Children and Young People's SAFEGUARDING POLICY

Pauline Quirke Academy Limited

Author: Mel Leicester-Evans

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Policy Review

This policy will be reviewed in full by PQA on an annual basis.

The policy was last reviewed and agreed by PQA in November 2018.

It is due for review in November 2019 (up to 12 months from the above date)

1 INTRODUCTION

Safeguarding Children is of paramount importance to ensure the safety of every child and young person in PQA. All staff will be aware of how they may access advice, understand their role in protection and understand importance of effective inter agency communication.

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

This Safeguarding Policy forms part of a suite of documents and policies which relate to the safeguarding responsibilities of PQA. In particular this policy should be read in conjunction with the Safer Recruitment Policy, Behaviour Policy, Physical Intervention Policy and Anti-Bullying Policy.

Purpose of a Child Protection Policy	To inform staff, parents and volunteers about PQA's responsibilities for safeguarding children. To enable everyone to have a clear understanding of how these responsibilities should be carried out.
PQA Staff & Volunteers	PQA staff and volunteers are particularly well placed to observe outward signs of abuse, changes in behaviour and failure to develop because they have regular contact with children. All staff and volunteers will receive safeguarding children training, so that they are knowledgeable and aware of their role in the early recognition of the indicators of abuse or neglect and of the appropriate procedures to follow. This training is refreshed every two years. Temporary staff will be made aware of the safeguarding policies and procedures by the relevant Principal. All staff will know how to report any alleged malpractice, allegations and/or concerns relating to a child and will be supported when dealing with safeguarding concerns.
Mission Statement	Establish and maintain an environment where children feel secure, are encouraged to talk, and are listened to when they have a worry or concern. Establish and maintain an environment where PQA staff and volunteers feel safe, are encouraged to talk and are listened to when they have concerns about the safety and wellbeing of a child.

Effective procedures are in place for responding to complaints, concerns and allegations of suspected or actual abuse.

Contribute to the five outcomes which are key to children's wellbeing:

- be healthy
- stay safe
- enjoy and achieve
- make a positive contribution
- achieve economic wellbeing

Implementation, Monitoring and Review of the Safeguarding Policy

The policy will be reviewed. It will be implemented through PQA's induction and training and as part of day to day practice. Compliance with the policy will be monitored by the Child Safeguarding Officer.

2 STATUTORY FRAMEWORK

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

- The Children Act 1998
- The Children Act 2004
- Education Act 2002 (section 175)
- Local Safeguarding Partnership Inter-agency Child Protection and Safeguarding Children Procedures
- Safeguarding Children and Safer Recruitment in Education (DfES 2006)
    - Keeping Children Safe in Education Statutory Guidance 2018
- Working Together to Safeguard Children (HM Government 2018)
- Dealing with Allegations of Abuse Against Teachers and Other Staff (DfE 2011)

3 THE SAFEGUARDING OFFICER

The Safeguarding Officer for PQA is: Mel Leicester-Evans

It is the role of the Safeguarding Officer to:

- Ensure that he/she receives refresher training at two yearly intervals to keep his or her knowledge and skills up to date
- Ensure that all staff who work with children undertake appropriate training to equip them to carry out their responsibilities for safeguarding children effectively and that this is kept up to date by refresher training at two yearly intervals
- Ensure that new staff receive a safeguarding children induction within 7 working days of commencement of their contract
- Ensure that temporary staff and volunteers are made aware of PQA's arrangements for safeguarding children within 7 working days of their commencement of work.
- Ensure that PQA operates within the legislative framework and recommended guidance
- Ensure that all staff and volunteers are aware of the LSCB Inter-agency Child Protection and Safeguarding Children Procedures
- Ensure that the Principal and Fergus Sturrock (PQA Chief Information Officer) are kept fully informed of any concerns
- Develop effective working relationships with other agencies and services
- Decide upon the appropriate level of response to specific concerns about a child e.g. discuss with parents or refer to the Local Children's Social Care.
- Liaise and work with Children's Social Care and the Police over suspected cases of child abuse
- Ensure that accurate safeguarding records relating to individual children are kept separate from the academic file in a secure place, marked 'Strictly Confidential'.
- Submit reports to, ensure the PQA's attendance at child protection conferences and contribute to decision making and delivery of actions planned to safeguard the child, when relevant
- PQA make parents aware of the safeguarding procedures used and how to access the safeguarding policy and will discuss with parents the role of PQA's safeguarding responsibilities.

4 PQA PROCEDURES – STAFF RESPONSIBILITES

If any member of staff is concerned about a child he or she must inform the Safeguarding Officer.

The member of staff must record information regarding the concerns on the same day. The recording must be a clear, precise, factual account of the observations and signed and dated.

The Safeguarding Officer will decide whether the concerns should be referred to the Local Children's Social Care or in certain cases the police. If it is decided to make a referral to Children's Social Care this will be discussed with the parents, unless to do so would place the child at further risk of harm.

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

5 DEFINITIONS

Definitions in relation to the following terms used within this document are taken from statutory guidance (HM Government, 2018):

"Child" or "young person", as in the Children Act 1989 and 2004, is anyone who has not yet reached their 18th birthday.

Safeguarding" and "promoting the welfare of children" is the process of protecting children from abuse or neglect and/or preventing impairment of their health or development. This includes ensuring that children are growing up in circumstances consistent with the provision of safe and effective care and taking action to enable all children to have the best life chances.

"Child Protection" is one element of safeguarding and promoting children's welfare. Child protection refers to the activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm. "Significant Harm" is the concept introduced by the Children Act 1989 as the threshold that justifies compulsory intervention in family life in the best interests of children. It gives Local Authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

Abuse is the violation of an individual's human and civil right usually for gratification. In the terms of safeguarding it is used to refer to any intentional or negligent act by another and any form of abuse is usually perpetrated as the result of deliberate intent.

"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 others (e.g. via the internet). They may be abused by an adult or adults, or another child or children.

6 WHEN TO BE CONCERNED

All staff and volunteers should be aware of the following types of abuse:

Physical – deliberate injury to a person however slight.

Emotional – Persistent ill treatment of a person that adversely affect their wellbeing or development. Emotional abuse is involved in all types of harm but can also occur on its own.

Sexual – the involvement of sexual activities when a person does not want or understand or who is unable to validate effective consent. This may include sexual assault, rape, exposure to inappropriate material or inappropriate sexual contact.

Neglect – continuous failure to prevent harm, not meeting a person's basic needs and/or psychological needs. Can impair health and development.

Online abuse - is any type of abuse that happens on the web, whether through social networks playing online games or using mobile phones. Children and young people may experience cyberbullying, grooming, sexual abuse, sexual exploitation or emotional abuse.

FGM (*Female Genital Mutilation*) – it is illegal in the UK and refers to a surgical procedure that intentionally change or cause injury to the female genital organs for non-medical reasons. It is also illegal to take a female out of the UK to do this.

Bullying – when either an individual or group of people engage in behaviour that is degrading, demeaning, aggressive, threatening and/or intimidating towards others.

Sexual exploitation – a type of sexual abuse where children are sexually exploited for power, status and/or money.

Radicalisation – is defined as a process when those who are vulnerable come to support terrorism and/or violent extremism to directly participate in or support terrorist groups.

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

Generally, in an abusive relationship the child may:

- Appear frightened of the parent/s or other household members e.g. siblings or others outside of the home
- Act in a way that is inappropriate to her/his age and development (full account needs to be taken of different patterns of development and different ethnic groups)
- Display insufficient sense of 'boundaries', lack stranger awareness
- Appear wary of adults

7 DEALING WITH A DISCLOSURE

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

- Keep calm
- Reassure the child that they were right to tell you, and that they are not to blame and take what the child says seriously.
- Be careful not to lead the child or put words into the child's mouth – ask questions sensitively
- Do not promise confidentiality.
- Fully document the conversation on a word by word basis immediately following the conversation while the memory is fresh.
- Fully record dates and times of the events and when the record was made and ensure that all notes are kept securely.
- Inform the child/ young person what you will do next.
- Refer to the Safeguarding Officer or Deputy.
- Decide if it is safe for a child to return home to a potentially abusive situation. It might be necessary to immediately refer the matter to social services and/or the police to ensure the child's safety.

Support - Dealing with a disclosure from a child, and safeguarding issues can be stressful. The member of staff/volunteer should, therefore, consider seeking support for him/herself and discuss this with the Safeguarding Officer.

8 CONFIDENTIALITY

Safeguarding children raises issues of confidentiality that must be clearly understood by all staff/volunteers in schools, but we must remember that Safeguarding overrides confidentiality and the Data Protection Act.

- All staff have a responsibility to share relevant information about the protection of children with other professionals, particularly the investigative agencies (Children's Social Services and the Police).
- If a child confides in a member of staff/volunteer and requests that the information is kept secret, it is important that the member of staff/volunteer tell the child in a manner appropriate to the child's age/stage of development that they cannot promise complete confidentiality – instead they must explain that they may need to pass information to other professionals to help keep the child or other children safe.
- Staff/volunteers who receive information about children and their families in the course of their work should share that information only within appropriate professional contexts.

9 COMMUNICATION WITH PARENTS

PQA will:

Undertake appropriate discussion with parents prior to involvement of another agency unless to do so would place the child at further risk of harm i.e. sexual abuse, Forced Marriage, HBV or physical abuse.

Ensure that parents understand the responsibilities placed on PQA and staff for safeguarding children.

10 RECORD KEEPING

When a child has made a disclosure, the member of staff/volunteer should:

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

All records need to be given to the Principal and the Child Protection Officer promptly. No copies should be retained by the member of staff or volunteer.

11 ALLEGATIONS INVOLVING SCHOOL STAFF / VOLUNTEERS

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

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

This applies to any child the member of staff/volunteer has contact within their personal, professional or community life.

The person to whom an allegation is first reported should take the matter seriously and keep an open mind. S/he should not investigate or ask leading questions if seeking clarification; it is important not to make assumptions. Confidentiality should not be promised and the person should be advised that the concern will be shared on a 'need to know' basis only.

Actions to be taken include making an immediate written record of the allegation using the informant's words - including time, date and place where the alleged incident took place, brief details of what happened, what was said and who was present. This record should be signed, dated and immediately passed on to the Safeguarding Officer.

If the concerns are about the Safeguarding Officer, then Fergus Sturrock should be contacted.

The recipient of an allegation must not unilaterally determine its validity, and failure to report it in accordance with procedures is a potential disciplinary matter.

The Principal will not investigate the allegation itself, or take written or detailed statements, but will refer the matter immediately to the Safeguarding Officer, who will assess whether it is necessary to refer the concern to the Local Authority Designated Officer. If the allegation meets any of the three criteria set out at the start of this section, contact should always be made with the Local Authority Designated Officer without delay.

If it is decided that the allegation meets the threshold for safeguarding, this will take place in accordance with Local Safeguarding Partnership Inter-agency Child Protection and Safeguarding Children Procedures.

If it is decided that the allegation does not meet the threshold for safeguarding, it will be handed back to PQA for consideration via PQA's internal procedures.

The Safeguarding Officer should, as soon as possible, following briefing and directions from the Local Authority Designated Officer inform the subject of the allegation.

APPENDIX 1 - INDICATORS OF HARM

PHYSICAL ABBUSE

May involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

Indicators in the child

Bruising

It is often possible to differentiate between accidental and inflicted bruises. The following must be considered as non-accidental unless there is evidence, or an adequate explanation provided:

- Bruising in or around the mouth
- Two simultaneous bruised eyes, without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive)
- Repeated or multiple bruising on the head or on sites unlikely to be injured accidentally, for example the back, mouth, cheek, ear, stomach, chest, under the arm, neck, genital and rectal areas
- Variation in colour possibly indicating injuries caused at different times
- The outline of an object used e.g. belt marks, hand prints or a hair brush
- Linear bruising at any site, particularly on the buttocks, back or face
- Bruising or tears around, or behind, the earlobe/s indicating injury by pulling or twisting
- Bruising around the face
- Grasp marks to the upper arms, forearms or leg
- Petechae haemorrhages (pinpoint blood spots under the skin.) Commonly associated with slapping, smothering/suffocation, strangling and squeezing

Fractures

Fractures may cause pain, swelling and discoloration over a bone or joint. It is unlikely that a child will have had a fracture without the carers being aware of the child's distress.

If the child is not using a limb, has pain on movement and/or swelling of the limb, there may be a fracture.

There are grounds for concern if:

- The history provided is vague, non-existent or inconsistent
- There are associated old fractures
- Medical attention is sought after a period of delay when the fracture has caused symptoms such as swelling, pain or loss of movement

Rib fractures are only caused in major trauma such as in a road traffic accident, a severe shaking injury or a direct injury such as a kick.

Skull fractures are uncommon in ordinary falls, i.e. from three feet or less. The

injury is usually witnessed, the child will cry and if there is a fracture, there is likely to be swelling on the skull developing over 2 to 3 hours. All fractures of the skull should be taken seriously.

Mouth Injuries

Tears to the frenulum (tissue attaching upper lip to gum) often indicates force feeding of a baby or a child with a disability. There is often finger bruising to the cheeks and around the mouth. Rarely, there may also be grazing on the palate.

Poisoning

Ingestion of tablets or domestic poisoning in children under 5 is usually due to the carelessness of a parent or carer, but it may be self-harm even in young children.

Fabricated or Induced Illness

Professionals may be concerned at the possibility of a child suffering significant harm as a result of having illness fabricated or induced by their carer. Possible concerns are:

- Discrepancies between reported and observed medical conditions, such as the incidence of fits
- Attendance at various hospitals, in different geographical areas
- Development of feeding / eating disorders, as a result of unpleasant feeding interactions
- The child developing abnormal attitudes to their own health
- Non organic failure to thrive - a child does not put on weight and grow and there is no underlying medical cause
- Speech, language or motor developmental delays
- Dislike of close physical contact
- Attachment disorders
- Low self esteem
- Poor quality or no relationships with peers because social interactions are restricted
- Poor attendance at school and under-achievement

Bite Marks

Bite marks can leave clear impressions of the teeth when seen shortly after the injury has been inflicted. The shape then becomes a more defused ring bruise or oval or crescent shaped. Those over 3cm in diameter are more likely to have been caused by an adult or older child.

A medical/dental opinion, preferably within the first 24 hours, should be sought where there is any doubt over the origin of the bite.

Burns and Scalds

It can be difficult to distinguish between accidental and non-accidental burns and scalds. Scalds are the most common intentional burn injury recorded.

Any burn with a clear outline may be suspicious e.g. circular burns from cigarettes, linear burns from hot metal rods or electrical fire elements, burns of uniform depth over a large area, scalds that have a line indicating immersion or poured liquid.

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

The following points are also worth remembering:

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

Scars

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

Emotional/behavioural presentation

Refusal to discuss injuries

Admission of punishment which appears excessive

Fear of parents being contacted and fear of returning home

Withdrawal from physical contact

Arms and legs kept covered in hot weather

Fear of medical help Aggression towards others Frequently absent from school

An explanation which is inconsistent with an injury

Several different explanations provided for an injury

Indicators in the parent

- May have injuries themselves that suggest domestic violence
- Not seeking medical help/unexplained delay in seeking treatment
- Reluctant to give information or mention previous injuries
- Absent without good reason when their child is presented for treatment
- Disinterested or undisturbed by accident or injury
- Aggressive towards child or others
- Unauthorised attempts to administer medication
- Tries to draw the child into their own illness.
- Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault
- Parent/carer may be over involved in participating in medical tests, taking temperatures and measuring bodily fluids
- Observed to be intensely involved with their children, never taking a much-needed break nor allowing anyone else to undertake their child's car
- May appear unusually concerned about the results of investigations which may indicate physical illness in the child
- Wider parenting difficulties may (or may not) be associated with this form of abuse
- Parent/carer has convictions for violent crimes.

Indicators in the family/environment

- Marginalised or isolated by the community
- History of mental health, alcohol or drug misuse or domestic violence
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.

EMOTIONAL ABUSE

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.

It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate.

It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Indicators in the child

- Developmental delay
- Abnormal attachment between a child and parent/carer e.g. anxious, indiscriminate or no attachment
- Aggressive behaviour towards others
- Child scapegoated within the family
- Frozen watchfulness, particularly in pre-school children
- Low self-esteem and lack of confidence
- Withdrawn or seen as a 'loner' - difficulty relating to others
- Over-reaction to mistakes
- Fear of new situations
- Inappropriate emotional responses to painful situations Neurotic behaviour (e.g. rocking, hair twisting, thumb sucking) Self harm
- Fear of parents being contacted Extremes of passivity or aggression Drug/solvent abuse
- Chronic running away Compulsive stealing Low self-esteem
- Air of detachment – 'don't care' attitude
- Social isolation – does not join in and has few friends
- Depression, withdrawal
- Behavioural problems e.g. aggression, attention seeking, hyperactivity, poor attention
- Low self-esteem, lack of confidence, fearful, distressed, anxious
- Poor peer relationships including withdrawn or isolated behaviour

Indicators in the parent

- Domestic abuse, adult mental health problems and parental substance misuse may be features in families where children are exposed to abuse.
- Abnormal attachment to child e.g. overly anxious or disinterest in the child
- Scapegoats one child in the family
- Imposes inappropriate expectations on the child e.g. prevents the child's developmental exploration or learning, or normal social interaction through overprotection
- Wider parenting difficulties, may (or may not) be associated with this form of abuse
- Indicators of in the family/environment Lack of support from family or social network. Marginalised or isolated by the community.
- History of mental health, alcohol or drug misuse or domestic violence.
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.

NEGLECT

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.

Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care- givers); or
- ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Indicators in the child

- Physical presentation
- Failure to thrive or, in older children, short stature
- Underweight
- Frequent hunger
- Dirty, unkempt condition
- Inadequately clothed, clothing in a poor state of repair
- Red/purple mottled skin, particularly on the hands and feet, seen in the winter due to cold
- Swollen limbs with sores that are slow to heal, usually associated with cold injury
- Abnormal voracious appetite
- Dry, sparse hair
- Recurrent / untreated infections or skin conditions e.g. severe nappy rash, eczema or persistent head lice / scabies/ diarrhoea
- Unmanaged / untreated health / medical conditions including poor dental health
- Frequent accidents or injuries
- Development
- General delay, especially speech and language delay
- Inadequate social skills and poor socialization
- Emotional/behavioural presentation
- Attachment disorders
- Absence of normal social responsiveness Indiscriminate behaviour in relationships with adults Emotionally needy
- Compulsive stealing
- Constant tiredness
- Frequently absent or late at school
- Poor self esteem
- Destructive tendencies
- Thrives away from home environment Aggressive and impulsive behaviour Disturbed peer relationships
- Self-harming behaviour

Indicators in the parent

- Dirty, unkempt presentation Inadequately clothed
- Inadequate social skills and poor socialisation
- Abnormal attachment to the child .e.g. anxious
- Low self-esteem and lack of confidence
- Failure to meet the basic essential needs e.g. adequate food, clothes, warmth, hygiene
- Failure to meet the child's health and medical needs e.g. poor dental health; failure to attend or keep appointments with health visitor, GP or hospital; lack of GP registration; failure to seek or comply with appropriate medical treatment; failure to address parental substance misuse during pregnancy
- Child left with adults who are intoxicated or violent
- Child abandoned or left alone for excessive periods
- Wider parenting difficulties, may (or may not) be associated with this form of abuse

Indicators in the family/environment

- History of neglect in the family
- Family marginalised or isolated by the community.
- Family has history of mental health, alcohol or drug misuse or domestic violence.
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Family has a past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.
- Dangerous or hazardous home environment including failure to use home safety equipment; risk from animals
- Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements, inadequate ventilation (including passive smoking) and lack of adequate heating
- Lack of opportunities for child to play and learn

SEXUAL ABUSE

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening.

The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual

activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).

Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Indicators in the child

- Physical presentation
- Urinary infections, bleeding or soreness in the genital or anal areas
- Recurrent pain on passing urine or faeces
- Blood on underclothes Sexually transmitted infections Vaginal soreness or bleeding
- Pregnancy in a younger girl where the identity of the father is not disclosed and/or
- there is secrecy or vagueness about the identity of the father
- Physical symptoms such as injuries to the genital or anal area, bruising to buttocks, abdomen and thighs, sexually transmitted disease, presence of semen on vagina, anus, external genitalia or clothing
- Emotional/behavioural presentation
- Makes a disclosure.
- Demonstrates sexual knowledge or behaviour inappropriate to age/stage of development, or that is unusually explicit
- Inexplicable changes in behaviour, such as becoming aggressive or withdrawn
- Self-harm - eating disorders, self-mutilation and suicide attempts
- Poor self-image, self-harm, self-hatred
- Reluctant to undress for PE Running away from home
- Poor attention / concentration (world of their own)
- Sudden changes in school work habits, become truant Withdrawal, isolation or excessive worrying Inappropriate sexualised conduct
- Sexually exploited or indiscriminate choice of sexual partners Wetting or other regressive behaviours e.g. thumb sucking Draws sexually explicit pictures
- Depression

Indicators in the parents

- Comments made by the parent/carer about the child. Lack of sexual boundaries
- Wider parenting difficulties or vulnerabilities
- Grooming behaviour
- Parent is a sex offender

Indicators in the family/environment

- Marginalised or isolated by the community.
- History of mental health, alcohol or drug misuse or domestic violence.
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Past history of childhood abuse, self-harm, somatising disorder or false allegations
- of physical or sexual assault or a culture of physical chastisement. Family member is a sex offender.

CHILD SEXUAL EXPLOITATION

Child sexual exploitation is a form of child sexual abuse. It occurs here an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

Indicators in the child

- Persistently going missing from school or home and / or being found out-of area;
- Unexplained acquisition of money, clothes, or mobile phones;
- Excessive receipt of texts / phone calls;
- Relationships with controlling / older individuals or groups;
- Leaving home / care without explanation;
- Suspicion of physical assault / unexplained injuries;
- Carrying weapons;
- Significant decline in school results / performance;
- Gang association or isolation from peers or social networks;
- Self-harm or significant changes in emotional well-being

ONLINE ABUSE

Online Abuse' relates to four main areas of abuse to children:

- Abusive images of children (although these are not confined to the Internet);
- A child or young person being groomed for the purpose of Sexual Abuse;
- Exposure to pornographic images and other offensive material via the Internet; and
- The use of the internet, and in particular social media sites, to engage children in extremist ideologies.

The term digital (data carrying signals carrying electronic or optical pulses) and interactive (a message relates to other previous message/s and the relationship between them) technology covers a range of electronic tools. These are constantly being upgraded and their use has become more widespread through the Internet being available using text, photos and video. The internet can be accessed on mobile phones, laptops, computers, tablets, webcams, cameras and games consoles.

Social networking sites are often used by perpetrators as an easy way to access children and young people for sexual abuse. In addition, radical and extremist groups may use social networking to attract children and young people into rigid and narrow ideologies that are intolerant of diversity: this is similar to the grooming process and exploits the same vulnerabilities. The groups concerned include those linked to extreme Islamist, or Far Right/Neo Nazi ideologies, various paramilitary groups, extremist Animal Rights groups and others who justify political, religious, sexist or racist violence.

Online abuse may also include cyber-bullying or online bullying (see Bullying). This is when a child is tormented, threatened, harassed, humiliated, embarrassed or otherwise targeted by another child using the Internet and/or mobile devices. It is essentially behaviour between children,

although it is possible for one victim to be bullied by many perpetrators. In any case of severe bullying it may be appropriate to consider the behaviour as child abuse by another young person.

Sexting describes the use of technology to generate images or videos made by children under the age of 18 of other children; images that are of a sexual nature and are indecent. The content can vary, from text messages to images of partial nudity to sexual images or video. These images are then shared between young people and/or adults and with people they may not even know. Young people are not always aware that their actions are illegal and the increasing use of smart phones has made the practice much more common place.

E-Safety is the generic term that refers to raising awareness about how children, young people and adults can protect themselves when using digital technology and in the online environment, and provides examples of interventions that can reduce the level of risk for children and young people.

APPENDIX 2 - PREVENTING EXTREMISM AND RADICALISATION POLICY

Introduction:

The Counter-Terrorism and Security Act 2015 states that 'due regard to the need to prevent people from being drawn into terrorism'. This duty is known as the Prevent duty (2015)

PQA is committed to providing a safe and secure environment for children, where they can feel safe and are kept safe.

Safeguarding is recognised by PQA as being everyone's responsibility irrespective of the role they undertake.

The Preventing Extremism and Radicalisation Policy is one element that contributes to our Safeguarding Policy to promote the safety and welfare of all students and will be incorporated with this policy.

Definition:

The Government definition for Extremism: -

'Vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths, beliefs; and /or calls for the death of members of our armed forces, whether in this county or overseas'.

Practise:

- There is no pace for extremist views of any kind within PQA either from internal/external sources, external agencies or individuals.
- We recognise that extremism and exposure to extremist materials and influences can lead to poor outcomes for children therefore this will be dealt with as a safeguarding concern, following our policy.
- Any prejudice, discrimination or extremist views and including derogatory language displayed by students or staff will be challenged.
- Extremism may place a child at risk of harm therefore staff are required to report all incidents where they believe a child might be at risk to PQA's Safeguarding Officer without delay.
- We will aim to ensure that all our staff are trained and equipped to recognize extremism and are confident to challenge language and/or behaviour appropriately.

Ethos:

PQA will promote and encourage individual liberty, respect and tolerance for those with different beliefs and faiths and encourage individuality with understanding and tolerance.

Prevent Lead:

All staff have a contact name and number within PQA to contact for further advise in relation to extremism and/or safeguarding concerns.

The Prevent Lead is Mel Leicester-Evans.