

Child Protection

The welfare and safety of the children in the school is paramount and the needs of children are paramount and should underpin all child protection work and resolve any conflicts of interest. The school follows guidance and procedures laid down by the Sussex County Council and appropriate DFCS documentation. A copy of these procedures can be found in the Staff Room. The 'Link Governor' responsible for Child Protection and its implementation is Fiona Bell. The Head Master has overall responsibility for child protection and welfare issues in the school and in conjunction with the Child Protection Officer for liaison with the S.S.D.

The school has two Child Protection Officers, one based on each site, neither of which is the Head Master. This is to ensure that children and staff may discuss Child Protection issues involving either the Head Master or a Child Protection Officer with another senior member of staff.

Child Protection will be an item on all beginning of term staff meetings in order to remind staff about their responsibilities, update staff on new initiatives and keep the safety of children in the forefront of their minds.

Notices concerning child welfare, including Child Line, are displayed throughout the school.

Following is some information that will help staff in identifying possible abuse

ABUSE

Child abuse may occur in many ways. It may include physical, sexual or emotional abuse, harassment because of race or gender, or different kinds of bullying. Staff should read the separate sheets which contain information on abuse. It must be remembered that as well as adults abusing children there may be instances of child on child abuse.

In all cases where teachers, or other members of staff, consider that they have good cause to suspect abuse, they should report their suspicions to the Head Master, who will follow the procedures laid down by the local S.S.D. which includes contact with a welfare agency within 24 hours of a disclosure or suspicion of abuse.

N.B. If the Head Master is involved in any allegations, the member of staff should then report to the Senior Master, who will report to the Chairman of Governors.

If child abuse is suspected, it will be essential to have a record of all the information available.

Staff should note what they have observed and when they observed it. They should record any information given and the action taken.

The Rule is: **OBSERVE, RECORD AND REPORT**

- R Respond without showing signs of disquiet, anxiety or shock;
- E Enquire casually about how an injury was sustained or why a child appears upset;
- C Confidentiality should **not** be promised to children or to adults;
- O Observe carefully the behaviour and demeanour of the child or the person expressing concern;
- R Record in detail what you have seen and heard - including setting of communication, time and persons present;
- D Do not interrogate or enter into detailed investigations; rather encourage the child to say what he or she wants until enough information is gained to decide whether or not a referral is appropriate. Do not ask any leading questions - allow the child to present his/her account, uninterrupted.

AND THEN REPORT TO THE HEAD MASTER.

INDICATORS OF CHILD ABUSE

- an unexplained physical injury.
- an injury that is inconsistent with the explanation
- the explanation for the injury changes.
- the child refuses to discuss the injury.
- an untreated injury or an unexplained delay before treatment was obtained.
- injuries of differing ages.
- there were no witnesses to the injury.
- a child being reluctant to change for P.E. or swimming.
- the child has a fear of the parents being contacted/going home.
- a child who exhibits sudden changes in behaviour/demeanour and/or deterioration of academic performance.
- child becomes aggressive towards others.
- a child with a knowledge of sexual matters beyond what would normally be expected.
- sexualised play or sexual talk.
- parents engaging in trivial discussions about minor ailments.
- parents hinting at other problems.

GOOD PRACTICE GUIDELINES FOR STAFF

These guidelines are to help staff be above reproach in their dealings with children within the school setting.

Good practice guidelines and sensible precautions will minimise the risk for both staff and children and are to protect both staff and pupils.

Where possible avoid being alone in a closed room with a child.

Always act in a way that is appropriate to the child's age and needs
Avoid having a 'favourite' child or group of children.

Avoid unnecessary, informal touching.

Avoid invading the privacy of children when they are using the toilet or showering.

Be sensitive to touch if you are dealing with a child who is distressed.

Restrain a child only to prevent the child from hurting themselves or others.

Be aware of the special needs of vulnerable children.

Do not allow unknown adults access to children. Visitors should be accompanied by a known person.

Be prepared to let your colleagues know if you consider their actions, language or attitude is inappropriate, or open to misinterpretation.

Be aware of the importance of maintaining appropriate boundaries with children and maintain an awareness of 'relationships of trust'.

SIGNS AND SYMPTONS OF ABUSE

NEGLECT

- looks extra-thin and poorly;
- well below average in height and weight; 'failing to thrive';
- complaints of hunger, lacking energy;
- has untreated nappy rash or other condition/injury untreated;
- has repeated accidents, especially burns;
- left alone at home inappropriately;
- repeatedly unwashed, smelly;
- kept away from medicals;
- reluctant to go home.

SEXUAL ABUSE

- what the child tells you;
- young children 'acting out' precocious sexual behaviour with others (e.g. simulating intercourse, grabbing genitals)
- repeated, open masturbation;
- young children, especially girls, behaving in a precocious sexually provocative way;
- running away;
- unhappy, isolated;
- aggressive eruptions/tantrums (still occurring after age of three);
- presence of a sexually transmitted disease on genitals or throat; (NB cannot be caught from 'sharing sheets' with an infected adult)
- kept away from medicals;
- persistent problems with sleeping, bed-wetting, nightmares;
- anorexia, bulimia; excessive 'comfort eating';
- reluctant to go home.

EMOTIONAL ABUSE

- low self esteem;
- apathy;
- being fearful or withdrawn or displaying 'frozen watchfulness';
- unduly aggressive behaviour;
- excessively clingy or attention-seeking behaviour;
- constantly seeking to please and be over ready to relate to anyone, including strangers.

PHYSICAL ABUSE

- injuries that are not adequately explained by the child;
- current bruising/injury, with long history of bruises and accidents;
- injuries getting progressively worse, or occurring in a time pattern (e.g. every Monday morning, or after visits to...);
- 'grip' marks on arms (may indicate severe shaking) or 'slap' markings (especially cheeks, buttocks, arms or legs).

NEGLECT AND NON-ORGANIC FAILURE TO THRIVE – CODE 'N'

DEFINITION

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. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

RECOGNITION

Although evidence of neglect is frequently accumulative, it can also be identified by the conditions a child lives in and may require assistance from Housing/Environmental Health and the Police in assessment.

Response to neglect (Joint Protocol November 1999 printed below)

- Refer to Social Services Help Desk.

JOINT PROTOCOL FOR NEGLECT

1. INVESTIGATION

The purpose of the investigation is to gather sufficient information to make a decision whether there is need for:

- services for a 'child in need';
- child protection case conferences;
- criminal proceedings/child care proceedings.

2. ASSESSMENT

The purpose of neglect assessment is to:

- identify the needs of the child, establishing where they are met and unmet;
- establish the risk of significant harm to the child, arising from his/her needs;
- establish the parent's capacity to change to meet any unmet needs;
- identify resources in the family or professional network which can be mobilised to meet the child's unmet needs;

- ensure the child's needs are met in the future.

3. PROCEDURES

Where a neglect referral is to be the subject of a Child Protection Investigation, existing procedure will apply.

In the circumstances where it is decided to undertake a Child Protection Neglect Assessment, it is important that the welfare of the child is not compromised by delay. Decisions to initiate court proceedings or a Child Protection Conference should be made, where appropriate, at any point in the assessment process.

ASSESSMENT

Phase 1.

A multi-agency discussion will be convened within seven working days of referral.

The purpose is to facilitate effective communication, establish facts, acknowledge differences, co-ordinate information and agree further action.

An Eco-map of all professionals who are or have been involved with family members will assist in ensuring the essential elements of the professional network are not over looked.

When agreement to undertake an assessment is reached, planning and completion of the assessment is required within a maximum of thirty-five working days.

A Core Group will be established to organise and implement agreed tasks within set time scales.

The discussion should be clearly recorded.

Phase 2.

During the assessment process all children in the household should be seen and, if possible, interviewed, to explore the child's experience of family life.

When a child has communication difficulties, or other disabilities, or where there is doubt about 'normal development', specialist input must be sought.

A paediatric assessment and comprehensive observation of the home could be essential elements.

Social, racial, cultural and religious factors need to be explored and, where appropriate, specialist advice sought. The focus on the needs of the child must not be compromised by these considerations.

Resource provision may assist in assessing the parent's ability to change.

Accurate contemporaneous recording is essential in all assessments, but the nature of neglect (mounting concern and minor incidents) requires detailed recording of what children say and with rigorous separation of fact and opinion.

Recording of apparently trivial events is also essential if a comprehensive picture of a child's situation is to be achieved. Chronologies should routinely be used.

Phase 3.

The multi-disciplinary discussion will be reconvened to review information gained through assessment.

All agencies must take responsibility for bringing detailed information to this meeting.

A risk analysis should be completed to inform recommendations for further actions.

Ordinarily the family will be invited to this meeting.

ASSESSMENT PROCESS

Phase One - Planning

- establish time scales;
- who will do what, where and when?
- are additional resources needed?
- read the files and prepare a chronology;
- writing agreements from parents, colleagues and child (where appropriate).

Phase Two - Doing

- inject resources, e.g. family centre, outreach, specialist help;
- monitor the home's physical condition;
- assessment of attachment relationships between parent(s) and child(ren), sibling group, extended family etc;

Phase Three - Reviewing

- identify what is known/not known;
- what is the child saying/showing?
- what are the child's psychological needs?

- what is the potential for change and how will it be tested?
- has ethnicity been addressed?
- how have resources been used – are more/different resources needed?

Risk Analysis

- what is the risk of significant harm to the child?
- what is the likely effect of change?
- what are the strengths/weaknesses of family network, environment?

Phase Four

- complete outstanding work;
- test judgements;
- write up;
- share with child and family;
- plan for what next.

See also:

- 7.6 Children with Disabilities;
- 7.7 Children Living in Situations of Domestic Violence;
- 7.13 Parents/Carers Who are Involved in Substance Misuse;
- 7.14 Parents/Carers with Learning Disabilities;
- 7.15 Parents/Carers with Mental Health Problems;
- 7.16 Working with Hostile and non-Compliant Parents/Carers

SEXUAL ABUSE – CODE ‘S’

Definition

Actual or likely sexual abuse/exploitation of a child or adolescent. Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) and non-penetrative acts. They may include non-contact activities such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways. (See 7.4 Children Involved in Prostitution).

A child can be caught in a double bind when deciding whether to disclose abuse. She/he may want the abuse to stop but still want to continue a relationship with the abuser. She/he may not want to carry the guilt of naming his/her abuser. She/he is unlikely to understand that the abuser must take responsibility for wrongdoing and will take that burden upon her/himself as part of her/his victim status. Where an abuser uses threats, a child may not disclose because of her/his level of fear. It is not unusual for a child to retract an allegation of sexual abuse because of the pressure she/he feels and her/his mistrust of the consequences.

Recognition

It is important to remember that boys and girls of all ages are abused. This form of abuse can be identified from a direct statement by a child but is more often suspected as a result of a child's behaviour and physical signs.

1. Physical Signs

a) Specific

- hymeneal tears, genital laceration and abnormal dilation of anus with other signs, e.g. venous engorgement;
- sexually transmitted disease;
- presence of semen on vagina, anus external genitalia or clothing;
- pregnancy in a younger girl where the identity of the father is not disclosed.

b) Non-Specific

- vaginal bleeding;
- vaginal irritation, soreness;
- pain on passing urine and recurrent urinary tract infections;
- abdominal pain;
- soiling.

BEHAVIOURAL INDICATORS

- a) **Specific**
- displays more knowledge of sexual matters than is usual in children of comparable age;
 - engages in inappropriate sexualised play or behaviour with other children;
 - sexually provocative relationship with adults.
- b) **Non-Specific**
- hints at sexual activity or secrets through words;
 - excessive preoccupation with sexual matters;
 - excessive masturbation;
 - occasionally requests information about contraception which may be indicative of a cry for help;
 - lack of trust in, or marked fear of, familiar adults;
 - child psychiatric problems, including onset of wetting or soiling, severe sleep disturbance, change in pattern of behaviour/eating habits, social isolation and withdrawal;
 - behaviour indicating role reversal in the home, e.g. daughter taking over mothering role;
 - inappropriate displays of physical contact between parents and their children;
 - learning difficulties, poor concentration, poor peer group relationships and inability to make friends;
 - school may be a haven for some sexually abused children; they arrive early, are reluctant to leave and often perform well;
 - marked reluctance to participate in physical activity or to change clothes for physical education;
 - truancy or running away from home;
 - self-harm, self-mutilation and suicide attempts;
 - dependence on alcohol and drugs;
 - promiscuity and involvement in prostitution.

RESPONSE

If anyone has concerns of sexual abuse of a child from observations then this should be discussed with a line manager or designated child protection liaison person.

All concerns should be discussed/referred to Social Services Help Desk. If sufficient concerns exist it may be appropriate to hold a multi-agency planning meeting. Alternatively, if the concerns are great enough it may be appropriate to hold a strategy meeting and plan further investigation.

See also:

- Section 7.1 Schedule One Offenders;
- Section 7.3 Young Perpetrators of Sexual Abuse;

- Section 7.4 Children Involved in Prostitution;
Section 7.5 Complex Abuse Protocol;
Section 7.6 Children with Disabilities.

EMOTIONAL ABUSE – CODE ‘E’

Definition

The persistent emotional ill treatment 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 involve causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional damage is involved in all types of ill treatment of a child, though emotional abuse may occur along.

Recognition

- reported or observed failure to thrive;
- abnormal attachments between a child and parent/carer e.g. anxious attachment;
- scape-goating of a child within a family;
- frozen watchfulness, particularly in pre-school children;
- where a child is withdrawn, seen as having low self-esteem, is aggressive and seeks negative attention;
- inability by a child to accept boundaries;
- indiscriminate attachment or failure to attach;
- where a child struggles to relate to a peer group or significant adults;
- speech delay, or under stimulation, considered to have a social cause.

“There is increasing evidence of the adverse long-term consequences for children’s development where they have been subject to sustained emotional abuse. Emotional abuse has an important impact on a developing child’s mental health, behaviour and self-esteem. It can be especially damaging in infancy. Underlying emotional abuse may be as important, if not more so, than other visible forms of abuse in terms of its impact on the child. Domestic violence, adult mental ill-health problems and parental substance misuse may be features in families where children are exposed to such abuse. (*Working Together to Safeguard Children 1999*).

Response

- refer to Social Services Help Desk;

- evidence of emotional abuse may exist along or as part of other abuse – by commission, or it may occur as a result of parent’s/carer’s inability to meet their own needs – by omission;
- examples of this are chaotic drug using parents; alcohol using parents;
- parents with chronic or acute mental health problems or parents with learning difficulties who, without support, may be unable to provide good enough care;
- emotionally abused children may initially be seen as children in need rather than children at risk.

Evidence of emotional abuse is more commonly found after a period of agency involvement and observation. Such cases will require careful monitoring and interagency liaison with primary health, education and the Police, to assess the risks to the child and verify the abuse.

Emotional abuse will always be considered in referrals of domestic violence.