats and intimidation (including racist or homophobic/religious remarks, cyber-bullying)

Isolating an individual from social activities

Sexting

Sexual abuse, including Sexting.

Indecent exposure, indecent touching or serious sexual assault

Forcing others to watch pornography or taking part in sexting

Sexual Exploitation

Encouraging other children to engage in inappropriate sexual behaviour

Photographing or videoing other children performing indecent acts

Procedure

If there is a safeguarding concern, the Designated Safeguarding Lead (DSL) should be informed.

1. A factual record should be made of the allegation, but no attempt at that stage should be made to investigate the circumstances (though further discussion with the alleged victim/perpetrator may be required by the school is further assessment required prior to safeguarding decision).
2. The Designated Safeguarding Lead should contact MASH to discuss the case.
3. The Designated Safeguarding Lead will follow through the outcomes of the discussion and make a referral when appropriate.
4. If the allegation indicates that a potential criminal offence has taken place, then MASH will consult with the police.
5. Parents of both the child being complained about and the alleged victim should be informed and kept updated on the progress of the referral, unless to do so would place the alleged victim at risk, and/or jeopardise a police investigation. If unsure, advice should be sought.
6. The Designated Safeguarding Lead will make a record of the concern and a copy will be kept on both childrens' files.
7. It may be appropriate to exclude the child being complained about for a period of time according to the Charity's behaviour policy and procedures.
8. Where neither Children's Social Care nor the Police accept the complaint, a thorough Charity investigation should take place in the matter using the school's usual disciplinary procedures.
9. In situations where the Charity considers a safeguarding risk is present, a risk assessment should be prepared along with a preventative plan. The plan should be monitored and a date set for a follow up review with everyone concerned.

ANNEX 3 – DEALING WITH A DISCLOSURE

If a child discloses that he or she has been abused in some way the member of staff should:

- Accept what the child says.
- Stay calm, the pace should be dictated by the child without them being pressed for detail. DO NOT ASK LEADING QUESTIONS such as "did x touch you there?" It is our role to listen - not to investigate.
- Use open questions such as "Is there anything else you want to tell me?" or "yes?" or "and?"
- Be careful not to burden the child with guilt by asking questions like "Why didn't you tell me before?" but you could ask 'Have you spoken to anyone else about this?'
- Acknowledge how hard it was for the child to tell you.
- Do not criticise the perpetrator, the child might have a relationship with them.
- Do not promise confidentiality, but reassure the child that they have done the right thing, explain whom you will have to tell (the designated lead) and why; and, depending on the child's age, what the next stage will be. It is important that you avoid making promises that you cannot keep such as "I'll stay with you all the time." or "It will be all right now.".

- If you are in any doubt as to whether to refer the matter, speak and discuss with MASH.

When recording information:

- Make detailed notes at the time or immediately afterwards; record the date, time, place and context of disclosure or concern. Record facts and what is said but not your assumption or interpretation.
- If it is observation of bruising or an injury try to record detail, e.g. "right arm above elbow". Do not take photographs!
- Note the non-verbal behaviour and the key words in the language used by the child (try not to translate into 'proper terms').
- It is important to keep these original notes and pass them on to the Designated Safeguarding Lead who may ask you to write a referral.

It is recognised that Charity staff who have become involved with a child who has suffered harm, or appears to be likely to suffer harm may find the situation stressful and upsetting. The Charity will support such staff by providing an opportunity to talk through their anxieties with the Designated Safeguarding Lead and to seek further support as appropriate.

ANNEX 4 – RECORDING FORM

Child's name:			
Date and time:		**DOB**	
Name and role of person raising concern:			

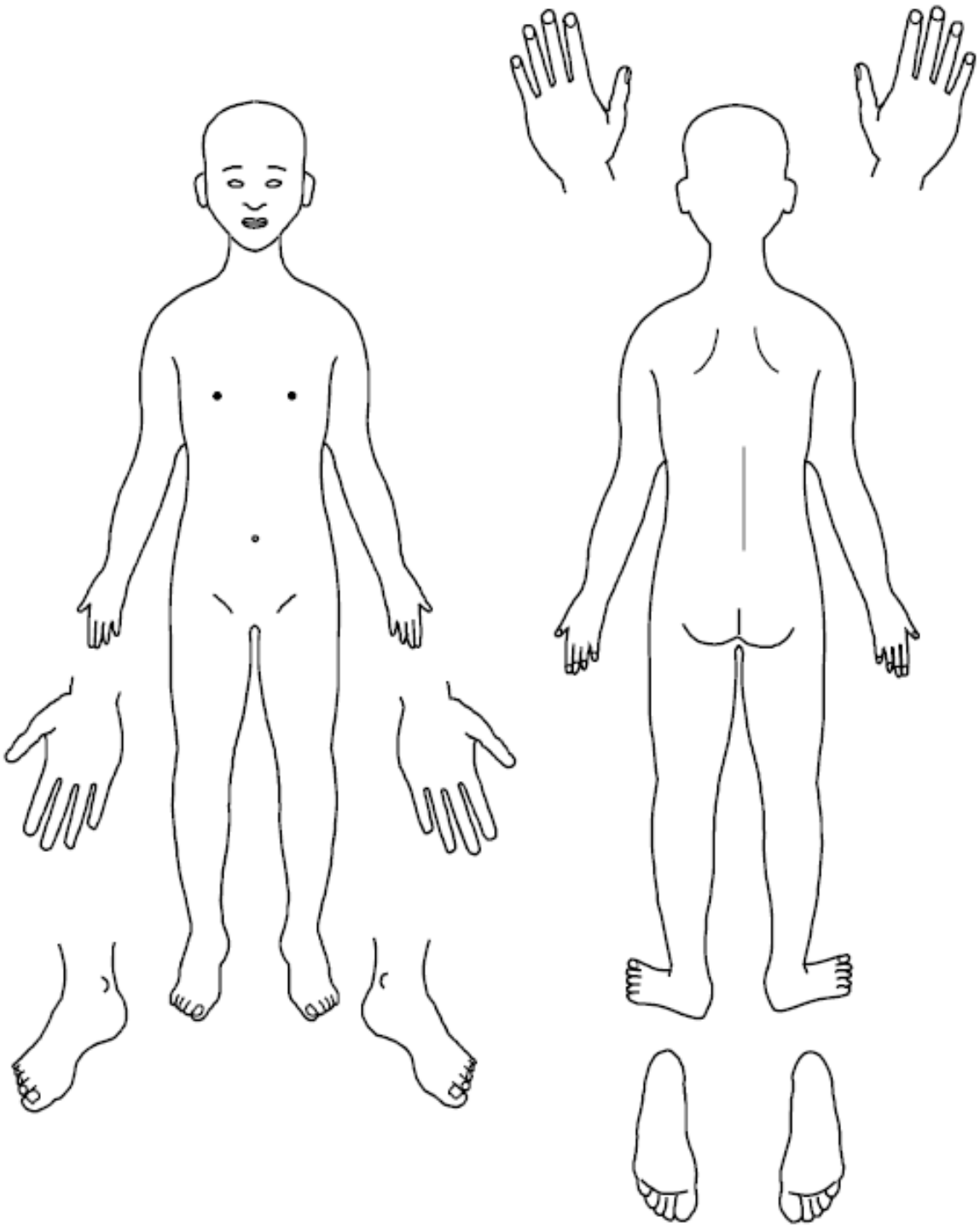
Details of concern (where? when? what? who? behaviours? use child's words)

Actions taken			
Date	**Person taking action**	**Action taken**	**Outcome of action**

Name: **Designation:**

Copied to:

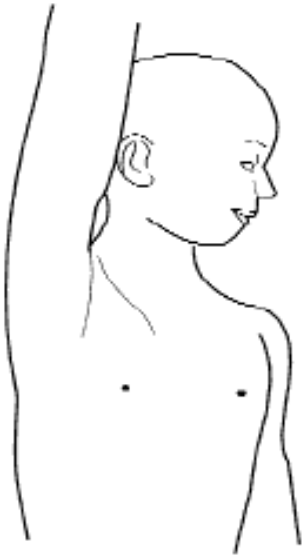
Skin map



Name of Child:
_____

Date of birth: _____ Date of recording: _____

Name of completer: _____



Any additional information: