



## St Mary's Child Protection Procedures

### School Child Protection Procedures

#### 1. What Should Staff/Volunteers Do If They Have Concerns About A Child or Young Person in School?

Practitioners in schools who are concerned about a child's welfare or who believe that a child is or may be at risk of harm from abuse or neglect should pass any information to the Designated Child Protection Person (DCPP) in school; this should *always* occur as soon as possible and certainly within 24 hours (see Flowchart at Appendix 1):

**The Designated Child Protection Person is: Jo McGarry**  
**Back Up Designated Child Protection Person is: Amanda Bright**

It is these senior colleagues who are responsible for taking action where the welfare or safety of children or young people is concerned. If staff are uncertain about whether their concerns are indeed 'child protection' then a discussion with their DCPP/line manager will assist in determining the most appropriate next course of action. The Salford City Council Bridge Social worker can also be consulted about this.

#### **Staff should never:**

- Do nothing/assume that another agency or practitioner will act or is acting.
- Attempt to resolve the matter themselves alone.

#### **What should the DCPP consider right at the outset?**

- Am I dealing with 'risk' or 'need'? (By definition, a child at risk is also a child in need. However, what is the *priority / level and immediacy* of risk / need?)
- Can the level of need identified be met:
  - In or by the school or by accessing universal services
  - By undertaking a Common Assessment (CAF), without referral to The Bridge
  - By working with the child, parents and colleagues?
- What resources are available to the practitioner and the school and what are their limitations?
- Is the level of need such that a referral needs to be made to The Bridge which requests that an assessment of need be undertaken? (Section 17 Child in Need referral)
- Is the level and/or likelihood of risk such that a child protection referral needs to be made (i.e. a child is suffering or is likely to suffer significant harm? (Section 47 Child Protection referral)
- What information is available re: Child, Parents, Family & Environment?
- What information is inaccessible and, potentially, how significant might this be? For example has the parent/carer denied that there is a problem and failed to co-operate with the school in resolving the issue?

- Who do I/don't I need to speak to now and what do they need to know?
- Where can I access appropriate advice and/or support?
- If I am not going to refer, then what action am I going to take? (e.g. time-limited monitoring plan, discussion with parents or other practitioners, recording etc)

## **2. Feedback to Staff Who Report Concerns to the Designated Child Protection Person (DCPP)**

Rules of confidentiality mean that it may not always be possible or appropriate for the DCPP to feedback to staff who report concerns to them. Such information will be shared on a 'need to know' basis only and the DCPP will decide which information needs to be shared, when and with whom. The primary purpose of confidentiality in this context is to safeguard and promote the child's welfare.

## **3. Thresholds for Referral to The Bridge**

In making a decision about whether a referral to The Bridge may be required, there are two thresholds for (and their criteria) and types of referral that need to be carefully considered:

### **(i) Is this a Child In Need?**

Under section 17 (s.17(10)) of the Children Act 1989, a child is in need if:

- (a) He is unlikely to achieve or maintain, or to have the opportunity to achieve or maintain, a reasonable standard of health or development, without the provision of services by a local authority;
- (b) His health or development is likely to be impaired, or further impaired, without the provision of such services;
- (c) He is disabled.

### **(ii) Is this a Child Protection Matter?**

Under section 47(1) of the Children Act 1989, a local authority has a duty to make enquiries where they are informed that a child who lives or is found in their area:

- (a) is the subject of an Emergency Protection Order;
- (b) is in Police Protection; or where they have
- (c) reasonable cause to suspect that a child is suffering or is likely to suffer significant harm.

Therefore, it is the 'significant harm' threshold' that justifies statutory intervention into family life. A practitioner making a child protection referral under s.47 must therefore provide information which clearly outlines that a child is suffering or is likely to suffer significant harm. The Designated Child Protection Person will make judgements around 'significant harm', levels of 'need' and when to refer.

#### 4. Making Referrals to CSC (Guidance for the Designated Child Protection Person)

##### (i) Child In Need/Section 17 Referrals

- Where a Common Assessment (CAF) already exists, the DCPD should send this with the referral to The Bridge.
- This is a request for assessment/support/services and, as such, you **must obtain the consent** of the parent(s) (and child/young person where appropriate). This should also be identified on the CAF.
- Where a parent/carer/young person refuses to consent, you should make clear your ongoing plans and responsibilities in respect of support, monitoring etc, and the possibility of a child protection referral at some point in future if things deteriorate or do not improve. (This is not about threats or saying that this is inevitable but about openness and transparency in dealings with parents).

##### (ii) Child Protection/Section 47 Referral

- Make a telephone call to The Bridge and forward for consideration.
- If a CAF exists this should be forwarded to The Bridge as soon as possible, and certainly within 48 hours.
- You **do not require the consent** of a parent or child/young person to make a child protection referral
- A parent should, **under most circumstances, be informed** by the referrer that a child protection referral is to be made. **The criteria for not informing parents are:**
  - (a) Because this would increase the risk of significant harm to a child(ren); or
  - (b) Because, in the referrer's professional opinion, to do so might impede an investigation that may need to be undertaken;
  - (c) Because there would be an undue delay caused by seeking consent which would not serve the child's best interests.

Fear of jeopardising a working relationship with parents because of a need to refer is **not** sufficient justification for not making a referral nor for not telling them that you need to refer. Lack of openness will do little to foster ongoing trust, particularly as the source of referrals will be disclosed to parents except in a limited number of circumstances. If you feel that your own or another adult's immediate safety would be placed at risk by informing parents then you should seek advice and/or make this clear on the CAF and in any telephone contact with The Bridge.

## 5. The Bridge Responses to Referrals and Timescales

In response to a referral, The Bridge may decide to:

- Provide advice to the referrer and/or child/family;
- Refer on to another agency who can provide services;
- Convene a Strategy Meeting (within five working days);
- Provide support services under Section 17;
- Undertake an Initial Assessment (completed within ten working days);
- Convene an Initial Child Protection Conference (within 15 working days of a Strategy Meeting)
- Undertake a Core Assessment (completed within 35 working days);
- Accommodate the child under Section 20 (with parental consent);
- Make an application to court for an Order;
- Take no further action.

## 6. Feedback from Bridge

The Bridge have 24 hours within which to make a decision about a course of action in response to a referral. A DCPD should expect to receive written confirmation about action following any referral within 7 days. If you do not receive any (same day) verbal feedback following an urgent child protection referral, and where this places school/a child or children in a vulnerable position, you should ask to speak to a Duty Social Worker, or the relevant Team Manager.

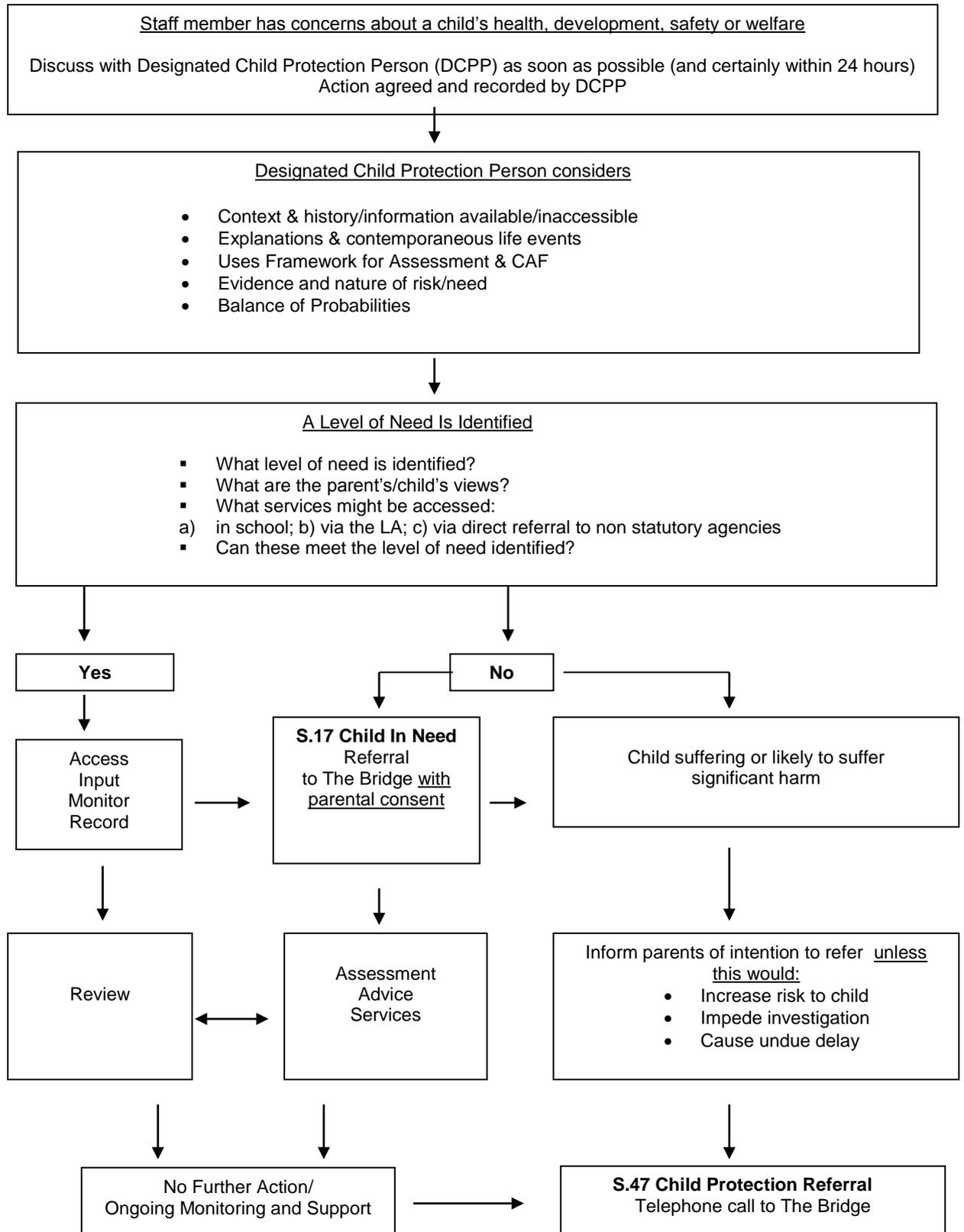
## 7. Risk Assessment 'Checklist'

- Does/could the suspected harm meet the SSCB definitions of abuse?
- Are there cultural, linguistic or disability issues?
- Am I wrongly attributing something to impairment?
- Does the chronology indicate any possible patterns which could/do impact upon the level of risk?
- Are any injuries or incidents acute, cumulative, episodic?
- Did any injuries result from spontaneous action, neglect, or intent?
- Explanations consistent with injuries/behaviour?
- Severity and duration of any harm?
- Effects upon the child's health/development?
- Immediate/longer term effects?
- Likelihood of recurrence?
- Child's reaction?
- Child's perception of the harm?
- Child's needs, wishes and feelings?
- Parent's/carer's attitudes/response to concerns?
- How willing are they to cooperate?
- What does the child mean to the family?

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- What role does the child play?
- Possible effects of intervention?
- Protective factors and strengths of/for child (i.e. resilience/vulnerability)
- Familial strengths and weaknesses?
- When and how is the child at risk?
- How imminent is any likely risk?
- How grave are the possible consequences?
- How safe is this child?
- What are the risk assessment options?
- What are the risk management options?
- What is the interim plan?

## Appendix 1: taking action on child welfare/protection concerns in school



## Appendix 2: talking and listening to children

### If a child wants to confide in you, you **SHOULD**

- Be accessible and receptive;
- Listen carefully and uncritically, at the child's pace;
- Take what is said seriously;
- Reassure children that they are right to tell;
- Tell the child that you must pass this information on;
- Make sure that the child is ok ;
- Make a careful record of what was said (see *Recording*).

### You should **NEVER**

- Investigate or seek to prove or disprove possible abuse;
- Make promises about confidentiality or keeping 'secrets' to children;
- Assume that someone else will take the necessary action;
- Jump to conclusions, be dismissive or react with shock, anger, horror etc;
- Speculate or accuse anybody;
- Investigate, suggest or probe for information;
- Confront another person (adult or child) allegedly involved;
- Offer opinions about what is being said or the persons allegedly involved;
- Forget to record what you have been told;
- Fail to pass this information on to the correct person (the Designated Child Protection Person).

### Children with communication difficulties, or who use alternative/augmentative communication systems

- While extra care may be needed to ensure that signs of abuse and neglect are interpreted correctly, any suspicions should be reported in exactly the same manner as for other children;
- opinion and interpretation will be crucial (be prepared to be asked about the basis for it and to possibly have its validity questioned if the matter goes to court).

### Recordings should

- State who was present, time, date and place;
- Be written in ink and be signed by the recorder;
- Be passed to the DCP or Head Teacher immediately (certainly within 24 hours);
- Use the child's words wherever possible;
- Be factual/state exactly what was said;
- Differentiate clearly between fact, opinion, interpretation, observation and/or allegation.

### What information do you need to obtain?

- Schools have **no investigative role** in child protection (Police and The Bridge will investigate possible abuse very thoroughly and in great detail, they will gather evidence and test hypotheses – leave this to them!);
- Never prompt or probe for information, your job is to listen, record and pass on;

- Ideally, you should be clear about what is being said in terms of **who, what, where and when**;
- The question which you should be able to answer at the end of the listening process is 'might this be a child protection matter?';
- If the answer is yes, or if you're not sure, record and pass on immediately to the Designated Child Protection Person /Head Teacher/line manager or consult directly with The Bridge.

#### **If you do need to ask questions, what is and isn't OK?**

- **Never** ask closed questions i.e. ones which children can answer yes or no to e.g. Did he touch you?
- **Never** make suggestions about who, how or where someone is alleged to have touched, hit etc e.g. Top or bottom, front or back?
- If we must, use only '**minimal prompts**' such as 'go on ... tell me more about that ... tell me everything that you remember about that ... ..'
- Timescales are very important: '**When was the last time this happened?**' is an important question.

#### **What else should we think about in relation to disclosure?**

- Is there a place in school which is particularly suitable for listening to children e.g. not too isolated, easily supervised, quiet etc;
- We need to think carefully about our own body language – how we present will dictate how comfortable a child feels in telling us about something which may be extremely frightening, difficult and personal;
- Be prepared to answer the 'what happens next' question;
- We should never make face-value judgements or assumptions about individual children. For example, we 'know that [child.....] tells lies';
- Think about how you might react if a child DID approach you in school. We need to be prepared to offer a child in this position exactly what they need in terms of protection, reassurance, calmness and objectivity;
- Think about what support **you** could access if faced with this kind of situation in school.

## Appendix 3 – What is abuse and neglect?

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

### Definitions of child abuse

There are four types of child abuse. They are defined in the UK Government guidance *Working Together to Safeguard Children 2010* (1.33 – 1.36) as follows:

- Physical Abuse
- Emotional Abuse
- Sexual Abuse
- Neglect

#### 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.

#### 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.

#### 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.

## **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)
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

## **Bullying**

Bullying may be defined as deliberately hurtful behaviour, usually repeated over a period of time, where it is difficult for those bullied to defend themselves. It can take many forms, but the three main types are:

- physical (for example, hitting, kicking, theft)
- verbal (for example, racist or homophobic remarks, threats, name-calling)
- emotional (for example, isolating an individual from the activities and social acceptance of their peer group)

The damage inflicted by bullying (including bullying via the internet) can frequently be underestimated. It can cause considerable distress to children, to the extent that it affects their health and development or, at the extreme, causes them significant harm (including self-harm). All settings in which children are provided with services or are living away from home should have in place rigorously enforced anti-bullying strategies.

## **Signs of abuse**

Recognising child abuse is not easy. Sometimes the signs are not obvious and sometimes signs that appear to be indicative of abuse can be due to other causes. Therefore it is very important that you use these signs to help you think about the concerns you have and how you will describe these when making a referral or consulting with the The Bridge team.

These definitions and indicators only serve as a guide to assist you. Remember that children may exhibit some of these indicators at some time, and that the presence of

one or more is not necessarily proof that abuse is occurring. There may be other reasons for changes in behaviour such as bereavement, significant changes in family relationships, including the birth of a new baby in the family or problems between parents/carers.

It is not your responsibility to decide whether or not child abuse has taken place or if a child is at significant risk of harm from someone. You do, however, have a responsibility and duty to act in order that the appropriate agencies can investigate and take any necessary action to protect a child. The social worker or police officer will always want to understand your concerns about the child in the context of the child's development and relationships.

The following information should help you to be more alert to the signs of possible abuse and to provide the necessary information when reporting your concerns.

### **Physical Abuse**

Most children in daily life will collect cuts and bruises. But each child is different and any perceived injuries should be interpreted in light of:

- the child's medical and social history
- the child's developmental stage
- the explanation given for the injury

Most accidental bruises are seen over bony parts of the body, e.g. elbows, knees, shins, and often on the front of the body.

Important indicators of physical abuse are bruises or injuries that are either unexplained or inconsistent with the explanation given, or visible on the 'soft' parts of the body where accidental injuries are unlikely, e.g. cheeks, abdomen, back and buttocks.

### **The physical signs of abuse may include:**

- Bruising, marks or injuries on any part of the body that are unexplained or not consistent with the explanation given for them
- Injuries which occur to the body especially in clusters and in places which are not normally exposed to falls or rough games
- Injuries which have not received medical attention or there has been a delay in getting medical attention (although note that burn injuries are often delayed in presentation due to blistering taking place some time later)
- Cigarette burns
- Human bite marks
- Broken bones
- Scalds
- Multiple burns

### **Changes in behaviour that can also indicate physical abuse:**

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- fear of parents being approached for an explanation
- fear of further enquiries being made
- aggressive behaviour or severe temper outbursts
- flinching when approached or touched
- reluctance to get changed, for example in hot weather, or to participate in games or swimming
- depression
- withdrawn behaviour
- running away from home or school

### **Emotional Abuse**

Emotional abuse can be difficult to identify, as there may be no outward physical signs.

There may be a developmental delay due to a failure to thrive and grow – but this will usually only be evident if the child puts on weight in other circumstances, for example when hospitalised or away from their parents' care.

Children who appear well-cared for may nevertheless be emotionally abused by being taunted, put down or belittled. They may receive little or no love, affection or attention from their parents or carers.

Emotional abuse can also take the form of children not being allowed to mix or play with other children.

### **Changes in behaviour or presentation which can indicate emotional abuse include:**

- Depression, aggression, extreme anxiety, changes or regression in mood or behaviour, particularly where a child withdraws or becomes clingy
- Neurotic behaviour e.g. sulking, hair twisting, rocking
- Obsessions or phobias
- Sudden underachievement or lack of concentration
- Seeking adult attention and not mixing well with other children
- Sleep or speech disorders
- Negative statements about self
- Extreme shyness or passivity
- Running away, stealing and lying
- Being unable to play
- Fear of making mistakes
- Sudden speech disorders
- Self-harm
- Fear of parent being approached regarding their behaviour
- Developmental delay in terms of emotional progress
- Reporting parental violence or discord (i.e. exposure to domestic violence)

### **Sexual Abuse**

Sexual abuse is known to take place against children and young people of all ages, including infants and toddlers.

Usually, in cases of sexual abuse it is the child's behaviour that may cause you to become concerned, although physical signs can also be present.

Children who tell about sexual abuse do so because they want it to stop. It is important, therefore, that they are listened to and taken seriously.

It is not just adult men who sexually abuse children – there are increasing numbers of allegations of sexual abuse of children against women and sexual abuse can also be perpetrated by other children or young people.

**The physical signs of sexual abuse may include:**

- pain or itching in the genital area
- bruising or bleeding near genital area
- sexually transmitted disease
- vaginal discharge or infection
- repeated urinary infections
- stomach pains
- discomfort when walking or sitting down
- pregnancy

**Changes in behaviour or presentation which can also indicate sexual abuse include:**

- any allegation by the child of sexual abuse
- sudden or unexplained changes in behaviour e.g. becoming aggressive or withdrawn
- fear of being left with a specific person or group of people
- having nightmares and severe or persistent sleep disturbance
- running away from home
- sexual knowledge beyond their age or developmental level; preoccupation with sexual matters
- sexual activity through drawings, language or play
- bedwetting
- eating problems such as overeating or anorexia
- self-harm or mutilation, sometimes leading to suicide attempts
- saying they have secrets they cannot tell anyone about
- substance or drug abuse
- suddenly having unexplained sources of money
- not being allowed to have friends (particularly in adolescence)
- acting in a sexually explicit way towards adults

**Neglect**

Neglect can be a difficult form of abuse to recognise but it has some of the most lasting and damaging effects on children.

**The physical signs of neglect may include:**

- constant or frequent hunger, sometimes stealing food
- constantly dirty or 'smelly'
- loss of weight, or constantly underweight
- inappropriate clothing for the conditions.
- Frequent diarrhoea
- Untreated illnesses, injuries or physical complaints

**Changes in behaviour or presentation which can also indicate neglect may include:**

- frequent tiredness
- overeating
- not requesting medical assistance and/or failing to attend appointments
- having few friends
- mentioning being left alone or unsupervised.

**Bullying**

Bullying is not always easy to recognise as it can take a number of forms

**Persistent bullying can result in:**

- depression
- low self-esteem
- shyness
- poor academic achievement
- isolation
- threatened or attempted suicide

**Signs that a child may be being bullied can be:**

- coming home with cuts and bruises
- torn clothes
- asking for stolen possessions to be replaced
- losing dinner money, travel passes etc
- falling out with previously good friends
- being moody and bad tempered
- wanting to avoid leaving their home
- aggression with younger brothers and sisters
- doing less well at school
- sleep problems
- anxiety
- becoming quiet and withdrawn

Policy reviewed June 2017