Safeguarding and Child Protection Policy

Document Management	
Date Last Updated:	25th August 2021
Review Date:	24th August 2022
Version:	1.7
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Contents

THE CHERRYCROFT PRACTICE

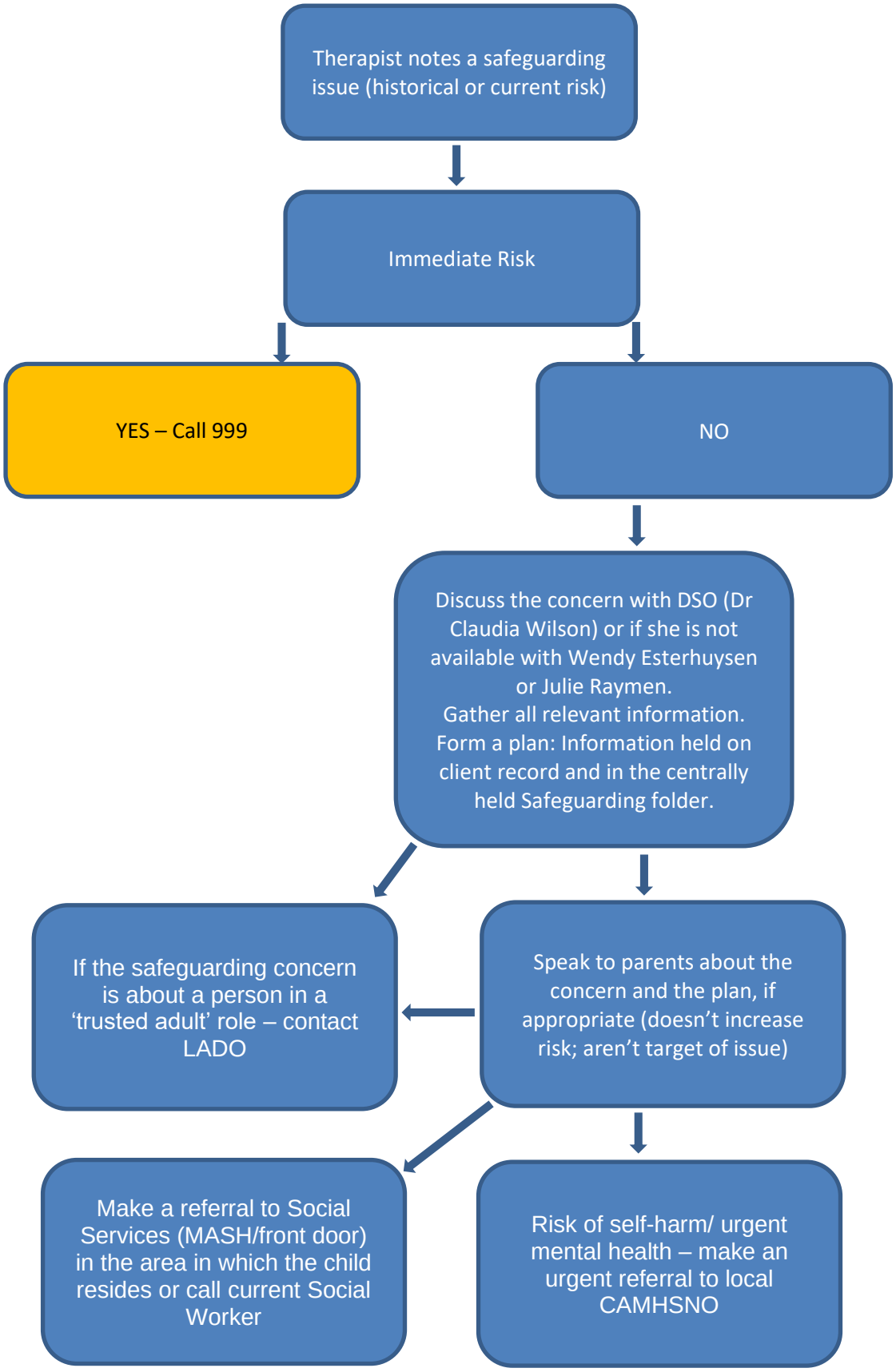
Document Version History

Document Name:		Safeguarding and Child Protection Policy		
Staff members consulted/part of the review:		Claudia Wilson Zane Wilson		
Author:		Claudia Wilson		
Version	**Date**	**Amendments made**	**By whom (name/job title)**	**Senior approval Claudia Wilson**
1.0	10.8.2018	Initial version	Claudia Wilson	
1.1	4.4.2019	Safer Recruitment Policy updated	Zane Wilson (Responsible Individual)	CW
1.2	30.7.2019	Safer Recruitment – new reference form created	CW	CW
1.3	30.8.2019	Added details of the Kingfisher unit which deal with child exploitation in Oxfordshire. Reviewed and expanded on types of Child Abuse and their indicators. Added a flow chart.	CW	CW
1.4	26.9.2019		CW	CW
1.5	20.07.2020	Deputy safeguarding lead. Reviewed and expanded on Child Protection and Safeguarding procedures. Reviewed and expanded on types of Child Abuse and their indicators.	MM	CW
1.6	24.8.2021	Sexual Offences Act 2003, FGM Act 2003, Children and Young Persons Act 2008, Children and Social Work Act 201, DfE Guidance Feb 2017 Child Sexual Exploitation, replacing the 2009 guidance 'Safeguarding children and young people from sexual exploitation' and DfE Guidance Feb 2017 Child Sexual Exploitation, replacing the 2009 guidance 'Safeguarding children and young people from sexual exploitation', added to legal framework. Added wording regarding the differentiation between fact & fiction in body of text page 7 & 8. Added out of hours no to OCC SC. Updated phone numbers.	WE	CW
1.7	24.08.2022	County lines and child criminal exploitation	MM & WE	CW

THE CHERRYCROFT PRACTICE

Safeguarding flow chart

Safeguarding Lead: Claudia Wilson (mobile 07931 374150)
Deputy Safeguarding Lead: Wendy Esterhuysen (07960 066883) & Julie Raymen (mobile: 07947 433054).



1. Introduction and Statement

The Cherrycroft Practice recognises its duty of care to safeguard children as detailed under the Children Acts' 1989 and 2004, Working Together to Safeguard Children 2018 Care Act 2000 and National Minimum Standards 2014 and ASA regulations 2005.

The Cherrycroft Practice is fully committed to safeguarding and protecting the welfare of all children and taking all reasonable steps to promote safe practice and protect children from harm, abuse and neglect.

The Cherrycroft Practice acknowledges its duty to act appropriately with regards to any allegations towards anyone working on its behalf, or towards any disclosures or suspicion of abuse.

The Cherrycroft Practice believes that:

- The welfare of all children and young people is paramount.
- All children, regardless of age, ability, gender, racial heritage, religious or spiritual beliefs, sexual orientation and /or identity, have the right to equal protection from harm or abuse.
- Some children are additionally vulnerable because of the impact of previous experiences, their level of dependency, communication needs or other issues.
- Working in partnership with children, their parents, carers, and other agencies is essential in promoting young people's welfare.
- Research shows that children and young people with learning disability have an increased vulnerability to abuse and so getting to know each child/young person and being sensitive to their communications is important.

2. Legal Framework

This policy has been developed in accordance with the principles established by the following legislation and guidance:

- Children Act 1989
- United Nations Convention on the Rights of the Child1991
- Care Standards Act 2000
- FGM Act 2003
- Sexual Offences Act 2003
- Children Act 2004
- The Adoption Support Agencies (England) and Adoption Agencies (Miscellaneous Amendments) Regulations 2005
- Children and Young Persons Act 2008
- Equality Act 2010
- Children and Families Act 2014
- Children and Social Work Act 2017
- Home Office Guidance of criminal exploitation of children and vulnerable adults: county lines, first published 2017.
- Special educational needs and disability (SEND) code of practice: 0 to 25 years.
- Working Together to Safeguard Children 2018
- What to do if you are worried a Child is being Abused 2018
- Keeping Children Safe in Education 2016
- DfE Guidance Feb 2017 Child Sexual Exploitation, replacing the 2009 guidance 'Safeguarding children and young people from sexual exploitation'.
- Oxfordshire Safeguarding Children Board and Berkshire Safeguarding Children Board guidelines.

This policy applies to all staff, including senior managers, paid staff, volunteers and sessional workers, agency staff, students or anyone in a position of trust.

A child is defined as a person under the age of 18 (The Children's Act 1989).

3. Organisational Policies and Procedures

This policy should be read alongside the following organisational policies and guidance:

- Safer recruitment
- Recording, storing, and sharing information
- Confidentiality and GDPR
- Code of conduct for staff and volunteers
- Health and safety
- Whistle blowing
- Training, supervision, and support.

4. Purpose of Policy

The purpose of this policy is to:

- Protect children and young people who receive services from The Cherrycroft Practice. This includes children of adults who use our services and vulnerable adults;
- Provide all those in a position of trust with the overarching principles that guide our approach to safeguarding and child protection.

To keep children safe The Cherrycroft Practice will:

- Provide a setting where children feel listened to, safe, secure, valued and respected
- Appoint a Designated Safeguarding Lead for children and ensure a clear line of accountability with regards to safeguarding concerns
- Ensure all those in a position of trust have been provided with up to date and relevant information, training, support and supervision to enable them to fulfil their role and responsibilities in relation to safeguarding and child protection
- Provide a clear procedure to follow when safeguarding and child protection concerns arise
- Ensure effective and appropriate communication between all individuals in a position of trust
- Build strong partnerships with other agencies to promote effective and appropriate multi- agency working, information sharing and good practice
- If an allegation is made against a member of staff, then the member of staff will either be suspended or be moved to a position where they do not have contact with families. Cherrycroft will co-operate with the Local Authority's Safeguarding Lead/LADO.

5. Roles and Responsibilities

All individuals in a position of trust must:

- Understand the different types of abuse and recognise the possible risks and Indicators. Summary is provided in Appendix B. Working Together to Safeguard Children 2018 is a comprehensive guide.
- Understand their responsibility to report any concerns that a child is being, or is at risk of being, abused or neglected. This includes reporting any concern they may have regarding another person's behaviour towards a child or children. Historical allegations of abuse must also be

reported unless it has already been dealt with

- If appropriate; liaise with other agencies, contribute to safeguarding assessments and attend child protection meetings / core groups /conferences.
- Record and store information legally, professionally, and securely in line with organisational policies and procedures.

Special attention is drawn to:

- All therapists are responsible for completing the Cherrycroft Risk Assessment form and keeping it up to date for each client. The Cherrycroft Risk Assessment form is available electronically and paper copies are kept in the admin office. All therapists are responsible for ensuring that an up-to-date paper copy is kept in client files in the locked filing cabinets. Any issues of risk and risky behaviour must be recorded in the notes and flagged. Before going on annual leave all therapists must let the Practice manager of any possible concerns or potential risk issues.
- All therapists are to undertake Safeguarding training every two years
- Undertake the required level of safeguarding training every two years for Designated Leads
- Understand the line of accountability for reporting safeguarding concerns and be fully aware of the organisation's safeguarding lead and their role within the organisation
- It is the Designated Safeguarding Officer to ensure that the central safeguarding record is kept according to the procedures.

- Designated Safeguarding Officer or Safeguarding Lead: Dr Claudia Wilson, mob: 07931374150.

- Deputy Safeguarding Lead: Wendy Esterhuysen, mob: 07960066883 or Julie Raymen, mobile: 07947 433054.

Procedure: Responding to a concern

We are obliged to report safeguarding or more specifically child protection concerns under section 47 of the Children's Act 1989. If you suspect, discover or if you are informed that a child or adult is suffering or likely to suffer abuse, harm, or neglect or if you are told that someone they know is suffering/has suffered or is likely to suffer abuse, harm or neglect, then:

- Accept what the person is saying and take it seriously and reassure them that they have done the right thing.
- Give the person the space to talk about their concern but do not probe or ask leading questions. The investigation is not your responsibility. Open questions like 'please can you tell me more...' are okay.
- Do not promise that you can keep any allegation a secret. Let the person know that you will have to discuss it with Claudia Wilson or in her absence Julie Raymen and that we will all follow the appropriate procedures.
- If you feel that the person is in immediate danger, then please take the appropriate action – seek Police or medical assistance as needed.
- If you receive a text or email that expresses details of abuse or possible abuse, then please respond to this as quickly as possible and within 24 hours.
- Fully record any allegation/disclosure as it is given, using the child or young person's own words and describe any concerning behaviours or injuries. Please ensure that there is a differentiation made between fact and opinion. This must be dated, timed, and signed by the therapist and the young person, as appropriate. All original notes must be retained for legal purposes. Paperwork must be completed as soon as possible, or within 24 hours. The formal recording of notes should not create a delay in reporting the safeguarding concern to Claudia Wilson or in her absence Julie Raymen.
- A copy of these notes must be placed on the child's electronic file and a copy must be sent to Claudia Wilson where it will be stored in a central file Safeguarding file as soon as possible, or within 24 hours.
- Discuss any safeguarding concerns with Claudia Wilson as the Designated Safeguarding Lead or if

absent with Julie Raymen or Wendy Esterhuysen as Deputy Safeguarding Leads immediately or within 24 hours if the concern relates to historical abuse or neglect and the child is safe (e.g., unknown historical concerns from birth family and the child is considered safe within their adoptive family).

- Together a plan will be formed. If it doesn't jeopardise the safety of the child, then please call the parent to let them know that we are concerned about a safeguarding issue and that we are obligated to report it and that we will try to be as supportive of the family as possible. If you feel that the child's safety is likely to be compromised, then we will need to move forward with reporting the safeguarding concern without the parents/family's awareness.
- The therapist with Wendy Esterhuysen or Julie Raymen present will call the MASH team that is local to where the child is living. Please see the phone numbers listed for the most common areas that our clients reside in. Verbal and telephone referrals must be followed up with a written referral (email or letter) within 24 hours. Children's Social Care should acknowledge the written referral within one working day and if they have not responded within 3 working days, then they should be contacted again.
- Clearly record the conversation around a referral; noting the date, time, and Social Worker the concern was reported to and clear and concise recording of the conversation, ensuring the difference between fact and opinion is stated within the conversation. These notes must be stored on the child's file and a copy must be sent to Claudia Wilson so that it can be stored centrally as part of the Child Protection/Safeguarding Chronological Record.
- During the referral, the person speaking to Social Care must establish or agree what the child/young person and parents will be told, by whom and when. This too must be noted on the child's file and a copy sent to the central Safeguarding file.
- The level of concern about risk must inform the speed of action. If for whatever reason the therapist is unable to contact the Designated Safeguarding Officer or Deputy, then it is important that the therapist makes the referral as soon as possible.
- Social Care are obliged to provide feedback about any decisions taken. If you and/or Claudia Wilson believes that the concerns are not being taken seriously enough, then this needs to be discussed and possible actions considered such as escalating to management in Social Care.
- You may be required to attend a Child Protection Conference or strategy meeting or other meeting as appropriate to which you are invited, and you will be expected to share information relating to the matters being investigated. You may ask that Wendy Esterhuysen or Julie Raymen attends such meetings with you.
- If a child or young person makes an allegation or disclosure about historical abuse or neglect, then the above procedure must be followed unless there is clear written evidence that the matter has already been dealt with.
- The Designated Safeguarding Officer will instigate the recording of a Child Protection/Safeguarding Chronological Record for each referral received.

Procedure: Acting on an allegation against anyone working with Cherrycroft or any other professional

- If you believe that there is a Child Protection issue directly relating to anyone working with Cherrycroft or a professional and any adult in a position of trust, then please discuss the issue immediately with the Designated Safeguarding Officer or in their absence the Deputy Safeguarding Officer.
- Fully record any allegation/disclosure as it is given, using the child or young person's own words and describe any concerning behaviours or injuries. This must be dated, timed and signed by the therapist and the young person, as appropriate. Please ensure that there is a clear distinction between fact and opinion. All original notes must be retained for legal purposes. Paperwork must be completed within 24 hours. The formal recording of notes should not create a delay in reporting the safeguarding concern to Claudia Wilson or in her absence Wendy Esterhuysen or Julie Raymen.
- The Designated Safeguarding officer/lead will refer the safeguarding issue to the LADO within the area that the child resides in and/or the Police within 24 hours. A list of contact details of the LADO is the various areas close to the Practice is noted in Appendix A. If the referral is completed verbally then notes must be fully recorded about the conversation around a referral; noting the date, time and Social Worker the concern was reported to and clear and concise recording of the conversation, including a differentiation between fact and opinion. All it must be agreed what will be communicated to the children

and parents. These notes must be stored on the child's file and a copy must be sent to Claudia Wilson (if not completed by her) or Zane Wilson so that it can be stored centrally as part of the Child Protection/Safeguarding Chronological Record.

- It is expected that LADO will respond to a referral within 24 hours with a decision as to whether the allegation meets their threshold criteria. If the threshold criteria are met, then a Child Protection Strategy meeting will be called with Social Care as the lead agency. The outcome of the Strategy meeting will fall into one of these five categories: Substantiated, Malicious, False, Unsubstantiated & Unfounded.
- All allegations even those that appear less serious must be followed up by someone independent of the organisation. All allegations must be considered by the LADO as they act for the LSCB agencies to monitor allegations and ensure that the actions taken are compliant.
- All documents relating to the allegation will be stored with restricted access in an allocated filing cabinet with keys held by either the DSO or Responsible Individual and electronically with restricted access. Information will be shared on a 'need to know' basis within Cherrycroft and on the same basis with professionals outside of the organisation.
- If the concerns relate to the Designated Safeguarding officer or the Responsible Individual then the following are possible points of contact: Children's Social Care, the Police, LADO, OFSTED or an officer in the NSPCC.
- Any disciplinary procedures within Cherrycroft or suspensions would be implemented in consultation with the LADO.
- If Cherrycroft removes a therapist from work because the person is deemed to pose a risk to children or the person leaves before being removed from the position, the organisation is obligated to make a referral to the Disclosure and Barring Service – it is an offence to not make a referral without good reason.

All individuals working in a position of trust at The Cherrycroft Practice will follow the Local Authority guidance in all cases of abuse, or suspected abuse. These can be found at

- Oxfordshire http://www.OSCB.org.uk
- Berkshire http://berks.proceduresonline.com/
- Hampshire https://www.hants.gov.uk/socialcareandhealth/childrenandfamilies/safeguardingchildren/childprotection
- Surrey http://www.surreycc.gov.uk/social-care-and-health/childrens-social-care/contact-childrens-services

The Management Committee is ultimately accountable for ensuring settings provided by The Cherrycroft Practice are safe, including the implementation of effective safeguarding procedures.

6. Safer Recruitment

The Safer Recruitment policy and procedures have been broken out into their own document, though they remain an integral part of the overall Safeguarding policy. Please refer to the Safer Recruitment documentation for details.

7. Notifiable Events

If a child is seriously injured or dies while attending a session at Cherrycroft then OFSTED must be informed under Government Guidance (https://www.gov.uk/guidance/report-a-serious-childcare-incident) and the RIDDOR processes will also need to be followed.

8. Monitoring and Review

The policy will be reviewed annually. Claudia Wilson is signed up to the update alerts service provided by some Local Authorities around any amendments to their safeguarding policies and procedures and will alert therapists as appropriate. All individuals in a position of trust should have access to this policy and

sign/indicate electronically in the *Breathe HR* system to the effect that they have read and understood its contents.

The Cherrycroft Practice will complete an annual self-assessment; taking into account of updates to the legislation. An annual audit of Risk Assessment tool will be undertaken to look at where it can be improved based on therapists' experiences, any support that is needed to do more effective risk assessments and to look at any trends in risk which can then also inform practice.

Appendix A - Child Protection and Safeguarding Procedures

Introduction

All professionals have a responsibility to report concerns to Children's social care under section 11 of the Children Act 2004, if they believe or suspect that the child;

- Has suffered significant harm;
- Is likely to suffer significant harm;
- Has a disability, developmental and welfare needs which are likely only to be met through provision of family support services (with agreement of the child's parent) under the Children Act1989;
- Is a Child in Need whose development would be likely to be impaired without provision of service?

When professionals make a referral to Children's social care, they should include any pre-existing assessments in respect of the child, if they have been completed. Any information they have about the child's developmental needs and the capacity of their parents and carers to meet these within the context of their wider family and environment should be provided as a part of the referral information. This should include any information that may inform contextual safeguarding concerns.

The referrer should always seek consent from parents they are referring unless to do so would put any child or young person at further risk. See Information Sharing Procedure, National Guidance on Information Sharing for further information on how and when to share safeguarding concerns.

The referrer will always have the opportunity to discuss their concerns with a practitioner in the first instance and should be requested to follow this up in writing.

What to do if you are concerned about a child

Supporting children

If/when a child reports they are suffering or have suffered significant harm through abuse or neglect, or have caused or are causing physical or sexual harm to others, the initial response from all professionals should be to listen carefully to what the child says and to observe the child's behaviour and circumstances to:

- Clarify the concerns;
- Offer re-assurance about how the child will be kept safe;
- Explain what action will be taken and within what time frame.

The child must not be pressed for information, led or cross-examined or given false assurances of absolute confidentiality, as this could prejudice police investigations, especially in cases of sexual abuse.

If the child can understand the significance and consequences of making a referral to children's social care, they should be asked for their views.

It should be explained to the child that whilst their view will be taken into account, the professional has a responsibility to take whatever action is required to ensure the child's safety and the safety of other children

Confidentiality

Children have a right to confidentiality under Article 8 of the European Convention on Human Rights. It's important to respect the wishes of a child or any person who doesn't consent to share confidential information.

If you're not given consent to share information, you may still lawfully go ahead if the child is experiencing, or is at risk of, significant harm.

Child protection concerns, disclosures from children or safeguarding allegations made against a person in a position of trust must not be discussed across the workforce as a whole. This information should be shared solely with Designated Safeguarding Leads, Children's Social Care and/or the Local Area Designated Officer (LADO) as appropriate.

Personal information which is shared by the child or young person on a 1:1 level, such as sexual orientation or gender identification, should not be disclosed to the workforce as a whole.

If staff and volunteers wish to discuss situations with colleagues to gain a wider perspective, this should be done on an anonymous basis with names and other identifying information relating to the child and their family remaining strictly confidential.

Seven golden rules for information sharing

1. Remember that the Data Protection Act 1998 and human rights law are not barriers to justified information sharing but provide a framework to ensure that personal information about living individuals is shared appropriately.

2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

4. Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.

5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up to date, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose. All records must be signed and dated.

Supporting those working with children

The Cherrycroft Practice recognises those in a position of trust emotionally “safe”. It is important that all staff supporting children are able to discuss safeguarding concerns with the Designated Safeguarding Lead’ and with their line manager in regular supervision. (Ref to training, supervision and support policy/s)

Reporting concerns

The referrer should provide information about their concerns and any information they may have gathered prior to referral. They will be asked for the following:

- Full names, dates of birth and gender of all child/ren in the household;
- Family address and (where relevant) school / nursery attended;
- Identity of those with parental responsibility and any other significant adults who may be involved in caring for the child such as grandparents;
- Names and date of birth of all household members, if available;
- Ethnicity, first language and religion of children and parents;
- Any special needs of children or parents;
- Any significant/important recent or historical events/incidents;
- Cause for concern including details of any allegations, their sources, timing and location;
- Child's current location and emotional and physical condition;
- Whether the child needs immediate protection;
- Details of alleged perpetrator, if relevant;
- Referrer's relationship and knowledge of child and parents;
- Known involvement of other agencies / professionals (e.g.GP);
- Information regarding parental knowledge of, and agreement to, the referral;
- The child's views and wishes, if known.

Other information may be relevant, and some information may not be available at the time of making the referral. However, the report should not be delayed, in order to collect information, if the delay may place the child at risk of significant harm.

Parents/carers must be informed about any referral unless to do so would place the child at an increased risk of harm. Where a professional decides not to seek parental consent before making a referral to Children's social care, the decision must be recorded in the child's file with reasons, dated and signed and this will be confirmed in the referral to Children's social care.

All referrals from professionals must be confirmed in writing, by the referrer, within 24 hours if requested by Children’s social care, otherwise all information will be documented on the referral record. The referrer should receive an acknowledgement within three working days of the outcome and if not received they should contact Children's social care.

To report a new concern

Immediate concerns about a child

The Multi-Agency Safeguarding Hub (MASH) is the front door to Children’s Social Care for all child protection and immediate safeguarding concerns. If there is an immediate safeguarding concern, for example:

- Allegations/concerns that the child has been sexually/physically abused.
- Concerns that the child is suffering from severe neglect or other severe health risks.
- Concern that a child is living in or will be returned to a situation that may place him/her at immediate risk.
- The child is frightened to return home.
- The child has been abandoned or parent is absent.

Area	Please note that Berkshire has a website that contacts all the procedure manuals for the all the Local Authorities in Berkshire http://berks.proceduresonline.com/ Thames Valley Police Tel: **0845 8505 505**	
Bracknell	MASH 8.30am to 5pm Monday to Friday	Tel: 0134 435 2005 https://www.bracknell-forest.gov.uk/health-and-social-care/keeping-adults-and-children-safe/protecting-children/multi-agency-safeguarding-hub-mash
	Out of hours - EDT	Tel: **01344 786 543** https://www.bracknell-forest.gov.uk/health-and-social-care/emergency-duty-service
Reading Brighter Futures for Children	Children's single point of access	https://brighterfuturesforchildren.org/concerned-about-a-child/ Tel: 0118 937 3641 (includes out of hours contact details) Website provides details of Threshold Guide plus a referral form.
	Out of hours- EDT	Tel: **01344 786 543**
RBWM Achieving for Children	Early Help and Safeguarding Referral and Assessment Team	01628 683 150 8.45am to 5,15pm Monday to Thursday; 8.45am to 4.45pm Fridays
	Out of Hours Duty Team	Tel: **01344 786 543** 5.15pm to 8.45am Monday to Thursday 4.45pm on Friday and all weekend
Wokingham	Children's Social Care (Duty Triage & Assessment Team)	Tel: 0118 908 8002 triage@wokingham.gcsx.gov.uk or triage@wokingham.gov.uk
	Out of hours -EDT	Tel: 01344 786 543
Slough Children First	Children's Services	Tel: 01753 690 450 http://berks.proceduresonline.com/slough/p_referrals.html#local_info https://www.sloughchildrenfirst.co.uk/first-contact/#:~:text=sloughchildren.referrals%40sloughchildrenfirst.co.uk.
	Out of hours social care issues, including child protection	Tel: **01344 786 543**
West Berkshire	Children and Families Social Care Services	Tel: 01635 503 090 child@westberks.gov.uk
	Out of hours- EDT	Tel: **0163 542 161**
Hampshire	MASH	Tel: 0300 555 1384 during office hours 8.30am to 5pm Monday to Thursday, 8.30am to 4.30pm on Friday https://www.hants.gov.uk/socialcareandhealth/childrenandfamilies/safeguardingchildren/childprotection/mash
	Out of hours - EDT	Tel: **0300 555 1373**

Surrey	MASH	Tel: 0300 470 9100 csmash@surreycc.gov.uk csmash@surreycc.gcsx.gov.uk https://www.surreycc.gov.uk/social-care-and-health/childrens-social-care/contact-childrens-services
	Out of hours – EDT	Tel: **01483 517898**
Buckinghamshire		Tel: 01296 383 962 https://www.buckscc.gov.uk/services/care-for-children-and-families/child-protection-and-safeguarding/
	Out of Hours	Tel: **0800 999 7677**
Oxfordshire	MASH	Tel: 0333 014 3325 or 0345 050 7666 (The latter number will take you through to Customer Services who will ask a series of questions and triage into MASH where safeguarding concerns are raised) Office hours (8.30am – 5pm, Monday to Thursday, 8.30am – 4pm, Friday): mash-childrens@oxfordshire.gcsx.gov.uk MASH no for open cases Tel: 0345 050 7666 **If you have a concern about a child/family but it is not an immediate safeguarding concern,** you should refer to the Threshold of Needs matrix which can be found at, http://www.oscb.org.uk/wp-content/uploads/Oxfordshire-Threshold-of-Needs_Final.pdf This tool is designed to support professionals to make decisions as to whether contact should be made with Children's Social Care. If after consulting the Threshold of Need, you still have concerns that do not require an immediate safeguarding response, you should contact the Locality and Community Support Service (LCSS) and request a 'no names' consultation (meaning you don't give the child's name). You can then discuss the situation with them, and they will advise you on what to do next. If a referral needs to be made, they will advise you of this. • LCSS Central Tel: 0345 2412705 • LCSS North (including Banbury, Witney, Bicester, Carterton, and Woodstock) Tel: 0345 241 2703 • LCSS South (including Abingdon, Farringdon, Wantage, Thame, Didcot and Henley) Tel:0345 2412608.
	Out of Hours- EDT	**0800 833 408**

Other useful organisations that can provide advice:

ChildLine	Tel: 0800 1111 www.childline.org.uk
NSPCC (National Society for the Prevention of Cruelty to Children)	24 Hour Helpline Tel: 0808 800 5000 5000 FREE https://www.nspcc.org.uk/keeping-children-safe/reporting-abuse/report/

Surrey Children's Services

Local Area Contact details

North East Tel: 0300 123 1610.

The north east area covers the following three boroughs:

- Elmbridge (Esher, Walton on Thames and Weybridge)
- Epsom and Ewell (Epsom, Ewell and part of both Stoneleigh and Worcester Park)
- Spelthorne (Ashford, Laleham, Shepperton, Staines-upon-Thames, Stanwell and Sunbury-on-Thames).

North West Tel: 0300 123 1630

The north west area covers the following three district and boroughs:

- Runnymede (Addlestone)
- Surrey Heath (Camberley)
- Woking (Woking).

South East Tel: 0300 123 1620

The South East area covers the following three district and boroughs:

- Tandridge (Caterham and Oxted)
- Reigate and Banstead (Redhill, Horley, Reigate and Banstead)
- Mole Valley (Dorking and Leatherhead).

South West Tel: 0300 123 1640

The South West area covers the following two boroughs:

- Guildford (Guildford)
- Waverley (Cranleigh, Farnham and Hazlemere).

Referrals on open cases

If you do not have the name and contact details for the relevant Social Worker, contact MASH/Children's Social Care on the telephone numbers provided for each area above.

Allegations against others working with children

All allegations of abuse by those who work with children must be taken seriously, whether they are in a paid or unpaid capacity. This procedure should be applied when there is an allegation or concern that a person who works with children, has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

To report an allegation or concern about a person in a position of trust, please contact the LADO

Bracknell LADO	LADO@bracknell-forest.gov.uk.	01344 351572/ - 01344 352 005
RBWM LADO	lado@rbwm.gcsx.gov.uk	01628 683 202
Wokingham LADO	LADO@wokingham.gov.uk	0118 974 6141
Reading LADO	LADO@reading.gov.uk	0118 937 2684
West Berkshire LADO		01635 503090
Slough LADO	mailto:LADO@slough.gcsx.gov.uk https://thelink.slough.gov.uk/safeguarding	01753 474 053 / 0788 5828 387
Surrey LADO	LADO@surreycc.gov.uk	0300 1231650
Hampshire LADO	Child.protection@hants.gov.uk	01962 876364
Buckinghamshire LADO	http://www.bucks-lscb.org.uk/parents-carers/allegations-against-staff-or-volunteers-lado/	
Oxfordshire LADO	LADO.safeguardingchildren@oxfordshire.gov.uk	01865 810603

Whistleblowing

We recognise that children cannot be expected to raise concerns in an environment where those in a position of trust fail to do so. All those in a position of trust should be aware of their duty to raise concerns about dangerous or illegal activity, or any wrongdoing within their organisation. (Please read the Whistleblowing Policy in conjunction with this one).

Appendix B

Definitions and Indicators of Abuse

The table below outlines the main categories of abuse as defined by the Department of Health 'Working Together to Safeguard Children' document 2018. (Full definitions can be found in this document). All staff should be aware that the possible indicators are not definitive and that some children may present these behaviours for reasons other than abuse.

Type of Abuse	Possible Indicators
Neglect Neglect is defined in Working Together to Safeguard Children as "the persistent failure to meet a child's basic physical, emotional 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. When the child is born, neglect may involve the parents or carers 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 caregivers); or • Ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs. Neglect is characterised by the absence of a relationship of care between the parent/carer and the child and the failure of the parent/carer to prioritise the needs of their child. It can occur at any stage of childhood, including the teenage years". Neglect can be defined from the perspective of a child's right not to be subject to inhuman or degrading treatment, for example in the European Convention on Human Rights, Article 3 and the United Nations Convention on the Rights of the Child (UNCRC), Article 19.	Signs that may indicate a child is living in a neglectful situation: • Excessive hunger • Poor personal hygiene • Frequent tiredness • Inadequate clothing • Frequent lateness or non-attendance at school • Untreated medical problems • Not brought • Poor relationships with peers • Compulsive stealing and scavenging • Rocking, hair twisting and thumb sucking • Running away • Loss of weight or being constantly underweight (the same applies to weight gain, or being excessively overweight • Low self esteem • Poor dental hygiene.

Teenage Neglect Older children can be just as vulnerable to neglect as younger children. The impact of neglect may be less obvious in older children whose behaviours, such as self-harm or offending behaviour, may be what bring these children to the attention of professionals. The impact of neglect on older children can be significant and, in some cases, life-threatening. Neglect can lead to problems in adolescence and adulthood including: • Poor mental and physical health; • Difficulties with interpersonal relationships; • Low educational attainment and/or poor school attendance; • Offending behaviour; • Substance misuse; • A high propensity for risk-taking behaviour; • Increase the possibility of experiencing exploitation; • Suicide. Older children who suffer neglect may have been neglected for many years and can carry the legacy and impact of neglect at a younger age with them into adolescence. This means they are often not well equipped to cope with the many challenges that older childhood brings and may not get the support from parents to manage this transition.	The signs of neglect of older children may be more difficult to identify than signs of neglect in younger children, and older children may present with different risks. For example, older children may want to spend more time away from a neglectful home, and given their experience of neglect, they may be more vulnerable to risks such as going missing, offending behaviour or exploitation.
Physical Abuse May involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces illness in a child.	Signs that may indicate physical abuse: • Physical signs that do not tally with the given account of occurrence, • Conflicting or unrealistic explanations of causer • Repeated injuries • Delay in reporting or seeking medical advice.

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. Sexual abuse can take place online, and technology can be used to facilitate offline abuse. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children. Many children and young people are groomed into sexually exploitative relationships. Often young people are bullied, coerced and threatened into sexual activities by peers or gang members, and this is then used against them as a form of extortion and to keep them compliant.	Signs that may indicate sexual abuse: • Unexplained money or gifts; • Going missing (for short or long periods), or during the course of the school day; • Being distressed or withdrawn on return; • Disengaging from existing social networks; • Secrecy around new associations; • Additional mobile phones or concerning use of technology; • Sexual health problems/ unplanned pregnancies; • Disclosure of rape/sexual assault (and reluctance to report); • Changes in temperament/emotional wellbeing; • Drug or alcohol misuse; • Involvement in criminal activity; • Secretive behaviour; • Unexplained physical injuries. It is also important to recognise there may be. **no signs**. Signs that may indicate grooming: • Giving presents – especially during the grooming phase; • Offering food treats; • Giving rewards such as mobile phone top-ups / credit; • Giving the child or young person attention; • Offering false promises of love and/or affection; • Offering false promises of opportunities – e.g., modelling, photography, acting; • Supplying alcohol; • Drugs – either supplying drugs to facilitate exploitation, and/or young person being sexually exploited as a means of paying off drug debt; • Constructing situations whereby a young person must pay off debt; • Mental manipulation; • Blackmail; • Fear; • Physical violence.

Emotional Abuse 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 a child 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 a 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 cyber bullying), 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.	Signs that may indicate emotional abuse: • Lack of self-confidence/esteem • Sudden speech disorders • Self-harming (including eating disorders) • Drug, alcohol, solvent abuse • Lack of empathy (including cruelty to animals) • Concerning interactions between parent/carer and the child (e.g., excessive criticism of the child or a lack of boundaries).

Child Sexual Exploitation (CSE) Child sexual exploitation is a form of child sexual abuse. It occurs where 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.	Signs that may indicate CSE: • Going missing from school/home/care placement • Associating with older people/adults • Isolation from family/friends/peer group • Physical symptoms including bruising/STI's • Substance misuse • Mental health • Unexplained possessions, goods and/or money The indicators can be spotted when speaking to the young person themselves or family/friends. If a child or young person has made a disclosure regarding sexual exploitation, or if you think a child may be at risk of being sexually exploited, please **contact the Kingfisher Team on 01865 309196. Out of hours calls will divert to Thames Valley Police Referral Centre.**

Other type of abuse you should be aware of

Child Exploitation

Child exploitation describes how gangs from large urban areas supply drugs to suburban and rural locations, using vulnerable children and young people to courier drugs and money.

Typically, gangs use mobile phone lines to facilitate drug orders and supply to users. They also use local property as a base; these often belong to a vulnerable adult and are obtained through force or coercion (this exploitation is sometimes referred to as 'cuckooing').

It also finds that the age of those involved is getting younger, with children as young as 12 being targeted. Gangs 'recruit' through deception, intimidation, violence, debt bondage and/or grooming into drug use and/or child sexual exploitation.

While there has been an increased awareness of the use of children and young people in county line markets, more needs to be done as it cuts across a number of issues such as drug dealing, violence, gangs, child sexual exploitation, safeguarding, modern slavery and missing persons.

Signs that may indicate drug/criminal exploitation are similar to CSE, as follows:

- Going missing from school/home/care placement
- Associating with older people/adults
- Isolation from family/friends/peer group
- Physical symptoms including bruising
- Substance misuse
- Mental health
- Unexplained possessions, goods and/or money.

Domestic Abuse

The definition of domestic abuse now includes young people aged 16 - 17 and aims to increase awareness that young people in this age group do experience domestic abuse.

"*Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:*

- *Psychological;*
- *Physical;*
- *Sexual;*
- *Financial;*
- *Emotional.*

Controlling behaviour is a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition includes 'honour' based abuse, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

While the cross-government definition above applies to those aged 16 or above, 'Adolescent to parent violence and abuse' (APVA) can involve children under 16 as well as over 16. See: Information guide: adolescent to parent violence and abuse (APVA) Home Office.

Where there is domestic abuse, the wellbeing of the children in the household must be promoted and all assessments must consider the need to safeguard the children, including unborn child/ren.

For more details of the national plans to tackle domestic abuse - see: Ending Violence against Women and Girls Strategy 2016 – 2020, March 2016 (revised 2019). This is intended to set out a life course approach to ensure that all victims – and their families - have access to the right support at the right time to help them live free from violence and abuse.

Forced marriage

A forced marriage (FM) is a marriage conducted without the valid consent of one or both parties and where duress is a factor. Forced marriage is now a specific offence under s121 of the Anti- Social Behaviour, Crime and Policing Act 2014 that came into force on 16 June 2014.

There is a clear difference between a forced marriage and an arranged marriage. In arranged marriages, the families of both spouses take a leading role in arranging the marriage, but the couple have the free will and choice to accept or decline the arrangement.

In forced marriages, one or both people do not (or in cases of people with learning disabilities or reduced capacity, cannot) consent to the marriage as they are pressurised, or abuse is used, to force them to do so. It is recognised in the UK as a form of domestic or child abuse and a serious abuse of human rights. The pressure put on people to marry against their will may be physical – for example, threats, physical violence or sexual violence; emotional and psychological – for example, making someone feel like they are bringing 'shame' on their family; financial abuse, for example taking someone's wages, may also be a factor.

Forced marriage involving anyone under the age of 18 constitutes a form of child abuse. A child who is forced into marriage is likely to suffer Significant Harm through physical, sexual or emotional abuse. Forced marriage can have a negative impact on a child's health and development and can also result in sexual violence including rape. If a child is forced to marry, he or she may be taken abroad for an extended period of time which could amount to child abduction. In addition, a child in such a situation would be absent from school resulting in the loss of educational opportunities, and possibly also future employment opportunities. Even if the child is not taken abroad, they are likely to be taken out of school so as to ensure that they do not talk about their situation with their peers.

Modern Slavery and Human Trafficking

Modern slavery can take many forms including the trafficking or people, forced labour, servitude and slavery. Victims can include adults and children and come from all walks of life and backgrounds. A quarter of all victims are children.

The Modern Slavery Act 2015 places a duty on specified public authorities to report details of suspected cases of modern slavery to the National Crime Agency.

Indicators of Modern Slavery can include:

- Lack of access to legal documents (e.g. passports)
- Appearance (malnourished, unkempt, etc.)
- Untreated or unexplained injuries
- Attitude (withdrawn, frightened, unable to speak for themselves)
- Indebtedness or in a situation of dependence
- Frequent changes of location or restrictions on movement

Female Genital Mutilation

Female genital mutilation (FGM), sometimes referred to as female circumcision, refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK.

There are no health benefits to FGM, it is carried out for cultural and social reasons within families and communities. The procedure is traditionally carried out by an older woman with no medical training. Anaesthetics and antiseptic treatment are not generally used, and the practice is usually carried out using basic tools such as knives, scissors, scalpels, pieces of glass and razor blades.

The Oxford Rose Clinic is a specialised clinic run at the John Radcliffe Hospital to address the health and safeguarding issues associated with FGM. Women should be referred to this clinic by emailing oxfordrose.clinic@nhs.net or calling 01865 222969.

Healthcare professionals have a duty to safeguard any children who may be at risk of FGM. Information about how to identify children at risk of FGM, including a screening tool and pathways are available on the Oxfordshire Safeguarding Children Board website.

Self-Harm

Deliberate self-harm is intentional self-poisoning or injury, irrespective of the apparent purpose of the act, (www.nice.org.uk). Self-harm is an expression of personal distress, not an illness.

Self-harm can involve:

- Cutting, burning, biting
- Head banging and hitting
- Picking and scratching
- Substance misuse
- Taking personal risk
- Self-neglect

- Pulling out hair
- Overdosing and self-poisoning
- Disordered eating

Indicators of self-harm may include:

- Changing in eating/sleeping habits
- Changes in activity and mood
- Increased isolation from friends and family
- Talking about self-harming or suicide
- Expressing feelings of failure, uselessness, or loss of hope
- Lowering of academic grades
- Abusing drugs or alcohol
- Becoming socially withdrawn
- Giving away possessions

Bullying

Bullying is defined as 'behaviour by an individual or group, usually repeated over time, which intentionally hurts another individual or group either physically or emotionally' (DfE definition).
The Anti-Bullying Alliance (ABA) and its members have a shared definition of bullying based on research from across the world over the last 30 years. ABA defines bullying as: "the repetitive, intentional hurting of one person or group by another person or group, where the relationship involves an imbalance of power."

Repeated bullying usually has a significant emotional component, where the anticipation and fear of being bullied seriously affects the behaviour of the victim.

It can be inflicted on a child by another child or an adult. Bullying can take many forms (for instance, face-to-face or online bullying via text messages or the internet – cyber bullying), and is often motivated by prejudice against particular groups, for example on grounds of race, religion, gender, sexual orientation, or can be because a child is adopted or has caring responsibilities. It might be motivated by actual differences between children, or perceived differences.

Bullying can be:

- Physical - for example, hitting, kicking, shoving, theft;
- Verbal - for example, threats, name calling, racist or homophobic remarks;
- Emotional - for example, isolating an individual from activities/games and the social acceptance of their peer group;
- Cyber-bullying/online bullying is defined as 'the use of Information Communications Technology (ICT), particularly mobile phones and the internet, deliberately to upset someone else' (DfE definition). It is another form of bullying which can happen at all times of the day, with a potentially bigger audience.
- Up skirting, which involves taking a picture under a person's clothing without them knowing, with the intention of viewing their genitals or buttocks to obtain sexual gratification, or cause the victim humiliation, distress or alarm; is a specific example of abusive behaviour which has been linked to online bullying and grooming. Up skirting is a criminal offence and should be reported to the Police.

Bullying often starts with apparently trivial events such as teasing and name calling which nevertheless rely on an abuse of power. Such abuses of power, if left unchallenged, can lead to more serious forms of abuse, such as domestic violence and abuse, racial attacks, sexual offences and self-harm or suicide.

Bullying is a type of behaviour which needs to be defined by the impact on the victim rather than the intention of the perpetrator.

Persistent bullying can result in depression, low self-esteem, shyness, poor academic achievement, isolation, threatened or attempted suicide.

Indicators a child is being bullied can be:

- Being frightened of walking to and from school and changing their usual routine
- Feeling ill in the morning
- Starting to truant

- Starting to perform poorly academically
- Coming home with cuts and bruises
- Torn clothes
- Asking for stolen possessions to be replaced
- Losing dinner money or starting to steal money (to pay the bully)
- Falling out with previously good friends
- Being moody and bad tempered
- Wanting to avoid leaving their home
- Aggression with younger brothers and sisters
- Attempting or threatening suicide
- Sleep problems – e.g., crying themselves to sleep, having nightmares
- Anxiety
- Becoming quiet and withdrawn.

Peer on Peer Abuse

Peer-on-peer abuse is any form of physical, sexual, emotional, and financial abuse, and coercive control, exercised between children and within children's relationships (both intimate and non-intimate).

Peer-on-peer abuse can take various forms, including serious bullying (including cyber-bullying), relationship abuse, domestic violence, child sexual exploitation, youth and serious youth violence, harmful sexual behaviour, and/or gender-based violence.

Prevent – Extremism

The Counterterrorism and Security Act 2015 places a safeguarding duty on settings to have “due regard to the need to prevent people from being drawn into terrorism”.

Settings subject to the Prevent Duty will be expected to demonstrate activity in the following areas:

- Assessing the risk of children being drawn into terrorism
- Demonstrate that they are protecting children and young people from being drawn into terrorism by having robust safeguarding policies.
- Ensure that their safeguarding arrangements take into account the policies and procedures of the Local Safeguarding Children Board.
- Make sure that staff have training that gives them the knowledge and confidence to identify children at risk of being drawn into terrorism, and to challenge extremist ideas which can be used to legitimise terrorism.
- Ensure children are safe from terrorist and extremist material when accessing the internet in the setting.

Preventing vulnerable adults and children from being drawn into extremism is a safeguarding concern. It is essential that frontline staff can spot the signs and make a safeguarding referral.

Indicators may include:

- Withdrawing from usual activities
- Accessing extremist literature/websites
- Expressing ‘us and them ’thinking
- Expressing feelings of anger, grievance, or injustice

To report concerns about child radicalisation:

- Make safe – If emergency services are required – call 999. Take reasonable steps to ensure that there is no immediate danger.

- Refer concern identified by member of the public or professional.
- Call MASH (see contact details above)

Faith-Related Harmful Practice

This policy aims to address certain kinds of child abuse linked to faith or belief. this includes: belief in concepts of witchcraft and spirit possession, demons or the devil acting through children or leading them astray (traditionally seen in some Christian beliefs), the evil eye or djinns (traditionally known in some Islamic faith contexts) and dakini (in the Hindu context); ritual or muti murders where the killing of children is believed to bring supernatural benefits or the use of their body parts is believed to produce potent magical remedies; and use of belief in magic or witchcraft to create fear in children to make them more compliant when they are being trafficked for domestic slavery or sexual exploitation. This is not an exhaustive list and there will be other examples where children have been harmed when adults think that their actions have brought bad fortune, such as telephoning a wrong number which is believed by some to allow malevolent spirits to enter the home. This policy does not include child abuse within culture or faith contexts in general. So, it does not seek to address female genital mutilation, forced marriage, excessive physical punishment or abuse relating to gender, sexuality, ethnicity, nationality, disability, or other differences recognised within social or cultural beliefs.

The term 'belief in spirit possession' is the belief that an evil force has entered a child and is controlling him or her. Sometimes the term 'witch' is used and is the belief that a child is able to use an evil force to harm others. There is also a range of other language that is connected to such abuse. This includes black magic, kindoki, ndoki, the evil eye, djinns, voodoo, obeah, demons, and child sorcerers. In all these cases, genuine beliefs can be held by families, carers, religious leaders, congregations, and the children themselves that evil forces are at work. Families and children can be deeply worried by the evil that they believe is threatening them, and abuse often occurs when an attempt is made to 'exorcise', or 'deliver' the child. Exorcism is the attempt to expel evil spirits from a child. (Safeguarding Children from Abuse Linked to a Belief in Spirit Possession 2007)

The belief in 'possession' or 'witchcraft' is widespread. It is not confined to particular countries, cultures, or religions, nor is it confined to new immigrant communities in this country.

Any concerns about a child which arise in this context must be taken seriously.

Common factors that put a child at risk of harm can include:

- Belief in evil spirits: this is commonly accompanied by a belief that the child could 'infect' others with such 'evil'. The explanation for how a child becomes possessed varies widely, but includes through food that they have been given or through spirits that have flown around them;
- Scapegoating because of a difference: it may be that the child is being looked after by adults who are not their parents (i.e., privately fostered), and who do not have the same affection for the child as their own children;
- Rationalising misfortune by attributing it to spiritual forces and when a carer views a child as being 'different' because of disobedience, rebelliousness, over-independence, bedwetting, nightmares, illness or because they have a perceived or physical abnormality or a disability;
- Disabilities involved in documented cases included learning disabilities, mental ill health, epilepsy, autism, a stammer, and deafness;
- Changes and / or complexity in family structure or dynamics: there is research evidence (see Stobart, Child Abuse linked to Accusations of Spirit Possession [DfES 2006]) that children become more vulnerable to accusations of spirit possession following a change in family structure (e.g., a parent or carer having a new partner or transient or several partners). The family structure also tended to be complex so that exact relationships to the child were not immediately apparent. This may mean the child is living with extended family or in a private fostering arrangement (see **Children Living Away from Home Procedure, Private Fostering**). In some cases, this may even take on a form of servitude;

- Change of family circumstances for the worse: a spiritual explanation is sought in order to rationalise misfortune and the child is identified as the source of the problem because they have become possessed by evil spirits. Research evidence is that the family's disillusionment very often had its roots in negative experiences of migration:
    - In the vast majority of identified cases in the UK to date, the families were first or second generation migrants suffering from isolation from extended family, a sense of not belonging or feeling threatened or misunderstood. These families can also have significantly unfulfilled expectations of quality of life in the UK;
- Parental difficulties: a parent's mental ill health appears to be attributed to a child being possessed in a significant minority of cases. Illnesses typically involved include post-traumatic stress disorder, depression, and schizophrenia.

Indicators of abuse can include:

- A child's body showing signs or marks, such as bruises or burns, from physical abuse;
- A child becoming noticeably confused, withdrawn, disorientated or isolated and appearing alone amongst other children;
- A child's personal care deteriorating, for example through a loss of weight, being hungry, turning up to school without food or food money or being unkempt with dirty clothes and even faeces smeared on to them;
- It may also be directly evident that the child's parent does not show concern for or a close bond with them;
- A child's attendance at school becoming irregular, or being taken out of school all together without another school place having been organised;
- A child reporting that they are or have been accused of being evil, and / or that they are having the devil beaten out of them.

Professionals who are best placed to recognise when a child has been labelled as spirit possessed are those who have regular contact with children - teachers and school nurses, health professionals, community groups and churches, and in some instances LA children's social care professionals. Professionals working with parents may also become aware that a parent has come to believe that an evil spirit has entered their child

Professional Response
Faith based abuse may challenge a professional's own faith and / or belief, or the professional may have little or no knowledge on the issues that may arise. This makes it difficult for the professional to identify what they might be dealing with and affect their judgement. It will often take a number of contacts with the child or pieces of information to recognise the abuse.

Professionals should consider:

- How to build a relationship of trust with the child, and whether there is another professional who already has a trusting relationship with the child;
- Whether to involve the family. A belief that the child is possessed may mean they are stigmatised in their family. If the child has been labelled as possessed, professionals should find out how this affects the child's relationship with others in the extended family and community;
- What the beliefs of the family are;
- Where to obtain expert advice about cultures or beliefs that are not their own;
- What pressures the family are under. These cases of abuse will sometimes relate to blaming the child for something that has gone wrong in the family. Professionals should consider whether there is anything that can or should be done to address relevant pressures on the family;
- That the abuser may have a deeply held belief that they are delivering the child of evil spirits and that they are not harming the child but actually helping them. Holding such a belief is no defence or mitigation should a child be abused.

Professionals should also consider:

- Whether these beliefs are supported by others in the family or in the community, and whether this is an isolated case or if other children from the same community are being treated in a similar manner;
- Whether there is a faith community and leader which the family and the child adhere to:
    - As a minimum, the full details of the faith leader and faith community to which the family and child adhere to should be obtained;
    - The exact address of the premises where worship or meetings take place should be obtained;
    - Further information should be sought about the belief of the adherents and whether they are aligned to a larger organisation in the UK or abroad (websites are particularly revealing in terms of statements of faith and organisational structures).
- The family structure:
    - The roles of the adults in the household should be clarified (e.g., who the child's main carer is, whether the child is being privately fostered);
    - Whether the abuse relates to the arrival of a new adult into the household or the arrival of the child, perhaps from abroad;
    - If the child has recently arrived, what their care structure in their country of origin was. What the child's immigration status is;
    - The identities and relationships of all members of the household. These should be confirmed with documentation; it may be appropriate to consider DNA testing.
- Whether there are reasons for the child to be scapegoated (e.g., the child's behaviour or physical appearance may be different from other children in the family or community, the child may be disabled or their parents labelled as possessed);
- Whether an interpreter is required. If working with a very small community, the professional should assure themselves that the interpreter and the family are not part of the same social network;
- Professionals should ensure that all the agencies in the child's network understand the situation so that they are in a position to support the child appropriately. The child can themselves come to hold the belief that they are possessed, and this can significantly complicate their rehabilitation;
- With careful and appropriate engagement and adequate support, harm can be reduced or in some cases totally removed.

Children being taken out of the UK

If a professional is concerned that a child who is being abused or neglected is being taken out of the country, it is relevant to consider:

- Why the child is being taken out of the UK;
- Whether the care arrangements for the child in the UK allow the local authority to discharge its safeguarding duties;
- What the child's immigration status is. Professionals should also consider whether the child recently arrived in the UK, and how they arrived;
- What the proposed arrangements are for the child in their country of destination, and whether it is possible to check these arrangements;
- Whether the arrangements appear likely to safeguard and promote the child's welfare;
- That taking a child outside of the UK for exorcism or deliverance type procedures is likely to cause significant harm.

Protection and Action to be taken

Where concerns arise about abuse linked to witchcraft and spirit possession a referral to Children's Social Care should be made and the **Referrals Procedure** followed to ensure children are seen and spoken to on their own. In assessing the risks to the child, the siblings or any other children in the household must also be considered as they may have witnessed or been forced to participate in abusive or frightening activities. An inspection of the child's physical environment must include their sleeping and living arrangements.

Assessments should aim to fully understand the background and context to the beliefs and must involve the particular faith group or person performing or advising the family about the child in order to establish the facts i.e., what is happening to the child. Independent advisors should be considered to act as advisors and mediators where possible.

The assessment may include key people in the community especially when working with new immigrant communities and different faith groups. In view of the nature of the risks, a full health assessment of the child should take place to establish the overall health of the child, the medical history and current circumstances.

County lines

County lines is a major, cross-cutting issue involving:

- Drugs
- Violence
- Gangs
- Safeguarding
- Criminal and sexual exploitation
- Modern slavery
- Missing persons.

And the response to tackle it involves:

- The police
- The National Crime Agency
- A wide range of government departments
- Local government agencies
- VCS (voluntary and community sector) organisations.

The UK government defines county lines as:

“County lines is a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of “deal line”. They are likely to exploit children and vulnerable adults to move and store the drugs and money and they will often use coercion, intimidation, violence (including sexual violence) and weapons.”
County lines activity and the associated violence, drug dealing, and exploitation has a devastating impact on young people, vulnerable adults, and local communities.

Signs to look out for:
A young person’s involvement in county lines activity often leaves signs. A person might exhibit some of these signs, either as a member or as an associate of a gang dealing drugs. Any sudden changes in a person’s lifestyle should be discussed with them.

Some potential indicators of county lines involvement and exploitation are listed below, with those at the top of particular concern:

- 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 and/or having multiple handsets
- Relationships with controlling / older individuals or groups
- Leaving home / care without explanation
- Suspicion of physical assault / unexplained injuries
- Parental concerns
- 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.

Any practitioner working with a vulnerable person who they think may be at risk of county lines exploitation should follow their local safeguarding guidance and share this information with local authority social services. If you believe a person is in immediate risk of harm, you should contact the police.

Your designated safeguarding lead has the responsibility for linking in with your local authority's social services. If you are not satisfied with the local authority's response, you should follow up your concerns by discussing these with your safeguarding lead.

If you are aware that a potential victim may have come from / travelled to another area as part of their involvement in county lines, you should include this information in your referral to enable liaison between safeguarding agencies in the different areas.

If you are worried that a vulnerable person is at immediate risk of harm you should also contact the police: your local public protection officer or, in the case of a child, local children's protection officer.

Child criminal exploitation

Child criminal exploitation is increasingly used to describe this type of exploitation where children are involved and is defined as: "Child criminal exploitation is common in county lines and occurs where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology."
Criminal exploitation of children is broader than just county lines and includes for instance children forced to work on cannabis farms or to commit theft.

Approval Signature

Dr Claudia Wilson
Clinical Lead Manager

THE CHERRYCROFT PRACTICE

Appendix C – Risk Assessment Tool

Child/Young Person's Details:			
Child/Young Person's Name:		Date of Birth:	
Date form completed:		Date for form to be reviewed:	

Significant historical factors e.g., history of early traumas such as neglect, physical or sexual abuse, emotional abuse, etc.

Risk of accidental or non-accidental self-harm or suicide: (A score of 1 indicates no or low risk. A score of 4 or above indicates the need for an immediate safety plan, and for considering a safeguarding referral to health / social care services).				
Factors known to increase risk in this area: **previous attempts, use of violent methods of self-harm (drowning, hanging, shooting), expressing suicidal ideation, expression of hopelessness, confusion/disorientation, sensory impairment (sight/hearing), agitation/anxiety, medication non-compliance, bereavement, social isolation, peer contagion of deliberate self-harm, damage to property, young males/Asian females, mood intolerance, appears to have well-formed plans, substance misuse, polypharmacy, other self-harm e.g. induced vomiting, delusional beliefs, hallucinations, homelessness, impulsivity/lack of impulse control.**				
1	2	3	4	5

Reason for today's score:	
What would need to happen before you were confident that this score could be reduced?	
What would lead to an increase in scoring (and where appropriate consideration to a safeguarding referral / multi agency meeting)?	

Risk of being abused / exploited (or engaging others in these behaviours): (A score of 1 indicates no or low risk. A score of 4 or above indicates the need for an immediate safety plan, and for considering a safeguarding referral to social care services).				
Factors known to increase risk in this area: **age, sensory impairment, confusion/disorientation, vulnerable, increased dependence, child protection issues, learning disability, putting self at risk on social media, previous history, disinhibition, lack of insight, perception disorder, increased social isolation, failure of parents to ensure adequate care, communication difficulties.**				
1	2	3	4	5
Reason for today's score:				
What would need to happen before you were confident that this score could be reduced?				
What would lead to an increase in scoring (and where appropriate consideration to a safeguarding referral / multi agency meeting)?				

Risk of violence or aggression towards others (family, professionals, other children/young people): (A score of 1 indicates no or low risk. A score of 4 or above indicates the need for an immediate safety plan, and for considering a safeguarding referral to social care services).				
Factors known to increase risk in this area: **previous history of violence/aggression, delusional ideation, confusion/disorientation, pain, statement of intent/threat, damage to property, previous use of weapons in assaults, substance misuse, hallucination (command/auditory), excess stimulation, racism/bullying/discrimination, medication non-compliance, forensic history (arson, violence only), previous placement in forensic settings.**				
1	2	3	4	5
Reason for today's score:				
What would need to happen before you were confident that this score could be reduced?				
What would lead to an increase in scoring (and where appropriate consideration to a safeguarding referral / multi agency meeting)?				
If you have identified that a sibling / child or vulnerable adult is, or may be at risk of, significant harm from the child / young person, have you considered your safeguarding duties in relation to this person(s)	Yes / No:			
	Steps taken / to be taken:			

Risk of family breakdown (parental separation, requesting child / young person be accommodated, safeguarding issues within the family): (A score of 1 indicates no or low risk. A score of 5 indicates the need for an immediate safety plan, and for considering a safeguarding referral to social care services).				
Factors known to increase risk in this area: **parental illness – physical/mental, parental separation, family conflict, single person, bereavement, lack of parental availability, parent experiences child as challenging, school difficulties leading to difficulties at home, parent in blocked care, family size, criminality in parents, homelessness, parental drug/alcohol misuse, social isolation, welfare/benefit issues, child on parent violence, child late removed and late adopted, child experienced domestic violence in birth family.**				
1	2	3	4	5
Reason for today's score:				
What would need to happen before you were confident that this score could be reduced?				
What would lead to an increase in scoring (and where appropriate consideration to a safeguarding referral / multi agency meeting)?				

Risk of young person making allegations: (A score of 1 indicates no or low risk. A score of 4 or above indicates the need for an immediate safety plan, and for considering a safeguarding referral to health / social care services).				
Factors that may increase risk in this area: **previously made allegations, made threats to that they'll make allegations, misinterpret other's actions (e.g., will perceive a slight touch as an injury)**				
1	2	3	4	5
Reason for today's score:				
What would need to happen before you were confident that this score could be reduced?				
What would lead to an increase in scoring (and where appropriate consideration to a safeguarding referral / multi agency meeting)?				

Risk of young person absconding: (A score of 1 indicates no or low risk. A score of 4 or above indicates the need for an immediate safety plan, and for considering a safeguarding referral to health / social care services).				
Factors that may increase risk in this area: previous episodes of absconding**, threats to run away, impulsivity, peers who run away, etc.**				
1	2	3	4	5

Reason for today's score:	
What would need to happen before you were confident that this score could be reduced?	
What would lead to an increase in scoring (and where appropriate consideration to a safeguarding referral / multi agency meeting)?	

Other Risks: (A score of 1 indicates no or low risk. A score of 4 or above indicates the need for an immediate safety plan, and for considering a safeguarding referral to health / social care services).				
Young people can present with other risk factors not covered in the above, for example gambling, internet addiction, etc.				
1	2	3	4	5

Reason for today's score:	
What would need to happen before you were confident that this score could be reduced?	
What would lead to an increase in scoring (and where appropriate consideration to a safeguarding referral / multi agency meeting)?	

Safety Plan:	
Date safety plan created:	
Date safety plan to be reviewed:	
Person(s) involved in creating safety plan:	
Anyone not in agreement with safety plan: (Please state areas of disagreement)	
What are the risks we are concerned about?	

What are we going to do to increase the safety for child/young person?	
Child / Young Person (If appropriate):	
Parent(s):	
Therapist:	
Other(s):	
Who needs to be informed about this risk assessment, and who will do this?	
Reasons for making / not making safeguarding referral(s) at this time?	

This risk assessment will be reviewed as part of each review meeting.
In the event of a score of 4 or 5, the risk assessment will be reviewed following each therapy session.

Signatures			
Name and signature of assessor(s)		**Date:**	
Signature of young person (Where appropriate)		**Date:**	
Signature of parent(s) / carer(s)		**Date:**	
Name and signature of assigned Clinician		**Date:**	