Vista St Albans CIC follows the Hertfordshire Policy for Schools

September 2016

C O N T E N T S

1. INTRODUCTION

Safeguarding is defined as protecting children from maltreatment, preventing impairment of health and/or development, ensuring that children grow up in the provision of safe and effective care and optimising children's life chances.

Purpose of a Child Protection Policy	To inform staff, parents, volunteers and governors about the school's responsibilities for safeguarding children. To enable everyone to have a clear understanding of how these responsibilities should be carried out.
Hertfordshire Safeguarding Children Board Child Protection Procedures	Vista follows the procedures established by the Hertfordshire Safeguarding Children Board; a guide to procedure and practice for all agencies in Hertfordshire working with children and their families.
Staff & Volunteers	All staff and volunteers are particularly well placed to observe outward signs of abuse, changes in behaviour and failure to develop because they have contact with children. All staff and volunteers will receive appropriate safeguarding training, so that they are knowledgeable and aware of their role in the early recognition of the indicators of abuse or neglect and of the appropriate procedures to follow. Every member of staff at Vista has an Enhanced CRB Disclosure which is renewed every three years.
Mission Statement	Ensure children know that there are adults in the school whom they can approach if they are worried.

2. STATUTORY FRAMEWORK

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

The Children Act 1989
The Children Act 2004
Education Act (2002), section 175
Hertfordshire Safeguarding Children Board Child Protection and Safeguarding Procedures (2007)
Safeguarding Children and Safer Recruitment in Education (2006)
Working Together to Safeguard Children (2013)
The Education Regulations (2005)

Schools are expected to ensure that they have appropriate procedures in place for responding to situations in which they believe that a child has been abused or are at risk of abuse - these procedures should also cover circumstances in which a member of staff is accused of, or suspected of, abuse.

Vista St Albans CIC staff should make themselves aware of the Designated Senior Officer at each school.

The school Designated Senior Person should have responsibility for co-ordinating action within the school and liaising with other agencies.

DfES guidance Safeguarding Children and Safer Recruitment in Education (2006) also states that "All parents need to understand that schools and FE colleges have a duty to safeguard and promote the welfare of children who are their pupils or students, that this responsibility necessitates a child protection policy and procedures, and that a school or FE college may need to share information and work in partnership with other agencies when there are concerns about a child's welfare."

3. THE DESIGNATED SENIOR PERSON in EACH SCHOOL

It is the role of the Designated Senior Person for Child Protection to:

- Ensure that he/she receives refresher training at two yearly intervals to keep his or her knowledge and skills up to date.
- Ensure that the headteacher and all staff memers receive appropriate child protection training which is regularly updated.
- Ensure that new staff receive safeguarding children induction within 7 working days of commencement of their contract.
- Ensure that temporary staff and volunteers are made aware of the school's arrangements for safeguarding children within 7 working days of their commencement of work.
- Ensure that the school operates within the legislative framework and recommended guidance.
- Ensure that all staff and volunteers are aware of the HSCB Inter-agency Child Protection and Safeguarding Children Procedures and any other relevant local guidance, eg. Safe drop off/collection of children guidance.
- Ensure that the headteacher is kept fully informed of any concerns.
- Develop effective working relationships with other agencies and services.
- Decide upon the appropriate level of response to specific concerns about a child eg. Discuss with parents, offer an assessment under the CAF or refer to Children, Schools and Families social care.
- Liaise and work with Children's Services: Safeguarding and Specialist Services over suspected cases child abuse.
- Ensure that accurate safeguarding records relating to individual children are kept separate from the academic file in a secure place, marked 'Strictly Confidential' and are passed securely should the child transfer to a new provision.
- Submit reports to, ensure the school's attendance at child protection conferences and contribute to decision making and delivery of actions planned to safeguard the child.
- Ensure that the school effectively monitors children about whom there are concerns, including notifying Childrens Services: Safeguarding and Specialist Services when there is an unexplained absence of more than two days for a child who is the subject of a child protection plan.
- Provide guidance to parents, children and staff about obtaining suitable support.

- Discuss with new parents the role of the DSP and the role of safeguarding in school. Make parents aware of the safeguarding procedures used and how to access the Child Protection Policy.

Vista St Albans CIC has one Director trained as Designated Senior Person - Jo Maher.

4. THE COMPANY

The Management has overall responsibility for ensuring that there are sufficient measures in place to safeguard the children they are working with.

In particular the Management must ensure:

- Child protection policy and procedures
- Safe recruitment procedures
- Relevant child protection training for staff/volunteers is attended
- Safe management of allegations
- Deficiencies or weaknesses in child protection arrangements are remedied without delay
- Safeguarding policies and procedures are reviewed annually and information provided to the local authority about them and about how the above duties have been discharged

5. SCHOOL PROCEDURES

If any member of staff is concerned about a child he or she must inform the Designated Senior Person at the school the child attends.

The member of staff must record information regarding the concerns on the same day. The recording must be a clear, precise, factual account of the observations. (Pro-forma is available on the Hertfordshire Grid for Learning).

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

Particular attention will be paid to the attendance and development of any child about whom the school has concerns, or who has been identified as being the subject of a child protection plan and a written record will be kept.

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

The Designated Senior Person is responsible for making the senior leadership team aware of trends in behaviour that may affect pupil welfare. If necessary, training will be arranged.

6. WHEN TO BE CONCERNED

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

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect

All staff and volunteers should be concerned about a child if he/she presents with indicators of possible significant harm – **see Appendix 1 for details**.

Generally, in an abusive relationship the child may:

- Appear frightened of the parent/s or other household members e.g. siblings or others outside of the home

- Act in a way that is inappropriate to her/his age and development
  (full account needs to be taken of different patterns of development and different ethnic groups)

- Display insufficient sense of 'boundaries', lack stranger awareness

- Appear wary of adults and display 'frozen watchfulness'

7. DEALING WITH A DISCLOSURE

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

- Listen to what is being said without displaying shock or disbelief

- Accept what is being said

- Allow the child to talk freely

- Reassure the child, but not make promises which it might not be possible to keep

- Not promise confidentiality – it might be necessary to refer to Children Schools and Families: Safeguaring and Specialist Services

- Reassure him or her that what has happened is not his or her fault

- Stress that it was the right thing to tell

- Listen, rather than ask direct questions

- Not criticise the alleged perpetrator

- Explain what has to be done next and who has to be told

- Make a written record (see Record Keeping)

- Pass information to the Designated Senior Person without delay

Support
Dealing with a disclosure from a child, and a child protection case in general, is likely to be a stressful experience. The member of staff/volunteer should, therefore, consider seeking support for him/herself and discuss this with the Designated Senior Person.

8. CONFIDENTIALITY
Safeguarding children raises issues of confidentiality that must be clearly understood by all staff/volunteers in schools.

- All staff have a responsibility to share relevant information about the protection of children with other professionals, particularly the investigative agencies (Children, Schools and Families and the Police).

- If a child confides in a member of staff/volunteer and requests that the information is kept secret, it is important that the member of staff/volunteer tell the child in a manner appropriate to the child's age/stage of development that they cannot promise complete confidentiality – instead they must explain that they may need to pass information to other professionals to help keep the child or other children safe.

- Staff/volunteers who receive information about children and their families in the course of their work should share that information only within appropriate professional contexts.

9. COMMUNICATION WITH PARENTS
Vista will undertake appropriate discussion with parents prior to involvement of another agency unless to do so would place the child at further risk of harm.

10. RECORD KEEPING
When a child has made a disclosure, the member of staff/volunteer should:

- Make brief notes as soon as possible after the conversation.
- Not destroy the original notes in case they are needed by a court.
- Record the date, time, place and any noticeable non-verbal behaviour and the words used by the child.
- Draw a diagram to indicate the position of any injuries.
- Record statements and observations rather than interpretations or assumptions.

All records need to be given to the Designated Senior Person in the school promptly. No copies should be retained by the member of staff or volunteer.

10. ALLEGATIONS INVOLVING STAFF/VOLUNTEERS

An allegation is any information which indicates that a member of staff/volunteer may have:

- Behaved in a way that has, or may have harmed a child
- Possibly committed a criminal offence against/related to a child
- Behaved towards a child in a way which indicates s/he would pose a risk of harm if they work regularly or closely with children

If an allegation meets any of the three criteria above , contact should always be made with the Local Authority Designated Officer without delay.

Childrens Services – 0300 123 4043

APPENDIX 1 - INDICATORS OF POSSIBLE SIGNIFICANT HARM

PHYSICAL ABUSE

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptons 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
- 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 eg. 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, smother/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, ie. 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 rA recorded. Any burn with a clear outline may be suspicious eg. Circular burns from cigarettes, linear burns from hot metal rods or electrical fire elements, burns of uniform depth over a large area, scalds that have a line indicating immersion or poured liquid.

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

The following points are also worth remembering:
- A responsible adult checks the temperature of the bath before the child gets in.
- A child is unlikely to sit down voluntarily in a hot bath and cannot accidentally scald its bottom without also scalding his or her feet.
- A child getting into too hot water of his or her own accord will struggle to get but there will be splash marks.

Scars
A large number of scars or scars of different sizes or ages, or on different parts of the body, or unusually shaped, may suggest abuse.

Emotional/behavioural presentation
Refusal to discuss injuries
Admission of punishment which appears excessive
Fear of parents being contacted and fear of returning home
Withdrawal from physical contact
Arms and legs kept covered in hot weather

Fear of medical help
Aggression towards others
Frequently absent from school
An explanation which is inconsistent with an injury
Several different explanations provided for an injury

Indicators in the parent

May have injuries themselves that suggest domestic violence
Not seeking medical help/unexplained delay in seeking treatment
Reluctant to give information or mention previous injuries
Absent without good reason when their child is presented for treatment
Disinterested or undisturbed by accident or injury
Aggressive towards child or others
Unauthorised attempts to administer medication
Tries to draw the child into their own illness
Past history of childhood abuse, self harm, somatising disorder or false allegations of physical or sexual assault.
Parent/carer maybe 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 withhtis 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 developmental 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, eg. Anxious
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 (eg. 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
Air of detachment – 'don't care' attitude
Social isolation – does not join in and has few friends
Depression and withdrawal
Behavioural problems, eg. Aggression, attention seeking, hyperactivity, poor attention
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 eg. overly anxious or disinterest in the child.
Scapegoats one child in the family
Imposes inappropriate expectations on the child, eg. 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 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 abandonement);***
- ***Protect a child from physical and emotional harm or danger;***
- ***Ensure adequate supervision (including the use of inadequate caregivers); 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
Re/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, eg. 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, eg. Anxious
Low self esteem and lack of confidence
Failure to meet the basic essential needs, eg. Adequate food, clothes, warmth, hygiene
Failure to meet the child's health and medical needs eg. 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 sue home safety equipment; risk from animals.
Poor state of home environment,, 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 achild 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 areas, 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, eg. 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 abused, self harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.
Family member is a sex offender