St Nicolas and St Mary CE Primary School
Child Protection Policy

Journey together, guided by God, to do the best we can.

Based on WSCC Model Policy written 2010
Reviewed/Updated: January 2012, May 2014, May 2015
Next review date: May 2017

The school has adopted the Model Policy written by West Sussex County Council **(see attached).**

Designated Person
The **Headteacher, David Etherton,** is the designated person for child protection. In his absence the Deputy Headteacher, Mr Andy Lincoln, should be approached. The designated person is responsible for keeping the Governing Body up to date on child protection matters including any changes and reviews of relevant policy and procedures, training and level of incidents/cases.

Training
At least one senior member of staff and at preferably at least one governor should have completed and passed the relevant Safer Recruitment training. All students and staff should complete the school's induction process which includes Child Protection. Volunteer helpers who regularly help in school should also complete an induction process.

Confidential Worry Book
The Headteacher keeps a confidential "Worry Book" where any concerns raised by staff, governors, parents or pupils, however small, can be recorded. Any patterns of behaviour can then be more easily identified.

Reporting Concerns
Concern Slips or "Worry slips" are kept in the school office/staff room for staff to record minor worries/incidents about children or any other person eg staff, pupil, student etc. These slips should then be passed onto the Headteacher (via the office if appropriate). The Headteacher will then follow up / add to Confidential Worry Book / file etc as appropriate. SIGNIFICANT CONCERNS SHOULD BE TAKEN STRAIGHT TO THE DESIGNATED PERSON FOR CHILD PROTECTION (The Headteacher, or Deputy Headteacher in Headteacher's absence).

Whistle Blowing / Confidential Reporting Policy
The "Whistle Blowing" Policy is available for staff, governors, students, parents and volunteers to see. (Policy File is kept in the school office). The list of key contacts for the Whistle Blowing Policy is on display by the Visitor Toilets.

DSB Checks
The school follows National and County guidelines for undertaking the relevant checks. The Office keeps a record of all DBS checks that have been undertaken and where no disclosures are made. If a positive disclosure is made for either a paid member of staff or volunteer, and it is still appropriate for them to work with children, then this must be recorded by the Headteacher on the relevant form, and kept strictly confidential. (See attached)

Further Information
- Childline posters are displayed at the school;
- Staff must follow ***"Guidance on Safer Working Practice"*** *(March 2009)* as set out by County which clearly state what is acceptable and what is unacceptable; ***"Keeping Children safe in education"*** (DfE April 2014) and "***Working Together" to Safeguard Children"*** (DfE, March 2015) and/or subsequent guidance (available near Visitor Toilets)
- More detailed information about child protection is available in the ACPC Procedures located in the school office.

Training and Qualifications
A record of qualifications and courses attended by staff and governors relating to Child Protection is displayed on the Health and Safety board near the Visitors' Toilet. This includes information about who has attended courses on Safer Recruitment, Training for Designated Members of Staff for Child Protection, and Child Protection and Safeguarding. Expiry dates of qualifications/courses are also given.

It is the role of the School Business Manager to ensure that sufficient staff have the required qualifications or attended relevant courses when required. Where necessary, the SBM will book up courses for staff to attend.

Vulnerable Children
The school recognises that a child who is abused, witnesses violence or is at risk of harm may need additional support and that the school may provide the only stability. Our school will support all pupils by promoting a caring, safe and positive environment within the school.

The school has a Vulnerable Children Policy which is available on request. The school keeps a Vulnerable Children Register and assigns a Key Worker where necessary to provide a key point of contact and liaison regarding the well-being of a vulnerable child.

CHILD PROTECTION POLICY

ST NICOLAS AND ST MARY CE PRIMARY SCHOOL

This policy was adopted on: 11th May 2015

The policy will next be reviewed in: May 2017

Key Contacts:	
Designated Member of Staff for Child Protection (DMS):	**David Etherton**
Lead Governor for Child Protection:	**Julie Searle**
West Sussex Children's Services: Children's Access Point: (CAP):	**Tel: 01403 229900 Fax: 01403 754205 cap@westsussex.gcsx.gov.uk**
Local Authority Designated Officer (LADO):	**0330 222 3337**

1 INTRODUCTION

1.1 The purpose of this policy is to inform staff[1], parents, volunteers and governors about the school's responsibilities for safeguarding children and to enable everyone to have a clear understanding of how these responsibilities should be carried out.

1.2 The Governing body takes seriously its responsibility to safeguard and promote the welfare of children in its care; and to work together with other agencies to ensure adequate arrangements within our school to identify, assess, and support children who are, or who may be, suffering harm.

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

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

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

This school will:

- Support the child's development in ways that will foster security, confidence and independence.
- Provide an environment in which children and young people feel safe, secure, valued and respected, and feel confident, and know how, to approach adults if they may be worried about being listened to.
- Provide a systematic means of monitoring children known or thought to be at risk of harm, and ensure we, the school, contribute to assessments of need and support packages for those children.
- Emphasise the need for good levels of communication between all members of staff and between the school and other agencies.
- Have and regularly review a structured procedure within the school which will be followed by all members of the school community in cases of suspected abuse.
- Develop and promote effective working relationships with other agencies, especially the Police and Children's Services.
- Ensure that all adults within our school who have substantial access to children have been recruited and checked as to their suitability in accordance with Part Three of Keeping Children Safe in Education (DfE 2014).

2 STATUTORY FRAMEWORK

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

- The Children Act 1989
- The Children Act 2004
- Education Act 2002
- Keeping Children Safe in Education (DfE 2014): https://www.gov.uk/government/publications/keeping-children-safe-in-education
- Working Together to Safeguard Children (2013): https://www.gov.uk/government/publications/working-together-to-safeguard-children
- The Education (Child Information) (England) Regulations 2005

3 RESPONSIBILITIES

3.1 General school staff responsibilities:

- Schools should be aware of and follow the Sussex Child Protection & Safeguarding Procedures, produced by West Sussex, East Sussex, and Brighton & Hove and available as an electronic copy at http://pansussexscb.proceduresonline.com/index.htm

[1] Wherever the word "staff" is used, it covers ALL staff on site, including ancillary and supply staff, and volunteers working with children

- 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 children, including procedures to be followed if a child harms another child or a member of staff is accused of abuse, or suspected of abuse
- A Designated Member of Staff for Child Protection (referred to in 'Keeping Children Safe in Education (DFE, April 2014) as 'Designated Safeguarding Lead') should have responsibility for co-ordinating action within the school and liaising with other agencies (see below for further details).
- Designated Members of Staff for Child Protection undergo updated child protection training every two years. The head teacher and all members of staff are provided with regular updated child protection training in line with advice from the West Sussex LSCB (currently every three years).
- The school's lettings policy will ensure the suitability of adults working with children on school premises at any time. Those authorised by the school to work with children on school premises should enter into a formal commitment to comply with the school's child safeguarding responsibilities. Community users organising activities for children will be made aware of the school's child protection guidelines and procedures and will confirm their commitment to abide by them.

3.2 Responsibilities of the Governing Body:

Governing bodies, trustees 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 in this school is:

Name: Julie Searle

The responsibilities placed on governing bodies and proprietors include:

- Ensuring that an effective child protection policy is in place and reviewed annually, together with a staff behaviour policy (code of conduct) and that these are provided to all staff – including temporary staff and volunteers – on induction and that staff are kept up to date with changes.
- Contributing to inter-agency working, which includes providing a coordinated offer of early help when additional needs of children are identified.
- Appointing a designated member of staff for child protection who should undergo refresher child protection training every two years.
- Ensuring that schools and colleges create a culture of safe recruitment and, as part of that, adopt recruitment procedures that help deter, reject or identify people who might abuse children (Part Three: Safer Recruitment. Keeping Children Safe in Education 2014).
- Ensuring that at least one member of an appointing panel will have attended safer recruitment training.
- Ensuring that the school/college keeps an up to date single central record of all staff and volunteers and the dates of all appropriate safeguarding checks.
- Monitoring the adequacy of resources committed to child protection, and the staff and governor training profile.
- Recognising that neither it, nor individual governors, have a role in pursuing or managing the processes associated with individual cases of child protection, nor a right to know details of such cases, except when exercising their disciplinary functions in respect of allegations against staff.
- Making sure that the child protection policy is available to parents on request.
- Ensuring that this policy and practice complements other policies e.g. anti-bullying including cyber bullying and health and safety to ensure safeguarding.
- Prioritising the welfare of children and young people and creating a culture where staff are confident to challenge senior leaders over any safeguarding concerns.

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

The nominated governor for child protection should agree with the Governing Body how these responsibilities should be monitored and reported.

4 THE DESIGNATED MEMBER OF STAFF (DMS) FOR CHILD PROTECTION

The Designated Member of Staff for Child Protection in this school is:

NAME: David Etherton, Headteacher

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

The Deputy Designated Member of Staff for Child Protection in this school is:

NAME: Andy Lincoln, Deputy Headteacher

The broad areas of responsibility for the designated member of staff are:

4.1 Managing referrals and concerns regarding individual children:

- Referring all cases of suspected abuse to the West Sussex Children's Access Point and to the Police (cases where a crime may have been committed).
- Sending a written record of the referral to the Children's Access Point by the end of the working day the referral is made.
- Keeping written records of concerns about a child even if there is no need to make an immediate referral, (the 'child protection file').
- Ensuring that all such records are kept confidentially and securely and are separate from child records, and if these are stored electronically, that they are differently password protected from the child's other files, and accessible only by the head teacher/designated leads.
- Ensuring that an indication of further record-keeping is marked on the child's records.
- Liaise with the head teacher or principal to inform him or her of issues especially new or on-going child protection investigation enquiries 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.

Ensuring that either they or the class teacher or *residential key worker*[2] attends Child Protection Conferences, core groups, or other multi-agency planning meetings, contributes to assessments, and provides a report which will normally have been shared with the parents. (In some circumstances it may not be appropriate to share the report to conference with parents. If the DMS is uncertain on this point advice can be obtained from the allocated social worker).

Ensuring that any child who is subject to a child protection plan and who is absent without explanation for two days or more is referred to their key worker's Social Care Team. In some cases any absence may be a cause for concern and warrant immediate reporting.

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 child file. (The original child protection file being retained by the former school or college).

4.2 Training

The Designated Member of Staff for Child Protection should undertake the initial designated member of staff training and subsequent refresher courses every two years in order to:

[2] this only applies to residential schools

- 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.
- Be alert to those children within the school who are at risk or experiencing: domestic violence; female genital mutilation; children missing from education; child trafficking; bullying which includes race/hate or homophobic behaviour.
- Have a working knowledge of how the local authority conducts 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.
- 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.
- Link with the West Sussex Local Safeguarding Children Board (LSCB) to make sure staff are aware of training opportunities and the latest local policies on safeguarding.
- Organising child protection training for all staff every three years.

Raising Awareness and other duties

- The designated member of staff should ensure the setting's policies are known and used appropriately: ensuring each member of staff has access to and understands setting's child protection policy and procedures, especially new and part time staff. In addition the DMS should ensure that **all staff read, at least, Part One of Keeping Children Safe in Education 2014.**
- Ensure the setting's child protection policy is reviewed annually, 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, parents are aware that referrals about suspected abuse or neglect may be made and the role of the school or college in this.

5 PROCEDURES

5.1 If any member of staff is concerned about a child he or she must inform the Designated Member of Staff for Child Protection.

5.2 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. Do not add comments or opinion although observations about a child's demeanour or emotional state may be recorded.

5.3 The Designated Member of Staff will decide whether the concerns should be referred to Children's Access Point. If it is decided to make a referral to the CAP this will be discussed with the parents, unless to do so would place the child at further risk of harm. (The CAP is able to provide advice on this question).

5.4 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.

5.5 If a child who is/or has been the subject of a child protection plan changes school, the Designated Member of Staff will inform the social worker responsible for the case and transfer the appropriate records to the Designated Member of Staff at the receiving school, in a secure manner, and separate from the child's academic file.

5.6 The Designated Member of Staff is responsible for making the senior leadership team aware of trends in behaviour that may affect child welfare. If necessary, training will be arranged.

5.7 Staff have a duty to refer safeguarding concerns to the Designated Member of Staff 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 the DMS or Headteacher in their school and/or contact a manager in the Children's Access Point.

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

5.9 If the allegations concern harm perpetrated by children in the school then staff should follow section 8.7 of the West Sussex Child Protection and Safeguarding Procedures - Children who Harm Other Children.

6 WHEN TO BE CONCERNED

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

Abuse: a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. They may be abused by an adult or adults or another child or children.

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

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

Sexual abuse: involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet) by establishing a close relationship or friendship. . Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

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

For further details of these categories please see Appendix 1.

Other aspects of risk requiring special attention

In addition school staff should be aware of these specific safeguarding issues Schools should ensure that, where such risks may be more likely, that staff are guided on how to understand and act accordingly where there is concern:

- child sexual exploitation (CSE) – see also Appendix 1 page 24
- bullying including cyberbullying
- domestic violence
- drugs
- fabricated or induced illness
- faith abuse
- female genital mutilation (FGM) – see also Appendix 1 page 24
- 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
- self-harm

Links to many of these topics can be found in Keeping Children Safe in Education
https://www.gov.uk/government/publications/keeping-children-safe-in-education page 9

7 CONFIDENTIALITY

7.1 We recognise that all matters relating to child protection are confidential.

7.2 The Headteacher or DMS will disclose any child protection related information about a child to other members of staff on a need to know basis only.

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

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

7.5 We will always undertake to share our intention to refer a child to Children's Services with the parents /carers unless to do so could put the child at greater risk of harm, or impede a criminal investigation. If in doubt, we will consult with the Duty Manager at the Assessment Team at Children's Services.

8 DEALING WITH A DISCLOSURE

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

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

8.2 When recording information:

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

8.3 We recognise that staff working in a school who have become involved with a child who has suffered harm, or appears to be likely to suffer harm may find the situation stressful and upsetting. We will support such staff by providing an

opportunity to talk through their anxieties with the DMS and to seek further support as appropriate. WSCC school staff have access to a free, 24/7 and confidential counselling service.

9 ALLEGATIONS AGAINST STAFF

9.1 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

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

9.3 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*'. It is best practice for a school to have a signed acknowledgement from staff members to show that this has occurred.

9.4 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.

9.5 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.

9.6 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: Mrs Julie Searle

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

NAME: Mr Stephen Paynter and Mrs Rebecca Allinson

Contact with the Chair or the Vice Chair of Governors can be made through the school office. If for any reason this causes a delay (for example the office is closed) then the concerns should be referred to the Children's Access Point.

9.7 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 or Chair 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 on 0330 222 3337:

9.8 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, the next steps will take place in accordance with section 8.2 of the Sussex Child Protection and Safeguarding Children Procedures.

9.9 If, at the completion of the allegations management process, a school or college dismisses an individual (or would have, had the person not left first) because the person poses a risk of harm to children, the organisation must make a referral to the Disclosure and Barring Service. It is an offence to fail to make a referral without good reason.

9.10 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.

10 WHISTLEBLOWING (CONFIDENTIAL REPORTING)

The School has/ has in development a whistleblowing policy (or Confidential Reporting Policy). This enables any member of staff to make complaints about conduct within the school to a person outside the school on a confidential basis and without fear that their confidentiality will be breached. This policy will rarely be applicable where a referral of abuse or risk to a child needs to be reported unless that abuse or risk arises within the school itself. Referrals in such cases should still be made to the DMS or as indicated in this policy. Where the circumstances are such that a member of staff believes that a complaint can only safely be made to person outside the school then reference should be made to the school's Confidential Reporting Policy.

11 PHYSICAL INTERVENTION

11.1 Our policy on physical intervention by staff is set out separately, and acknowledges that staff must only ever use physical intervention as a last resort, when a child is endangering him/herself or others, and that at all times it must be the minimal force necessary to prevent injury to another person.

11.2 Such events should be recorded and signed by a witness.

11.3 Staff who are likely to need to use physical intervention will be appropriately trained in the Team Teach technique.

11.4 We understand that physical intervention of a nature which causes injury or distress to a child may be considered under child protection or disciplinary procedures.

12 BULLYING

Our policy on bullying (this includes homophobic and gender related bullying) is set out in a separate document.

13 RACIST INCIDENTS

Our policy on racist incidents is set out in a separate document.

14 PREVENTION

We recognise that the school plays a significant part in the prevention of harm to our children by providing them with good lines of communication with trusted adults, supportive friends and an ethos of protection.

The school community will therefore:

- Establish and maintain an ethos where children feel secure and are encouraged to talk and are always listened to.
- Ensure that all children know there is an adult in the school whom they can approach if they are worried or in difficulty.
- Include across the curriculum, including Personal, Social, Health and Economic Education and Citizenship (PSHCEd and C), opportunities which equip children with the skills they need to stay safe from harm and to know to whom they should turn for help.

15 HEALTH & SAFETY

Our Health & Safety policy, set out in a separate document, reflects the consideration we give to the protection of our children both physically within the school environment, and for example in relation to internet use, and when away from the school when undertaking school trips and visits.

West Sussex would like to acknowledge the assistance of Hertfordshire County Council and Shropshire County Council whose documentation was referred to during the preparation of this model policy.

APPENDIX 1 – INDICATORS OF HARM

PHYSICAL ABUSE

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

Indicators in the child

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

- 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.

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.

Specific Safeguarding Issues:

Please see page 9 of this policy for a list of specific issues relating to safeguarding and details of links to government web-sites with more information regarding these issues.

In addition the following information is from Keeping Children Safe in Education 2014 page 10:

Further information on Child Sexual Exploitation and Female Genital Mutilation

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

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