**Glenfall Community Primary School**

**Early Help Offer**

**Date Ratified by Governors September 2015**

**Date of Review September 2016**

**Early Help**

Everyone needs help at some time in their lives and therefore an ethos of early help is important for any school. The co-ordinated **Glenfall Primary offer of early help** is outlined in the table (pages 17 – 25). We believe that early interventions for children or families, in many cases, will prevent children from experiencing harm. Glenfall Primary offer a number of early preventative measures. In particular we have a Play Therapist and a Pastoral Support Worker who is able to work with children or families who are struggling with a range of difficulties or sign-post them on to other appropriate agencies or organisations.

Expert and professional organisations are best placed to provide up-to-date guidancesupport and intervention on specific safeguarding issues when and if they arise. School will refer to appropriate agencies when help is required to support children, young people or families or to prevent harm.

**All staff there is any offer of early help that we can make in order to help a child thrive. TheGCSB ‘continuum of need’ windscreen is an important diagram to keep in mind forall children.** [**http://www.gscb.org.uk/article/113294/Gloucestershire-procedures-andprotocols**](http://www.gscb.org.uk/article/113294/Gloucestershire-procedures-andprotocols)**(select ‘levels of intervention’). A copy of the GSCB ‘continuum of need’windscreen is in Appendix 5.**

**Our aim is to help pupils and families as early as possible when issues arise: ‘theright help at the right time to stop any issues getting worse’. Early help is an**

**approach not necessarily an action. It includes prevention education as well as**

**intervention where necessary or appropriate. In some cases immediate urgent action**

**might be necessary if a child or young person is at risk of immediate harm.**

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| **Glenfall Primary offer of Early Help** |
| Universal source ofhelp for all families inGloucestershire:**Gloucestershire****Family Information****Service (FIS)** | Gloucestershire Family Information Service (FIS) advisors give impartial information on **childcare, finances, parenting and education**. FIS are a useful source of information for parentsand professionals. They support families, children and young people aged 0-19 years of age (25 for young people with additional needs) and professionals working with these families.They can help link parents up with other organisations that mightbe able to help or provide the information themselves e.g.parents could ask them about holiday clubs for your childrenacross Gloucestershire.Contact the FIS by emailing:familyinfo@gloucestershire.gov.ukOr telephone: (0800) 542 0202 or (01452) 427362. FIS alsohave a website which has a wealth of information to supportmany issues such as childcare and support for children withdisabilities. www.glosfamilies.org |
| GSCB(GloucestershireSafeguardingChildren’s Board)website. | http://www.gscb.org.ukImportant information for parents and professionals across Gloucestershire in relation to keeping children safe and avenues of support including early help options. |
| Glenfall Primary universalsupport for all pupilsand families. | All staff are available in a pastoral capacity should parents havea concern about anything at all. Staff may not have the answerbut will try to find out the answer or sign-post parents/otherprofessionals in the right direction. Parents can either talkdirectly with the staff or telephone the Head. Staffs are availablewithin office hours (9am – 5pm on weekdays during term-time).General office number01242 234055 (to contact all staff). |
| Glenfall Primary PSHCE /SMSC curriculum | Glenfall Primary have combined PSHE (Personal Social HealthEducation), SRE (Sex and Relationships Education) and SMSC(Spiritual Moral Social and Cultural) Education and called it theSMSC Curriculum. This comprehensive curriculum coversmany aspects of keeping young people safe, healthy, resilientand aware of the world around them so that they can makeinformed decisions. Where pupils have specific issues that needdiscussing or addressing we will make their wellbeing curriculumbespoke to them. Other specific topics helping pupils stay safecovered within the curriculum include(age appropriate content):**Sex education:** Children in Y5 and 6 have formal Sex education– discussing puberty, changes, personal hygiene.(Gloucestershire health living and learning team (GHLL)resource).**Gender, identity and tolerance:** preventing homophobic andtransphobic bullying; preventing bullying of pupils from differenttypes of families (e.g. same sex parents); avoiding anti gayderogatory language; Gender identity - there isn’t such thing asa typical girl or a typical boy. Understanding and acceptance ofothers different than us, including those with different religions.**Drugs:** Alcohol, Smoking and illegal drugs.**Keeping Safe:** E-safety (facebook and internet); personal safety(out and about); How to respond to an emergency**Emotional well-being:** Where to go for help if you, your friendor family member is struggling with emotional well-being/mentalhealth problems? What are the signs someone is struggling?What makes you feel good; How to look after you own emotionalwell-being; Personal strength and self esteem; Being happy!**Relationships:** How to make and maintain friendship; familyrelationships; different types of families; (SEAL)**Healthy Living:** Taking responsibility for managing your ownhealth; Importance of sleep; The main components of healthyliving (diet, exercise and wellbeing);Focus on breakfast;Managing health and wellbeing when you are unwell (makingsure you take your medicine when you should, have the rightperspective, doing what you can do within the limitations of yourhealth condition. |
| Home-school support | All of our Early Help is offered in partnership with parents /carers. |
| E-safety | E-safety is a key part of the ongoing (PSHE/SMSC/SRE)curriculum.-PACE (parents against child exploitation) UK is a useful websiteto engage parents with e-safety issues. [www.paceuk.info/](http://www.paceuk.info/)- All staff undertake annual e-safety  |
| Maria Smith Pastoral Support Worker | Maria works 1 day a week on this role in school and is readily available to supportchildren and families on a needs basis.She will sign post families to furtherservices if further support is required. |
| Transition between classes | A transition folder for the class with important information is kept by class teachers and is updated with a child’s personal information. It is passed up and discussed with the teachers as children go through the school.3 Transition afternoons are also scheduled for children during the summer term when they pass up through the classes. |
| Achievement for All (AFA) | The Achievement for All Schools Program is a program for primary and secondary schools, academies and free schools; PRUs; and for special schools.It has been shown to close the achievement gap between children deemed vulnerable to underachievement - including those on free school meals, looked-after children, and those identified with SEND - and their peers.At Glenfall we are a leading AFA school and our Coach, (Bob Bromburg) has supported us with implementing a program tailored to the needs of our school. Regular structured conversations are held with theSENCo and parents of identified vulnerable children and the progress of these children is tracked and monitored closely to provide intervention to close any gaps. |
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| Bullying (includingcyber-bullying)/childdeath/suicideprevention | All Gloucestershire schools including Glenfall Primary are committed totackling bullying. We want to know immediately if there anyissues with bullying at school so that it can be addressed. Itcould be that bullying is related to a child’s home-school. Schoolcan also offer bespoke lessons on anti-bullying for anyone whohas suffered bullying to encourage behaviours that might avert itin the future (e.g. assertiveness) or to boost self esteem. Wehave a series of teaching resources produced by theGloucestershire healthy living and Learning Team(www.ghll.org.uk) to support this. In serious cases of bullyingparents should contact the police; particularly if there are threatsinvolved. In an emergency call 999. Other sources of help andadvice are: www.gscb.org (Gloucestershire Safeguardingchildren’s board) http://www.bullying.co.uk . GloucestershireHealthy Living and Learning team provide alerts and resourcesin relation to supporting young people being bullied. Educationabout bullying is an integral part of the GLENFALL PRIMARYWellbeing programme www.ghll.org.uk. |
| Children or youngpeople with multipleneeds (vulnerable) ormultiple needs(complex) requiringmulti-agency input orassessment. | Within Gloucestershire Targeted Support Teams provide multiagencysupport for children and families. A phone call to discussa possible referral is helpful before making written referral.School actively refer to when appropriate:**Targeted support Teams (TST):** Gloucester (tel:01452328076**)**, Stroud (tel: **01452 328130**); Tewkesbury (tel: 01684 328 250), Cotswold (tel: 01452 328101**)**, Forest of Dean(tel: 01452 328048) and Cheltenham (tel: 01452 328160)**.** Theseteams are made up of the following professionals: CAF Coordinators;Community Lead Professional - disabled childrenand young people; Inclusion Co-ordinator; Community SocialWorker; Family Support Workers. They all work together fromone base so they can recognise and respond to local needs andact as a focal point for co-ordinating support for vulnerablechildren, young people and their families.Support provided includes: Support for school and communitybased lead professionals working with children and familiesthrough the CAF process; Collaboration with social care referralsthat do not meet their thresholds, to co-ordinate support withinthe community; Work in partnership to support children withspecial educational needs in school; Advice and guidance froma social work perspective on a 'discussion in principle basis' ;Support children with disabilities and their families to accessactivities and meet specific needs; Advice and guidance to lead professionals and the provision of high quality parenting andfamily support services to families. |
| Drug concerns | www.infobuzz.co.uk/: Info Buzz provides individual targetedsupport around drugs & emotional health issues, development ofpersonal & social skills, and information & support aroundsubstance misuse.Drugs education is covered in the school curriculum. The LifeEducation Bus visits every 3 years as part of this provisionPSHE/SMSC) curriculum as a preventative measure. |
| Mental healthconcerns | * Referral to school nurses may be appropriate.
* Referral to CYPS (Gloucestershire’s mental healthservices) via your own GP.
* For children/young people/adults with existing mentalhealth difficulties concerns should be discussed with theexisting medical professionals (consultant psychiatrists).
* In an emergency call 999 or 111.
* **CYPS\* Practitioner advice line (for professionals tocall) tel: 01452 894272.**
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| Child Sexualexploitation (CSE) | CSE screening tool (can be located on the GSCB website:www.gscb.org.uk/article/113294/Gloucestershire-proceduresand-protocols) This should be completed if CSE suspected.Clear information about Warning signs, the screening tool andGloucestershire's multi-agency protocol for safeguardingchildren at risk of CSE are at www.gscb.org. Referrals should bemade to Gloucestershire social care and the GloucestershirePolice.**Gloucestershire Police CSE Team:**The CSE team sits within the Public Protection Bureau19Single agency team (Police)DS Nigel Hatten, DC Tess Nawaz, DC Kim Toogood,PC Dawn Collings, PC Nicki Dannatt, PC Jenny Kadodia,PC Christina Pfister (Missing persons Coordinator)01242 276846All referrals to go to the Central Referral Unit 01242 247999• **Further information**: National Working Group (Networktackling Child Sexual Exploitation)www.nationalworkinggroup.org and PACE UK (ParentsAgainst Child Sexual Exploitation) www.paceuk.info |
| Domestic violence | The GSCB (Gloucestershire Safeguarding Children’s board)have published a Domestic Abuse pathway for educationalwhich is on the GSCB website. If a child or youngperson is suspected of living at home with a domesticallyabusive parent or if a young person has domestic abuse in theirown relationship then the usual procedures should be followedand a referral made to the children’s helpdesk (tel: 01452426565). The response will vary according to the age of theyoung person so that the appropriate agencies are involved.**Gloucestershire Domestic Abuse Support Service (GDASS)****www.gdass.org.uk****MARAC Gloucestershire Constabulary:** Multi Agency RiskAssessment Conferences (MARACs) prioritise the safety ofvictims who have been risk assessed at high or very high risk ofharm. The MARAC is an integral part of the Specialist DomesticViolence Court Programme, and information will be sharedbetween the MARAC and the Courts, in high and very high riskcases, as part of the process of risk management. |
| Faith abuse | www.gov.uk/government/publications/national-action-plan-totackle-child-abuse-linked-to-faith-or-belief for copy of DfEdocument ‘**national action plan to tackle child abuse linkedto faith or belief.’**Judith Knight; Diocese of Gloucester Head of Safeguarding/faithabuse contact: jknight@glosdioc.org.uk. For other faith groupscontact Jane Bee (GCC LADO). |
| Female genitalmutilation (FGM) | http://www.nhs.uk/Conditions/female-genital-mutilationfor NHS information and signs of FGM. Any suspicion of FGMshould be referred to the Police and social care.- Meg Dawson (Head) has completed the online home officetraining, ‘*Female Genital Mutilation: Recognising and PreventingFGM*’- E-learning package- http://www.fgmelearning.co.uk/ forinterested staff or professionals (free home office e-learning)Posters/leaflets on FGM shared with staff and pupils. |
| Mental health | CYPS (Gloucestershire’s mental health services)CYPS (Gloucestershire children’s mental health services).Consultant psychiatrists.PSHCE / SMSC curriculum – emotional wellbeing, stressmanagement |
| Private fostering | http://www.gloucestershire.gov.uk/privatefosteringGloucestershire County council website information on privatefostering. Refer to Gloucestershire Children & Families Helpdeskon **01452 426565** or Gloucestershire Private Fostering SocialWorker **01452 427874.**A private fostering arrangement is essentially one that is madewithout the involvement of a local authority. Private fostering isdefined in the Children Act 1989 and occurs when a child oryoung person under the age of 16 (under 18 if disabled) is caredfor and provided with accommodation, for 28 days or more, bysomeone who is not their parent, guardian or a close relative.(Close relatives are defined as; step-parents, siblings, brothersor sisters of parents or grandparents). |
| radicalisation | **Gloucestershire Constabulary:** 101 and Jane Bee (LADO)**Anti-Terrorist Hotline:** 0800 789 321*See Appendix 2 for further information on radicalisation.*Prevention: GLENFALL PRIMARY teach traditional British valuesthrough the curriculum: democracy, rule of law, respect forothers, liberty, tolerance of those with different faiths and beliefsand promotion of ‘Britishness’. |
| Children who run away(missingpersons/missingchildren) | **PC Christina Pfister (Missing persons Coordinator****Gloucestershire Police). Tel: 101 (Gloucestershire Police).*****GSCB Missing Children Protocol*** *http://www.gscb.org.uk:**Gloucestershire's protocol on partnership working when childrenand young people run away and go missing from home or care.*ASTRA (Gloucestershire): The ASTRA (Alternative Solutions ToRunning Away) has the primary aim of reducing the incidence ofpersistent running away across Gloucestershire. The projectprovides support, advice and information to young people up toeighteen years old who have run away. This might be from afamily home, foster home or from a residential unit. ASTRAprovides support after the event to enable a young person toaddress the causes of running away. The ASTRA project offersyoung people help and the support required in order to findAlternative Solutions To Running Away. Freephone Telephonenumber: 0800-389-4992 EXCLUSIVELY for young people whohave run away and have no money. All other callers are askedto use the 'ordinary' number ( tel: 01452 541599). |
| CME (Childrenmissing education) | **Anyone concerned that a child is missing education (CME)can make a referral to the Education Entitlement andInclusion team (EEI) at Gloucestershire County Council. Tel:01452 426960/427360. Children Missing Education (CME)**refers to 'any child of compulsory school age who is **not**registered at any formally approved education activity e.g.school, alternative provision, elective home education, **and** hasbeen out of education provision for at least 4 weeks'. **CME** alsoincludes those children who are **missing** (family whereaboutsunknown), and are usually children who are registered on aschool roll / alternative provision. This might be a child who isnot at their last known address **and either:** has not taken up anallocated school place as expected, or has 10 or more days ofcontinuous absence from school without explanation, or leftschool suddenly and the destination is unknown. It is theresponsibility of the Education Entitlement and Inclusion team,on behalf of the Local Authority (LA), to: Collate information onall reported cases of CME of statutory school aged children inGloucestershire maintained schools, academies, free schools,alternative provision academies and Alternative ProvisionSchools (APS). The EEI Team will also liaise with partneragencies and other LAs and schools across Britain to trackpupils who may be missing education and ensure each childmissing education is offered full time education within 2 weeks ofthe date the LA was informed. |
| **Other sources of help and information in Gloucestershire :** | **Gloucestershire MAPPA (Multi-Agency Public Protection Arrangements)** are a set ofarrangements to manage the risk posed by the most serious sexual and violent offenders(MAPPA-eligible offenders) under the provisions of sections 325 to 327B of the CriminalJustice Act 2003. They should be contacted without delay if there is any concern is reportedabout a serious sexual or violent offender. (Contact Bernie Kinsella – Chair of MAPPA –detective chief superintendant – Gloucestershire Constabulary – Tel: 101) |

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**Conclusion**

**Safeguarding children is an issue that has to be a priority that underpins all the workwe do at Glenfall Primary and as such will be reflected in all our documentation andany new policies and procedures that are agreed, as well as being reflected in ourday to day practice.**

**CATEGORIES OF ABUSE AND INDICATORS OF HARM**

**Categories of Abuse:**

1**.Physical Abuse**

**2.Emotional Abuse (including Domestic Abuse)**

**3. Neglect**

**4. Sexual Abuse**

**Signs of Abuse in Children:**

The following non-specific signs may indicate something is wrong:

• Significant change in behaviour

• Extreme anger or sadness

• Aggressive and attention-seeking behaviour

• Suspicious bruises with unsatisfactory explanations

• Lack of self-esteem

• Self-injury

• Depression

• Age inappropriate sexual behaviour

• Child Sexual Exploitation.

**Risk Indicators**

The factors described in this section are frequently found in cases of child abuse. Their

Presence is not proof that abuse has occurred, but:

Must be regarded as indicators of the possibility of significant harm

Justifies the need for careful assessment and discussion with designated / named /

24lead person, manager, (or in the absence of all those individuals, an experienced

colleague)May require consultation with and / or referral to Social Care

The absence of such indicators does not mean that abuse or neglect has not occurred.

In an abusive relationship the child may:

Appear frightened of the parent/s

Act in a way that is inappropriate to her/his age and development (though fullaccount needs to be taken of different patterns of development and different ethnicgroups)

The parent or carer may:

Persistently avoid child health promotion services and treatment of the child’sepisodic illnesses

Have unrealistic expectations of the child

Frequently complain about /to the child and may fail to provide attention or praise

(high criticism/low warmth environment).

Be absent or misusing substances.

Persistently refuse to allow access on home visits.

Be involved in domestic abuse.

Staff should be aware of the potential risk to children when individuals, previouslyknown or suspected to have abused children, move into the household.

***1.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 symptomsof, or deliberately induces, illness in a child.***

**Indicators in the child**

**Bruising**

It is often possible to differentiate between accidental and inflicted bruises. The followingmust 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 injuredaccidentally, for example the back, mouth, cheek, ear, stomach, chest, under thearm, 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 ortwisting

Bruising around the face

Grasp marks to the upper arms, forearms or leg

Petechae haemorrhages (pinpoint blood spots under the skin.) Commonlyassociated with slapping, smothering/suffocation, strangling and squeezing

**Fractures**

Fractures may cause pain, swelling and discolouration over a bone or joint. It is unlikelythat 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 maybe 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 causedsymptoms such as swelling, pain or loss of movementRib fractures are only caused in major trauma such as in a road traffic accident, a severeshaking 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 isusually witnessed, the child will cry and if there is a fracture, there is likely to be swelling onthe 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 ababy or a child with a disability. There is often finger bruising to the cheeks and around themouth. Rarely, there may also be grazing on the palate.

**Poisoning**

Ingestion of tablets or domestic poisoning in children under 5 is usually due to thecarelessness 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 aresult of having illness fabricated or induced by their carer. Possible concerns are:

Discrepancies between reported and observed medical conditions, such as theincidence of fits

Attendance at various hospitals, in different geographical areas

Development of feeding / eating disorders, as a result of unpleasant feedinginteractions

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 isno 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 hasbeen inflicted. The shape then becomes a more defused ring bruise or oval or crescentshaped. Those over 3cm in diameter are more likely to have been caused by an adult orolder child. A medical/dental opinion, preferably within the first 24 hours, should be soughtwhere there is any doubt over the origin of the bite.

**Children and young people who havedog bites should always be referred to the Multi Agency Safeguarding Hub for furtherinvestigation.**

**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, linearburns from hot metal rods or electrical fire elements, burns of uniform depth over a largearea, scalds that have a line indicating immersion or poured liquid.

Old scars indicating previous burns/scalds which did not have appropriate treatment oradequate explanation. Scalds to the buttocks of a child, particularly in the absence of burnsto 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 scaldits bottom without also scalding his or her feet.

A child getting into too hot water of his or her own accord will struggle to get out andthere 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 ofphysical or sexual assault

Parent/carer may be over involved in participating in medical tests, taking temperatures andmeasuring bodily fluids

Observed to be intensely involved with their children, never taking a much needed breaknor allowing anyone else to undertake their child's care.

May appear unusually concerned about the results of investigations which may indicatephysical 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.

***2. EMOTIONAL ABUSE***

***Emotional abuse is the persistent emotional maltreatment of a child such as to causesevere and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, orvalued only insofar as they meet the needs of another person.It may include not giving the child opportunities to express their views, deliberatelysilencing them or ‘making fun’ of what they say or how they communicate.***

***It may feature age or developmentally inappropriate expectations being imposed onchildren. These may include interactions that are beyond the child’s developmentalcapability, as well as overprotection and limitation of exploration and learning, orpreventing the child participating in normal social interaction.***

***It may involve seeing or hearing the ill-treatment of another. It may involve seriousbullying (including cyberbullying), causing children frequently to feel frightened or indanger, 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 noattachment

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 befeatures 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 developmentalexploration 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 thefamily

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 psychologicalneeds, likely to result in the serious impairment of the child’shealth or development. Neglect may occur during pregnancy as a result of maternalsubstance 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 orabandonment);***

• ***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 emotionalneeds.***

**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 orpersistent 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 toattend 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 parentalsubstance 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 thefamily

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 safetyequipment; risk from animals

Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleepingarrangements, inadequate ventilation (including passive smoking) and lack of adequateheating

Lack of opportunities for child to play and learn

***4. 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 notthe child is aware of what is happening.***

***The activities may involve physical contact, including assault by penetration (forexample, 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 lookingat, or in the production of, sexual images, watching sexual activities, encouragingchildren to behave in sexually inappropriate ways, or grooming a child in preparationfor abuse (including via the internet). Sexual abuse is not solely perpetrated by adultmales. 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 issecrecy 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 thefamily

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.

**Sexual Abuse by Young People**

The boundary between what is abusive and what is part of normal childhood or youthfulexperimentation can be blurred. The determination of whether behaviour is developmental,inappropriate or abusive will hinge around the related concepts of true consent, powerimbalance and exploitation. This may include children and young people who exhibit arange of sexually problematic behaviour such as indecent exposure, obscene telephonecalls, fetishism, bestiality and sexual abuse against adults, peers or children.

Developmental Sexual Activity encompasses those actions that are to be expected fromchildren and young people as they move from infancy through to an adult understanding oftheir physical, emotional and behavioural relationships with each other. Such sexual activityis essentially information gathering and experience testing. It is characterised by mutualityand of the seeking of consent.

Inappropriate Sexual Behaviour can be inappropriate socially, inappropriate to

development, or both. In considering whether behaviour fits into this category, it is importantto consider what negative effects it has on any of the parties involved and what concerns itraises about a child or young person. It should be recognised that some actions may bemotivated by information seeking, but still cause significant upset, confusion, worry,physical damage, etc. It may also be that the behaviour is “acting out” which may derivefrom other sexual situations to which the child or young person has been exposed.

If an act appears to have been inappropriate, there may still be a need for some form ofbehaviour management or intervention. For some children, educative inputs may beenough to address the behaviour.

Abusive sexual activity included any behaviour involving coercion, threats, aggressiontogether with secrecy, or where one participant relies on an unequal power base.

**Assessment**

In order to more fully determine the nature of the incident the following factors should begiven consideration. The presence of exploitation in terms of:

**Equality** – consider differentials of physical, cognitive and emotional development,power and control and authority, passive and assertive tendencies

**Consent** – agreement including all the following:

o Understanding what is proposed based on age, maturity, development level, functioningand experience

o Knowledge of society’s standards for what is being proposed

o Awareness of potential consequences and alternatives

o Assumption that agreements or disagreements will be respected equally

o Voluntary decision

o Mental competence



**Coercion –** the young perpetrator who abuses may use techniques like bribing,manipulation and emotional threats of secondary gains and losses that is loss oflove, friendship, etc. Some may use physical force, brutality or the threat of theseregardless of victim resistance.

In evaluating sexual behaviour of children and young people, the above information shouldbe used only as a guide.

**Child Sexual Exploitation**

The following list of indicators is not exhaustive or definitive but it does highlight commonsigns which can assist professionals in identifying children or young people who may bevictims of sexual exploitation.

Signs include:

underage sexual activity

inappropriate sexual or sexualised behaviour

sexually risky behaviour, 'swapping' sex

repeat sexually transmitted infections

in girls, repeat pregnancy, abortions, miscarriage

receiving unexplained gifts or gifts from unknown sources

having multiple mobile phones and worrying about losing contact via mobile

having unaffordable new things (clothes, mobile) or expensive habits (alcohol, drugs)

changes in the way they dress

going to hotels or other unusual locations to meet friends

seen at known places of concern

moving around the country, appearing in new towns or cities, not knowing wherethey are

getting in/out of different cars driven by unknown adults

having older boyfriends or girlfriends

contact with known perpetrators

involved in abusive relationships, intimidated and fearful of certain people orsituations

hanging out with groups of older people, or anti-social groups, or with othervulnerable peers

associating with other young people involved in sexual exploitation

recruiting other young people to exploitative situations

truancy, exclusion, disengagement with school, opting out of education altogether

unexplained changes in behaviour or personality (chaotic, aggressive, sexual)

mood swings, volatile behaviour, emotional distress

self-harming, suicidal thoughts, suicide attempts, overdosing, eating disorders

drug or alcohol misuse

getting involved in crime

police involvement, police records

involved in gangs, gang fights, gang membership

injuries from physical assault, physical restraint, sexual assault.

**Female Genital Mutilation (FGM) – signs of**

It is essential that staff are aware of FGM practices and the need to look for signs,symptoms and other indicators of FGM. FGM is sometimes known as ‘female genitalcutting’ or ‘female circumcision.’ Communities tend to use local names referring to thispractice, including ‘sunna’

**What is FGM?**

It involves procedures that intentionally alter/injure the female genital organs for nonmedicalreasons.

4 types of procedure:

Type 1 Clitoridectomy – partial/total removal of clitoris

Type 2 Excision – partial/total removal of clitoris and labia minora

Type 3 Infibulation entrance to vagina is narrowed by repositioning the inner/outer labia

Type 4 all other procedures that may include: pricking, piercing, incising, cauterising andscraping the genital area.

Why is it carried out?

Belief that:

FGM brings status/respect to the girl – social acceptance for marriage

Preserves a girl’s virginity

Part of being a woman / rite of passage

Upholds family honour

Cleanses and purifies the girl

Gives a sense of belonging to the community

Fulfils a religious requirement

Perpetuates a custom/tradition

Helps girls be clean / hygienic

Is cosmetically desirable

Mistakenly believed to make childbirth easier

Is FGM legal?

FGM is internationally recognised as a violation of human rights of girls and women.

**It is illegal in most countries including the UK.**

Circumstances and occurrences that may point to FGM happening:

Child talking about getting ready for a special ceremony

Family taking a long trip abroad

Child’s family being from one of the ‘at risk’ communities for FGM (Kenya, Somalia,

Sudan, Sierra Leon, Egypt, Nigeria, Eritrea as well as non-African communitiesincluding Yemeni, Afghani, Kurdistan, Indonesia and Pakistan)

Knowledge that the child’s sibling has undergone FGM

Child talks about going abroad to be ‘cut’ or to prepare for marriage

A sign that may indicate a child has undergone FGM:

Prolonged absence from school and other activities

Behaviour change on return from a holiday abroad, such as being withdrawn andappearing subdued

Bladder or menstrual problems

Finding it difficult to sit still and looking uncomfortable

Complaining about pain between the legs

Mentioning something somebody did to them that they are not allowed to talk about

Secretive behaviour, including isolating themselves from the group

Reluctance to take part in physical activity

Repeated urinal tract infection

Disclosure

The ‘One Chance’ ruleAs with Forced Marriage there is the ‘One Chance’ rule. It is essential that settings/schools/colleges take action **without delay**. Staff should activate local safeguardingprocedures, using existing national and local protocols for multi-agency liaison with policeand children’s social care.

**Further information on Trafficking**

Child trafficking is a form of child abuse where children are recruited and moved to beexploited, forced to work or sold. They are often subject to multiple forms of exploitationincluding: child sexual exploitation, benefit fraud, forced marriage, domestic servitudeincluding cleaning, childcare and cooking, forced labour in agriculture or factories, criminalactivity such as pickpocketing, begging, transporting drugs, working on cannabis farms,selling pirated DVDs , bag theft.

Traffickers trick, force or persuade children to leave their homes and then move them toanother location. Trafficked children are often controlled with violence and threats and maybe kept captive, resulting in long lasting and devastating effects on their mental andphysical health. It is not easy to identify trafficked children, but you may notice unusualbehaviour or events that just don’t add up. Both boys and girls are victims of trafficking.

Trafficked children may be from the UK or have been moved from another country. Poverty,war or discrimination can put children more at risk of trafficking. Traffickers may promisechildren education or respectable work, or persuade parents that their child can have abetter future in another place. It can be very difficult to identify a child who has beentrafficked, as they are deliberately hidden and isolated. They may be scared, or they maynot realise that they are a victim or are being abused. While there may not be any obvioussigns of distress or harm, a trafficked child is at risk and may experience physical abuse,emotional abuse and/or neglect.

Many children are trafficked in to the UK from abroad, but children can also be traffickedfrom one part of the UK to another. Even a child being moved from one side of the street toa different address for a short period of time with the intent of exploitation would beidentifiable as a trafficking crime. Any suspicion of trafficking must be reported to the LADOand the Police without delay.

**Further information on Radicalisation** (in line with the PREVENT DUTY)

Radicalisation refers to the process by which a person comes to support terrorism andforms of extremism leading to terrorism. To reduce the risk from terrorism we need not onlyto stop terrorist attacks but also to prevent people becoming terrorists. This is one objectiveof Prevent, part of CONTEST, the Government’s strategy for countering internationalterrorism. All the terrorist groups who pose a threat to us seek to radicalise and recruitpeople to their cause. The aim of Prevent is to stop people becoming or supportingterrorists, by challenging the spread of terrorist ideology, supporting vulnerable individuals,and working in key sectors and institutions. Work to safeguard children and adults,providing early intervention to protect and divert people away from being drawn into terroristactivity, is at the heart of the Prevent strategy. Supporting vulnerable individuals requiresclear frameworks – including guidance on how to identify vulnerability and assess risk,where to seek support and measures to ensure that we do not ever confuse prevention and

early intervention with law enforcement. Channel is a key element of the Prevent strategy. Itis a multi-agency approach to protect people at risk from radicalisation. Channel usesexisting collaboration between local authorities, statutory partners (such as the educationand health sectors, social services, children’s and youth services and offendermanagement services), the police and the local community to identify individuals at risk ofbeing drawn into terrorism; assess the nature and extent of that risk; and develop the mostappropriate support plan for the individuals concerned. Channel is about safeguardingchildren and adults from being drawn into committing terrorist-related activity. It is aboutearly intervention to protect and divert people away from the risk they face before illegalityoccurs.

**Indicators of vulnerability to radicalisation**:

1. **Radicalisation** refers to the process by which a person comes to support terrorism andforms of extremism leading to terrorism.

2. **Extremism** is defined by the Government in the Prevent Strategy as: Vocal or activeopposition to fundamental British values, including democracy, the rule of law, individualliberty and mutual respect and tolerance of different faiths and beliefs. We also include inour definition of extremism calls for the death of members of our armed forces, whether inthis country or overseas.

3. **Extremism is defined by the Crown Prosecution Service as: The demonstration ofunacceptable behaviour by using any means or medium to express views which:**

**Encourage, justify or glorify terrorist violence in furtherance of particular beliefs;**

**Seek to provoke others to terrorist acts;**

**Encourage other serious criminal activity or seek to provoke others to seriouscriminal acts; or**

**Foster hatred which might lead to intercommunity violence in the UK.**

4. There is no such thing as a “typical extremist”: those who become involved in extremistactions come from a range of backgrounds and experiences, and most individuals, eventhose who hold radical views, do not become involved in violent extremist activity.

5. Pupils may become susceptible to radicalisation through a range of social, personaland environmental factors \_ it is known that violent extremists exploit vulnerabilities inindividuals to drive a wedge between them and their families and communities. It is vitalthat school staff is able to recognise those vulnerabilities.

6. Indicators of vulnerability include:

Identity Crisis – the student / pupil is distanced from their cultural / religious heritage and

experiences discomfort about their place in society;

Personal Crisis – the student / pupil may be experiencing family tensions; a sense of isolation; and low selfesteem; they may have dissociated from their existing friendshipgroup and become involved with a new and different group of friends; they may besearching for answers to questions about identity, faith and belonging;

Personal Circumstances – migration; local community tensions; and events affecting thestudent / pupil’s country or region of origin may contribute to a sense of grievance that istriggered by personal experience of racism or discrimination or policy;

Unmet Aspirations – the student / pupil may have perceptions of injustice; a feeling offailure; rejection of civic life;

Experiences of Criminality – which may include involvement with criminal groups,imprisonment, and poor resettlement / reintegration?

Special Educational Need – students / pupils may experience difficulties with social

interaction, empathy with others, understanding the consequences of their actions andawareness of the motivations of others.

7. However**,** this list is not exhaustive, nor does it mean that all young people experiencingthe above are at risk of radicalisation for the purposes of violent extremism.

8. **More critical risk factors could include**:

Being in contact with extremist recruiters;

Accessing violent extremist websites, especially those with a social networking element;

Possessing or accessing violent extremist literature;

Using extremist narratives and a global ideology to explain personal disadvantage;

Justifying the use of violence to solve societal issues;

Joining or seeking to join extremist organisations; and

Significant changes to appearance and / or behaviour;

Experiencing a high level of social isolation resulting in issues of identity crisis and orpersonal crisis.

**Staff should be alert to any warning signs of radicalisation and hold an attitude of ‘itcould happen here.’**

**When a child tells me about abuse s/he has suffered, what must I remember?**

* Stay calm.
* Do not communicate shock, anger or embarrassment.
* Reassure the child. Tell her/him you are pleased that s/he is speaking to you.
* Never enter into a pact of secrecy with the child. Assure her/him that you will try to helpbut let the child know that you will have to tell other people in order to do this. State whothis will be and why.
* Tell her/him that you believe them. Children very rarely lie about abuse; but s/he mayhave tried to tell others and not been heard or believed.
* Tell the child that it is not her/his fault.
* Encourage the child to talk but do not ask "leading questions" or press for information.
* Listen and remember.
* Check that you have understood correctly what the child is trying to tell you.
* Praise the child for telling you. Communicate that s/he has a right to be safe andprotected.
* Do not tell the child that what s/he experienced is dirty, naughty or bad.
* It is inappropriate to make any comments about the alleged offender.
* Be aware that the child may retract what s/he has told you. It is essential to record all youhave heard.
* At the end of the conversation, tell the child again who you are going to tell person or those people need to know.
* As soon as you can afterward, make a detailed record of the conversation using the child’s own language. Include any questions you may have asked. Do not add any opinionsor interpretations. NB It is not education staff’s role to seek disclosures. Their role is toobserve that something may be wrong, ask about it, listen, be available and try to maketime to talk.

**Immediately afterwards**

**You must not deal with this yourself. Clear indications or disclosure of abuse mustbe reported to children’s social care without delay, by the Head of Service or theDesignated Safeguarding Lead. If the child is at immediate risk you make the referralyourself.**

Children making a disclosure may do so with difficulty, having chosen carefully to whomthey will speak. Listening to and supporting a child/young person who has been abused canbe traumatic for the adults involved. Support for you will be available from your DesignatedSafeguarding Lead.