Berkshire Sensory Consortium Service (SCS)

Child Protection Policy

Department:	
Author:	**Gillian Coles**
Date of issue:	**December 2014**
Review date:	**December 2015**
Reference:	

Policy Review

This policy will be reviewed in full by the Joint Management Group annually.

The policy was last reviewed and agreed by the Joint Management Group on *……01.01.15……*

It is due for review on *insert date* (up to 12 months from the above date).

Designated Safeguarding Lead ….……Date …01.01.16……

Head of Service : Gillian Coles. Date ….……05.01.2015…

Joint Management December via e-mail……..Date…December 2014……

C O N T E N T S

1. INTRODUCTION

Safeguarding is defined as protecting children from maltreatment, preventing impairment of health and/or development, ensuring that children grow up in the provision of safe and effective care and taking action to enable all children to have the best life chances.

This Child Protection Policy forms part of a suite of documents and policies which relate to the safeguarding responsibilities of Berkshire Sensory Consortium Service (SCS).

In particular this policy should be read in conjunction with the *Safer Recruitment Policy (RBWM), Behaviour Policy (School), Physical Intervention Policy(School), Anti-Bullying Policy(School), Code of Conduct/Staff Behaviour Policy (SCS) and ICT Acceptable Usage Policy (RBWM and school)*.

Purpose of a Child Protection Policy	To inform staff, parents, volunteers and stakeholders about the Service's responsibilities for safeguarding children. To enable everyone to have a clear understanding of how these responsibilities should be carried out.
Local Safeguarding Children Board (LSCB) Child Protection Procedures	The Service follows the procedures established by the LSCB (Local Safeguarding Children's Board) – Child Protection Procedures for all Berkshire unitary authorities **http://berks.proceduresonline.com**
SCS Staff	All Service staff have responsibility to provide a safe environment in which children can learn. Service staff and volunteers are particularly well placed to observe outward signs of abuse, changes in behaviour and failure to develop because they have daily contact with children. All Service staff will receive appropriate safeguarding children training (which is updated regularly – every 3 years Service staff and 2 years for the Designated Safeguarding Lead, so that they are knowledgeable and aware of their role in the early recognition of the indicators of abuse or neglect and of the appropriate procedures to follow. It is good practice for the Designated Safeguarding Lead to enable an annual update as part of Team meetings. Temporary staff will be made aware of the safeguarding policies and procedures by the Designated Safeguarding Lead.
Mission Statement	Establish and maintain an environment where children feel secure and are listened to when they have a worry or concern. Establish and maintain an environment where Service staff feel safe, are encouraged to talk and are listened to when they have

concerns about the safety and well being of a child.

Ensure children know that there are adults in the school whom they can approach if they are worried.

Ensure that children who have been abused will be supported in line with a child protection plan, where deemed necessary. This will often be through working with the Designated Safeguarding Lead in the school that the child or young person attends.

Ensure that in the curriculum delivery for children there are opportunities for them to develop the skills they need to recognise and stay safe from abuse.

Contribute to the five outcomes which are key to children's wellbeing:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic wellbeing

Consider how children may be taught about safeguarding, including online, through teaching and learning opportunities, as part of providing a broad and balanced curriculum.

Staff members working with children are advised to maintain an attitude of 'it could happen here' where safeguarding is concerned. When concerned about the welfare of a child, staff members should always act in the interests of the child.

Implementation, Monitoring and Review of the Child Protection Policy

The policy will be reviewed annually by the Joint Management Group. It will be implemented through the Service's induction and training programme, and as part of day to day practice. Compliance with the policy will be monitored by the Designated Senior Lead and through staff performance measures.

2. STATUTORY FRAMEWORK

In order to safeguard and promote the welfare of children, the Service will act in accordance with the following legislation and guidance:

- The Children Act 1989
- The Children Act 2004
- Education Act 2002 (section 175)
- Local Safeguarding Children's Board (LSCB) Child Protection and Safeguarding Children Procedures (Electronic)

- Keeping Children Safe in Education (DFE 2014)
- Keeping Children Safe in Education: information for all school and college staff (DFE 2014) – APPENDIX 2
- Working Together to Safeguard Children (DfE 2013)
- The Education (Pupil Information) (England) Regulations 2005

Working Together to Safeguard Children (DfE 2013) requires all schools to follow the procedures for protecting children from abuse which are established by the LSCB. Berkshire Sensory Consortium Service as a teaching service will be working within the framework required for schools.

Schools are also expected to ensure that they have appropriate procedures in place for responding to situations in which they believe that a child has been abused or are at risk of abuse - these procedures should also cover circumstances in which a member of staff is accused of, or suspected of, abuse.

Furthermore

Keeping Children Safe in Education (DfE April 2014) places the following responsibilities on all schools:

- Schools should be aware of and follow the procedures established by the Local Safeguarding Board

- Staff should be alert to signs of abuse and know to whom they should report any concerns or suspicions

- SCS should have procedures (of which all staff are aware) for handling suspected cases of abuse of pupils, including procedures to be followed if a member of staff is accused of abuse, or suspected of abuse

- A Designated Safeguarding Lead should have responsibility for co-ordinating action within the Service and liaising with other agencies

- Staff with the designated safeguarding lead should undergo updated child protection training every two years

Keeping Children Safe in Education (DfE April 2014) also states:

The Joint Management Group should ensure there is an effective child protection policy in place together with a staff behaviour policy (code of conduct). Both should be provided to all staff – including temporary staff – on induction. The child protection policy should describe procedures which are in accordance with government guidance and refer to locally agreed inter-agency procedures put in place by the LSCB, be updated annually, and be available publicly by the Service website.

3. THE DESIGNATED SAFEGUARDING

The Joint Management Group should ensure that SCS designates an appropriate senior member of staff to take lead responsibility for child protection. This person should have

the status and authority within the Service to carry out the duties of the post including committing resources and, where appropriate, supporting and directing other staff.

The Designated Safeguarding Lead (DSL) for Child Protection in this school is:

NAME: Gillian Coles (Head of Berkshire Sensory Consortium Service)

A Deputy DSP should be appointed to act in the absence/unavailability of the DSP.

The Deputy DSL for Child Protection in this school is:

NAME: Liz Butler (Service Development Co-ordinator)

The broad areas of responsibility for the designated safeguarding leads are:

Managing referrals

Refer all cases of suspected abuse to the local authority children's social care (pre-school) and support Service staff to ensure that the DSL in the relevant school does so for school aged children and young People:

- Police (cases where a crime may have been committed).
- Liaise with the head teacher or principal to inform him or her of issues especially ongoing enquiries under section 47 of the Children Act 1989 and police investigations
- 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

Training

The designated safeguarding lead should receive appropriate training carried out every two years in order to:

- Understand the assessment process for providing early help and intervention, for example through locally agreed common and shared assessment processes such as early help assessments
- 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 and ensure that relevant Service staff are also able to do so
- Ensure each member of staff has access to and understands the Service's child protection policy and procedures, especially new and part time staff
- Be alert to the specific needs of children in need, those with special educational needs

- Be able to keep detailed, accurate, secure written records of concerns and referrals

- Obtain access to resources and attend any relevant or refresher training courses

- 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

Raising Awareness

- The designated safeguarding lead should ensure the SCS's policies are known and used appropriately:

- Ensure the SCS child protection policy is reviewed annually and the procedures and implementation are updated and reviewed regularly, and work with the Joint Management Group regarding this

- Ensure the child protection policy is available publicly and parents are aware of the fact that referrals about suspected abuse or neglect may be made and the role of the SCS in this

- Link with the local LSCB to make sure staff are aware of training opportunities and the latest local policies on safeguarding

- Ensure their child protection file held by SCS is copied for the placement school so that it can be transferred as part of the school Child Protection file in accordance with the school placement procedures.

4. THE JOINT MANAGEMENT GROUP

The Joint Management Group with the support of the Host authority Royal Borough of Windsor and Maidenhead must ensure that they comply with their duties under legislation. They must also have regard to this guidance to ensure that the policies, procedures and training in their schools or colleges are effective and comply with the law at all times.

The nominated lead authority for child protection is:

NAME Royal Borough Windsor and Maidenhead (Host authority).

In particular the Joint Management Group must ensure that the SCS:

- contributes to inter-agency working, which includes providing a coordinated offer of early help when additional needs of children are identified

- ensuring that an effective child protection policy is in place, together with a staff behaviour policy

- appointed a designated safeguarding lead who should undergo child protection training every two years

- prioritises the welfare of children and young people and creating a culture where staff are confident to challenge senior leaders over any safeguarding concerns

- make sure that children are taught about how to keep themselves safe.

5. SCS PROCEDURES - STAFF RESPONSIBILITIES

If any member of staff is concerned about a child he or she must inform the Designated Safeguarding Lead.

The member of staff must record information regarding the concerns on the same day. The recording must be a clear, precise, factual account of the observations. (Pro-forma is available on the SCS Y drive). This should be shared with the DSL in the school where the child is placed if not a pre-school child. A copy should be provided for the SCS DSL.

The Designated Safeguarding Lead will decide whether the concerns should be referred to Children's Services: Safeguarding and Specialist Services. If the SCS DSL decides that a referral to Children's Services: Safeguarding and Specialist Services is relevant the SCS staff member will encourage the school DSL to make this referral supported by the SCS DSL or in the case of pre-school children make this referral unless to do so would place the child at further risk of harm. Where the school decision differs from the SCS decision then the safeguarding concerns for the child or young person will be the primary decider as to whether the SCS DSL should take the lead on the basis of being the primary Service in receipt of the safeguarding disclosure or concern.

Particular attention will be paid to the attendance and development of any child about whom SCS has concerns, or who has been identified as being the subject of a child protection plan and a written record will be kept.

If a pupil who is/or has been the subject of a child protection plan changes school, the Designated Safeguarding Lead will ensure that the SCS records have been provided for the current school so that they can provide for the receiving school, in a secure manner, and separate from the child's academic file.

The Designated Safeguarding Lead is responsible for making the senior leadership team aware of trends in behaviour that may affect pupil welfare. If necessary, training will be arranged.

As a person who works with children, staff have a duty to refer safeguarding concerns to the designated safeguarding lead for child protection. However if:

- concerns are not taken seriously by an organisation or
- action to safeguard the child is not taken by professionals and
- the child is considered to be at continuing risk of harm

Then Staff should speak to a DSL in their school or contact the LSCB Services (including out of hours) on 01344 786543

If, at any point, there is a risk of immediate serious harm to a child a referral should be made to children's social care immediately. Anybody can make a referral. If the child's situation does not appear to be improving the staff member with concerns should press for re-consideration. Concerns should always lead to help for the child at some point.

If the allegations raised by the staff member are against other children the school should follow section 2.4 of the LSCB Child Protection Procedures
http://berks.proceduresonline.com

6. WHEN TO BE CONCERNED

All staff and volunteers should be aware that the main categories of abuse are:
PENS

- Physical abuse
- Emotional abuse
- Neglect
- Sexual abuse

All staff should be concerned about a child if he/she presents with indicators of possible significant harm – **see Appendix 1 for details**.

Generally, in an abusive relationship the child may:

- Appear frightened of the parent/s or other household members e.g. siblings or others outside of the home
- Act in a way that is inappropriate to her/his age and development
- Display insufficient sense of 'boundaries', lack stranger awareness
- Appear wary of adults and display 'frozen watchfulness'

Full account needs to be taken of different patterns of development and different ethnic groups

7. DEALING WITH A DISCLOSURE

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

- Listen to what is being said without displaying shock or disbelief
- Accept what is being said
- Allow the child to talk freely

- Reassure the child, but not make promises which it might not be possible to keep
- Not promise confidentiality – it might be necessary to refer to Children's Services: Safeguarding and Specialist Services
- Reassure him or her that what has happened is not his or her fault
- Stress that it was the right thing to tell
- Listen, only asking questions when necessary to clarify
- Not criticise the alleged perpetrator
- Explain what has to be done next and who has to be told
- Make a written record (see Record Keeping)
- Pass the information to the Designated Safeguarding Lead in the school where relevant without delay with a copy for the Designated Safeguarding Lead for the Service

Support

Dealing with a disclosure from a child, and safeguarding issues can be stressful. The member of staff should therefore, consider seeking support for him/herself and discuss this with the Designated Safeguarding Lead.

8. CONFIDENTIALITY

Safeguarding children raises issues of confidentiality that must be clearly understood by all SCS staff.

- All SCS staff, both teaching and non-teaching staff, have a responsibility to share relevant information about the protection of children with other professionals, particularly the investigative agencies (Children's Services: Safeguarding and Specialist Services and the Police).
- If a child confides in a member of staff and requests that the information is kept secret, it is important that the member of staff tells the child in a manner appropriate to the child's age/stage of development that they cannot promise complete confidentiality – instead they must explain that they may need to pass information to other professionals to help keep the child or other children safe.
- Staff that receive information about children and their families in the course of their work should share that information only within appropriate professional contexts.

9. COMMUNICATION WITH PARENTS

Berkshire Sensory Consortium Service will:

Ensure the child protection policy is available publicly either via the SCS website.

Parents should be informed prior to referral (other than to the School DSL), unless it is considered to do so might place the child at increased risk of significant harm by:

- The behavioural response it prompts e.g. a child being subjected to abuse, maltreatment or threats / forced to remain silent if alleged abuser informed;
- Leading to an unreasonable delay;
- Leading to the risk of loss of evidential material;
- Placing a member of staff from any agency at risk.

Ensure that parents have an understanding of the responsibilities placed on SCS staff for safeguarding children.

10. RECORD KEEPING

When a child has made a disclosure, the member of staff should:

- Record as soon as possible after the conversation. Use the school record of concern sheet wherever possible. (available from the school DSL or if not SCS record)
- Don't destroy the original notes in case they are needed by a court
- Record the date, time, place and any noticeable non-verbal behaviour and the words used by the child
- Draw a diagram to indicate the position of any injuries shown or observed
- Record statements and observations rather than interpretations or assumptions

The records should be passed to the school DSL and SCS DSL promptly. No copies should be retained by the SCS member of staff otherwise.

The Designated Safeguarding Lead will ensure that all safeguarding records are managed in accordance with the Education (Pupil Information) (England) Regulations 2005.

11. ALLEGATIONS INVOLVING SCHOOL STAFF/VOLUNTEERS

An allegation is any information which indicates that a member of staff/volunteer may have:

- Behaved in a way that has, or may have harmed a child
- Possibly committed a criminal offence against/related to a child
- 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

This applies to any child the member of staff/volunteer has contact within their personal, professional or community life.

To reduce the risk of allegations, all staff should be aware of safer working practice and should be familiar with the guidance contained in the SCS'*Guidance for Safer Working Practice for Adults who work with Children and Young People in Education Settings*'.

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.
Actions to be taken include 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. This record should be signed, dated and immediately passed on to the Head Teacher in the school and the SCS DSL.

If the concerns are about the Head Teacher in the school then it should go to the SCS DSL who will contact the Chair of Governors for the school. If it is about the SCS Headteacher it would be reported to Host Authority JMG lead.

NAME:	CONTACT NUMBER:
Alison Alexander	01628 796673

In the absence of the Host authority JMG Lead, the Deputy Host Authority JMG lead should be contacted. :

NAME:	CONTACT NUMBER:
Debbie Verity	01628 685878

The recipient of an allegation must **not** unilaterally determine its validity, and failure to report it in accordance with procedures is a potential disciplinary matter.

The Head Teacher will not investigate the allegation itself, or take written or detailed statements, but will assess whether it is necessary to refer the concern to the Local Authority Designated Officer:

- Children's Services –

Bracknell: 01344 352020;
Reading: 0118 937 3641;
Slough: 01753 690898 / 875591;
West Berkshire: 01635 503090;
Windsor and Maidenhead: 01628 683150;

Wokingham: 0118 908 8002;

Berkshire LSCB (Out of Hours Service-Children's Services – 01344 - 786543

If the allegation meets any of the three criteria set out at the start of this section, contact should always be made with the Host Local Authority Designated Officer without delay.

If it is decided that the allegation meets the threshold for safeguarding 2.1, this will take place in accordance with section 6.3 of the LSCB Protection Procedures
If it is decided that the allegation does not meet the threshold for safeguarding, it will be handed back to the employer for consideration via the Service's internal procedures.

The Head Teacher should, as soon as possible, **following briefing** from the Local Authority Designated Officer inform the subject of the allegation.

For further information see:http://berks.proceduresonline.com
LSCB Berkshire 5.6 Whistle Blowing

APPENDIX 1 - 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:

- Any bruise in a non mobile baby should always be reported
- 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 but 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 heath, 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 heath, 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 heath, 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 heath, 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.

APPENDIX 2 - LOCAL AUTHORITY CONTACTS

http://berks.proceduresonline.com/chapters/p_app_three.html

APPENDIX 3 - KEEPING CHILDREN SAFE IN EDUCATION: INFORMATION FOR ALL SCHOOL AND COLLEGE STAFF (DFE, 2014)

Part one: Safeguarding information for all staff

Please note that this refers to guidance where schools and colleges are specifically mentioned. Therefore the wording has not been revised to reflect the fact the SCS Service has the same responsibilities in connection to safeguarding Children and Young People.

What SCS staff should know and do

1. Safeguarding and promoting the welfare of children is defined for the purposes of this guidance as: protecting children from maltreatment; preventing impairment of children's health or development; ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and taking action to enable all children to have the best outcomes.

2. Children includes everyone under the age of 18.

3. Where a child is suffering significant harm, or is likely to do so, action should be taken to protect that child. [1] Action should also be taken to promote the welfare of a child in need of additional support, even if they are not suffering harm or are at immediate risk. [2]

The role of the school or college

4. Everyone who comes into contact with children and their families has a role to play in safeguarding children. School and college staff are particularly important as they are in a position to identify concerns early and provide help for children, to prevent concerns from escalating. Schools and colleges and their staff form part of the wider safeguarding system for children. This system is described in statutory guidance *Working Together to Safeguard Children 2013*. [3] Schools and colleges should work with social care, the police, health services and other services to promote the welfare of children and protect them from harm.

5. Each school and college should have a designated safeguarding lead who will provide support to staff members to carry out their safeguarding duties and who will liaise closely with other services such as children's social care.

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[1] Such action might be taken under section 47 and section 44 of the Children Act 1989.
[2] Such action might be taken under section 17 of the Children Act 1989.
[3] Department for Education guidance: Working Together to Safeguard Children 2013

The role of school and college staff

6. The *Teacher Standards 2012* [4] state that teachers, including headteachers, should safeguard children's wellbeing and maintain public trust in the teaching profession as part of their professional duties.

7. All school and college staff have a responsibility to provide a safe environment in which children can learn.

8. All school and college staff have a responsibility to identify children who may be in need of extra help or who are suffering, or are likely to suffer, significant harm. All staff then have a responsibility to take appropriate action, working with other services as needed.

9. In addition to working with the designated safeguarding lead staff members should be aware that they may be asked to support social workers to take decisions about individual children.

What school and college staff need to know

10. All staff members should be aware of systems within their school or college which support safeguarding and these should be explained to them as part of staff induction. This includes: the school's or college's child protection policy; the school's or college's staff behaviour policy (sometimes called a code of conduct); and the designated safeguarding lead.

11. All staff members should also receive appropriate child protection training which is regularly updated.

What school and college staff should look out for

12. All school and college staff members should be aware of the signs of abuse and neglect so that they are able to identify cases of children who may be in need of help or protection.

13. Staff members working with children are advised to maintain an attitude of 'it could happen here' where safeguarding is concerned. When concerned about the welfare of a child, staff members should always act in the interests of the child.

[4] The Teachers' Standards apply to: trainees working towards QTS; all teachers completing their statutory induction period (newly qualified teachers [NQTs]); and teachers in maintained schools, including maintained special schools, who are covered by the 2012 appraisal regulations.

14. There are various expert sources of advice on the signs of abuse and neglect. Each area's Local Safeguarding Children Board (LSCB) should be able to advise on useful material, including training options. One good source of advice is provided on the NSPCC website. Types of abuse and neglect, and examples of specific safeguarding issues, are described in paragraphs 20-25. [5]

15. Knowing what to look for is vital to the early identification of abuse and neglect. If staff members are unsure they should always speak to children's social care.

16. A child going missing from education is a potential indicator of abuse or neglect. School and college staff members should follow the school's or college's procedures for dealing with children who go missing from education, particularly on repeat occasions, to help identify the risk of abuse and neglect including sexual abuse or exploitation and to help prevent the risks of their going missing in future. More information can be found in this guidance about children who run away or go missing from home or care.

What school and college staff should do if they have concerns about a child

17. If staff members have concerns about a child they should raise these with the school's or college's designated safeguarding lead. This also includes situations of abuse which may involve staff members. The safeguarding lead will usually decide whether to make a referral to children's social care, but it is important to note that any staff member can refer their concerns to children's social care directly. [6] Where a child and family would benefit from coordinated support from more than one agency (for example education, health, housing, police) there should be an inter-agency assessment. These assessments should identify what help the child and family require to prevent needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act 1989. The early help assessment should be undertaken by a lead professional who could be a teacher, special educational needs coordinator, General Practitioner (GP), family support worker, and/or health visitor.

18. **If, at any point, there is a risk of immediate serious harm to a child a referral should be made to children's social care immediately. Anybody can make a referral. If the child's situation does not appear to be improving the staff member with concerns should press for re-consideration. Concerns should always lead to help for the child at some point.**

[5] Department for Education (DfE) training materials on neglect

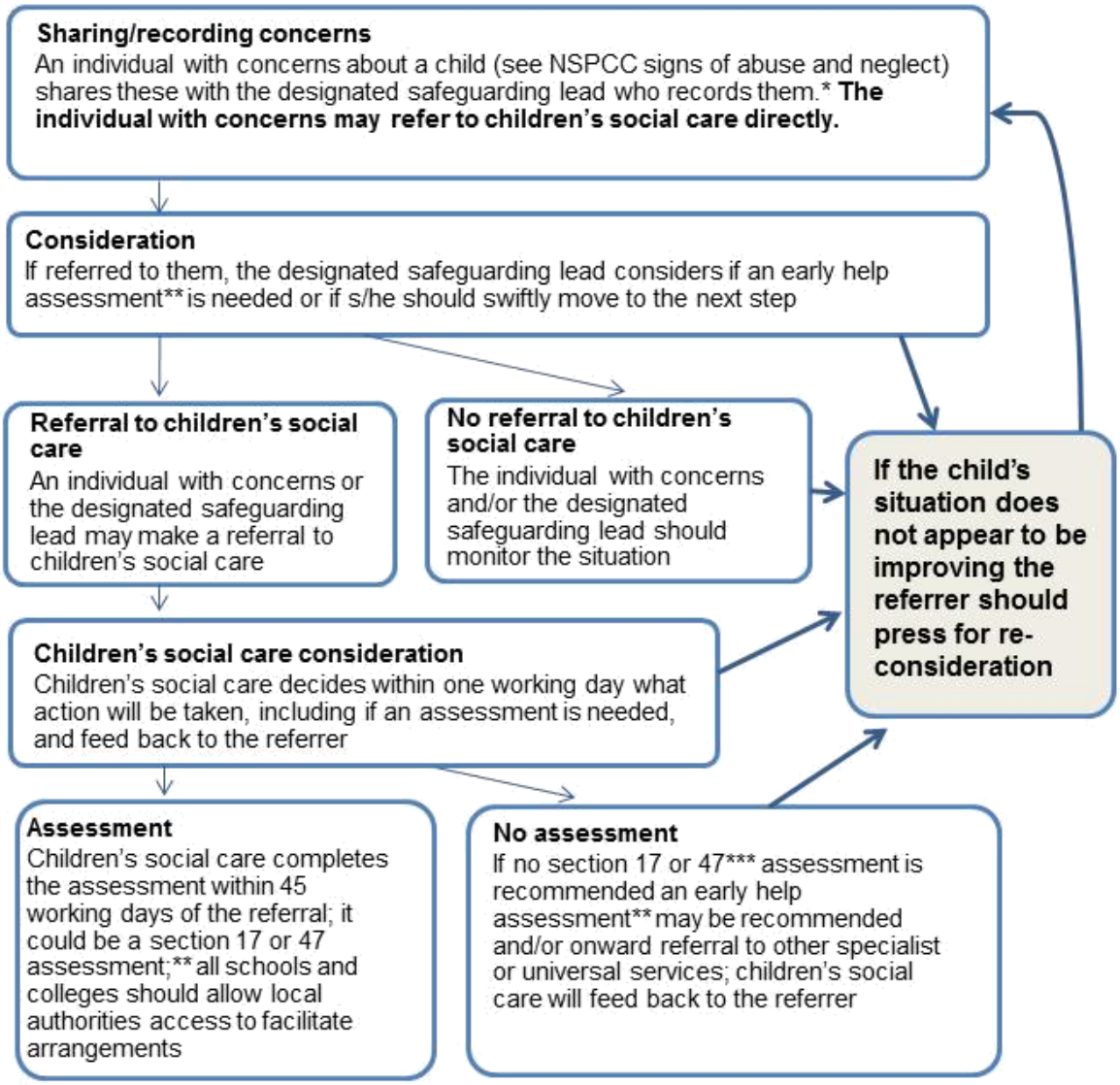
[6] Advice on whistleblowing can be found on GOV.UK

19. It is important for children to receive the right help at the right time to address risks and prevent issues escalating. Research and Serious Case Reviews have repeatedly shown the dangers of failing to take effective action. Poor practice includes: failing to act on and refer the early signs of abuse and neglect, poor record keeping, failing to listen to the views of the child, failing to re-assess concerns when situations do not improve, sharing information too slowly and a lack of challenge to those who appear not to be taking action. [7]

[7] Brandon et al, Learning from Serious Case Reviews (SCRs) 2011

Action when a child has suffered or is likely to suffer harm

This diagram illustrates what action should be taken and who should take it when there are concerns about a child. If, at any point, there is a risk of immediate serious harm to a child a referral should be made to children's social care immediately. **Anybody can make a referral.**



* In cases which also involve an allegation of abuse against a staff member, see part four of this guidance which explains action the school or college should take in respect of the staff member

** Where a child and family would benefit from coordinated support from more than one agency (eg, education, health, housing, police) there should be an inter-agency assessment. These assessments should identify what help the child and family require to prevent needs escalating to a point where intervention would be needed via a statutory assessment under the Children Act 1989. The early help assessment should be undertaken by a lead professional who could be a teacher, special educational needs coordinator, General Practitioner (GP), family support worker, and/or health visitor.

*** Where there are more complex needs, help may be provided under section 17 of the Children Act 1989 (children in need). Where there are child protection concerns local authority services must make enquiries and decide if any action must be taken under section 47 of the Children Act 1989.

Types of abuse and neglect

20. **Abuse**: 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.

21. **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.

22. **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 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, although it may occur alone.

23. **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.

24. **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.

Specific safeguarding issues

25. Expert and professional organisations are best placed to provide up-to-date guidance and practical support on specific safeguarding issues. For example NSPCC offers information for schools and colleges on the TES website and also on its own website www.nspcc.org.uk Schools and colleges can also access broad government guidance on the issues listed below via the GOV.UK website:

- child sexual exploitation (CSE) – see also below
- bullying including cyberbullying
- domestic violence
- drugs
- fabricated or induced illness
- faith abuse
- female genital mutilation (FGM) – see also below
- forced marriage
- gangs and youth violence
- gender-based violence/violence against women and girls (VAWG)
- mental health
- private fostering
- radicalisation
- sexting
- teenage relationship abuse
- trafficking

Further information on Child Sexual Exploitation and Female Genital Mutilation

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.

Female Genital Mutilation (FGM): 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. There is a range of potential indicators that a child or young person may be at risk of FGM, which individually may not indicate risk but if there are two or more indicators present this could signal a risk to the child or young person. Victims of FGM are likely to come from a community that is known to practise FGM. Professionals should note that girls at risk of FGM may not yet be aware of the practice or that it may be conducted on them, so sensitivity should always be shown when approaching the subject. Warning signs that FGM may be about to take place, or may have already taken place, can be found on pages 11-12 of the Multi-Agency Practice Guidelines referred to above. Staff should activate local safeguarding procedures, using existing national and local protocols for multi-agency liaison with police and children's social care.