Roysia Middle School
We care; they flourish

# Child Protection Policy

## Issue date: March 2016

## Review Date: July 2017

**Policy Review**

This policy will be reviewed in full by the Governing Body on an annual basis.

The policy was last reviewed and agreed by the Governing Body on

It is due for review by July 2017 (up to 12 months from the above date).

Signature ……. Z Linington…….. Date …10/05/16……..

Head Teacher

Signature …… D Brynjolffsen…….. Date …10/05/16……..

Chair of Governors

**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 the school.

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

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| **Purpose of a Child Protection Policy** | To inform staff, parents, volunteers and governors about the school's responsibilities for safeguarding children.<br><br>To enable everyone to have a clear understanding of how these responsibilities should be carried out. |
| **Hertfordshire Safeguarding Children Board Inter-agency Child Protection and Safeguarding Children Procedures** | The school follows the procedures established by the Hertfordshire Safeguarding Children Board; a guide to procedure and practice for all agencies in Hertfordshire working with children and their families. |
| **School Staff & Volunteers** | All school and college staff have a responsibility to provide a safe environment in which children can learn.<br><br>School 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.<br><br>All school staff will receive appropriate safeguarding children training (which is updated regularly – Hertfordshire Safeguarding Children Board advises every 3 years), 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 deliver an annual update.<br><br>Temporary staff and volunteers 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, are encouraged to talk, and are listened to when they have a worry or concern.

Establish and maintain an environment where school staff and volunteers 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.

Include opportunities in the curriculum for children 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 governing body. It will be implemented through the school's induction and training programme, and as part of day to day practice. Compliance with the policy will be monitored by the Designated Safeguarding Lead and through staff performance measures.

## 2. STATUTORY FRAMEWORK

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

- The Children Act 1989
- The Children Act 2004
- Education Act 2002 (section 175)
- Hertfordshire Safeguarding Children Board Inter-agency Child Protection and Safeguarding Children Procedures (Electronic)
- Keeping Children Safe in Education (DFE 2015)
- Keeping Children Safe in Education: information for all school and college staff (DFE 2015) – APPENDIX 2
- Working Together to Safeguard Children (DfE 2015)
- The Education (Pupil Information) (England) Regulations 2005
- Counter Terrorism and Security Act 2015 (Section 26)

Working Together to Safeguard Children (DfE 2015) requires all schools to follow the procedures for protecting children from abuse which are established by the Hertfordshire Safeguarding Children Board.

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.

The school will also follow guidance in relation the specific safeguarding issues outlined in Appendix 2. This will include the Prevent Duty Guidance 2015, in the exercise of their functions, to have due regard to the need to prevent people from being drawn into terrorism. Furthermore Section 5B of the Female Genital Mutilation Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) will place a statutory duty upon **teachers, along with social workers and healthcare professionals, 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. It will be rare for teachers to see visual evidence, and they should not be examining pupils, but the same definition of what is meant by "to discover that an act of FGM appears to have been carried out" is used for all professionals to whom this mandatory reporting duty applies.

Furthermore

Keeping Children Safe in Education (DFE, 2016) places the following responsibilities on all schools:

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

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

- Schools 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 (referred to in 'Keeping Children Safe in Education (DFE, 2016 ) as Designated Safeguarding Lead') should have responsibility for co-ordinating action within the school 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 2016) also states:

**Governing bodies and proprietors 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 and volunteers – 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 either via the school or college website or by other means.**

## 3. THE DESIGNATED SAFEGUARDING LEAD (referred to in 'Keeping Children Safe in Education (DFE, September 2016 ) as Designated Safeguarding Lead')

**Governing bodies and proprietors should ensure that the school or college designates an appropriate senior member of staff to take lead responsibility for child protection. This person should have the status and authority within the school to carry out the duties of the post including committing resources and, where appropriate, supporting and directing other staff.**

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

NAME: Mrs K Jandu

The Deputy Designated Safeguarding Persons for Child Protection who will act in the event of the absence/unavailability of the DSL in this school is:

NAME: Mrs L Rawlings and Mr I Wheeler.

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

- Ensure that he/she receives refresher training at two yearly intervalsto keep his or her knowledge and skills up to date
- Ensure that all staff who work with children undertake appropriate training to equip them to carry out their responsibilities for safeguarding children effectively and that this is kept up to date by refresher training at three yearly intervals
- Ensure that new staff receive a safeguarding children induction within 7 working days of commencement of their contract
- Ensure that temporary staff and volunteers are made aware of the school's arrangements for safeguarding children within 7 working days of their commencement of work.
- Ensure that the school operates within the legislative framework and recommended guidance
- Ensure that all staff and volunteers are aware of the HSCB Inter-agency Child Protection and Safeguarding Children Procedures and any other relevant local guidance e.g. safe drop off/collection of children guidance.
- Ensure that the Headteacher is kept fully informed of any concerns

- Develop effective working relationships with other agencies and services
- Decide upon the appropriate level of response to specific concerns about a child e.g. discuss with parents, offer an assessment under the Common Assessment Framework (CAF) or refer to Children, Schools and Families social care.
- Liaise and work with Children's Services: Safeguarding and Specialist Services over suspected cases of child abuse
- Ensure that accurate safeguarding records relating to individual children are kept separate from the academic file in a secure place, marked 'Strictly Confidential' and are passed securely should the child transfer to a new provision
- Submit reports to, ensure the school's attendance at child protection conferences and contribute to decision making and delivery of actions planned to safeguard the child
- Ensure that the school effectively monitors children about whom there are concerns, including notifying Children's Services: Safeguarding and Specialist Services when there is an unexplained absence of more than two days for a child who is the subject of a child protection plan
- Provide guidance to parents, children and staff about obtaining suitable support
- Discuss with new parents the role of the DSP and the role of safeguarding in the school. Make parents aware of the safeguarding procedures used and how to access the child protection policy.

**Managing referrals**

Refer all cases of suspected abuse to the local authority children's social care and:

- 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 .
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**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

- Ensure each member of staff has access to and understands the school's or college'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 and young carers

- 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 school or college's policies are known and used appropriately:

- Ensure the school or college's child protection policy is reviewed annually and the procedures and implementation are updated and reviewed regularly, and work with governing bodies or proprietors 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 school or college in this

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

- Where children leave the school or college ensure their child protection file is copied for any new school or college as soon as possible but transferred separately from the main pupil file

## 4. THE GOVERNING BODY

Governing bodies and proprietors 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 governor for child protection is:

NAME: MR T SHEPHERD.

In particular the Governing Body must ensure:

- The responsibilities placed on governing bodies and proprietors include:
- their contribution 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
- appointing a designated safeguarding lead who should undergo child protection training every two years
- prioritising the welfare of children and young people and creating a culture where staff are confident to challenge senior leaders over any safeguarding concerns
- making sure that children are taught about how to keep themselves safe.

## 5. SCHOOL 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 Hertfordshire Grid for Learning).

The Designated Safeguarding Lead will decide whether the concerns should be referred to Children's Services: Safeguarding and Specialist Services. If it is decided to make a referral to Children's Services: Safeguarding and Specialist Services this will be discussed with the parents, unless to do so would place the child at further risk of harm.

Particular attention will be paid to the attendance and development of any child about whom the school 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 inform the social worker responsible for the case and transfer the appropriate records to the Designated Safeguarding Lead at 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 Hertfordshire Children's Services (including out of hours) on 0300 123 4043.

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 4.3 of the Hertfordshire Safeguarding Children Board Procedures Manual - Children Who Abuse Others

**Mandatory Reporting Duty**

Section 5B of the Female Genital Mutilation Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) will place a statutory duty upon **teachers, along with social workers and healthcare professionals, 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. It will be rare for teachers to see visual evidence, and they should not be examining pupils, but the same definition of what is meant by "to discover that an act of FGM appears to have been carried out" is used for all professionals to whom this mandatory reporting duty applies.

## 6. WHEN TO BE CONCERNED

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

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect

All staff and volunteers 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 (full account needs to be taken of different patterns of development and different ethnic groups);

- display insufficient sense of 'boundaries', lack stranger awareness;

- appear wary of adults and display 'frozen watchfulness'.

## 7. DEALING WITH A DISCLOSURE

If a child discloses that he or she has been abused in some way, the member of staff / volunteer 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 without delay

**Support**

Dealing with a disclosure from a child, and safeguarding issues can be stressful. The member of staff/volunteer 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 staff/volunteers in schools.

- All staff in schools, 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/volunteer and requests that the information is kept secret, it is important that the member of staff/volunteer tell 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/volunteers who 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

Roysia Middle School will:

Ensure the child protection policy is available publicly either via the school or college website or by other means.

Parents should be informed prior to referral, 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 the school and staff for safeguarding children.

## 10. RECORD KEEPING

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

- Record as soon as possible after the conversation. Use the school record of concern sheet wherever possible. (pro-forma available on the Hertfordshire Grid for Learning)
- 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
- Record statements and observations rather than interpretations or assumptions

All records need to be given to the Designated Safeguarding Lead promptly. No copies should be retained by the member of staff or volunteer.

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 staff handbook, school code of conduct or Government document '*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.

If the concerns are about the Head Teacher, then the Chair of Governors should be contacted. The Chair of Governors in this school is:

NAME: Mr D Brynjolffssen CONTACT NUMBER: 01763 242339

_____ _____

In the absence of the Chair of Governors, the Vice Chair should be contacted. The Vice Chair in this school is:

NAME: Mr A Moorley CONTACT NUMBER: 01763 246258

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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 – 03001234043

SOOHS (Out of Hours Service-Children's Services) – 03001234043.

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

If it is decided that the allegation meets the threshold for safeguarding, this will take place in accordance with section 4.1 of the Hertfordshire Safeguarding Children Board Inter-agency Child Protection and Safeguarding Children 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 school'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:**

HSCB Inter-agency Child Protection and Safeguarding Children Procedures (Electronic)

Section 4.1 Managing Allegations Against Adults who work with Children and Young People

## 12. INDICATORS OF HARM

***PHYSICAL ABUSE***

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

**Indicators in the child**

**Bruising**

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

- Bruising in or around the mouth
- Two simultaneous bruised eyes, without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive)
- Repeated or multiple bruising on the head or on sites unlikely to be injured accidentally, for example the back, mouth, cheek, ear, stomach, chest, under the arm, neck, genital and rectal areas
- Variation in colour possibly indicating injuries caused at different times
- The outline of an object used e.g. belt marks, hand prints or a hair brush
- Linear bruising at any site, particularly on the buttocks, back or face
- Bruising or tears around, or behind, the earlobe/s indicating injury by pulling or twisting
- Bruising around the face
- Grasp marks to the upper arms, forearms or leg
- Petechae haemorrhages (pinpoint blood spots under the skin.) Commonly associated with slapping, smothering/suffocation, strangling and squeezing.

**Fractures**

Fractures may cause pain, swelling and discolouration over a bone or joint. It is unlikely that a child will have had a fracture without the carers being aware of the child's distress.

If the child is not using a limb, has pain on movement and/or swelling of the limb, there may be a fracture.

There are grounds for concern if:

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

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

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

**Mouth Injuries**

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

**Poisoning**

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

**Fabricated or Induced Illness**

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

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

**Bite Marks**

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

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

**Burns and Scalds**

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

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

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

The following points are also worth remembering:

- A responsible adult checks the temperature of the bath before the child gets in.
- A child is unlikely to sit down voluntarily in a hot bath and cannot accidentally scald its bottom without also scalding his or her feet.
- A child getting into too hot water of his or her own accord will struggle to get 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 health, alcohol or drug misuse or domestic violence
- History of unexplained death, illness or multiple surgery in parents and/or siblings of
- the family
- Past history of childhood abuse, self harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.

***EMOTIONAL ABUSE***

***Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.***

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

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

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

***Some level of emotional abuse is involved in all types of maltreatment***

***of a child, though it may occur alone.***

**Indicators in the child**

- Developmental delay
- Abnormal attachment between a child and parent/carer e.g. anxious, indiscriminate or no attachment
- Aggressive behaviour towards others
- Child scapegoated within the family
- Frozen watchfulness, particularly in pre-school children
- Low self-esteem and lack of confidence
- Withdrawn or seen as a 'loner' - difficulty relating to others
- Over-reaction to mistakes
- Fear of new situations
- Inappropriate emotional responses to painful situations
- Neurotic behaviour (e.g. rocking, hair twisting, thumb sucking)
- Self-harm
- Fear of parents being contacted
- Extremes of passivity or aggression
- Drug/solvent abuse
- Chronic running away
- Compulsive stealing
- Low self-esteem
- Air of detachment – 'don't care' attitude
- Social isolation – does not join in and has few friends
- Depression, withdrawal
- Behavioural problems e.g. aggression, attention seeking, hyperactivity, poor attention
- Low self-esteem, lack of confidence, fearful, distressed, anxious
- Poor peer relationships including withdrawn or isolated behaviour.

**Indicators in the parent**

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

**Indicators of in the family/environment**

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

***NEGLECT***

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

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

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

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

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

**Indicators in the child**

**Physical presentation**

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

**Development**

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

**Emotional/behavioural presentation**

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

**Indicators in the parent**

- Dirty, unkempt presentation
- Inadequately clothed
- Inadequate social skills and poor socialisation
- Abnormal attachment to the child .e.g. anxious
- Low self esteem and lack of confidence
- Failure to meet the basic essential needs e.g. adequate food, clothes, warmth, hygiene
- Failure to meet the child's health and medical needs e.g. poor dental health; failure to attend or keep appointments with health visitor, GP or hospital; lack of GP registration; failure to seek or comply with appropriate medical treatment; failure to address parental substance misuse during pregnancy
- Child left with adults who are intoxicated or violent
- Child abandoned or left alone for excessive periods
- Wider parenting difficulties, may (or may not) be associated with this form of abuse.

**Indicators in the family/environment**

- History of neglect in the family
- Family marginalised or isolated by the community.
- Family has history of mental health, alcohol or drug misuse or domestic violence.

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

***SEXUAL ABUSE***

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

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

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

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

***<u>Child Sexual Exploitation</u>***

*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.* **(Keeping Children Safe in Education – DfE, 2015)**

**Indicators in the child**

**Physical presentation**

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

**Emotional/behavioural presentation**

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

**Indicators in the parents**

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

**Indicators in the family/environment**

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

## APPENDIX 1: KEEPING CHILDREN SAFE IN EDUCATION (DfE 2016)

### Part One: Information for all school and college staff

### Annex A: Further information

On publication of this Child Protection Policy (July 2016), the May 2016 version of the statutory guidance '**Keeping Children Safe In Education'** available online, has been denoted by DfE as 'for information only'. The guidance commences on 5th September 2016. The DfE have confirmed that this guidance will be updated annually thereafter.

The existing version of the statutory guidance mentions that there will be also be updates likely before September 2016 in respect to the definition of Child Sexual Exploitation and also regulations relating to Children Missing from Education.

The CPSLO Service have therefore decided to provide the hyperlink only to Keeping Children Safe in Education in this policy rather than the document in its entirety, due to likely frequent change in content.

It is **essential** that **all** staff have access to this online document and read Part 1 and Annex , which provides further information on:

-children missing from education
- child sexual exploitation
-'honour based' violence
-FGM mandatory reporting duty
-forced marriage
- preventing radicalisation

This is to assist staff to understand and discharge their role and responsibilities as set out in this guidance.

We highly recommend that staff are asked to sign to say they have read these sections (please see Appendix 2) and should subsequently be re-directed to these online documents again should any changes occur.

## Link to Keeping Children Safe in Education:

**https://www.gov.uk/government/publications/keeping-children-safe-in-education--2**

## APPENDIX 2: DECLARATION FOR STAFF

## Child Protection Policy and Keeping Children Safe in Education (DfE 2016)

School/College name ……. Academic Year ……..

Please sign and return to ……. ……(DSP) by ……<insert date>…….

I, _____**<insert name>**_____ have read and am familiar with the contents of the following documents and understand my role and responsibilities as set out in these document(s).:

(1) The School/College's Child Protection Policy
(2) **Part 1 and Annex A** of **'Keeping Children Safe in Education'** DfE Guidance , 2016

<Please insert any other relevant documentation/guidance for your school/college>

I am aware that the DSPs are:

…… …… ……..

…… …… …… …… ……

……

…… …… …… …… ……..

and I able to discuss any concerns that I may have with them.

I know that further guidance, together with copies of the policies mentioned above, are available ……<insert location>…….

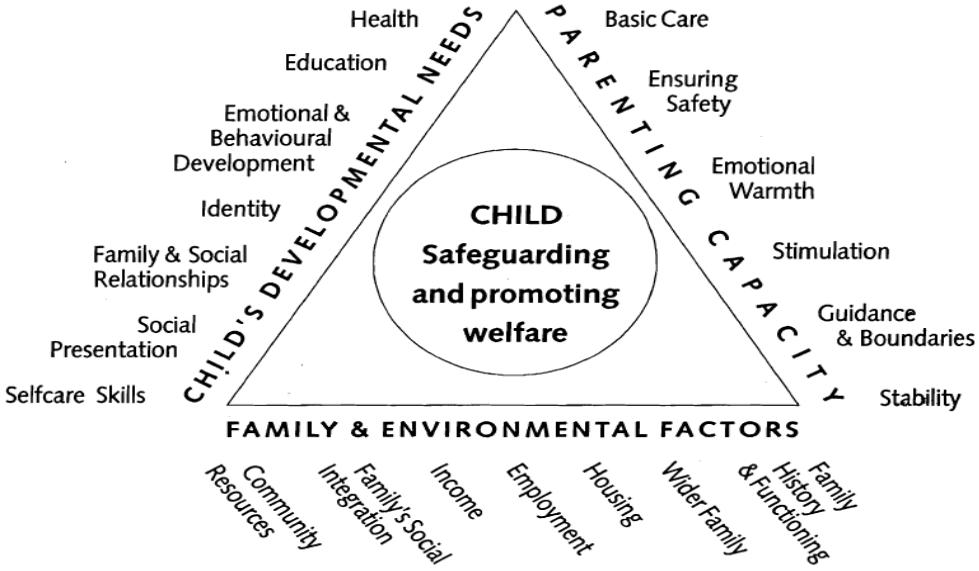
Signed_____ Date_____

## APPENDIX 3: WHAT TO DO IF YOU ARE WORRIED A CHILD IS BEING ABUSED: ADVICE FOR PRACTITIONERS (DfE 2015)

### Flowchart

## APPENDIX 4: INDICATORS OF ABUSE AND NEGLECT

**The framework for understanding children's needs:**




***Working Together to Safeguard Children (DFE, 2015)***

| **Physical abuse**<br>***Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child.*** | |
|---|---|
| **Child** | |
| Bruises – shape, grouping, site, repeat or multiple | Withdrawal from physical contact |
| Bite-marks – site and size<br>Burns and Scalds – shape, definition, size, depth, scars | Aggression towards others, emotional and behaviour problems |
| Improbable, conflicting explanations for injuries or unexplained injuries | Frequently absent from school |
| Untreated injuries | Admission of punishment which appears excessive |
| Injuries on parts of body where accidental injury is unlikely | Fractures |
| Repeated or multiple injurie | Fabricated or induced illness - |
| **Parent** | **Family/environment** |
| Parent with injuries | History of mental health, alcohol or drug misuse or domestic violence. |
| Evasive or aggressive towards child or others | Past history in the family of childhood abuse, self- |

| | |
|---|---|
| | harm, somatising disorder or false allegations of physical or sexual assault |
| Explanation inconsistent with injury | Marginalised or isolated by the community. |
| Fear of medical help / parents not seeking medical help | Physical or sexual assault or a culture of physical chastisement. |
| Over chastisement of child | |

| **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, not giving the child opportunities to express their views, 'making fun' of what they say or how they communicate - hearing the ill-treatment of another and serious bullying (including cyber bullying).*** | |
| **Child** | |
| Self-harm | Over-reaction to mistakes / Inappropriate emotional responses |
| Chronic running away | Abnormal or indiscriminate attachment |
| Drug/solvent abuse | Low self-esteem |
| Compulsive stealing | Extremes of passivity or aggression |
| Makes a disclosure | Social isolation – withdrawn, a 'loner' Frozen watchfulness particularly pre school |
| Developmental delay | Depression |
| Neurotic behaviour (e.g. rocking, hair twisting, thumb sucking) | Desperate attention-seeking behaviour |
| **Parent** | **Family/environment** |
| Observed to be aggressive towards child or others | Marginalised or isolated by the community. |
| Intensely involved with their children, never allowing anyone else to undertake their child's care. | History of mental health, alcohol or drug misuse or domestic violence. |
| Previous domestic violence | History of unexplained death, illness or multiple surgery in parents and/or siblings of the family |
| History of abuse or mental health problems | Past history in the care of childhood abuse, self harm, somatising disorder or false allegations of physical or sexual assault |
| Mental health, drug or alcohol difficulties | Wider parenting difficulties |
| Cold and unresponsive to the child's emotional needs | Physical or sexual assault or a culture of physical chastisement. |
| Overly critical of the child | Lack of support from family or social network. |

| **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.*** | |
| **Child** | |
| Failure to thrive - underweight, small stature | Low self-esteem |
| Dirty and unkempt condition | Inadequate social skills and poor socialisation |
| Inadequately clothed | Frequent lateness or non-attendance at school |
| Dry sparse hair | Abnormal voracious appetite at school or nursery |

| | |
|---|---|
| Untreated medical problems | Self-harming behaviour |
| Red/purple mottled skin, particularly on the hands and feet, seen in the winter due to cold | Constant tiredness |
| Swollen limbs with sores that are slow to heal, usually associated with cold injury | Disturbed peer relationships |
| **Parent** | **Family/environment** |
| Failure to meet the child's basic essential needs including health needs | Marginalised or isolated by the community. |
| Leaving a child alone | History of mental health, alcohol or drug misuse or domestic violence. |
| Failure to provide adequate caretakers | History of unexplained death, illness or multiple surgery in parents and/or siblings of the family |
| Keeping an unhygienic dangerous or hazardous home environment | Past history in the family of childhood abuse, self harm, somatising disorder or false allegations of physical or sexual assault |
| Unkempt presentation | Lack of opportunities for child to play and learn |
| Unable to meet child's emotional needs | Dangerous or hazardous home environment including failure to use home safety equipment; risk from animals |
| Mental health, alcohol or drug difficulties | |

| **Sexual abuse**<br>***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 or non-contact activities, such as involving children in looking at sexual images or being groomed on line / child exploitation.*** | |
|---|---|
| **Child** | |
| Self-harm - eating disorders, self-mutilation and suicide attempts | Poor self-image, self-harm, self-hatred |
| Running away from home | Inappropriate sexualised conduct |
| Reluctant to undress for PE | Withdrawal, isolation or excessive worrying |
| Pregnancy | 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 | Poor attention / concentration (world of their own) |
| Pain, bleeding, bruising or itching in genital and /or anal area | Sudden changes in school work habits, become truant |
| Sexually exploited or indiscriminate choice of sexual partners | |
| **Parent** | **Family/environment** |
| History of sexual abuse | Marginalised or isolated by the community. |
| Excessively interested in the child. | History of mental health, alcohol or drug misuse or domestic violence. |
| Parent displays inappropriate behaviour towards the child or other children | History of unexplained death, illness or multiple surgery in parents and/or siblings of the family |
| Conviction for sexual offences | Past history in the care of childhood abuse, self harm, somatising disorder or false allegations of physical or sexual assault |
| Comments made by the parent/carer about the child. | Grooming behaviour |
| Lack of sexual boundaries | Physical or sexual assault or a culture of physical chastisement. |

## APPENDIX 5: ADDENDUM TO POLICY

The following additional information should be read in conjunction with the section, 'Peer on peer Abuse' on pages 12 and 13.

**Staff should recognise that children are capable of abusing their peers and should not be tolerated or passed off as "banter" or "part of growing up".**

**In order to minimise the risk of peer on peer abuse the school:**

- **Provides a developmentally appropriate PSHE curriculum which develops students understanding of acceptable behaviour and keeping themselves safe.**
- **Have systems in place for any student to raise concerns with staff, knowing that they will be listened to, believed and valued.**
- **Develop robust risk assessments where appropriate (e.g. Using the Risk Assessment Management Plan and Safety and Support Plan tools).**
- **Have relevant policies in place (e.g. behaviour policy).**