Low Farm Therapy Centre Safeguarding and Child Protection Policy and Procedures

Written October 2015 by Ruth Lo
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This document had been written with reference to:

London Child Protection Procedures-5th Edition 2013
NSPCC guidelines
Working together to safeguard children 2018
Working Together Guidance 2013
Keeping Children Safe in Education 2016
Munro Review May 2011
Suffolk Safeguarding Children's Board Arrangements for Managing Allegations of Abuse against People who Work with Children or Those who are in a Position of Trust
The Prevent Duty 2015
What to do if you are worried about a child: advice for practitioners 2015

This document should be read alongside the following:

Safer Recruitment Policy
Hygiene and Toileting Procedures
Mobile Phone and Social Networks Policy
First Aid and Medication Policy
Lost or Uncollected Child policy
Video and Photographs policy and form
Whistleblowing Policy
Touch and Physical Handling Policy

Introduction

The protection and welfare of the children at Low Farm Therapy Centre (hereafter known as 'the Centre') is of paramount importance. Children and parents/carers have a right to expect the Centre to provide a safe and secure environment and the Centre has a general duty for children's welfare as part of its role *"in loco parentis".* Whilst Low Farm Therapy Centre is a therapeutic rather than educational provision, the Senior Management Team recognise that staff have a similar role to those in education in terms of close and regular contact with children and their families, and therefore should believe that it is appropriate that they work to similar guidelines.

The policy applies to all staff and volunteers working in the Centre. There are five main elements:

Ensuring safe recruitment in checking the suitability of staff and volunteers to work with children (please see Safer Recruitment Policy).

Raising awareness of child protection issues and equipping children with the skills needed to keep them safe.
Developing and then implementing procedures for identifying and reporting cases, or suspected cases of abuse.
Establishing a safe environment in which children can learn and develop.
Supporting children who may be subject to a child protection or child in need plan.

SAFEGUARDING

Safeguarding and promoting the welfare of children is defined as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- Ensuring children are growing up in circumstances consistent with the provision of safe and effective care

All staff should aim to proactively safeguard and promote the welfare of pupils so that the need for action to protect them from harm is reduced.

It is recognised that the children who attend the Centre, due to their Special Educational Needs, face additional barriers when recognising signs of abuse, and that practitioners should be alert to the potential need for early help. Barriers include the following:

- Assumptions that indicators of possible abuse such as behaviour, mood and injury relate to the child's disability without further exploration.
- The potential for children with SEN and disabilities being disproportionally impacted by behaviours such as bullying, without outwardly showing any signs.
- Communication barriers and difficulties in overcoming these barriers.

Good Practice for Safeguarding Children

The Centre believes in safeguarding and promoting the welfare of children by developing children's understanding, awareness, and resilience.

In addition, all staff should adhere to and be alert to the following principles and actions:

Always work in an open environment (e.g. avoiding private or unobserved situations and encouraging open communication with no secrets)

Promote fairness, and confront and deal with all forms of bullying

Treat all children equally and with respect and dignity

Always put the welfare of the young person first

Maintain a safe and appropriate distance with the children attending the Centre.

Be an excellent role model

Always give enthusiastic and constructive feedback rather than negative criticism

Secure written parental consent for the Centre to act in "*loco parentis",* for the administration of emergency first aid or other medical treatment if the need arises

Keep a written record of any injury that occurs, along with details of any treatment given - to be kept in the office. 'Existing injuries' should also be recorded.

Follow guidelines in the Mobile Phone and Social Networks Policy

Follow safe recruitment practices.

Visiting professionals

Independent and Local Authority professionals (e.g. Educational Psychologists) who may come to observe children in the Centre, and students on short or long-term placement, are required to show their DBS check to staff before working with a child unsupervised. A copy will be taken and kept on file. Visitors without a valid DBS check will not be left unsupervised.

Safer Recruitment

The Centre recognises the need to be alert to the risks posed by strangers or others who may wish to harm children. Correct procedures will be followed to ensure that all staff recruited are subject to the appropriate regulatory checks. Please refer to the Safer Recruitment Policy.

Specific Safeguarding Issues

Expert and professional organisations are best placed to provide up-to-date guidance and practical support on specific safeguarding issues. Government guidance on the issues listed below, can be accessed via the GOV.UK website. In addition, the NSPCC offers information on its own website www.nspcc.org.uk. (Please see **Appendix 3** for detailed descriptions of the issues listed below).

- Child sexual exploitation (CSE) – see also below
- Bullying including cyber bullying
- 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
- Peer on peer abuse

Looked after children

Relevant staff will be provided with the information they need in relation to a child's looked after legal status, and contact arrangements with birth parents or those with parental responsibility. They will also have information about the child's care arrangements and the levels of authority delegated to the carer by the authority looking after him/her. Ruth Lo will also have details of the child's social worker and the name of the virtual school head in the authority that looks after the child

CHILD PROTECTION

All children have a right to be safe. The welfare and safety of all the children are our first priority. Therefore, all adults in the Centre are obliged to follow this policy and have a duty to recognise and report concerns.

Child protection is a part of **safeguarding** and promoting welfare. It refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. Effective child protection is essential as part of wider work to safeguard and promote the welfare of children.

This policy details the procedures for reporting any concerns about child safety. It also describes possible signs of potential child abuse in all its forms and the positive ways in which the centre works to prevent abuse.

The Centre has a guiding principle of partnership between home and centre, but with child abuse, or suspicion of child abuse, our first and only responsibility is to the child. This may mean that parents are not informed or consulted in some instances.

We may not be able to prevent child abuse, but by following child protection procedures, we are trying our best to protect all our children.

All adults at the Centre do their best to ensure that the children are kept safe, remain healthy and are able to say "NO". This means that staff get to know each child as an individual and, as a matter of routine, consider how their situation feels to them.

Staff listen to what the children say, observe how they are from day to day, and take serious account of their views in supporting their needs.

Staff recognise that it is important that children in their care view the adults in the Centre as significant and trustworthy adults.

Suspected cases of child abuse are reported, procedures adhered to and subsequent actions are left to the appropriate agencies. In addition, all adults at the Centre understand that some of the children in their care may have previously been abused and we make every effort to understand their situation.

STAFF TRAINING IN SAFEGUARDING AND CHILD PROTECTION

All new staff, including any volunteers and trainees, will be required to undergo induction in Child Protection issues in the first week of work with the Designated Safeguarding Lead, Ruth Lo. They will also be required to read this Safeguarding and Child Protection Policy, the Whistleblowing Policy, the Code of Conduct, and 'Keeping Children Safe in Education 2018'.

The Designated Safeguarding Leads will undergo appropriate training every two years. There will be level 2 training for all staff every three years and an annual INSET session will be devoted to reviewing the policy with all staff.

There is currently no access for pupils to the internet on site. However, a member of staff has completed online safety training as a precautionary measure. An Ipad may be purchased which will be used under staff supervision.

All Safeguarding and Child Protection training undertaken will be recorded in the Child Protection folder.

SAFEGUARDING and CHILD PROTECTION PROCEDURES

The Designated Safeguarding Lead (DSL) is **Ruth Lo (Level 3). She can be contacted on 01502575427 and ruthlo@lowfarmtherapycentre.co.uk.**

The Assistant Safeguarding Leads (ASL) are **Nick Lo (Level 3)** and **Sarah Baillie (Level 3).** In Ruth Lo's absence they will deputise for her, and inform her of any actions taken as soon as possible.

A Safeguarding Lead must be on the premises at all times when there are children receiving therapy onsite.

When staff are working in nurseries or schools as direct employees or associates of Low Farm Therapy Centre the Safeguarding procedures for that organisation should be followed, and Ruth Lo informed.

If other professionals or organisations are hiring Low Farm's premises it is their responsibility to have their own safeguarding procedures in place.

Reasons for Following Procedures:

- It protects the child to the best of our ability
- It avoids delay
- It provides consistency
- It protects all staff

Staff are in regular contact with children all day and are in a position to detect possible abuse. They must not think that by voicing concern they are necessarily starting procedures. The criteria should be that they have reasonable suspicion that the child is being or has been abused, or may suffer in future.

Child abuse is taken to refer to any child under the age of 18 years who, through the actions of parents or other carers, or through their failure to act, has suffered or is likely to suffer harm. Low Farm recognises that peer-on- peer abuse is a possibility and that staff must be vigilant to this, and provide support as needed. Some examples would include touching, sexting, hazing, and violence.

Please refer to:

Appendix 1 for categories of abuse
Appendix 2 for signs of abuse
Appendix 3 for details of specific safeguarding issues including Female Genital Mutilation (FGM) and Child Sexual Exploitation (CSE)

Guidelines for staff:

If you see possible signs of injury or of abuse you should:

- Ask the child or young person how it happened. You must listen carefully to what the child is saying, treat it seriously, and value what they say. Record what you have seen and heard. If the child is unable to tell you anything you should also record that. (*If you can, write brief notes of what they are telling you while they are speaking-keep your original notes, however rough, they may help you later if you have to remember exactly what was said).*

- Record what has been observed & said as soon as possible after speaking to the child and **immediately inform Ruth Lo (or in her absence Nick Lo or Sarah Baillie)**.

- **Do not promise the child or young person that it will be kept a secret.** You have a responsibility to report it so that action can be taken. Give reassurance that only those who need to know will be told.

- **It is crucial not to ask leading questions.** These might give your own idea of what might have happened *(E.g. "Did he do X to you?"*). Just ask open questions such as *"What happened?"; "Is there anything else that you want to say?"*

- **Do not investigate yourself.**

N.B. In circumstances where a child has a suspicious injury which requires urgent medical attention, the CP referral process should **not** delay the administration of First Aid or emergency medical assistance.

If a pupil is thought to be at immediate risk because of, for example, parental violence, drunkenness or other incapacity, urgent police intervention will be requested.

Procedures to be followed by Designated Safeguarding Lead (DSL)

- Decide in discussion with relevant staff and, *if necessary,* the Suffolk Multi-Agency Safeguarding Hub (MASH), how to proceed;
- Discuss low level concerns with parents or carers;
- Monitor low level concerns to ensure that they are not accumulating to the extent that they become major concerns
- If the DSL deems it necessary to take further steps they will discuss matters of major concern with the Suffolk MASH team. The Consultation line number is **0345 606 1499. I**n conjunction with the MASH team a decision will be made as to whether the child or young person's home LA needs to be involved (if relevant as children and may been seen at the Centre but live in other counties) and what further action needs to be taken. Parent/carer's agreement will be sought unless seeking agreement is likely to place the child at risk of significant harm, either through delay or the parent's actions or reactions.
- Record all decisions and actions taken in the Child Protection file.

Making a referral to Social Care/MASH Team

If it is suspected that a child **is being abused or neglected, or is at risk of being abused or neglected,** then a referral should be made to using the Multi-Agency Hub Portal https://earlyhelpportal.suffolk.gov.uk/web/portal/pages/marf#h1 or if the child is at immediate risk then **Customer First on 0808 800 4005** should be called. According to the seriousness of the situation it may also be appropriate to contact **the Police on 01473613500 or 999**.

Concerns should be discussed with the parent/carer and agreement sought for a referral to Social Care/ the MASH team, unless seeking agreement is likely to place the child at risk of significant harm through delay or the parent/carer's actions or reactions.

Where a professional decides not to seek parental permission before making a referral to Social Care /the MASH team, the decision must be recorded in the child's file with reasons, dated and signed and confirmed in the referral Social Care.

A child protection referral from a professional cannot be treated as anonymous, so the parent/carer will ultimately become aware of the identity of the referrer. Where the parent/carer refuses to give permission for the referral, but the Designated Safeguarding Lead still considers that there is a need for referral:

- The reason for proceeding without parental agreement must be recorded;
- The parent/carer's withholding of permission must form part of the verbal and written referral to Social Care/the MASH team;
- The parent/carer should be contacted to inform them that, after considering their wishes, a referral has been made.

When calling Social Care/the MASH Team the following information should be provided with the referral (but absence of information must not delay referral):

- Full names, date of birth and gender of child/ren
- Family address
- Identity of those with parental responsibility
- Full names and date of birth of all household members (parents and others who live in the home)
- Ethnicity, first language and religion of children and parents/carers
- Full names, date of birth and gender of all siblings
- Information about the siblings (which school they attend etc.)
- Any special needs of child/ren
- Any significant/important recent or historical events/incidents in child or family's life
- Cause for concern including details of any allegations, their sources, timing and location
- Child's current location and emotional and physical condition
- Referrer's relationship and knowledge of child and parents/carers
- Known involvement of other agencies/professionals
- Record of any previous or current interventions that may be in place (CASA, children centre registration form etc.)
- Assessment of risk
- Information regarding parental knowledge of, and agreement to, the referral

Recording

The referrer should keep a written record of discussions with child/young person, parent, staff and the information provided to Social Care/the MASH team.

The referrer should keep a written record on file (including any notes made at the time) of the decisions taken in the course of the discussion with Social Care/the MASH team and ensure that these are clearly dated, timed and signed. The outcome of the referral should be followed up with Social Care if this is not forthcoming within a day.

Records should be:

- Clear
- In straightforward language
- Concise
- Accurate in fact
- Differentiate between: fact, observation, allegation, opinion

The Supporting Families Team - Enhanced Preventative Support

If the child or family are in need of **Enhanced Preventative Support,** then the level of risk to the child needs to assessed. If the risk is high and a child is at risk of being abused or neglected, then a referral to the MASH team should be made (see above).

However, if the risk is assessed as lower, and feel the family could wait a few weeks to receive support, then the CAF Form should be completed, which are available online at http://www.suffolk.gov.uk/care-and-support/children-young-people-and-families/common-assessment-framework-caf/common-assessment-forms/.

Once completed this should be sent by secure encrypted email to the CAF Admin team, cafadmin@suffolk.gcsx.gov.uk . **Alternatively the** CAF assessment should be double-enveloped and the inner envelope must state "addressee only". It should be sent by Royal Mail Recorded 'Sign For' delivery to:
CAF Administration, Suffolk County Council, 3rd Floor, Landmark House, 4 Egerton Road, Ipswich IP1 5PF
A copy of the signed consent must also be scanned or posted to the CAF Admin team.

Children's Centres - Universal Preventative Support

If the child or family are in need of **Universal Preventative Support,** this can be obtained by contacting their local Children's Centre. Parents can be signposted to these services here: http://www.suffolk.gov.uk/childrenscentres

The nearest Children's Centre to Low Farm Therapy Centre is Dragonflies in Halesworth which offers a range of services including:

> Early learning and childcare. Effective links with Job-centre Plus. Base for childminder network. Child and family health services. Support for children and parents with special needs. Family support and parental outreach services.Regular Flagship Housing Support and citizens advice bureau drop-in sessions.

Procedures for allegations against a member of staff

There are a wide range of situations which fall under the term 'allegation', but generally it will include concerns about a member of staff, manager, student, or volunteer who has:

- Behaved in a way that has, or may have, harmed a child;
- Possibly committed a criminal offence against or in relation to a child;
- Behaved towards a child in a way that indicates s/he is unsuitable to work with children

Concerns may be raised by other staff (whistleblowing), parents, the general public or other professionals, or it may be the case that information comes to light in other ways, for example, a concern about a member of staff outside of their work.

The designated senior manager to whom allegations or concerns should be reported is Ruth Lo. These should be reported immediately and at least within one working day.

If the allegation or suspicion is about Ruth Lo, Pascale Lo (Lo and Lo Education) should be contacted immediately. Contact details are available in reception and staff area.

When informed of a concern or allegation, the designated senior manager should not investigate the matter or interview the member of staff, child concerned or potential witnesses.

They should:

- Obtain written details of the concern/allegation, signed and dated by the person making and receiving it;
- Approve and date the written details;
- Record any information about times, dates and location of incident/s and names of any potential witnesses;
- Record discussions about the child and/or member of staff, any decisions made, and the reasons for those decisions.

It may be necessary to ask any staff involved to provide a written account about what happened, but this should be in the staff's own words and should be signed and dated. This should not be an investigation, but information gathering. There should be no collaboration amongst staff about their written accounts.

If an allegation or concern arises about a member of staff outside of their work with children, and this may present a risk of harm to child/ren for whom the member of staff is responsible, or affect their suitability to work with children, this must be also be reported to the LADO (e.g. a member of staff whose own children have been placed on a child protection plan, or a member of staff who has disclosed that they live with a convicted paedophile).

The Designated Senior Manager must contact the LADO on:

LADO@suffolk.co.uk or telephone number 0300 123 2044 within one working day (or within 4 hours if the matter is urgent and the children are at immediate risk).

If the outcome of subsequent discussion is that a referral to Childrens Specialist Services and police should be made then the LADO should inform the Multi-Agency Safeguarding Hub (MASH) via the Customer First Contact Centre that a referral is forthcoming. Likewise the referrer should note on their referral they have spoken to the LADO who has advised them to make the referral to CYPS.

If an allegation requires immediate attention, but is received outside normal office hours, then then Customer First and/or local police should be contacted and the LADO informed as soon as possible.

The referrer will be asked to provide the following information and should have as much of it available as possible when they call:

- Name, address and date of birth of the child/ren involved
- Name, address and contact number of the child/ren's father

- Name, address and contact number of the child/ren's mother
- Your name and address
- The name of the owner/manager of the Centre
- A brief summary of the allegation and the written account of the person making the allegation. This should include:

(i) confirmation of the day/s the alleged incident occurred
(ii) the name/s of the staff member who they are making the allegation against
(iii) the name/s of the child/ren who were involved
(iv) a summary of the what has been alleged

- The name and date of birth of the accused member/s of staff
- The date the accused member of staff/s took up employment with the establishment
- Details of the accused member of staff/s' CRB
- Whether the member of staff/s has been suspended from work, or if not, what other arrangements have been put in place to ensure children are safeguarded
- Name and phone number of person making the referral

Every effort should be made to maintain confidentiality and guard against publicity while an allegation is being investigated or considered. Apart from keeping the child, parent/carers and accused person (where this would not place the child at further risk) up to date with progress of the case, information should be restricted to those who have a need to know in order to protect children, facilitate enquiries, and manage related disciplinary or suitability processes.

Strategy Meeting/Discussion/Initial Evaluation

The LADO will decide what action to take. Procedures beyond this point are documented in detail in the 'Suffolk Safeguarding Children's Board Arrangements for Managing Allegations of Abuse against People who Work with Children or Those who are in a Position of Trust' document attached.

If the staff member has harmed, poses a risk of harm, is dismissed or would have been had they not resigned, this must be reported to the Disclosure and Barring Service.

The Low Farm Therapy Centre procedures for responding to accidents, incidents and death are documented in the First Aid, Medical and Medication Policy, and for responding to a missing child are documented in the Lost or Uncollected Child policy.

Appendix 1: Categories of Abuse

The following are different types of abuse for which to be vigilant-

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.

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 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 ill-treatment of another. It may involve serious bullying, causing children 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.

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)
- ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

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 (e.g. rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

Sexual abuse includes non-contact activities, such as involving children in looking at, including online and with mobile phones, or in the production of pornographic materials, watching sexual activities or 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.

In addition; sexual abuse includes abuse of children through sexual exploitation. Penetrative sex where one of the partners is under the age of 16 is illegal, although prosecution of similar age, consenting partners is not usual. However, where a child is under the age of 13 it is classified as rape under s5 Sexual Offences Act 2003. See appendix 3 for details of specific safeguarding issues, including sexual exploitation and Female Genital Mutilation.

Domestic Violence:

Included in the four categories of child abuse and neglect above, are a number of factors relating to the behaviour of the parents and carers which have significant impact on children such as domestic violence. Research analysing Serious Case Reviews has demonstrated a significant prevalence of domestic abuse in the history of families with children who are subject of Child Protection Plans. Children can be affected by seeing, hearing and living with domestic violence and abuse as well as being caught up in any incidents directly, whether to protect someone or as a target. It should also be noted that the age group of 16 and 17 year olds have been found in recent studies to be increasingly affected by domestic violence in their peer relationships.

The Home Office definition of Domestic violence and abuse was updated in March 2013 as: "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence and abuse between those aged 16 or over, who are or have been intimate partners or family members regardless of gender and sexuality."

This can encompass, but is not limited to, the following types of abuse: Psychological, Physical, Sexual, Financial or Emotional.

Appendix 2: Signs of Abuse

This is intended as a guide. Please remember that the presence of one or more factors does not necessarily give proof that child abuse has occurred. It may, however, indicate that investigation should take place. No list of abuse or neglect indicators can include all signs, and staff are advised to use their best judgement.

Indicators of Physical Abuse	**Indicators of Emotional Abuse**
• Unexplained injuries, bruising or burns/scalds • Recurring injuries • Untreated injuries • Admission of punishment which appears excessive • Bald patches • Head/abdominal injuries • Soft tissue injury is ***very much a cause for concern.*** • Bruise marks in or around the mouth • Black eyes, especially if both eyes are black and there are no marks to forehead or nose • Grasp marks • Finger marks • Bruising of the ears • Linear bruising (particularly buttocks or back) • Bruising of differing age • injuries to genital areas* • Bite marks • Unexplained burns ,cigarette burns ,rope burns (*these are rarely accidental)* • General physical disability **Behavioural indicators** • Behavioural extremes (withdrawal, aggression, regression, depression) • Inappropriate or excessive fear of parent or caretaker • Antisocial behaviour such as substance abuse, running away, truancy, fear of going home.	• Physical, mental and emotional development lags • Low self-esteem • Sudden speech disorders • Fear of new situations • Inappropriate emotional responses to painful situations • Eating disorders, including obesity or anorexia • Nervous disorders (rashes, hives, facial tics, stomach aches) • Self-harm • Fear of parents being contacted • Running away • Compulsive stealing, scavenging • Difficulty in forming relationships • Soiling and wetting • Unresponsiveness in the child • Change in behavioural pattern • 'Frozen' look • Attention seeking • Sudden poor performance in school **Behavioural indicators** • Habit disorders (biting, rocking, head-banging) • Behaviours such as rocking, hair twisting etc • Cruel behaviour, seeming to get pleasure from hurting children, adults or animals • Age inappropriate behaviours (bedwetting, wetting, soiling) • Behavioural extremes, such as overly compliant-demanding; withdrawn-aggressive; listless-

• Unbelievable or inconsistent explanation for injuries • Refusal to discuss injuries • Withdrawal from physical contact • Sudden poor performance in school • Self destructive tendencies • Aggression towards others • Over compliance • Resistance to PE (undressing) **See further details of FGM in Appendix 3**	excitable. • Acceptance of excessive punishment • Over-reaction to mistakes • Continual self deprecation

Indicators of Neglect	Indicators of Sexual Abuse
• Constant hunger • Constant tiredness • Frequent lateness or non-attendance • No social relationships • Poor personal hygiene • Low self –esteem • Poor state of clothing • Unsuitable clothing; missing key articles of clothing(underwear, socks) • Repeated infections etc. • Untreated injury or illness • Lack of immunisations • Indications of prolonged Exposure to elements(excessive sunburn, insect bites, colds) • Unkempt appearance • Height and weight significantly below age level **Behavioural indicators** • Sudden poor performance in school • Compulsive stealing or scavenging • Destructive tendencies • Neurotic behaviour • Running away • Unusual school attendance	• Torn stained or bloody underclothes • Frequent unexplained sore throats, yeast or urinary infections • Somatic complaints, including pain and irritation of the genitals. • Sexually transmitted diseases • Bruises or bleeding from external genitalia, vaginal or anal region. • Self mutilation • Extremes of passivity or aggression • Withdrawal from physical contact • Fear of returning home • Emotionally distant • Self destructive tendencies • Confusing affectionate displays • Sexualised drawings and play • Soiling and wetting • Sexually precocious behaviour • Attention seeking **Behavioural indicators** • Disclosure of sexual abuse • Regressive behaviours (thumb sucking, bed wetting, fear of the dark) • Promiscuity or seductive behaviours • Sexually explicit behaviour • disturbed sleep patterns (recurrent nightmares) • unusual and age *inappropriate* interest in sexual matters • Avoidance of undressing or wearing extra layers of clothes • Sudden decline in school performance, truancy • Difficulty in walking or sitting. • Low self-esteem • Self-harm • Extremes of passivity or aggression

	• Drug/solvent abuse • Running away • Neurotic behaviour • Sexually inappropriate play for age of child • Withdrawal from physical contact • Fear of returning home • Emotionally distant • Self destructive tendencies • Confusing affectionate displays • Sexualised drawings and play • Soiling and wetting • Sexually precocious behaviour • Attention seeking • Sudden poor performance in school **See further details of child sexual exploitation and FGM in Appendix 3**

Appendix 3: Specific safeguarding issues- descriptions

Child Sexual Exploitation (CSE)

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.

Bullying including cyber bullying

Bullying is behaviour by an individual or group, repeated over time, that intentionally hurts another individual either physically or emotionally. Bullying can take many forms (e.g. cyber bullying via text messages or social networking sites), and is often motivated by prejudice against race, religion, gender, sexual orientation, or individual differences. Stopping violence and ensuring immediate physical safety is a priority; however emotional bullying can often be more damaging than physical. Bullying usually involves an imbalance of power between the perpetrator and the victim. This could involve perpetrators of bullying having control over the relationship which makes it difficult for those they bully to defend themselves. It can result in intimidation through the threat of violence or social isolation either physically or online.

Domestic Violence (DV)

Domestic violence can be defined as: *"Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence and abuse between those aged 16 or over, who are or have been intimate partners or family members regardless of gender and sexuality."*
This can encompass, but is not limited to: Psychological, Physical, Sexual, Financial and Emotional abuse. Children can be affected by seeing, hearing and living with domestic violence and abuse as well as being caught up in any incidents directly, whether to protect someone or as a target.

Drugs

This includes the misuse of, or exposure to: unauthorised medicines; volatile substances; alcohol; tobacco; illegal drugs; new psychoactive substances and other unauthorised substances that are harmful to health. Whilst alcohol and tobacco are legal for adults over the age of 18, excessive consumption within the household may result in inability to provide adequate parenting. Education on drug and alcohol use is provided as part of PSHE.

Fabricated or induced illness

Fabricated or induced illness is a rare form of child abuse. It occurs when a parent or carer exaggerates or deliberately causes symptoms of illness in the child. Fabricated or induced

illness covers a wide range of cases and behaviours involving parent/carers seeking healthcare for a child. This ranges from extreme neglect (failing to seek medical care) to induced illness e.g. a parent/carer who convinces their child they are ill when they are perfectly healthy; a parent/carer who exaggerates or lies about their child's symptoms; a parent/carer who manipulates test results to suggest the presence of illness – for example, by putting glucose in urine samples to suggest the child has diabetes; a parent/carer who deliberately induces symptoms of illness – for example, by poisoning his/her child with unnecessary medication or other substances.

Faith abuse

Faith abuse is a form of child abuse that is linked to faith or belief. Children may experience harm due to: a belief in concepts of witchcraft and spirit possession; a belief that demons or the devil acting through children or leading them astray (traditionally seen in some Christian beliefs, the evil eye or djinns (traditionally known in some Islamic faith contexts) or dakini (in the Hindu context); ritual mutilation or murders where the killing of children is believed to bring supernatural benefits or the use of their body parts is believed to produce potent magical remedies; or the use of belief in magic or witchcraft to create fear in children to make them more compliant. This is not an exhaustive list and there will be other examples where children have been harmed as a result of a belief that they are bringing bad fortune.

Honor-Based Violence

So-called 'honour-based' violence (HBV) encompasses crimes which have been committed to protect or defend the honour of the family and/or the community, including Female Genital Mutilation (FGM), forced marriage, and practices such as breast ironing. All forms of so called HBV are abuse (regardless of the motivation) and should be handled and escalated as such. If in any doubt, staff should speak to the designated safeguarding lead. Professionals in all agencies, and individuals and groups in relevant communities, need to be alert to the possibility of a child being at risk of HBV, or already having suffered HBV. Indicators There are a range of potential indicators that a child may be at risk of HBV. Guidance on the warning signs that FGM or forced marriage may be about to take place, or may have already taken place, can be found on pages 38-41 of the Multi agency statutory guidance on FGM (pages 59-61 focus on the role of schools and colleges) and pages 13-14 of the Multi-agency guidelines: Handling case of forced marriage. Actions If staff have a concern regarding a child that might be at risk of HBV, they should activate local safeguarding procedures, using existing national and local protocols for multiagency liaison with police and children's social care. Where FGM has taken place, since 55 31 October 2015 there has been a mandatory reporting duty placed on teachers80 that requires a different approach (see following section).

Female Genital Mutilation (FGM)

Female Genital Mutilation comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. It is sometimes referred to as 'female genital cutting' or 'female circumcision'.

There are no health benefits to FGM and it is recognised internationally as a human rights violation. 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. 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, are outlined below:

Indications that FGM may be about to take place include:

- The family comes from a community that is known to practice FGM, e.g. Kenyans, Somalis, Sudanese, Sierra Leoneans, Egyptians, Nigerians and Eritreans. However women from non-African communities that are at risk of FGM include Yemeni, Kurdish, Indonesian and Pakistani women.
- It may be possible that the family will practice FGM if a female family elder is around
- Parents state that they or a relative will take the child out of the country for a prolonged period;
- A child may talk about a long holiday to her country of origin or another country where the practice is prevalent, including African countries and the Middle East. Girls are at particular risk of FGM during school summer holidays
- A child may confide to a professional that she is to have a 'special procedure' or to attend a special occasion
- A professional hears reference to FGM in conversation, for example a child may tell other children about it
- A child may request help from a teacher or another adult

Indications that FGM may have already taken place include:

- A child may spend long periods of time away from the classroom during the day with bladder or menstrual problems
- There may be prolonged absences from school
- A prolonged absence from school with noticeable behaviour changes on the girl's return could be an indication that a girl has recently undergone FGM
- Professionals also need to be vigilant to the emotional and psychological needs of children who may / are suffering the adverse consequence of the practice, e.g. withdrawal, depression etc.
- A child requiring to be excused from physical exercise lessons without the support of her GP
- A child may confide in a professional

If there are suspicions that a FGM has taken place or be about to take place:

Section 5B of the Female Genital Mutilation Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) places a statutory duty upon teachers along with regulated health and social care professionals in England and Wales, to report to the police where they discover (either through disclosure by the victim or visual evidence) that FGM appears to have been carried out on a girl under 18. Those failing to report such cases will face disciplinary sanctions.

Forced marriage

A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. It is an appalling and indefensible practice and is recognised in the UK as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights. The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're bringing shame on their family).

Gangs and youth violence

'Gangs' are groups of children who gather together for the purpose of socialising or engaging in anti-social behaviour. Youth violence is often associated with gang activity. The definition of 'serious youth violence' currently in use by the Metropolitan Police Service is 'any offence of most serious violence or weapon enabled crime, where the victim is aged 1-19' i.e. murder, manslaughter, rape, wounding with intent and causing grievous bodily harm. Children in gangs may be caught with prohibited items such as: knives and weapons; alcohol, illegal drugs; stolen items; tobacco and cigarette papers; fireworks; pornographic images or any article which may be used to damage property.

Gender-based violence/violence against women and girls (VAWG)

This includes domestic violence and abuse, rape and sexual violence, stalking, forced marriage and FGM (see above).

Mental health

This can include behavioural disorders such as ADHD, OCD or Conduct Disorder; mood disorders such as anxiety, depression or psychosis; or eating disorders such as anorexia or bulimia. Other mental health concerns include: self harm, sleep problems, hearing voices, hallucinations or suicidal tendencies. Children with suspected mental health concerns should be referred to CAMHS (Child and Adolescent Mental Health Service).

Private fostering

Private fostering is when a child under the age of 16 (under 18 if disabled) is cared for by someone who is not their parent or a 'close relative'. This is a private arrangement made between a parent and a carer, for 28 days or more. Close relatives are defined as step-parents, grandparents, brothers, sisters, uncles or aunts. Anyone else wishing to foster a child must undergo legal checks in order to protect the child against abuse or neglect and ensure the child is being looked after properly.

Radicalisation

Radicalisation is a process by which an individual or group comes to adopt increasingly extreme political, social, or religious ideals and aspirations that reject or undermine the status quo or reject or undermine contemporary ideas and expressions of freedom of choice. The current threat from terrorism in the United Kingdom can involve the exploitation of vulnerable people, including children, young people and vulnerable adults to involve them in terrorism or activity in support of terrorism. This may include: encouraging, justifying or glorifying terrorist violence in furtherance of particular beliefs; seeking to engage or provoke others to terrorist acts; or fostering hatred which might lead to inter-community violence. The Counter-Terrorism and Security Act, which received Royal Assent on 12 February 2015, places a duty on specified authorities, including local authorities and childcare, education and other children's services providers, in the exercise of their functions, to have due regard to the need to prevent people from being drawn into terrorism . The Prevent Duty came into place in June 2015. This requires Schools and Childcare Providers to have "due regard to the need to prevent people from being drawn into terrorism".

Channel School and college: staff should understand when it is appropriate to make a referral to the Channel programme. Channel guidance is available at: Channel guidance. An e-learning channel awareness programme for staff is available at: Channel General Awareness. 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. In addition to information sharing, if a staff member makes a referral to Channel, they may be asked to attend a Channel panel to discuss the individual referred to determine whether support is required.

Sexting

Sexting is when someone sends or receives a sexually explicit text, image or video on their mobile phone, usually in a text message. This can include: naked pictures, underwear shots, images or videos of sexual acts, or sexually explicit messages. It is illegal to take, possess or share 'indecent images' of anyone under 18.

Teenage relationship abuse

This includes violence, abuse, controlling behaviour, sex without consent (rape), or sex under the legal age of 16 whereby there is an imbalance of power e.g. if the other partner is much older, or if the person does not have the mental capacity to consent to sexual acts. To help protect younger children the law says anyone under the age of 13 can never legally give consent. This means that anyone engaging in sexual activity with a child who is 12 or younger will be subject to penalties set out under the Sexual Offences Act 2003.

Trafficking

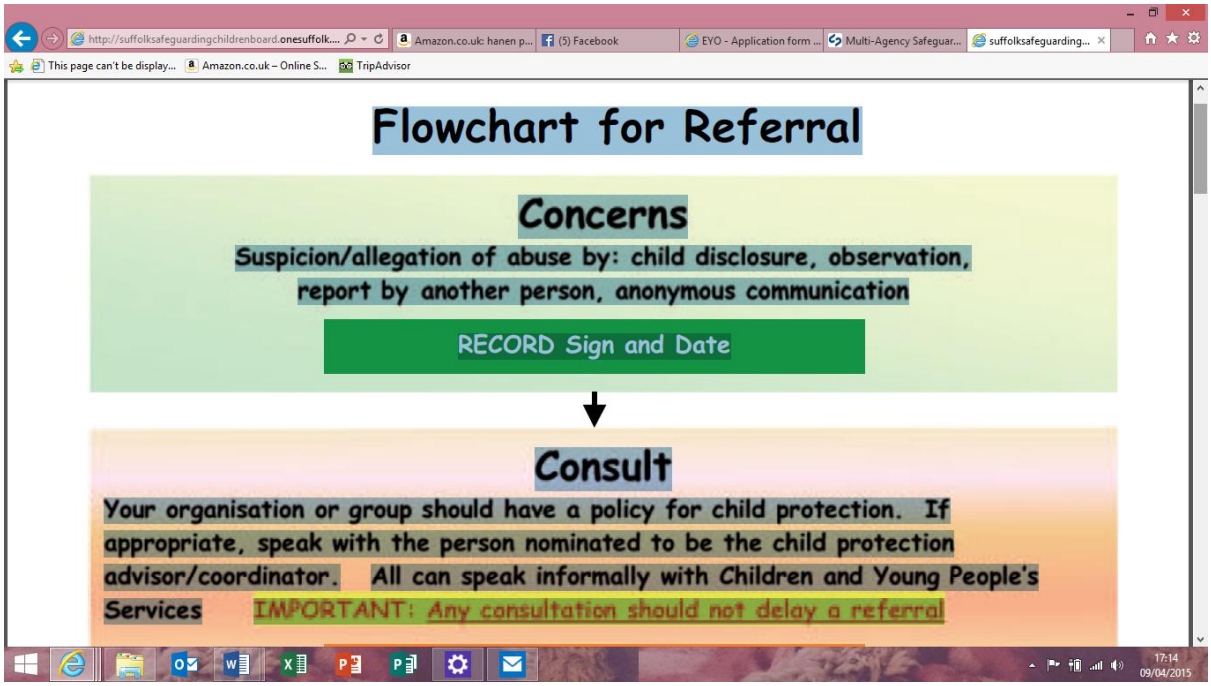
Child trafficking is where children are recruited, moved or transported and then exploited, forced to work or sold. They are often subject to multiple forms of exploitation. Children may be trafficked for: sexual exploitation including prostitution; benefit fraud; forced marriage; domestic servitude such as cleaning, childcare or cooking; forced labour in

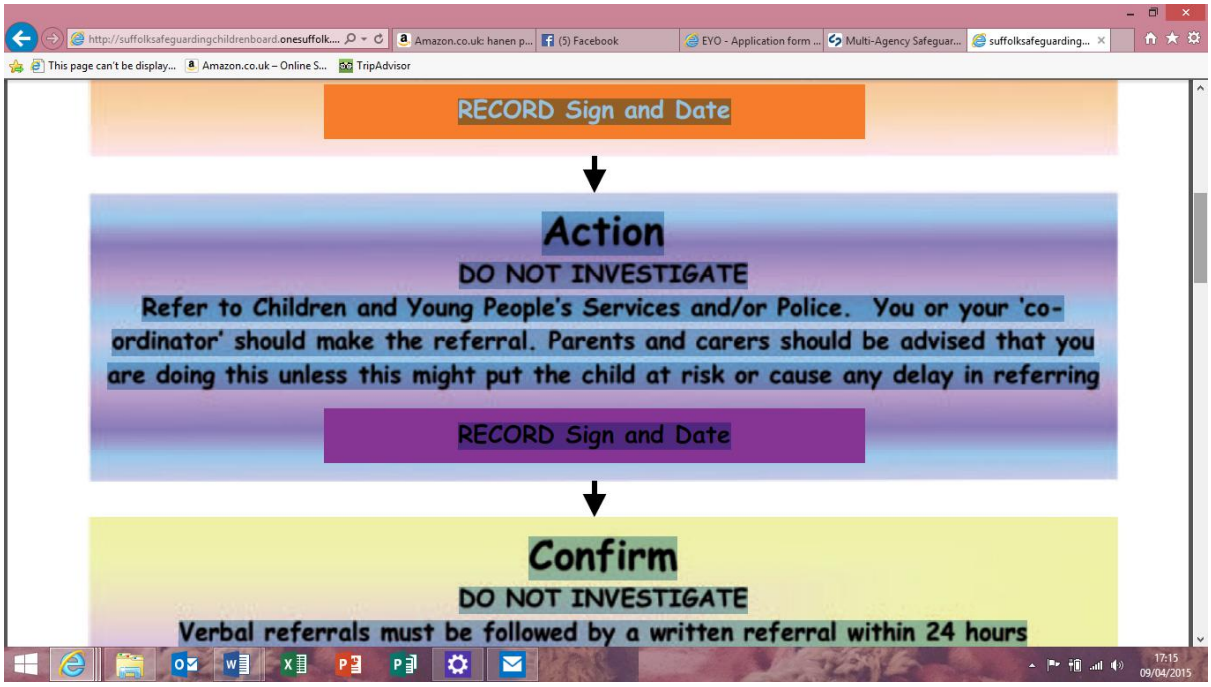
factories or agriculture; or criminal activity such as pick-pocketing, begging, transporting drugs, working on cannabis farms, selling pirated DVDs, bag theft etc. Many children are trafficked into the UK from abroad, but children can also be trafficked from one part of the UK to another.

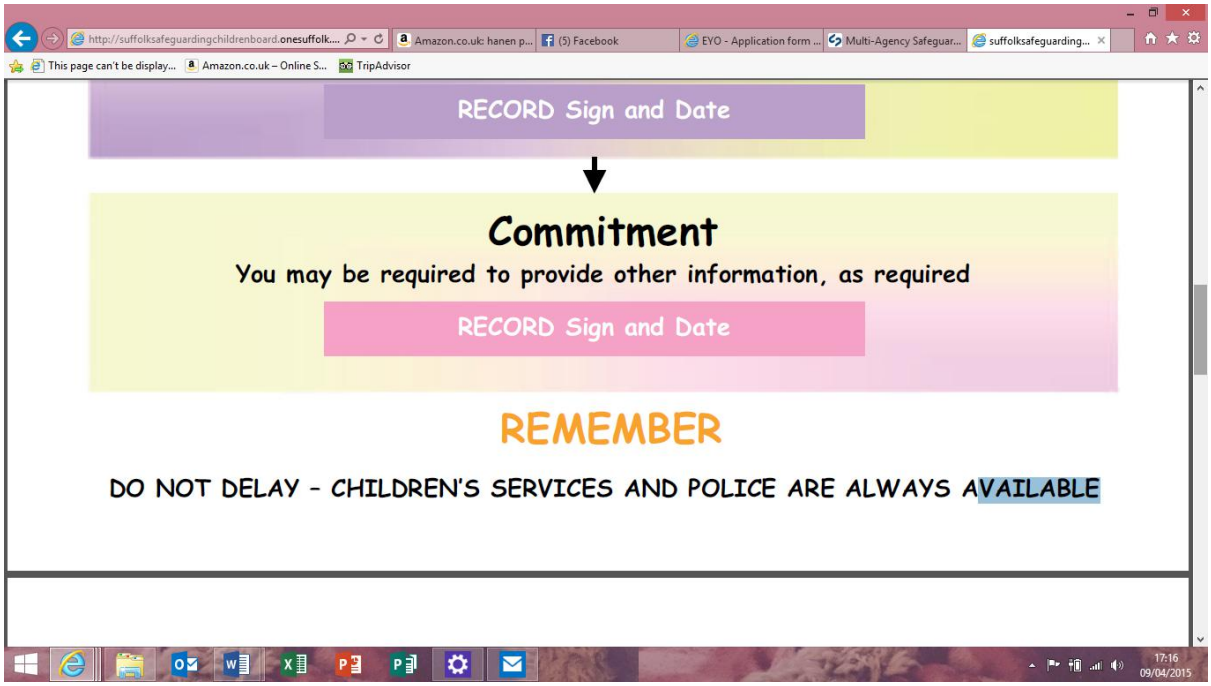
Peer on peer abuse

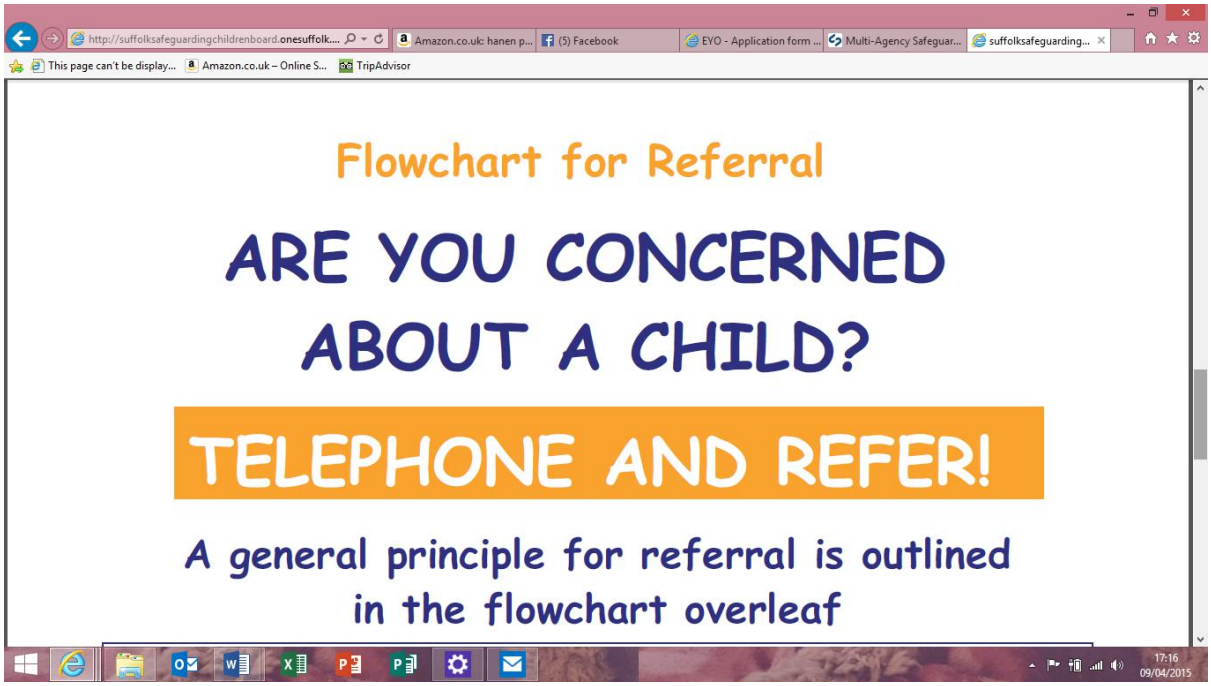
Children can abuse other children. This is generally referred to as peer on peer abuse and can take many forms. This can include (but is not limited to) bullying (including cyberbullying); sexual violence and sexual harassment; physical abuse such as hitting, kicking, shaking, biting, hair pulling, or otherwise causing physical harm; sexting and initiating/hazing type violence and rituals. Sexual violence and sexual harassment

Appendix 4: Suffolk Procedures Flowchart

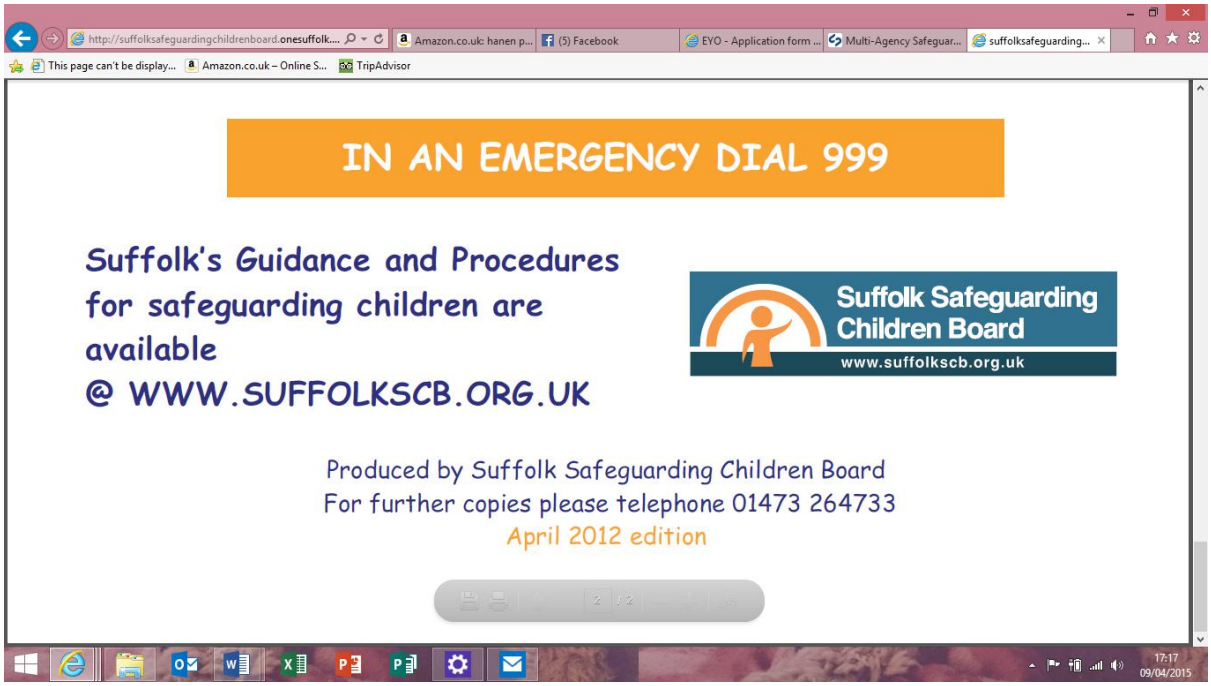





RECORD Sign and Date
Commitment
You may be required to provide other information, as required
RECORD Sign and Date
REMEMBER
DO NOT DELAY - CHILDREN'S SERVICES AND POLICE ARE ALWAYS AVAILABLE


Flowchart for Referral
ARE YOU CONCERNED ABOUT A CHILD?
TELEPHONE AND REFER!
A general principle for referral is outlined in the flowchart overleaf


Telephone Numbers:
Children's Services:
Customer First freephone No: 0808 800 4005
Emergency Duty Service
Week days: 5.20pm to 8.45am
Weekends: 4.25pm Friday to 8.45am Monday 0808 800 4005
Suffolk Police:
Main Switchboard No: 01473 613500



Appendix 5: Information sharing (Working together to safeguard children 2018)

Sharing information enables practitioners and agencies to identify and provide appropriate services that safeguard and promote the welfare of children. Below are common myths that may hinder effective information sharing.

Data protection legislation is a barrier to sharing information

No – the Data Protection Act 2018 and GDPR do not prohibit the collection and sharing of personal information, but rather provide a framework to ensure that personal information is shared appropriately. In particular, the Data Protection Act 2018 balances the rights of the information subject (the individual whom the information is about) and the possible need to share information about them.

Consent is always needed to share personal information

No – you do not necessarily need consent to share personal information. Wherever possible, you should seek consent and be open and honest with the individual from the outset as to why, what, how and with whom, their information will be shared. You should seek consent where an individual may not expect their information to be passed on. When you gain consent to share information, it must be explicit, and freely given. There may be some circumstances where it is not appropriate to seek consent, because the individual cannot give consent, or it is not reasonable to obtain consent, or because to gain consent would put a child's or young person's safety at risk.

Personal information collected by one organisation/agency cannot be disclosed to another

No – this is not the case, unless the information is to be used for a purpose incompatible with the purpose for which it was originally collected. In the case of children in need, or children at risk of significant harm, it is difficult to foresee circumstances where information law would be a barrier to sharing personal information with other practitioners.

The common law duty of confidence and the Human Rights Act 1998 prevent the sharing of personal information

No – this is not the case. In addition to the Data Protection Act 2018 and GDPR, practitioners need to balance the common law duty of confidence and the Human Rights Act 1998 against the effect on individuals or others of not sharing the information.

IT Systems are often a barrier to effective information sharing

No – IT systems, such as the Child Protection Information Sharing project (CP-IS), can be useful for information sharing. IT systems are most valuable when practitioners use the shared data to make more informed decisions about how to support and safeguard a child.

Signed: 

Ruth Lo (Designated Safeguarding Lead)