Safeguarding Children Guidance

CONTENTS

Key

GBC	Gingerbread Corner
CEO	Chief Executive
FD	Finance Director
HCCS	Head of Child Care Services
TL	Team Leader
ELT	Executive Leadership Team (comprising the Executive Advisor, CEO and Finance Director)
EMT	Executive Management Team (comprising the ELT plus Head of Child Care Services, Director of IT & Facilities and Office Manager)

SMT	Senior Management Team (comprising the EMT plus the Team Leaders)
SGL	Safeguarding Lead
LADO	Local Authority Designated Officer
OOS	Out of School
EY	Early Years
SEND	Special Educational Needs and Disability
Carer	Primary caregiver/first named carer on the Admission Form unless indicated otherwise
Staff	All workers, plus students and volunteers

INTRODUCTION

1. GBC's Safeguarding responsibilities are as laid out in our Safeguarding Policy (Appendix A).

2. The SGL is the HCCS and the Deputy SGL is the CEO. There are Assistant SGLs (the Finance Director and the TLs) and there is also a Lead SG Trustee.

3. When the SGL is unavailable and an urgent decision is deemed necessary or preferable, then one of the following will take temporary responsibility in this order: the CEO, the Finance Director, one of the TLs.

4. GBC has a statutory responsibility to safeguard children in our care, which means we must recognise, record and report any signs and symptoms of, or concerns regarding, child abuse, and all staff have an individual responsibility and duty to ensure the safety and well-being of these children and their siblings, etc. See Appendix B for Guidance on Indications, Signs and Symptoms and Appendix C for Sketches Showing Typical Accidental and Non-Accidental Injuries.

5. Abuse may be physical, emotional or sexual. Neglect, Domestic Violence, Radicalisation and Female Genital Mutilation (FGM) are also forms of abuse. Staff must also be alert to the possibility of peer-on-peer abuse. All forms of abuse are outlined in the document, Signs and Symptoms of Abuse and action to take regarding peer-on-peer abuse is indicated in Childcare Management and Operations.

6. GBC has a duty to ensure, as far as practicable, the well-being of staff so any staff member for whom safeguarding work has caused emotional distress should see the CEO for support and/or signposting for counselling.

7. This Guidance is focussed on our direct Safeguarding and Child Protection duties. Other matters, such as the physical environment, internet safety, infectious diseases, behaviour management and physical intervention, anti-bullying, staffing levels, data protection, etc., are dealt with elsewhere.

8. All staff must have read and understood the written procedures for managing allegations of harm to a child. All new staff sign their Induction Form to indicate that they have read and understood the documents, in particular the Safeguarding Policy and associated documentation. When new drafts of the Safeguarding Policy (or associated documentation) are agreed, all staff will be emailed a copy and asked to confirm that they have received and understood it.

9. All carers have information on the procedures for managing allegations of harm to a child, and the Safeguarding Policy and the two flow charts (for reporting concerns to Children's Services and/or to the LADO, Appendices D and E) will form part of the Carers' Virtual Pack from 2022. All carers will be required to acknowledge receipt, and their understanding, of these written procedures.

10. Posters are displayed showing the Designated and Deputy Designated Safeguarding Leads.

SAFER RECRUITMENT AND EMPLOYMENT

11. The Chief Executive has prime responsibility for the safer recruitment and employment of all staff. See the Recruitment and Selection Procedure.

DBS CERTIFICATES

12. We ensure that all our staff[1] have a satisfactory Enhanced Disclosure and Barring Service (DBS) certificate[2] (currently at our own expense). These checks are the prime responsibility of the CEO.

13. We sign up all employees to the Update Service as soon as possible and currently at our expense. In or around January every year, each staff member is checked against the Update Service. As long as no new information is revealed, the Certificate Check Result is scanned for the file. If new information is revealed, the Investigation and Disciplinary Process must be followed.

14. Once an employee has left our employment, the CEO immediately cancels our Update Service subscription for them, which in turn cancels their DBS certificate being linked to that subscription.

AGENCY STAFF

15. We will only accept agency staff whose agency has provided us with written confirmation that they have a satisfactory Enhanced DBS check obtained within the last 12 months. This may not apply if the agency staff member has subscribed to the update service, in which case we would request their certificate number and date of birth and check their DBS ourselves.

SUITABILITY DECLARATIONS

16. All staff are required to complete a satisfactory Suitability Declaration before their appointment and thereafter annually in or around January. Any areas which indicate a cause for concern will be dealt with by the SGL.

17. It is against the law for GBC to employ anyone, in a paid or unpaid position, if they are barred from working with children.

18. All new staff have an induction which covers Safeguarding.

PERFORMANCE REVIEWS

19. Staff have regular and effective Reviews, in which safeguarding issues are discussed, including any material changes in the staff member's private life and any concerns about any children, carers or staff, including any children with whom the staff member has a relationship outside of work (e.g. friend, relative).

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[1] Except for students or volunteers under 16 years

[2] See Recruitment and Selection Procedure for more information on Safer Recruiting

20. New employees have five Performance Review meetings during their six month probation period. These are monitored by the CEO.

21. Thereafter, child-care staff have at least three Performance Review meetings annually and all other staff have at least one annually.

22. Long-term students and volunteers have at least one support and supervision at the end of each term (monitored by the HCCS).

TRAINING

23. The SGL, Deputy SGL and Assistant SGLs must all undertake Designated Lead Safeguarding training at least every two years. In the meantime, they may attend other SG courses and must keep up to date with best practice.

24. The Safeguarding Lead Trustee should ideally be already trained on appointment or undergo Safeguarding training within six months of appointment.

25. Staff have ongoing training, including up-dating safeguarding knowledge, at least every two years.

26. Safeguarding is on every staff and management committee meeting agenda, and staff are encouraged to reflect on safeguarding issues.

COLOUR-CODED LANYARD SYSTEM

27. This is used to ensure the easy identification of adults at GBC, as under:

27.1. Blue lanyards: experienced staff (whether permanent, time limited or zero hours)

27.2. Grey lanyards:

27.2.1. new staff - until the decision is taken that they can change to blue, which will usually be after they have completed between eight-26 weeks' service with us, depending upon their ability, qualifications and experience, and the age group involved. The decision will be taken by any three of the SMT, to include one EMT member and the worker's Line Manager.

27.2.2. Grey lanyards: agency staff

27.3. Yellow lanyards: volunteers and students

27.4. Red lanyards: visitors (including tradespeople).

28. Only those with blue lanyards may be on their own with any group of children aged under three or with any single child (and this includes toileting, dealing with an accident or giving first aid).

TRUSTEES

29. Trustees are required by Ofsted to either provide a satisfactory enhanced and relevant DBS or complete their DBS application and to subscribe to the update service within ten working days of the Meeting at which they were appointed as provisional Company Member. The CEO must have seen and made a copy of the original DBS certificate within three months of their appointment, and will check the update service annually, in or around January.

30. All Trustees are required to complete a satisfactory Suitability Declaration at the first Management Committee meeting following their election and thereafter annually within ten working days of receiving the request – which will be in or around January.

31. All Trustees must begin the completion of Form EY2, the declaration and consent form for all individuals connected with a registered provision, within ten working days of their becoming a Trustee and complete the Form within two days of the receipt of their DBS certificate.

32. Until such time as GBC has seen the original DBS certificate, Trustees may not carry out any duties in relation to their role which bring them or may bring them in contact with the children.

33. The Trustees take responsibility for ensuring any necessary improvements to the policy and guidance are made.

KEEPING CHILDREN SAFE

34. GBC recognises that additional barriers may exist when recognising the signs of abuse (including neglect) of children with SEND. Staff are therefore required to be especially vigilant and to be particularly cognisant of their – and the child's - language.

35. Generally, if a child is absent for more than three consecutive working days without an adequate or any explanation, the HCCS must contact the carer, as we are aware that an unexplained absence could mean that the child is at risk (e.g. from physical harm, radicalisation or FGM).

    However, if Social Services are involved or we have had any concerns about the safety of the child or carer, we contact the carer on the second day of absence and notify the child's social worker if there is an unexplained absence of more than two days.

36. GBC does not discourage children from giving staff a hug. That said, staff must be careful about entering a child's space unasked and children *must not be encouraged* to sit on staff member's laps, etc. It is not expected ever to see older children sitting on laps. If this sort of inappropriate behaviour is witnessed, it must be brought to the attention of one of the SGL.

37. Staff should only change nappies in Kangas' bathroom or in Tiggers' and Pooh Bears' changing rooms – usually using the latter if the children are upstairs, e.g. Robins. Where older children need changing, this should be done in one of the Disabled Toilets – only after another staff member has been informed.

38. The main doors to the children's toilets in OoS must be wedged or fixed open whenever there are children attending. Any staff member in the toilet must be challenged as to their purpose.

39. Because blurred boundaries diminish children's safety, staff are discouraged from baby-sitting for our families, including taking children from GBC and looking after children at other times – whether this is a paid or unpaid service. Express and written permission from a member of the EMT would be required and no permission would be granted until the relevant documentation has been completed and the staff member has had a meeting with the SGL in which the risks would be explained. Failure to comply could be considered a disciplinary matter.

40. Where staff are known to be friends or relatives of GBC families, particular care will be taken by managers to reduce the risk of blurred boundaries. We actively discourage staff looking after any GBC child and the relevant paperwork will need to be completed if this is to be allowed. Students and volunteers who make friendships subsequent to their work with us will also be discouraged to

look after a GBC child outside working hours.

41. Staff may not appear to have ‘favourites’, e.g. children routinely selected for trips or activities, or have a clique of children often around them. If this sort of behaviour is witnessed, it must be challenged or brought to the attention of the SGL.

PROMOTING CHILDREN’S ABILITY TO KEEP THEMSELVES SAFE

42. GBC promotes and supports children’s safety and wellbeing.

43. In Early Years, issues such as road safety, personal space and the ability to say no, physical risks (e.g. from climbing on furniture, handling scissors) are discussed in Circle Time and wherever relevant throughout the day. These discussions should be recorded in their learning journals.

44. With the older children, online safety is discussed and promoted.

MESSAGES FROM SCHOOLS

45. When a school asks GBC staff to pass on a message to a child’s carer, e.g. regarding an accident, staff must inform the school that it is their responsibility to contact the carer direct, although staff may then pass on the message.

VISITORS

46. We welcome visitors in a safe and secure manner.

47. All visitors must sign in and out, stating who they are visiting.

48. No visitor may be allowed in an area where they have unsupervised access to children (e.g. in Out of School when the children are present) unless they are accompanied or have a satisfactory DBS certificate.

49. Children may only be changed by their carer in a designated place and not where there could be unsupervised access to other children, e.g. the Out of School children’s toilets.

SAFEGUARDING LEAD’S RESPONSIBILITIES

50. The SGL is responsible for leading the staff team in terms of safeguarding and for ensuring good working practices, and holds prime responsibility for safeguarding children and for annually reviewing this Policy, taking into account any new guidance or best practice.

51. The SGL is responsible for ensuring the following are displayed in each of the EY Rooms and in the Staff Room:

    - ◊ up to date flow charts on referrals to the Multi-Agency Safeguarding Hub and to the LADO
    - ◊ information on Whistleblowing

52. The SGL is responsible for ensuring that records are kept of all incidents, discussions and decisions, in line with GBC’s Data Protection Policy.

53. The SGL submits a Safeguarding Audit to each Management Committee meeting, which includes:

- ◊ Confirmation that all new staff have been recruited safely and that a record of all staff members' vetting checks is up-to-date and complete
- ◊ Confirmation that all child protection records are stored securely
- ◊ Details of safeguarding and child protection information given to carers
- ◊ Number of child protection referrals made to Children's Services
- ◊ Anonimised data on any child protection conferences or meetings attended
- ◊ Number of children who are, or have been, subject to a Child Protection Plan
- ◊ Anonimised information on any allegations against staff and confirmation that they have been reported to the Local Authority Designated Officer

RECORD-KEEPING

CHILD CONCERN DIARIES

54. In EY, there is a Diary in each room and the OOS Diary is kept in the HCCS' office.

55. The purpose of the Diaries is to record any minor issues that do not warrant a Child Concern Record (see Appendix F) but that the staff nonetheless believe should be noted and can be used:

    - ◊ To identify any patterns. For example, dirty or inadequate clothing, minor behavioural change may not warrant the completion of a Child Concern Record unless the incidents are repeated
    - ◊ To note a slight injury with which a child has come in, but which is not deemed to be Non-Accidental, e.g. a scratch to the forehead or a bruised shin[3]
    - ◊ To record, in OOS, any messages from the school that a child was in a heightened emotional state

56. In addition, there must always be an entry in the Diary to indicate whenever a Child Concern Record is completed.

57. TLs should check their Diaries at least daily and all staff covering each room should be encouraged to look at any entries since they were previously in that room.

58. All Diaries should be checked regularly by the HCCS who should initial each page.

CHILD CONCERN LOGS

59. If the matter is deemed to warrant a Child Concern Record, this should be completed and passed, through Admin, to the SGL without delay.

60. Notes of any conversations with the child or carer must be made at the time or as soon as possible thereafter, and the original notes kept even if they are then transferred to a Record. The original notes could be required if legal action is taken so they must be dated, timed and signed and attached to the appropriate Record. Where possible, direct quotations must be used, including

[3] Staff can check the Sketches showing Typical NAI and Accidental Injuries if they are unsure.

questions and responses. It is essential that we keep accurate records of events, observations and professional judgements.

61. No derogatory or slang language, generalisations or jargon may be used.

62. Where there is a physical injury requiring completion of a Child Concern Record, a Body Map (see Appendix G) must be completed. However, it would not normally be appropriate for any staff member to undress a child specifically in a deliberate attempt to see physical injury.

63. If there is a concern about on-going abuse (including signs of inappropriate or sexualized behaviour), the List of Concerns Template (Appendix I), should be used to keep a record which should be inserted in the front of the family's hard copy safeguarding folder.

SGL REPORTING BACK

64. The SGL must inform the reporting staff member of what action has been taken following receipt of a Child Concern Record. Should the staff member be unhappy with that action, they may take the matter up with another Safeguarding Lead or follow the Whistleblowing Procedure.

GBC'S SAFEGUARDING PROCEDURE

65. <u>When in doubt report it</u>.

66. If a child tells us about abuse, we must never promise not to tell anyone else. We must not question a child more than is absolutely essential in order to find out that abuse may have taken place, as detailed questioning should be left to trained police officers/social workers. See Appendix H Safeguarding - What to Say and Do".

67. When a concern is reported, via a Child Concern Record or otherwise, the SGL will decide what action to take, if any, including one or more of the following:

67.1. Assess any urgent medical needs and, if the child needs urgent medical treatment, seek immediate help

67.2. Check all documentation to see if there are any others to do with the particular child or their family and if the child is subject to a Child Protection Plan or known to the local authority

67.3. Consider whether the matter should be discussed with the child's carers, bearing in mind Point 47 below

67.4. File the Record if there the SGL believes there are insufficient grounds to take any further action, recording their reasons for that judgement.

67.5. Set up a Case Team (see below)

67.6. Make a referral to the local authority, the Police if the child might be at immediate risk.

68. A Case Team normally comprises the HCCS and the child's key-worker and/or staff members to whom they are particularly close or to whom they made a disclosure. Discussions may also be held with the other members of the EMT and other staff as appropriate (bearing in mind the need for confidentiality).

69. The Case Team will review the evidence and determine what course of action to take. Excluding referrals, the options would include:

69.1. talking to the child to determine if there is indeed cause for concern (e.g. checking out how an injury occurred)

69.2. asking the carer about the child's injury or behaviour

69.3. taking no immediate action but monitoring the case carefully

69.4. considering whether the child has suffered, or is likely to suffer significant harm

69.5. liaising with other agencies, e.g. schools, health visitors

69.6. referring the carer for help within GBC, e.g. caring support, or outside, e.g. Croydon HomeStart, NSPCC, their GP, Children's Centre, Health Visitor

69.7. alerting relevant staff to the concern about the child.

70. Unless there is a real reason not to do so, the SGL seeks permission for and/or informs the carer of our actions because it is important that we do our best to ensure that a good working relationship is maintained with them. However, in some situations, carers should not be pre-warned of concerns. For example if:

70.1. the child could be in immediate and present danger

70.2. there is the possibility of violence to the child or a staff member

70.3. the concern is about sexual abuse or serious physical abuse

70.4. someone might attempt to "agree a story" with the child before an investigation could take place

70.5. the carer may alert the possible perpetrator/s.

CRITERIA FOR REFERRAL

71. The Case Team will decide when a referral must be made, and the following list indicates the circumstances that would dictate a referral:

71.1. there is actual and suspicious injury to a child

71.2. the child intentionally/unintentionally tells about abuse

71.3. there are fresh injuries to, or concerns about, a registered child or a child of the same household, or there is reason to believe abuse is continuing

71.4. the attitude of the carer towards the child causes grave concern

71.5. the carer intentionally/unintentionally speaks about abuse

71.6. we learn of a high level of concern from neighbours, relatives or other acquaintances of the family or household

71.7. there are a number of warning signs present that might indicate abuse of some kind, either from the carer or from the child

71.8. there is concern about a child being at risk of FGM or having had FGM, irrespective of whether there are any other concerns about the family

72. The SGL or the Case Team will decide to which agency the referral should be made as under. However, it should be noted that, were the family to live out of Borough, then that Borough or County's local authority should be contacted.

73. Croydon's Single Point of Contact (SPOC) acts as a central point for all safeguarding concerns, and can be contacted on or 020 8239 4307 or via https://my.croydon.gov.uk/ChildReferrals?qWname=New&qServiceRef=ChildReferral.

74. If there is an urgent child protection matter that requires a same day intervention from a social worker action, SPOC can be contacted on 0208 255 2888.

75. Croydon's Contact Centre on 020 8726 6400 can be contacted outside opening hours. The consultation line, where advice can be sought, is on 020 8726 6464.

76. If the concern is about radicalisation, the Department for Education has dedicated a telephone helpline (020 7340 7264).

77. If required, the Police should be contacted on 101 or, if there is a clear and present danger to the child or an urgent radicalisation concern, 999.

78. The LADO must be informed of any referrals to SPOC or the police only if the carer works in a profession where they may come into contact with children.

CONFIDENTIALITY

79. See the Staff Conduct Guidelines.

ALLEGATIONS AGAINST STAFF

80. If an allegation of abuse is made against a staff member, GBC is required to notify, without delay, the LADO, Steve Hall, and he can be contacted on 020 8255 2889 or via email: lado@croydon.gov.uk. Any phone call should be followed up by a confirmatory email, in order to ensure there is an evidence trail.

81. No investigation may be undertaken by GBC without the permission of the LADO or someone acting on their behalf.

82. Ofsted (0300 123 1231) must be notified of any allegations of serious harm or abuse and of any action taken in respect of the allegations, as soon as possible and certainly within 14 days of the allegation being made. Failure to comply with these requirements could be an offence.

83. Whoever the allegation is made by, it will be taken seriously and the investigation and disciplinary procedure followed.

84. If there is an investigation regarding an allegation where the harm or abuse does not immediately appear to be serious, its remit could include checking the timing, asking any witnesses (including children, depending on their age), establishing if there were any underling difficulties between the staff member and the accuser, and checking the CCTV.

85. However, in the case of a serious allegation, any individual/s concerned will be suspended, pending a full investigation.

86. Any suspension does not imply guilt.

87. One of the EMT will take prime responsibility for keeping the carer informed of any developments in the investigation unless it is believed that they were involved in some way.

88. If any investigation results in an allegation being founded and finds that any of the following had occurred, then the CEO must inform Ofsted and make a referral to Children's Services and/or the Child Abuse Investigation Team (Police) within one working day:

88.1. Staff committed an assault or sexual abuse
88.2. A child has suffered significant harm as a result of an incident, not only if medical treatment were required
88.3. A pattern has emerged, involving a number of previous complaints or allegations

89. If a staff member is under investigation by an outside agency of abuse against their own children or step children, GBC will instigate a full investigation and is likely to suspend the staff member while any external and/or internal investigations take place. GBC would also need to consider in the longer term if the staff member is still suitable to work with children. During the investigation or if the allegation were substantiated, GBC would not accept any resignation from the staff member and, even if the staff member withdraws their services or refuses to cooperate with the investigation, the allegation would still be subject to the full investigation. Children's Services and/or the Police must be informed immediately if any of the bullet points in Clause 60 apply.

90. If an allegation is made against the SGL, then the Deputy SGL will become the lead person for safeguarding.

91. Where an allegation is received against an inter-agency professional, then a senior manager in the relevant agency will also be notified. Where an allegation is made against a student, an appropriate senior teacher/manager must also be informed from the learning institute.

92. If a staff member is dismissed from our employment due to misconduct or if they cease to work for us following an allegation (relating to harming a child or vulnerable adult through their actions or inactions or representing a risk of harm to a child or vulnerable adult or having received a caution or conviction for a relevant offence), the SGL will consult with the LADO about whether there should be a referral to the Disclosure and Barring Service and/or any professional regulatory body. The staff member must be informed of such a referral, which should be made on the appropriate form[4].

Children with a Child Protection Plan

93. Children's Services will provide information to enable us to support a child who is subject to a Child Protection Plan.

Further Information

94. Further information may be found within the Safer Environment Protocol, Childcare Management and Operations, and the Whistleblowing and Data Protection Policies and via the following links:

    Working together to safeguard children – statutory guidance on everything safeguarding and our duty
    https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf
    Information sharing: advice for practitioners – when and how to share information with others
    https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf
    LA – CSCB Threshold Guidance –criteria on when a referral should be made to children's social care https://croydonlcsb.org.uk/professionals/policies/#early-help-amp-thresholds-documents

Review

[4] Currently to be found at https://www.gov.uk/government/publications/dbs-referrals-form-and-guidance

95. This Guidance and associated Safeguarding documentation are normally reviewed annually unless changes to best practice or legislation indicate an earlier review.

96. This review took place in August 2021 and the next review date for all Safeguarding documentation is in or around August 2022.

APPENDIX A SAFEGUARDING POLICY

INTRODUCTION

1. Gingerbread Corner recognises that the welfare of a child is paramount, and this Policy comprises the overarching principles that guide our approach to Safeguarding the children who receive our services (and, where relevant, their siblings).

2. All children, regardless of age, disability, gender identity, race, religion or belief, gender, sexual orientation or any other characteristic (such as appearance or accent) have a right to equal protection from all types of harm or abuse.

3. Some children are additionally vulnerable because of the impact of previous experiences, their level of dependency, Special Educational Needs, disability, etc.

4. Children may be at risk of a range of types of abuse, including:

    - Emotional
    - Neglect
    - Physical
    - Sexual
    - Female Genital Mutilation
    - Breast Ironing
    - Radicalisation
    - Peer on peer

    Children who witness Domestic Abuse (or are in a home where Domestic Abuse exists) require Safeguarding.

WORK WITH OUR CHILDREN AND FAMILIES

5. We promote a caring, safe, respectful and positive environment for all our children, encouraging self-esteem and assertiveness. This environment increases the likelihood of the children being aware of unacceptable behaviours and having the confidence to express their concerns.

6. We maintain an anti-bullying environment and deal quickly and effectively with any instances of bullying that arise.

7. Staff actively engage with carers, building up trust and mutual respect.

PARTNERSHIP WORKING

8. We use our Safeguarding procedures to share concerns and relevant information with appropriate agencies, involving children and carers as appropriate.

9. We take opportunities to engage in partnership-working with relevant services and agencies.

HUMAN RESOURCES & TRAINING

10. We provide effective management for staff through performance reviews, support, training and quality assurance measures.

11. All staff are required to follow our code of conduct.

12. We use our procedures to manage any allegations against staff appropriately.

13. Staff receive regular Safeguarding training in line with our Safeguarding Guidance and training will be offered to the Trustee Lead if they are not experienced or qualified in Safeguarding,

POLICIES, PROCEDURES AND PROCESSES, ETC.

14. Our Safeguarding Policy is underpinned by a number of procedures and processes, including Safeguarding Children Guidance[5], Complaints, Whistleblowing, Health and Safety, GDPR, Safer Recruitment and Employment.

15. We appoint a Safeguarding Lead, Deputy and Assistant Leads and a Lead Trustee.

PROVISION OF INFORMATION

16. We provide carers and staff[6] with essential information to reduce opportunities for abuse, by disseminating safeguarding information through our website, social media, posters, etc.

CONTACT DETAILS

17. Our Designated Safeguarding Leads:
    - The Designated Safeguarding Lead (DSL) is Gemma Brown, Head of Child Care Services gemma@gingerbreadcorner.co.uk
    - The Deputy DSL is Leanne Jones, CEO leanne@gingerbreadcorner.co.uk

[5] Which itself comprises a range of documentation
[6] The term Staff here should be taken to include permanent, casual and agency workers, students and volunteers

- The Assistant DSL is Paula Carter, Finance Director and Deputy CEO paula@gingerbreadcorner.co.uk

- The DSL Trustee is Maria Martin, reached care of Gingerbread Corner.

18. Contact details for the Local Authority Designated Officer are within our Safeguarding Guidance documentation.

REVIEW

19. This Policy is reviewed and agreed by Trustees annually.

20. Child protection and safeguarding guidance and procedures are reviewed annually or sooner if best practice or other guidance so warrants.

APPENDIX B GUIDANCE ON INDICATIONS, SIGNS AND SYMPTOMS

INTRODUCTION

1. We may not always have enough information to be absolutely certain that abuse has occurred or is occurring. When in doubt report it.

2. Always pay close attention to identifying any differences in the child's story and the carer's. Should this occur, a child concern log must always be completed.

3. Notice any changes in a child's behaviour, which could indicate abuse. But also be aware that the child may already be suffering abuse when they start with us.

4. You need to be aware of the types of child abuse: Emotional, Physical[7], Sexual[8], Neglect, Radicalisation, Domestic Abuse

5. You may be the only person who stands between a child and their abuser.

FAMILIES WHO MAY BE PARTICULARLY AT RISK FROM ABUSE

6. Whilst anyone may have the potential for child abuse, there are specific risk factors:

    - Known history of previous unexplained or inadequately explained injuries.
    - Previous episode of child abuse
    - Domestic abuse
    - Abuse of pets
    - Carer is lonely and socially isolated
    - Carer suffers from an emotional or mental health issue, e.g. depression, especially where there is inexplicable anger or violence
    - Carer is known to have been subjected to rejection or abuse in their own childhood
    - If children are born a year or less apart – simply because being exhausted might make it more difficult to cope with ordinary problems
    - Carer is subjected to stress, especially where there is a recent accumulation, such as issues to do with: employment, finances, housing, physical or mental ill-health, alcohol or drugs
    - Carer has unrealistic expectations of the child
    - Carer has been heard carer saying things such as:

        - I wish my child had never been born
        - I knew it was a mistake the moment I found out I was pregnant
        - My child doesn't love me
        - My child deliberately upsets me

    - Carer is mainly giving negative attention to the child - the relationship seems hostile with persistent criticisms for the child's efforts.
    - Carer give frequent orders, shout at or smack babies and toddlers for things they cannot understand. They scold their child for reflex behaviour such as vomiting, wetting, etc.
    - Children who scream or cry a great deal
    - Children who are the result of an unwanted pregnancy
    - Disabled children
    - Very premature babies (particularly more than five weeks premature)

GENERAL WARNING SIGNS AND WORRYING BEHAVIOURS IN CHILDREN

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[7] This includes Female Genital Mutilation and Breast Ironing

[8] This includes peer on peer sexual abuse

7. Physically under-developed without a medical cause

8. In babies and toddlers:

    - Gaze avoidance, in which the baby, from three or four months onwards
    - Smiling is fleeting or muted instead of joyous and exuberant
    - Lack of liveliness and withdrawal - hard to catch the baby's attention
    - Inability to 'cuddle in' or to be easily comforted by the carer's voice or by feeding, holding, rocking or play
    - Poor feeding and sleep without a physical reason
    - Persistent vomiting or loose stools – again, there may be physical causes
    - Inadequate hygiene and skin care - persistent severe nappy rash, etc.

9. In children aged three years or more:

    - Self-comforting, by rocking, excessive thumb sucking or masturbation
    - Signs of frustration such as head banging, hair pulling, hand biting and other self injury
    - Lack of lively, exploratory behaviour
    - Wailing, hopeless crying with no expectation of relief
    - Chaotic-hyperactive play with little concentration or attention span
    - Persistent disturbances in eating, sleeping, toileting
    - Persistent disobedience and negativism
    - Constant, watchful eye contact with an adult's face
    - Ducking or face-shielding, indicating that the child may be attempting to avoid blows
    - Misleading cheerfulness - especially when apart from their carers
    - Inappropriate acceptance of strangers
    - Not seeking comfort from carer when hurt or distressed, e.g. a child who is hurt and crying, but stops if their carer enters the room
    - The child who holds their arms stiffly in the air whilst being dressed or undressed, waiting to be told when to put them down, indicating that the child may have been handled roughly
    - Always tired and falling asleep - if there is no medical cause, then the child may be unable to sleep because of family problems, or the carers are neglecting to regulate their routine
    - The child appears afraid of going home
    - Not referencing back to their carer by looking, talking or touching, whilst in the same room; the carer not glancing back to the child either (although this behaviour, when a carer is leaving the child, could be because the carer doesn't wish to see their child upset or crying as they leave them)

EMOTIONAL ABUSE

10. Emotional abuse occurs when the carer surrounds the child with a negative emotional atmosphere or is verbally abusive. It can be done subtly, including the carer's apparent lack of love and proper direction, inability to accept the child's potentialities and limitations, and failure to encourage the child's normal development by assurance of love and acceptance.

11. Examples of emotional abuse could be:

    - Giving their toys away because they didn't tidy up
    - Continually comparing a child to a 'better' sibling
    - Making the child feel worthless for bad grades at school.
    - Repeatedly telling the child that they are stupid, clumsy or worthless
    - Using sarcasm, teasing, labelling, ridicule, insults, bad language, etc.

12. Emotional neglect occurs when:

    - The carer is very distant from the child, showing them neither negative or positive feelings

- Carers give children money and material things instead of time and interest, which often results in a child behaving “badly” simply to gain attention

13. Babies deprived of emotional warmth will not gain weight and develop properly

14. Signs of emotional abuse/neglect include:

- Delayed or inappropriate emotional development
- Loss of or low self-confidence/self-esteem
- Appearing withdrawn, disinterested or unenthusiastic
- Depression
- Avoidance of certain situations
- Desperately seeking affection
- Being overly-affectionate towards strangers or people they haven’t known for very long
- Being overly wary, anxious or clingy
- Not appearing to have a close relationship with their carer
- Being aggressive towards other children and animals
- Eating disorders or changes in eating habits
- Wetting or soiling their clothes
- Taking risks
- Obsessive behaviours
- Self-harming or expressing suicidal thoughts
- Age-inappropriate language or behaviours or have age-inappropriate knowledge
- Struggling to control strong emotions or have extreme outbursts
- Appearing isolated from their parents
- Lacking social skills
- Having few, if any, friends
- Attention seeking behaviours

PHYSICAL NEGLECT

15. Physical neglect is the failure to provide adequate food, clothing, shelter, supervision, stimulation and play, medical/dental care and protection. Serious physical neglect can kill.

16. Common indications of neglect include:

- Inadequate supervision
- Not taking reasonable precautions for safety
- Leaving children alone for extended periods or leaving young children in the care of siblings under twelve years of age
- Children dressed inadequately for the weather, who may suffer persistent illness like chest infections, frostbite or sunburn
- Severe nappy rash or other persistent skin disorder resulting from improper hygiene
- Children whose appearance indicates a lack of hygiene
- Children who are chronically absent
- Children who consistently rummage for food, or complain of hunger
- Children who fail to develop and gain weight because they are underfed and/or who have severe development delays
- Children living in unsanitary housing conditions

PHYSICAL ABUSE

17. Any physical punishment that leaves a mark is unlawful.

18. Certain injuries, sometimes apparently trivial, are characteristic of abuse (see the Injury Mark Sheets for more detailed information). Abuse is not usually an isolated incident and there will normally be several signs and symptoms to indicate that injuries are non-accidental.

19. Physical abuse includes physical harm to a child including the deliberate fabrication or causation of illness in a child (sometimes known as Munchausen's by Proxy Syndrome).

20. General indicators that the injuries were caused by abuse include:

    - Skin lesions or soft tissue injury
    - Black eyes, finger tip bruising, cigarette burns
    - Combination of injuries of varying ages
    - Children aged under three years with fractures
    - Delay in the carer seeking treatment
    - Frequent attendances at GP or A&E
    - Absence of any explanation or inadequate or conflicting explanations
    - Carers being touchy or defensive - compared with a genuine accident when a carer may be distressed and possibly blaming themselves
    - Child being developmentally incapable of sustaining the injury accidentally, e.g. the true case of the 13 day old baby who "fell" onto the floor from the middle of a double bed

21. Head injuries may be caused by a direct blow, or by swinging or shaking the child. (A child who has been shaken badly may have bruising inside the skull caused by tearing of the fine blood vessels on the surface of the brain. The bleeding accumulates, pressing on the brain, and the baby may become drowsy, vomit, be unwilling to feed or have fits. This can happen slowly over time with few noticeable symptoms, although the child's brain will suffer progressive damage.)

22. Bruises and welts **(**although most of these injuries could well be accidental):

    - Pattern of injury - accidental bruises are usually of different sizes and shapes
    - Fingertip bruising - three or four small marks on one side and one on the other
    - Pinch marks - two small bruises close together

    - Flat of hand marks - particularly on face or buttocks
    - Grasp marks – on the back and front of chest, over shoulder area or on the arms
    - "Blue spotted" ears (little pinpoint marks which are tiny haemorrhages in the skin of the ear lobe) However, such pinpoints may also be seen on the neck, face and eye balls particularly if the child has been choked or strangled
    - Bruises under nails
    - Bite marks - two crescent marks or bruises
    - Black eyes - these cannot be caused by a fall on a flat surface. (Two black eyes with no bruise to forehead or nose would require two separate injuries)
    - Ligature marks - red mark or bruising around wrists, ankles or neck
    - Stick marks - linear marks or bruises – most often seen on buttocks or back of thighs
    - Strap or lash marks - bruises or wheals curving around body, which could be caused by sticks, wires, belts - sometimes, the mark of a buckle may be also be present.
    - Bruising around mouth or chin - caused by squeezing the child's face
    - Bruises in different stages of healing. Bruises change colour as they get older so bruises of different colours will have occurred at different times. If a child has three bruises on the cheek, all a different colour, and the explanation is that the child fell out of a tree, then the story does not match the findings.
    - Bruises on soft parts of the body. Bruises on the chest, genitals, back of legs, abdomen or around the mouth rarely occur accidentally. Similarly, any bruises on a baby that is not mobile, are suspicious. (A child that is walking will get lots of bruises, usually on the shins, knees, and forehead, where there is a bone near the surface.)
    - Unusually shaped bruises. Accidental bumps leave a round or oval bruise but an instrument or hand will leave a definite shape.

23. The following is a list of fractures that would be of particular concern:

    - Fractures in babies under a year old
    - Skull fractures

- Spiral fractures of long bones – accidental fractures are usually of the greenstick variety
- Fractured ribs
- Fractures involving a joint

24. Burns, which may cause redness, blistering or peeling of the skin, will be of particular concern in the following cases:

    - Scalds - "glove" or "stocking" scalds of hands or feet which could be caused by dunking in hot water, or scalds on buttocks
    - Cigarette burns - small circular burns, most typically on the back of the hands or forearms. These burns are small and round and may be seen in clusters and of different ages
    - Friction burns (these can be accidental, especially over bony areas, e.g. spine or face)

25. Parallel scratch marks from a comb of stiff brush may look like a graze from a fall on a rough surface Some scratch marks may be deliberately caused by finger nails.

26. Mouth injuries, such as tearing of the inside of the upper lip, especially in babies.

27. Any poisoning of a child must be a cause for concern, either because it could be deliberate or because it could be an indicator of neglect.

SEXUAL ABUSE

28. Any allegation by a child that they have been sexually abused must be reported, even if the child later retracts their allegation.

29. It can be challenging to decide if a relationship is sexualised. It is right and natural for carers to clothe, feed and wash their children and to cuddle, hug, kiss and stroke them. Pay attention to your intuition and report any concerns.

30. However, these same gestures are indicative of abuse if:

    - they appear too lingering and seductive
    - they are continued too long into adolescence
    - they become centred on the sex organs, anus, breasts or other erotic areas
    - if the adult appears sexually excited or aroused

31. The term "sexual abuse" covers a wide range of behaviours, including:

Non-contact	Sexual comments Exposure Voyeurism
Touching	Contact with a child's breast, genitals, buttocks (often with a rationalisation) Tricking/coercing/forcing the child into touching the abuser
Digital or object penetration	Fingers into vagina/anus Objects put inside child, e.g. screwdriver, crayons Child tricked/coerced/forced into penetrating them
Oral sex	French kissing Kissing, licking, biting other parts of body Cunnilingus - licking, kissing, biting or sucking female genitalia Fellatio - licking, kissing, biting or sucking the penis Analingus - licking, kissing, biting or sucking the anal area
Penile penetration	Vaginal or anal
Child pornography/	Child exposed to pornography as part of' grooming' process by offender Child abused in photographs, home made videos

prostitution	Child forced/coerced into prostitution
Bestiality	Child forced, persuaded or tricked into engaging in sexual acts with animals
Sexual sadism	A child injured, mutilated or killed for sexual gratification

32. The following list outlines possible physical indicators of sexual abuse:

- Torn or stained underclothes
- Difficulties in walking and sitting (because of soreness and bruising in the genital area)
- Pain on urination or recurrent urinary infection
- Injuries in the genital area: genital infections, itching, abnormal discharges, warts, bruising around the genital/anal areas
- Foreign body in urethra, bladder, vagina or anal canal, or abnormal dilation of these orifices
- Disturbed sleep, nightmares, bedwetting.

33. Behavioural signs include children who:

- Engage in sexual play beyond age-appropriate curiosity
- Masturbate
- Express sexual acts in drawings
- Appear concerned or frightened about family troubles or secrets
- Seem distrustful of adults, particularly those who are close
- Are moody, perhaps with regressive behaviour (rocking/thumb sucking/etc.)
- Suffer from psychosomatic complaints, headaches, tummy pains and sickness
- Have sudden learning difficulties and failure at school
- Have sexual awareness or knowledge which are not age-appropriate to their age
- Behave seductively
- Revert to younger behaviour
- Appear to be depressed
- Have relationships with adults which are secretive and exclude others
- Display aggressive behaviour, or have severe tantrums
- Have an air of 'detachment' or 'don't care' attitude
- Are overly compliant behaviour, 'watchful' attitude
- Display aggressive disruptive behaviour
- Have fears or phobias
- Have overly compulsive behaviour
- Suffer separation anxiety
- Have an unexplained pregnancy
- Engage in self-mutilation/self-harm
- Run away from home
- Talk about, or attempt, suicide
- Engage in substance abuse to escape from the reality
- Have role-reversal in the home, e.g. the child in a carer's role of housekeeping, cooking, washing etc.
- Have eating problems, whether over-eating and loss of appetite

34. When children are abused, they sometimes re-enact the abuse with another child. This may amount to peer-on-peer abuse or may requires the re-education of the children so that they can find more appropriate ways to play with one another. A report should always be made in these cases.

INCEST

35. There are signs which may indicate incest between parent and child, as opposed to other forms of sexual abuse

- Child takes role of parent and partner in family
- Parent acts as child's suitor

- Parent acts as rival to child
- Parent jealous of child being with their friends
- Parent over-possessive of child or reacting jealously to an older child's boy or girlfriend
- Favouritism by parent towards one child over other children in family
- Other children in the family jealous of child chosen by parent
- Child has poor self-image
- Child is secretive
- Child behaves seductively

36. Signs of sibling incest include:

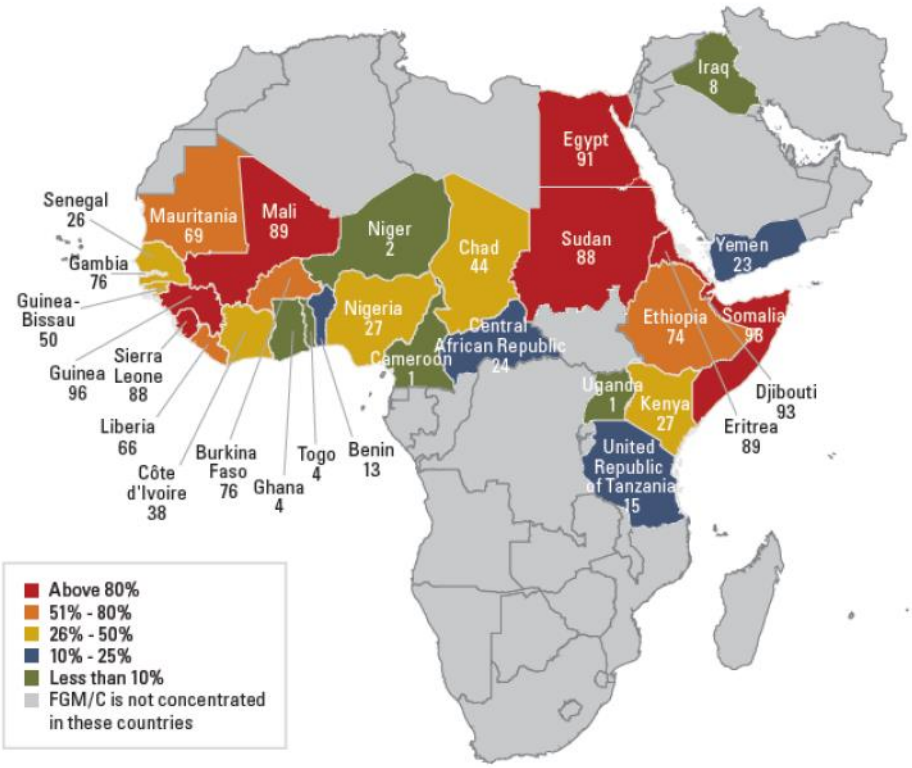
    - Siblings behave like boy or girlfriends
    - One sibling appears fearful of being alone with another
    - Siblings appear embarrassed when found alone together for no apparent reason
    - One sibling antagonises the other, who does not retaliate

FEMALE GENITAL MUTILATION

37. Female Genital Mutilation (FGM) is a serious issue, with 2% of females in London having been abused, which abuse can happen to girls as young as three years old. is illegal under the Female Genital Mutilation Act 2003 regardless of nationality or residence status (unless the operation is performed of physical or mental health grounds by a registered medical practitioner).

38. A November 2014 study estimated that approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM and approximately 10,000 girls aged under 15 who have migrated to England and Wales have undergone FGM. It is likely that FGM is significantly more prevalent than these figures show.

39. The following map shows the incidence of FGM in women aged 15-49 across Africa and the Middle East, where its practice is most prevalent. However, care must be taken to not simply stereotype nationalities.



40. There are a number of other factors that could increase a child's risk of FGM, including being the child a woman who has been subjected to FGM and if the family is part of a community that is segregated from UK society.

41. The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is newborn, during childhood or adolescence, at marriage or during the first pregnancy. The majority of cases of FGM are thought to take place between the ages of 5 and 8 and therefore girls within that age bracket are at a higher risk.

42. It is likely that a report should be made in most of the following circumstances:

    - a girl of school age is taken abroad at the start of the school holidays because that would allow sufficient time for her to recover
    - a female family elder is around, particularly when she is visiting from a country of origin
    - staff hear a girl make a reference to FGM in conversation
    - a girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'
    - a carer states that the child out of the country for a prolonged period without explanation
    - a girl may talk about a long holiday to her country of origin or another country where the practice is prevalent

43. It is important that we also look out for signs that FGM has taken place so that:

    - the girl or woman affected can be supported to deal with the consequences of FGM
    - other female family members can be safeguarded from harm
    - criminal investigations can take place

44. There are a number of indications that a girl or woman has already been subjected to FGM:

- difficulty or discomfort when walking, sitting or standing
- spending longer in the toilet due to difficulties urinating or with menstrual problems
- frequent urinary, menstrual or stomach problems
- there may be prolonged or repeated absences, particularly with noticeable behaviour changes, particularly on the girl's return after an absence
- being particularly reluctant to undergo normal medical examinations
- attempts to confide in staff or ask for help, whilst being unable to be explicit about the problem due to embarrassment or fear
- she may talk about pain or discomfort in the area

BREAST IRONING

45. Breast Ironing (also known as "Breast Flattening") is the process whereby young girls' breasts are ironed, massaged and/or pounded down through the use of hard or heated objects in order for the breasts to disappear or to delay the development of the breasts. The rationale for this abuse is to protect young girls from harassment, rape, abduction and early forced marriage.

46. The mutilation is a traditional practice from Cameroon, and is also practiced elsewhere, including Benin, Ivory Coast, Chad, Guinea-Bissau, Kenya, Togo, Zimbabwe and Guinea-Conakry.

47. The practice is designed to make teenage girls look less "womanly" and is commonly performed by family members, 58% of the time by the mother. The girl generally believes that the practice is being carried out for her own good and therefore will not report the abuse.

48. Damage caused by the 'ironing' can leave women with malformed breasts, difficulty breastfeeding or producing milk, severe chest pains, infections and abscesses, and may cause breast cancer.

49. Indicators that a girl has undergone breast ironing include:

- Unusual behaviour after an absence such as depression, anxiety, aggression or withdrawal
- Asking for help, without being explicit about the problem (due to embarrassment or fear)
- Bandages being visible or the child fearing that her scars or bandages be seen

RADICALISATION

50. Under the Counter Terrorism and Security Act 2015, GBC has a Prevent Duty, under which due regard must be paid to prevent people being drawn into terrorism. Staff must be vigilant and report any concerns to the relevant agencies if they suspect a child is being exposed to extremism or is at risk of being radicalised. As part of our Prevent work, GBC promotes and embeds fundamental British values. (For more information, see https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/439598/prevent-duty-departmental-advice-v6.pdf.

51. Even young children can be at risk of being radicalised and under the Counter Terrorism and Security Act 2015, GBC has a Prevent Duty, under which due regard must be paid to prevent people being drawn into terrorism.

52. Signs of someone becoming radicalised include:

- their views become increasingly extreme regarding another section of society or government policy
- they are observed downloading, viewing or sharing extremist propaganda
- they become withdrawn and focused on one ideology
- they become increasingly intolerant of more moderate views
- they may change their appearance, their health may suffer (including mental health) and they may become isolated from family, friends, peers or social groups
- they express a desire/intent to take part in or support extremist activity

DOMESTIC ABUSE

53. Any domestic abuse is automatically a safeguarding concern, so any allegations must be recorded.

54. Domestic abuse is any type of controlling, coercive, bullying, threatening or violent behaviour between people in a relationship. This includes emotional, physical, sexual, financial or psychological abuse, such as:

    - sexual abuse and rape (including within a relationship)
    - punching, kicking, cutting, hitting with an object
    - withholding money or preventing someone from earning money
    - taking control over aspects of someone's everyday life, which can include where they go, who they see, what they wear
    - not letting someone leave the house
    - reading emails, text messages or letters
    - threatening to kill or harm the victim, the children, a new partner, a family member or a pet.

55. Abusive behaviour can occur in any relationship. It is likely to continue (or may even start) after the relationship has ended. Perpetrators are not gender specific.

56. Domestic abuse can seriously harm children and young people. Witnessing or being aware of domestic abuse is child abuse. It is really distressing and frightening for a child. Children living in a home where domestic abuse is happening are at risk of other types of abuse too. Children can experience domestic abuse or violence in lots of different ways. They might:

    - witness the abuse (of whatever type)
    - hear the abuse from another room
    - see a parent's injuries or distress afterwards
    - witness coercion and control
    - be hurt by being nearby or trying to stop the abuse

57. Abusers usually act very differently when other people are around.

58. Signs of domestic abuse include the following behaviours in a child

    - Being withdrawn
    - Suddenly behaving differently
    - Anxiety
    - Being clingy, depressed, aggressive
    - Having problems sleeping
    - Having or developing an eating disorder or changing their eating habits
    - Soiling or wetting themselves
    - Taking risks
    - Missing school
    - Obsessive behaviours
    - Self-harming or thoughts about suicide

PEER ON PEER ABUSE

59. Peer-on-peer abuse is any form of physical, sexual, emotional and financial abuse, or coercive control, exercised between children and within children's relationships and may include bullying, coercive behaviour and harmful sexual behaviour.

60. So, we must distinguish between problematic/abusive sexual behaviour and age-appropriate curiosity.

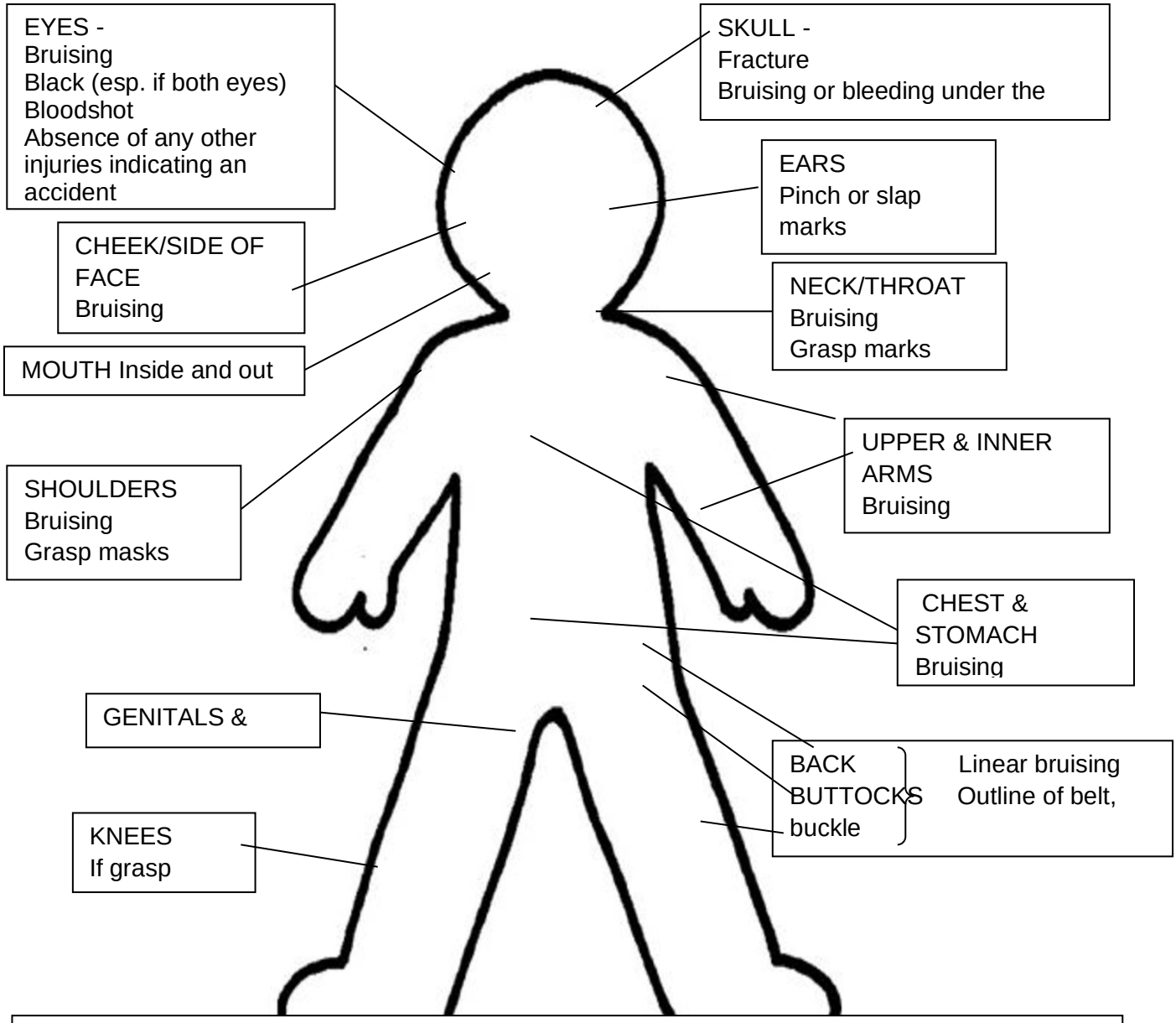
61. HSBs are defined by the NSPCC as "Sexual behaviours expressed by children…that are developmentally inappropriate, may be harmful towards self or others, or be abusive towards

another child…or adult."

62. See Professor Simon Hackett's continuum model showing sexual behaviours from those that are normal to those that are highly deviant (https://learning.nspcc.org.uk/media/1657/harmful-sexual-behaviour-framework.pdf)

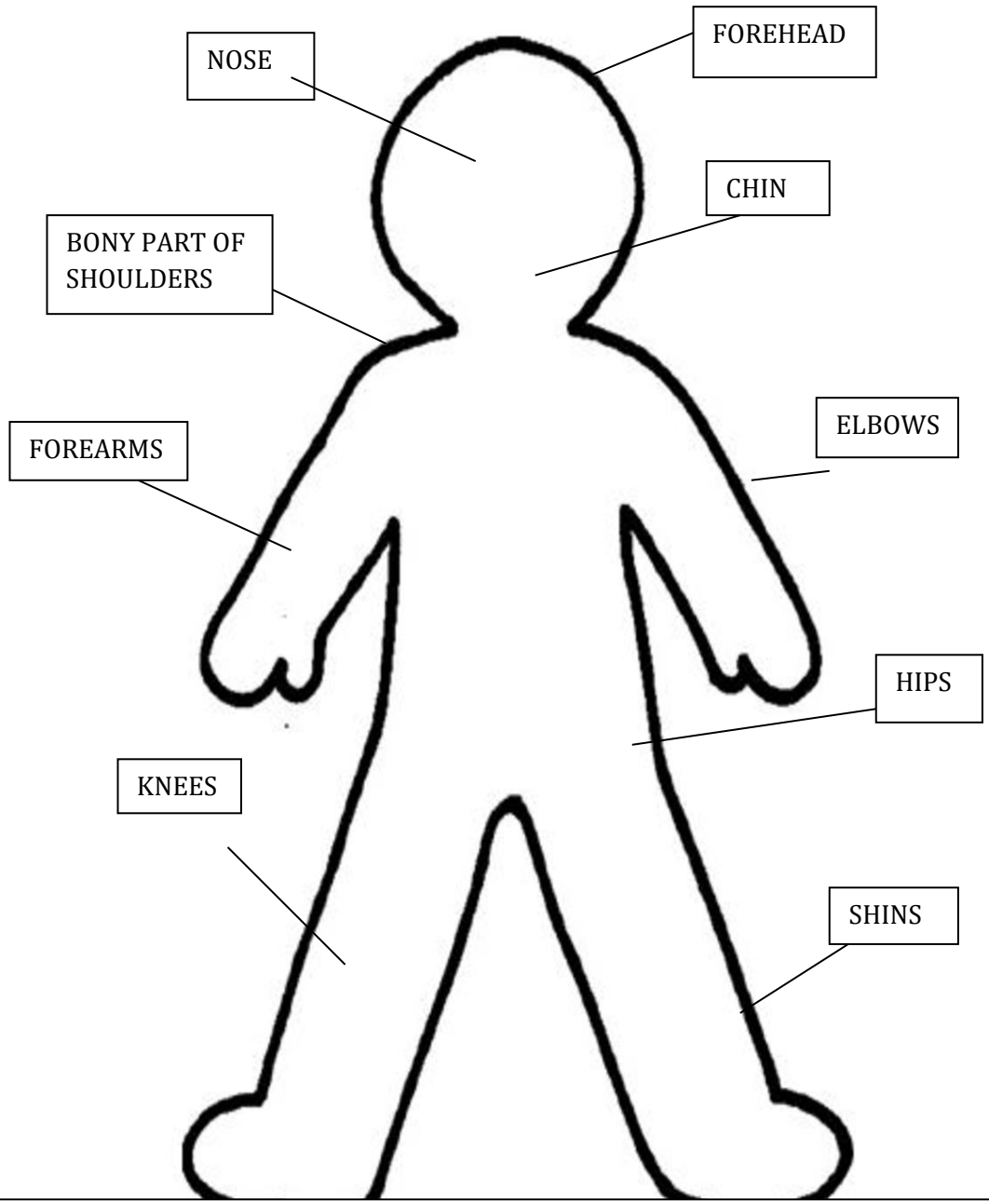
APPENDIX C SKETCHES SHOWING TYPICAL ACCIDENTAL AND NON-ACCIDENTAL INJURIES

Common sites for non-accidental injury:



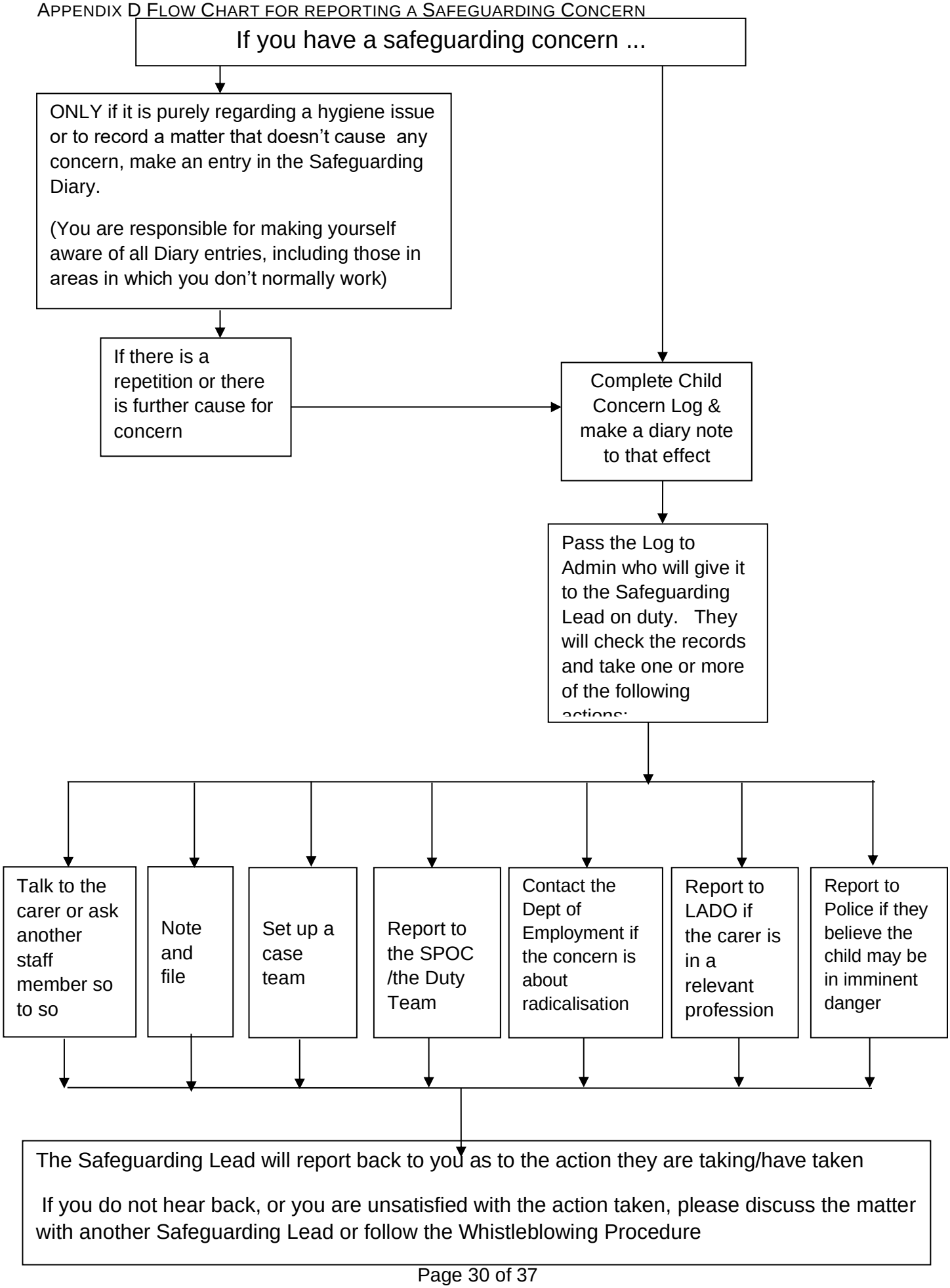
INJURIES - suspicious if	
Pinpoint haemorrhages in the skin of neck, face, ear lobes or eye balls	
Bite marks	Fingernail marks
Incisions (e.g. from razor blade)	Large and/or deep scratches
Parents give vague/conflicting/inconsistent explanations	Fingertip bruising
Pinching or gripping marks	Stick, lash or strap marks, outlines of fingers or hands
BRUISES - likely to be	FRACTURES - likely to be
Frequent	Numerous, healed at different times
Patterned (e.g. finger & thumb marks)	Consider:
Old & new in same place (different colours	Age of child (always suspicious if under two)
	Any delay in seeking treatment
BURNS & SCALDS - likely to have	SEXUAL ABUSE - may result in
Clear outline	Unexplained soreness, bleeding, discharge or injury in genital or anal area
Splash marks around burn area	
Unusual position (e.g. back of hand)	Sexually transmitted diseases
Indicative of shapes (e.g. cigarette burn)	
“Glove” or “sock” burns (from dunking into hot water)	

Common sites for accidental injury:

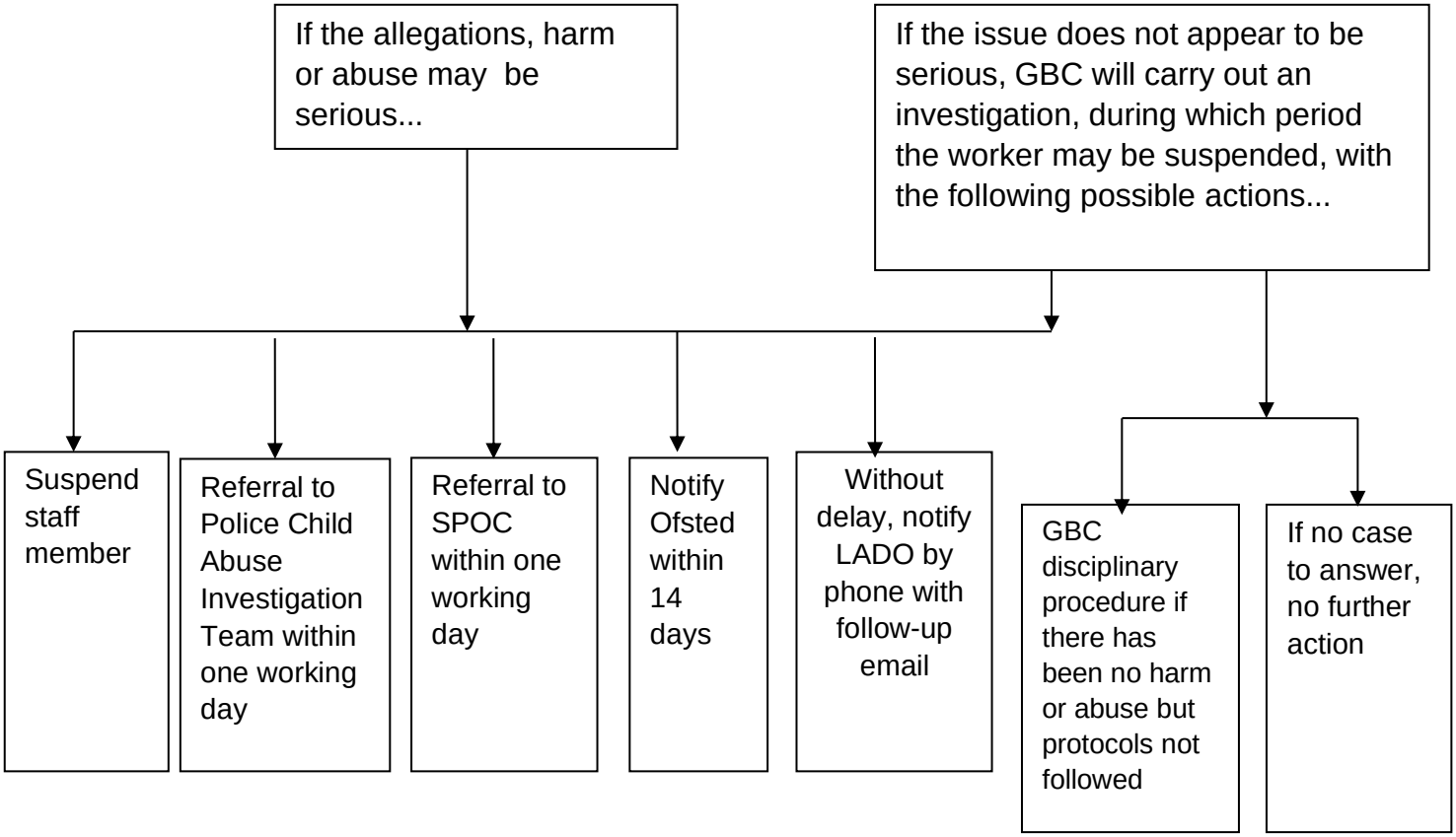


INJURIES - likely to be minor & superficial, easily explained, treated	
BRUISES - likely to be Few but scattered No pattern Same colour & age Consider: age and activity of child (e.g. learning to walk), possible confusion with e.g. birth marks	FRACTURES - likely to be Of arms and legs Seldom on ribs, except for road traffic accidents Rare in very young children Rarely due to brittle bone syndrome
BURNS & SCALDS - likely to be Treated Easily explained Consider: Confusion with nappy rash or other condition e.g. impetigo)	GENITAL AREA Injury may be accidental (referral required) Soreness may be nappy rash or due to skin irritation or constipation

APPENDIX D FLOW CHART FOR REPORTING A SAFEGUARDING CONCERN



APPENDIX E FLOWCHART FOR REPORT TO LADO (LOCAL AUTHORITY DESIGNATED OFFICER)



Depending on action by/advice from police, LADO and Ofsted, further action may be required by GBC, such as disciplinary action.

A similar procedure will be followed for volunteers and students (where an appropriate senior teacher/manager will also be informed).

The LADO is Steve Hall – 020 8255 2889, lado@croydon.gov.uk.

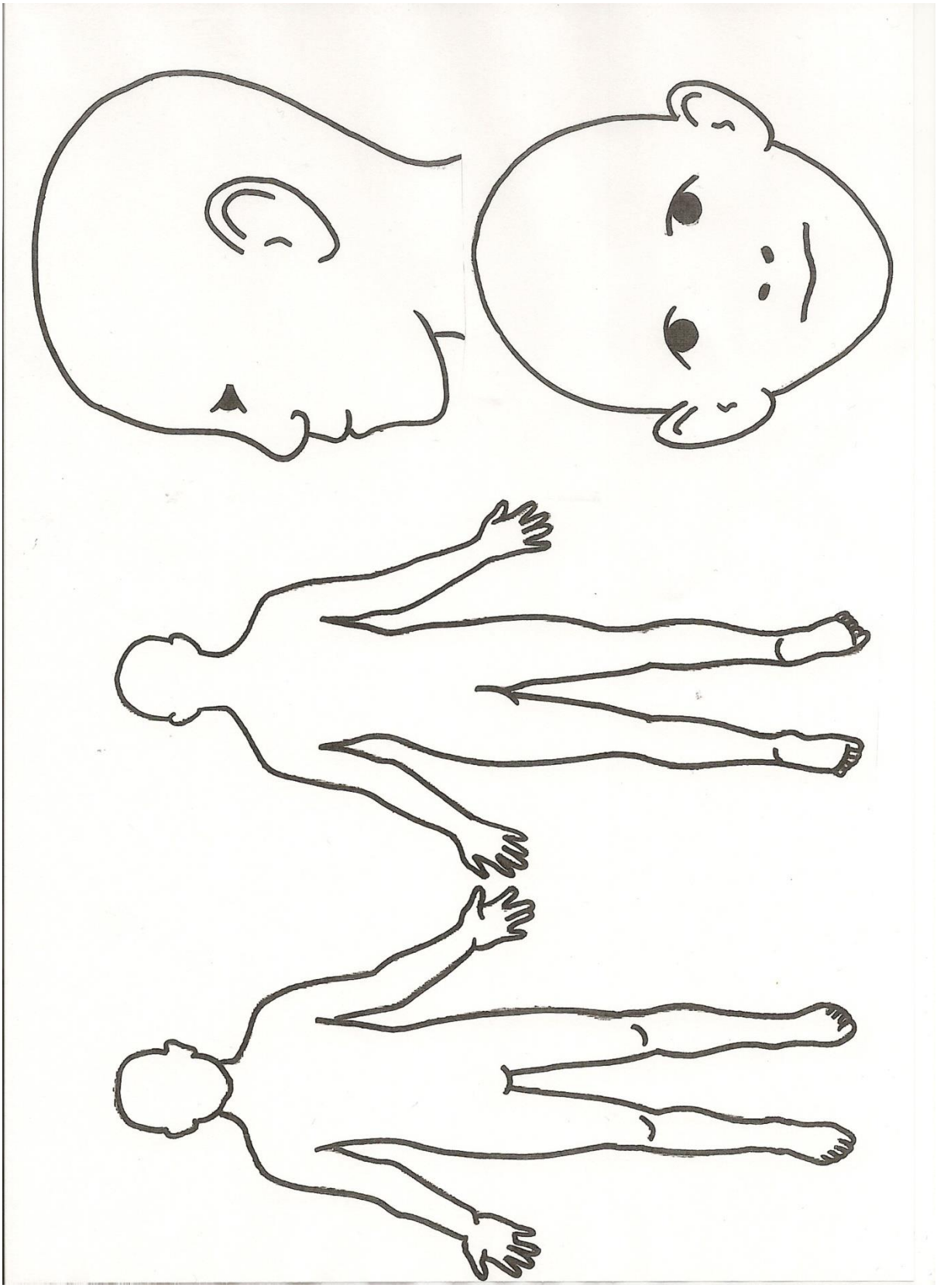
To be passed to Admin for the Safeguarding Lead, the Head of Child Care Services. If they are unavailable, and the matter is urgent, Admin will pass to another staff member, in the following order: the CEO, the Finance Director, one of the Team Leaders. The "Action Box" must be completed by the person taking action.

- *Remember: sign, date and attach to this document any original notes that you made*
- If completing hard copies, use further sheets of paper if necessary – do not try and squash the notes into the boxes

Your name	Date and time the concern came to your attention
Child's name	Name/s of parent/s
Have you *consulted* anybody else? If so, who and why?	Are there any diary records on this child? YES / NO
Brief description of what caused you concern	
Physical signs? (Complete Body & Head Map if there are physical signs)	
Behavioural signs?	

Have you spoken to the child about the concern? If so, what was said?
Have you spoken to the parent about the concern? If so, what was said?
Were there any other *witnesses* to the behaviour or physical signs? If so, give details
Your signature: Time and date:

SAFEGUARDING LEAD'S ACTION	
Is there a previous Child Concern Log?	
Is there a record of the child being subject to a Child Protection Plan?	
Will there be further action / No further action (delete as appropriate)	
If further action:	
If the carer has already been spoken to, does there need to be a further discussion?	
Are there any urgent medical needs and, if so, is immediate help required?	
Is there a need to set up a Case Team?	
Will this matter be referred to SPOC / Police / LADO? If so, by whom?	
Notes on actions or non-actions:	
Referring staff member informed of action	
SGL's signature Date	



Listen carefully: this is vital to safeguarding children

Listen very carefully to what a child tells you because they may be trying to say that they are worried. You may find it helpful to use reflective listening (repeating back what you have heard the child say) as this helps them to feel heard and, importantly, makes sure that you have understood the situation correctly.

Be alert to a child asking "what if" questions, e.g. "what would happen if my daddy hit me" or "what would you do if my mummy said she hates me". NEVER say "oh don't worry, that would never happen to you".

Ask as few questions as possible

You may not need to ask any questions at all. Questions should only be asked if you need to find out more in order to decide if you are either completely reassured or if you need to report it.

Don't asking "leading questions" e.g. is it your daddy/mummy who has hurt you?
Avoid "closed questions", i.e. those to which the child can reply with a *yes* or *no* answer.
Use open ended questions, making use of words like: when, where, how, what and who.

Don't make any promises
Don't make promises that you can't keep – for example, very importantly, you can't promise the child that you will keep anything "a secret".

If you see inappropriate sexualised behaviour or sex games

Do not say "Stop that, it's naughty" or anything similar.
Instead, ask "Who told you about that game?" or "how do you know about that?"

If a child confides in you:

Believe them
Say: "I believe you".

Listen to them without interruption. Do not ask leading questions. Don't ask for any more information than you really need
Say: "I'm glad you told me, you've done the right thing".

Reassure them that they are not to blame for what has happened.
Say: "It's not your fault"

Let them know that they are not alone and you will do your best to protect them
Say: "I'm sorry this has happened to you"
Say: "I'm going to help you". Let them know that, in order to keep them safe from harm, you will have to pass on the information they have shared.

Action you must to take

If you become aware of a concern, it is <u>your</u> responsibility to complete the Log, irrespective of the views of any other staff members.

Subsequent Action

If you report a concern, the Safeguarding Lead will inform you of what action they propose to take or have taken. If you report a concern and are unhappy with the Safeguarding Lead's action, you should discuss the issue with them and, if you are still unsatisfied, follow the Whistleblowing Procedure.

Name of child:		**Name of Primary Carer:**
Date	**Description of Injury/Incident/Behaviour**	**Any explanation of Injury/Incident from carer?**