West Haddon Endowed C of E School

SAFEGUARDING

Additional information

APPENDIX 1

CHILDREN NOT COLLECTED AFTER SCHOOL HOURS

A Note for Parents

There are rare occasions when, perhaps due to an emergency, parents are not able to collect their children promptly from school, or make arrangements for their collection, at the end of the school day.

When a child remains on school premises at the end of the day, the school needs to know that it has parental authority to do what is necessary to look after the child. If the child is not collected, the school will make enquiries to find the parents using the contact numbers given by them. If that fails, however, the school will need to make temporary arrangements for the children to be cared for elsewhere.

Unless we hear to the contrary, we assume you agree to the school and other agencies making whatever arrangements are necessary to ensure your child's welfare.

Protocol to be followed by all Northamptonshire Primary Schools when children are not collected

1. Introduction

On rare occasions, instances occur where children of Primary School age are left uncollected for considerable lengths of time. These guidelines are written to help staff in school respond sensitively yet consistently to ensure the safety and welfare of such children. These guidelines have been developed in conjunction with colleagues in Social Services and the Police.

2. Parental Information

On admission to a school, parents should provide:

- Accurate information about who holds Parental Responsibility for their children ie names, addresses and telephone numbers.
- Names and telephone numbers of 2/3 emergency contact persons.
- Information if anyone other than the parent/carer is to collect a child from school.

Schools must ensure that parents are provided with information about the times of the school day and the expectation regarding the delivery and collection of children.

This information should be updated at least annually and parents must be told of the need to inform the Head Teacher if there are changes to the details given on admission.

3. Children Not Collected

- If any child is not collected from school 15 minutes after the end of the school day, the School will telephone (if possible) the parents/carers.

- If there is no response, the Head Teacher will attempt to contact those persons identified as emergency contact numbers.

- If, after 60 minutes, it has not been possible to contact parents/carers or emergency contacts then the local Police should be informed of the situation. The Head Teacher should also contact the Referral Team of the local Social Services Office to inform them of a possible problem.

- Police will liaise with Social Services and the school to make arrangements for someone to collect and care for the child. Detailed, timed records of the action taken and calls made by the Head Teacher should be kept. Consideration should be given to subsequently notify Social Services to investigate the circumstances under child protection or child welfare procedures/services.

APPENDIX 1 INDICATORS OF HARM (Not a check list – guide to help consider possible signs of abuse)

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 out 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

Safeguarding against female genital mutilation

Female genital mutilation (FGM) is a collective term for all procedures involving the partial or tonal removal of external female genitalia for cultural or other nontherapeutic reasons.

Four types of FGM

There are four types of FGM:-

1. Clitoridectomy – partial or total removal of the clitoris.
2. Excision – partial or total removal of the clitoris and the labia minora, with or without the excision of the labia majora.
3. Infibulation – narrowing of the vaginal opening.
4. All other harmful non-medical procedures to female genetalia.

The practice is normally carried out on girls between the ages of 4 and 13, although the majority of cases are thought to take place between the ages of 5 and 8.

Countries where FGM is practised

FGM is practised in 28 African countries and parts of the Middle East and the Far East. It continues to be practised in some communities in Western Europe.

The Ofsted briefing quotes that up to 24,000 girls under the age of 15 might be at risk in the UK. Some 66,000 women in England and Wales are living with the consequences of FGM.

Countries in which FGM is particularly common practice include:

Burkina Faso
Djibouti
Egypt
Eritrea
Ethiopia
The Gambia
Guinea
Liberia
Mali
Mauritania
Sierra Leone
Somalia
Sudan

One of the difficulties is that FGM-practising families may not see it as an act of abuse. It is accepted practice in some communities, and this can make it very difficult for a girl or any other member of her family to come forward. Not having undergone FGM can be considered to make a girl unsuitable for marriage.

The impact on girls

The procedure has no health benefits and can cause:

Severe bleeding
Inflection
Problems urinating
Potential childbirth complication leading to deaths of newborn babies.

The impact of undergoing FGM is not only physical; the fact that the procedure has been inflicted on the girl by her family makes it particularly traumatic.

How to identify FGM

The time when FGM is most likely to take place is at the start of the summer holidays, as there is then sufficient time for the girl to recover before returning to school.

Risk factors

Schools should be particularly alert for signs when a girl comes from a community where FGM is practised.

Other risk factors include:

- Where the family is less integrated within UK society
- Where the mother or other women in the extended family have also been subject to FGM
- Where a girl has been withdrawn from sex education lessons and there is a reluctance for her to be informed about her body and her rights.

Indicators that FGM is imminent

Indicators that it might be about to take place include:

- Being a girl between the ages of 5 and 8 within a community where FGM is practised
- Where a female family elder visits, particularly if she arrives from another country
- A girl talking about a “special procedure” or saying that she is attending a special ceremony to become a woman

- A girl being taken out of the country for a prolonged period.

Indicators that it has taken place
Indications that FGM has already taken place include:

- A girl having difficulty walking, sitting or standing
- She spends longer than normal going to the toilet
- She spends long periods of time away from the classroom during the day because of bladder or menstrual problems
- Prolonged or repeated absences from school or college, withdrawal or depression when a girl returns to school after a prolonged period of absence
- Reluctance to undergo normal medical examinations.

What schools should do
As FGM is a form of child abuse, it should be dealt with according to your existing child protection policy.

Do not reveal that any enquiries might be related to FGM, as this could increase the risk to the girl.

Do not engage at this stage with the pupil's family or others within the community.

Contact social care
Your designated senior person must share any concerns that the school has with social care.

Children's social care may approach the police for assistance and there might be a joint investigation. Particular attention may be given to other family members who might also be at risk.

Support the girl
If a girl does make a disclosure, it is important to note that it must be reported to social care even if it is against the girl's wishes, as it is child abuse and against the law. However, the reasons for this should be explained.

Counselling and other forms of support that the school might have should be made available.

Make a referral
If you suspect that a pupil has been removed from school as a result of FGM, you should refer your concerns to children's social care and the police.

Once a referral has been made by a school, a strategy meeting will be arranged as soon as possible. It will include health providers or voluntary organisations with specific expertise in FGM.

Social care providers are advised that they should first determine whether the parents or the girl are aware of the harmful aspects of FGM and the law in the UK. The main focus is to prevent the child from experiencing FGM, rather than the removal of the child from the family. However, if it is felt that there is immediate risk of FGM taking place, then an Emergency Protection Order might be sought.

Encourage an open environment in school
Schools are requested to ensure that:

- They have an "open environment", where students feel able to discuss issues that they may be facing
- The designated senior person is aware of the issues surrounding FGM
- Material explaining FGM are available for staff and students
- Advice and signposts are available for accessing additional help, e.g. the NSPCC's Helpline, Childline services and appropriate black and minority ethnic women's groups
- Girls have access to a private telephone, should they wish to use it
- Training about FGM is incorporated in the school's safeguarding training.

Train staff in FGM issues
It is important that staff are made aware of the possibility of FGM occurring.

Training should include:

- An overview of FGM
- The socio-cultural context
- Facts and figures
- UK FGM and child protection law
- FGM complications
- Policy – and what staff should do if they suspect FGM
- The roles of different professionals.

What Ofsted will be looking for
Ofsted inspectors are asked to check whether:

- Designated staff are aware of the issue and have ensured that staff in the school are aware of the potential risks

- Staff are aware of the possible signs that a child has been subject to FGM or is at risk
- There have been concerns raised about particular children, and whether action has been taken as a result.

Find out more
Useful documents include:

Multi-Agency Practice Guidelines: Female Genital Mutilation (HM Government, 2011)
Briefings and Information for Use During Inspections of Maintained Schools and Academies (Ofsted, updated December 2012)

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
Paret/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 and 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.

Use of ICT

Inappropriate use ICT by either adults or pupils is dealt with following the school's Acceptable Use Policy.

Awareness of radicalisation in schools

Supporting Children and Young People Vulnerable to Violent Extremism as a school we will follow the guidance as set out in the document on the Northamptonshire county council website.
http://northamptonshirescb.proceduresonline.com/chapters/p_yp_links.html

APPENDIX 3

West Haddon Endowed C. of E. Primary School

Child welfare concerns - recording sheet

Your name:		Your position:	
Child's name:		Child's year grp	
Sibling links:			
Nature of concern/allegation:			
Observations made by you or to you (e.g. description of visible bruising, other injuries, child's emotional state etc): *NB Make a clear distinction between what is fact, opinion or hearsay.*			
Exactly what the child/parent said and what you said (Remember, do not lead the child– record actual details. Continue on reverse of sheet if necessary):			
Action you have taken (if any):			
Your signature:		Date:	
Management actions to be taken: Other services notified ☐ Yes ☐ No Who/what/when:			
Management print name:			
Signed:		Date:	