Safeguarding and Child Protection Policy and Procedure

**1st Steps Designated Safeguarding Officers (DSO)**

**Alex Walker, Bev Bowden, Maria Tomkinson, Sandra Clayton, Christina Neary,**

**Sam Nolan Booth, Jess Smith**

Here at 1st Steps, in our position of ‘carer to the child’, the welfare of all of our children attending the nursery is paramount. .  “We are committed to safeguarding and promoting the welfare of children and young people and we expect all staff and volunteers to share this commitment.” Our obligation to take ‘care’ is that of a ‘caring parent and child care professional with varied skills’ in all aspects of the day. We have a legal and moral duty to promote the well-being of children, and protect them from harm, and respond to child abuse. We provide a safe and healthy environment. This will meet the child’s physical, emotional and educational needs according to their age, sex, race, religion and language. This policy has been revised and written in conjunction with the documents *‘Keeping Children Safe in Education’ (Sept 2016),‘Guidance for Safer Working Practice for Adults working with Children and Young People’ (DCSF, 2009), Working Together to Safeguard Children 2018 & 2015*, *The Prevent Duty Guidance(March 2015)*, *Mandatory Reporting of Female Genital Mutilation: procedural information (October 2015)* have been used to ensure the safeguarding of our pupils is of the highest standard. It should be read in conjunction with *What to do if you are worried a child is being abused 2017 – Advice for Practitioners* (available as an Appendix to this policy).

We may be called upon to receive unexpected information of a very delicate nature; delve diplomatically; exercise discretion and attempt to reach conclusions based upon young children’s uncertain, imprecise information or assertions about situations which we have little fundamental knowledge or experience.

It is the duty of all members of staff to be aware of what the words ‘Child Abuse’ means and its implications. Don’t forget that child abuse is not necessarily confined to the home, it can also occur in the work place. It is the duty of all members of staff to report any incident, no matter how small to the DSO’s. The DSO is a senior member of staff with knowledge and skills in recognising and acting on child protection concerns. They will act as a source of expertise and advice, and is responsible for co-ordinating action within the nursery and liaising with other agencies to offer a co-ordinated approach to safeguarding. When the senior member of staff is off-site, there will always be a deputy designated member of staff with the relevant skills and knowledge to safeguard children effectively.

Safeguarding and promoting the welfare of children is defined as:

• Protecting children from maltreatment;

• Preventing impairment of children’s health or development;

• Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and undertaking that role so as to enable those children to have optimum life chances and to enter adulthood successfully.

Child protection is a part of safeguarding and promoting welfare. It refers to the activity that is undertaken to protect specific children who are suffering, or are at risk of suffering, significant harm.

*Working Together to Safeguard Children* defines four broad categories of abuse:

* Neglect
* Physical abuse
* Sexual abuse
* Emotional abuse

**Emotional abuse**

These categories overlap and an abused child does frequently suffer more than one type of abuse. It is important to remember that children may be abused in a family or in an institution 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.

***Physical abuse***

1.4.15. Physical abuse may take many forms for example hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating a child to name but a few.

1.4.16. It may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child. This unusual and potentially dangerous form of abuse is now described as “fabricated or induced illness”.

***Emotional abuse***

1.4.17. Emotional abuse is the persistent emotional ill treatment of a child such as to cause severe and persistent 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;

• Not letting them express their views, deliberately silencing them ‘making fun’ of what they say or how they communicate.

• Age of developmental expectations, interactions beyond the child’s developmental capability, overprotection and limitation of exploring and learning, prevention of the child in normal social interactions.

• Seeing or hearing the ill-treatment of another.

• Serious bullying (including cyber bullying)

• Causing children to feel frightened or in danger - e.g. witnessing domestic violence;

• Exploitation or corruption of children. CSE – Child sexual exploitation

1.4.18. Some level of emotional abuse is involved in most types of ill treatment of children, though emotional abuse may occur alone.

***Sexual abuse***

1.4.19. Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening and includes penetrative (e.g. vaginal or anal rape or buggery) and non-penetrative acts (e.g. oral sex).

1.4.20. It may also include non-contact activities, such as involving children in looking at, or in the production of, pornographic materials, watching sexual activities or encouraging children to behave in sexually inappropriate ways.

• Sexual abuse is not solely perpetrated by men, women can also commit sexual abuse as can other children.

***Neglect***

1.4.22. Neglect involves 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 and development. Neglect may occur in pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

1.4.23. Provide adequate food, shelter or clothing, failure to protect from physical harm or danger or failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or being unresponsive to, a child’s basic emotional needs, including to feel loved and secure. The 2012 EYFS concentrates heavily on PSED. A child’s emotional development is paramount in both the physical and emotional development and must not be overlooked due to the sensitive nature and subjectivity involved in recognising this form of neglect.

1.4.24. Neglect may involve a parent failing to:

• Provide adequate food and clothing;

• Provide 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-takers;

• Ensure access to appropriate medical care or treatment.

• Protect children from cases of domestic violence. If we feel that your child is living in this type of environment, we will refer to social care.

**Specific Safeguarding Issues** In addition to the above types of abuse or neglect, members of staff should have an awareness of safeguarding issues listed below. Staff should be aware that behaviours linked to e.g. drug taking, alcohol abuse, truanting, and sexting, put children in danger. These include Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM) please see Appendix 2, Breast Ironing see Appendix 3, Witchcraft see Appendix 4

**Training**

It is everyone’s responsibility to look out for the welfare of all children, therefore, we are committed at 1st Steps to ensuring that all staff receive training and support to understand their roles within the nursery. All staff receive safeguarding training and this is reviewed, updated and training is recorded in our CPD log. It is essential that we are trained in safeguarding as we are highly skilled in recognising when a child might fail into one of these areas and it is our duty to contact relevant agencies so that no chid will ever be put into a position of abuse.

* All members of staff receive induction training, which gives an overview of the organisation and ensure that they know its purpose, values, services and structure, as well as identifying and reporting abuse, and confidentiality issues.
* Our Safeguarding policy is part of every staff’s induction as is our Code of Conduct and Duty of Care documents which staff are expected to agree and sign to as part of their induction and form the basis of 1st Steps high expectations of staff conduct. Ongoing regular training and updates (at least termly), along with appraisal and supervision ensure that all staff in the nursery maintain a mind-set of vigilance and are alert to the possibility that a child is at risk of suffering harm, and know how to report concerns or suspicions and who to.
* All staff will be expected to attend training on safeguarding children that will enable them to fulfil their responsibilities in respect of child protection effectively.
* Safeguarding regularly features in our staff meetings in all forms e.g. Domestic Violence, FGM, CSE, Risk assessment training, child protection, substance misuse and the effects, incoming injury training, Prevent and the likes.
* Staff will attend refresher training every three years with regular updates throughout the year.
* The designated safeguarding officer (DSO) will refresh training every two years with at least annual updates.
* All staff and volunteers must receive appropriate safeguarding training at induction with additional information at least annually, and be able to demonstrate their knowledge through questionnaires, role play scenarios and interactive monthly staff training.
* All staff, students and parents receive our Safeguarding policy. Staff are quizzed on their understanding of the policy and other key policies during the year to check understanding.
* Safeguarding information is displayed in the staff room as a reminder of what it may involve.
* Staff under investigation for safeguarding issues advice will be sort from our local MASH team and advice followed re suspension/actions to be taken.
* Staff are reminded not to work alone in line with safer working practice, whenever possible with children, due to the possibility of allegations being made.
* Staff will be reminded that unnecessary or inappropriate physical contact must be avoided at all times.
* Staff are made aware of the Department of Health’s booklet ‘What to do if you’re worried a child is being abused? 2017, A copy is on display in the staff room for staff to peruse.
* **Staff and students are made aware that if they have suspicion that a child may be suffering, or may be at risk of suffering significant harm, that they MUST refer such concerns to the DSO, who may refer on to Children’s Services as outlined below.**
* Staff are aware that if they are not satisfied with how a referral has been handled

then they must follow LSCB Escalation Procedures

(<http://www.seftonlscb.co.uk/media/6214/Escalation-Procedure-Final-Dec-13.pdf>) should there be professional disagreement regarding the determination of the level of need or to challenge existing provision for children and families.

* All staff must maintain an attitude of **‘it could happen here’** where safeguarding is concerned. When concerned about the welfare of a child, staff members should always act **in the best interests of the child**.
* Sefton’s 7 minute briefings are incorporated into staff meetings which cover a variety of topics from Bruising in Non mobile babies to Record Keeping, information sharing, etc.

**Signs of abuse**

These may include the following:

* Significant changes in the child’s behaviour
* Deterioration in the child’s general well-being
* Unexplained bruising, marks or signs of possible abuse or neglect especially in non-mobile infants
* Children’s comments which give cause for concern
* Any reason to suspect neglect or abuse outside the setting (DSO to review LSCB Neglect strategy to support referral process)
* Inappropriate behaviour displayed by other members of staff or person at work with the children. E.g. inappropriate sexual comments, excessive 1 to 1 attention, inappropriate sharing of images.

### **Vulnerable Children**

Some children may have an increased risk of abuse. It is important to understand that this increase is due to factors that can contribute including prejudice and discrimination, isolation, social exclusion, communication issues and reluctance on the part of some adults to accept that abuse can occur and child protection procedures that fail to acknowledge children’s diverse circumstances. To ensure that all children receive equal protection, we will give special consideration to children who are:

* Disabled or have special educational needs (with or without an EHCPlan). Staff should be mindful that additional barriers can exist when recognising abuse and neglect in this group of children.
* assumptions that indicators of possible abuse such as behaviour, mood and injury relate to the child’s disability without further exploration;
* children with SEN and disabilities can be disproportionately impacted by things like bullying – without outwardly showing any signs;
* Communication barriers and difficulties in overcoming these barriers.
* Living in domestic abuse situation
* Affected by parental substance misuse
* Affected by parental mental health conditions
* Affected by parents with anti-social behaviour
* Asylum seekers
* Living away from home
* Young carers and teenage parents
* Vulnerable to being bullied or engaging in bullying
* Living in temporary accommodation or have transient lifestyles
* Living in chaotic and unsupportive home situations
* Vulnerable to discrimination and maltreatment on the grounds of race, ethnicity, religion or sexuality
* Involved directly or indirectly in child exploitation or child trafficking
* Do not have English as a first language
* Subject to a Child Protection Plan – reporting incidents or concerns immediately to the allocated Social Worker.
* Living in care or being fostered.

**LOOKED AFTER CHILDREN**

The DSO also has the responsibilities associated with the role of Designated officer for Looked After Children: to promote the educational achievement of children who are looked after. Through appropriate training, we will ensure the Designated officer and staff have the skills, knowledge and understanding necessary to keep looked after children safe. Appropriate staff will have the information they need in relation to a child’s looked after legal status (whether they are looked after under voluntary arrangements with consent of parents or an interim or full care order); contact arrangements with birth parents or those with parental responsibility; the child’s care arrangements and the levels of authority delegated to the carer by the authority looking after him/her. The Designated officer will hold details of the child’s social worker and the name and contact details of the **Local Authority’s Virtual School Head teacher 0151 934 3832** who looks after the child. We will work with the Virtual Head teacher to decide on the most appropriate expenditure of Pupil Premium funding to support the progress of the looked after child and meet the needs identified in the child’s Personal Education Plan.

**Non Attendance**:

Children’s attendance will be monitored at 1st Steps. If a child does not attend each day without prior reasons being given to the nursery, action will be taken. In particular, if the child is known to social care for CP, CIN or Early Help reasons

* The room leader/key-carer will contact the parent or care giver to find out the reason for non-attendance. The explanation will be logged on Nursery In a Box (NIB) – This will keep a permanent record.
	+ If there is no answer, each other contact will be tried and messages will be left for the parents to contact nursery as soon as possible. If the level of concern is sufficient, nursery may make a home visit to check the family.
	+ If there is no contact or improvement in attendance, a call to the MASH team for advice will be made and referral will be made to social care if advised to.
* 2 Year Offer children
	+ Persistent nonattendance will result in a call to the school readiness team to discuss the place. They may follow up with a home visit to investigate attendance issues further.
	+ A possible referral may be made after discussion with the school readiness team.

All funded children with poor attendance and no contact with the family or advice from social care within 4 weeks will have their place suspended and notice served. A log of calls made will be kept on Nursery In a Box

**Siblings collecting children:**

The majority of our children are aged 0 – 5 years and we believe that siblings collecting younger children is not ideal. If parents want their older children to collect their babies, we will need confirmation to do so. Our children will not be released to siblings without prior consent under the age of 16.

**Staff or parent concerns**

Staff with concerns for children who may disclose something must record all details of the disclosure for use as possible evidence. You need to pay particular attention to detail. Please take into account the following guidelines when dealing with matters of child abuse accusations or manifestations.

* Initially believe the child’s accusation or revelation.
* Assure the child that you are taking their information seriously. Emphasize to them that they must be accurate in what they say.
* Indicate that them telling you the truth is a very brave action, requiring great strength and determination, as well as honesty.
* Reassure the child that what has happened is not their fault.
* Be honest about your position, the steps, which will have to be taken and the people with whom you will have to liaise.
* Keep calm and do not give way to shows of anger no matter how shocked you are.
* Do not make rash or unrealistic promises.
* Do not interrogate the child with lots of questions. It is not your role to carry out a complete investigation. **Simple questions such as ‘who did you say did that’ ‘what happened’, ‘where did it happen’ and ‘when did it happen’, are suffice.**
* Record all information as soon as possible to include date, name, the event, a record of what was said and any action taken. ‘If it is not recorded, then it did not happen’. Remember to be factual, document what was said, not what you think was meant. **Who, What, Where, When, this may be the only time the child is confident to disclose what they are saying!**
* Similarly, if a child has an unexplained injury and the parent cannot offer an explanation, simple questions can be used such as ‘what happened’, ‘when did it happen’ and ‘where did it happen’, ‘who did you say did that’ are suffice. **The injury will be recorded on an incoming injury form. It will be shared with parents and filed with the child’s records. Accidents are monitored and patterns emerging are monitored. Any concerns will be discussed with the DSO.**
* **Remember - strict confidentiality must be maintained.**

**Receiving an allegation from a parent/ carer or a child about a parent or carer.**

Any incidents that occur or concerns with children which may refer to any of the types of abuse above (this could be between two children, two parents, staff and a child, etc) should be reported to the DSO who will deal with them as follows:

Person receiving the allegation must write down all the details from the child:

* **Who** was involved
* **What** is alleged to have taken place
* **Where** the alleged incident took place
* **When** the alleged incident took place

**NB**. Neither party should be interviewed further.

* Report to Alex Walker / Bev Bowden / Maria Tomkinson immediately (Sandra, Sam or other senior NN in charge of setting at the time of the incident)
* Depending on the incident they will:
	+ Discuss the incident with the parents/ main carer.
	+ Discuss with the child’s health visitor.
	+ Discussions will be recorded and the parent/main carer will have access to such records where appropriate. In cases of Fabricated and Induced Illness, records may need to be confidential even to parents during investigations by police, doctors and social workers.
	+ If there appear to be any queries regarding the injury or concerns that are none explicable, we will contact the MASH team on 0151 934 4481/4013 for advice or make a referral straight to the social care access team.

**Making a referral**:

Referrals should be made to the Sefton Multi-agency Safeguarding Hub (MASH) using the online form on the Sefton Internet or Local Safeguarding Children’s Board (LSCB) website. **The only exception to this is in a case of suspected FGM when the Police must be contacted.** Referrals can be verbally discussed with the Social Worker Manager in the MASH Team prior to a referral being made if a discussion regarding clarification of a referral is required. Telephone calls to make a referral can be made in the first instance but must be followed up with a completion of the online form. It is good practice to inform the parents/carers that a referral is being made **except in the following circumstances:**

* Where it is thought the child is at risk by going home
* Where FGM is suspected (see appendix for further information)
* Where Fabricated Induced Illness is suspected
* Where Forced Marriage is suspected
* If you need advice regarding a concern, call the MASH team on 0151 934 4481
* Complete the online e-referral form <http://www.seftonlscb.co.uk/>referring to the Sefton LSCB **Level of Need guidance** to determine what threshold has been met for referral.
* Call 0345 1400845/0151 934 3737 to refer if no immediate internet access.
* If the emergency is out of hours (after 5.30pm), call social services contact number: **0151 934 3555** /**0345 140 0845**   (from 5.30pm Mon to Thurs, and 4pm Friday and weekends).
* All details will be disclosed to the social care team, questions answered and instructions followed, Including staff/parent or child’s name, date of birth, address and any relevant history. When a referral is made, we will agree with the recipient of the referral what the child and parents will be told, by whom and when. If a referral is made by telephone, we will confirm it in writing within 48 hours using the Sefton Agency Referral Form. Children’s social care should acknowledge our referral within 3 working days, otherwise we make a follow up call.
* The Sefton Council contact centre is open Monday – Thursday, 8.30am to 5.30pm, Friday 8.30 – 3.45pm
* OFSTED will be informed **0300 123 1231** where necessary within 14 working days.

Where consent is not obtained, the rationale/reason must be included in the referral.

In circumstances where a child has an unexplained or suspicious injury, that requires urgent medical treatment, the child protection referral should not delay the administration of first aid or emergency medical assistance.

NB: Children from other authorities will need to be referred to their authority. See Appendix 1 for contacts in Liverpool; Knowsley and Lancashire.

**If you feel that your concerns have not been dealt with internally, you are duty bound to go above the DSO’s head, call Sefton Children’s Services on the above numbers and follow the referral/escalation procedures.**

**If you believe that the level of need is insufficient to meet a child protection or child in need plan, an Early Help Plan may help to resolve any issues. Advice can be sought on 0151 9343506 or email EIP.Gateway@sefton.gov.uk**

**If the allegation is against a member of staff**

Follow above procedures for recording information.

* Please be aware of 1st Steps Whistle-blowing policy and Report to DSO’s Alex Walker, Bev Bowden or Maria Tomkinson (Sandra, or other senior NN in charge of setting at the time of the incident)
* The nature of the allegation is **assessed** in order to understand what safeguarding procedure should be followed if any.

To assess the situation Senior Managers **must** consider:-

1. What information do I have about the subject of the allegation?
2. What information do I have about the child/adult making the allegation?
3. Am I aware of any incident/tension/friction between the parties?

Senior Managers **must** then consider whether the allegation suggests the individual has:

1. Behaved in a way that has harmed, or may have harmed, a child
2. Possibly committed a criminal offence against/relating to a child
3. Behaved towards a child or children in a way that indicates s/he is unsuitable to work with children.
* Once we have assessed the information we would contact the Local Authority Designated Officer (LADO) on **0151 934 3783.**
* We would present the information gathered so far and then follow the DO’s advice and refer to them and social care if necessary.
* OFSTED will be informed **0300 123 1231.**
* Managers and staff will liaise with these agencies and any others as much as possible. Information is confidential and of a sensitive nature. Children, staff and parents will be supported within the setting and offered help to deal with the issues raised.
* Legal advice will be sought if necessary.

**If you feel that your concerns have not been dealt with internally, you are duty bound to go above the DSO’s head and call and Sefton LADO / Ofsted.**

# Confidentiality (***See Policy on Confidentiality) & Information Sharing***

All members of staff at the nursery will ensure that all data about children is handled in accordance with the requirements of the law, and any national and local guidance. Any member of staff who has access to sensitive information about a child or the child’s family must take all reasonable steps to ensure that such information is only disclosed to those people who need to know.

Regardless of the duty of confidentiality, if any member of staff has reason to believe that a child may be suffering harm, or be at risk of harm, their duty is to forward this information without delay to the Designated Officer/Social Care as **data sharing concerns should not come before safeguarding a child** (see Information Sharing policy).

This policy should be read in accordance with other safeguarding policies such as:

- Anti-Bullying, - Safer recruitment and code of conduct for staff, - E-Safety,

- Equality, - Confidentiality, - Behaviour and Discipline Policy, - Health & Safety,

- Fire Risk Assessment, - SEND& Inclusion, - First Aid, Incoming Injury Policy

- Mobile Phone Policy - Intimate Care Policy - Whistle Blowing, - Radicalisation Policy

**CONCERNS ABOUT NURSERY’S SAFEGUARDING PROCEDURES AND PRACTICES**

Any member of staff or student who has any concern regarding poor or unsafe practice or potential failures in the nursery’s safeguarding ethos, practice or procedures should raise their concern with a member of the Senior Leadership Team or go directly to Children’s services, the Designated Officer **0151 934 3783 or the** NSPCC whistleblowing helpline 0800 028 0285. Ofsted: 0300 123 1231

See Appendix 1: CSE, FGM & Prevent

See Appendix 2: Safeguarding procedures flow chart

Reviewed by: Alex Walker/ Bev Bowden/Maria Tomkinson, January 2020

Next Review: January 2021

**Safeguarding**

Appendix 1

Local Authority Contact information for referrals and concerns.

* Liverpool Careline Children’s Services: 0151 233 3700 (open 24 hours)
* Knowlsey MASH: 0151 443 2600 office hours. Call 999 out of hours
* Lancashire: Social Care 01254 666400/ Out of hours 01254 587547.
	+ DO: 01254 585184.

Appendix 2

**Child Sexual Exploitation (CSE)**

Child sexual exploitation is a form of sexual abuse where children are sexually exploited for money, power or status. It can involve violent, humiliating and degrading sexual assaults. In some cases, young people are persuaded or forced into exchanging sexual activity for money, drugs, gifts, affection or status. Consent cannot be given, even where a child may believe they are voluntarily engaging in sexual activity with the person who is exploiting them. Child sexual exploitation does not always involve physical contact and can happen online. A significant number of children who are victims of sexual exploitation go missing from home, care and education at some point. Some of the following signs may be indicators of sexual exploitation:

* Children who appear with unexplained gifts or new possessions;
* Children who associate with other young people involved in exploitation;
* Children who have older boyfriends or girlfriends;
* Children who suffer from sexually transmitted infections or become pregnant;
* Children who suffer from changes in emotional well-being;
* Children who misuse drugs and alcohol;
* Children who go missing for periods of time or regularly come home late; and
* Children who regularly miss school or education or do not take part in education.

For referrals specifically in relation to concerns about Child Sexual Exploitation, two forms, in addition to the Child Referral form should be completed: CSE Referral Form and a Referral Risk Assessment Form which should be securely emailed to SocialCareCustomerAccessTeam@sefton.gcsx.gov.uk. The forms are available by following the following link to Sefton LA website <https://www.sefton.gov.uk/social-care/report-a-child-or-young-person-at-risk/information-for-professionals.aspx>.

**Female Genital Mutilation (FGM)– reporting duty**

Female Genital Mutilation (sometimes known as female circumcision) refers to the procedure that alters or causes injury to the female genital organs for non-medical reasons. It has no health benefits and harms girls and women in many ways. It involves removing and/or damaging healthy and normal female genital tissue, and hence interferes with the natural function of girls and women’s bodies. FGM causes severe pain and has several immediate and long-term health consequences, including difficulties in childbirth, also causing dangers to the child. It is practiced by families for a variety of complex reasons but often in the belief that it is beneficial for the girl or woman. FGM is practiced in many African countries as well as part of the Middle East and Asia. The practice is illegal in the UK. It has been estimated that 20,000 girls under the age of 15 years are at risk of FGM in the UK each year, and that 66,000 women in the UK are living with the consequences of FGM. The girls may be taken to their country of origin so that FGM can be carried out during the summer holidays, allowing them time to ‘heal’ before they return to school. Some girls may have FGM performed in the UK. Professionals should note that girls at risk of FGM may not yet be aware of the practice or that it may be conducted on them, so sensitivity should always be shown when approaching the subject. FGM is child abuse and a form of violence against women and girls. **It is a mandatory duty for teachers to report suspected FGM in children under 18 years of age.**

Section 5B of the Female Genital Mutilation Act 2003 (as inserted by section 74 of the Serious Crime Act 2015) places a statutory duty upon teachers along with regulated health and social care professionals in England & Wales, to report to the police where they discover (either through disclosure by the victim or visual evidence) that FGM appears to have been carried out on a girl under 18 years of age. Those failing to report such cases will face disciplinary sanctions. It will be rare for practitioners to see visual evidence, and they should not be examining pupils, but the same definition of what is meant by ‘to discover that an act of FGM appears to have been carried out’ is used for all professionals to whom this mandatory reporting duty applies. Information on when and how to make a report can be found in the document – **Mandatory reporting of female genital mutilation procedural information.**

Practitioners **must** personally report to the police cases where they discover that an act of FGM appears to have been carried out. Unless the practitioner has a good reason not to, they should also consider and discuss any such case with DSO and involve children’s social care as appropriate. The duty does not apply in relation to at risk or suspected cases (i.e. where the practitioner does not discover that an act of FGM appears to have been carried out, either through disclosure by the victim or visual evidence) or in cases where the woman is 18 or over. In these cases, practitioners should follow local safeguarding procedures.

**Appendix 3 – Breast Ironing**

**What is breast ironing?**

Breast Ironing is practiced in some African countries, notably Cameroon. Girls aged between 9 and 15 have hot pestles, stones or other implements rubbed on their developing breast to stop them growing further. In the vast majority of cases breast ironing is carried out by mothers or grandmothers and the men in the family are unaware. Estimates range between 25% and 50% of girls in Cameroon are affected by breast ironing, affecting up to 3.8 million women across Africa.

**Why does breast ironing happen?**

The practice of breast ironing is seen as a protection to girls by making them seem ‘child-like’ for longer and reduce the likelihood of pregnancy. Once girls’ breasts have developed, they are at risk of sexual harassment, rape, forced marriage and kidnapping; consequently, breast ironing is more prevalent in cities. Cameroon has one of the highest rates of literacy in Africa and ensuring that girls remain in education is seen as an important outcome of breast ironing.

**Breast ironing is physical abuse**

Breast ironing is a form of physical abuse that has been condemned by the United Nations and identified as Gender-based Violence. Although, countries where breast ironing is prevalent have ratified the African Charter on Human Rights to prevent harmful traditional practices, it is not against the law.

Breast ironing does not stop the breasts from growing, but development can be slowed down. Damage caused by the ‘ironing’ can leave women with malformed breasts, difficulty breastfeeding or producing milk, severe chest pains, infections and abscesses. In some cases, it may be related to the onset of breast cancer.

**Appendix 4 – Witchcraft**

Witchcraft was always associated with old men and women. Thus in reality, branding children as witches is a recent development among African communities. It seems to be quite contrary to the values that Africans attach to children. Many attribute this new phenomenon to poverty, a breakdown of family and extended family structures, a dereliction of responsibility to protect the vulnerable by communities and institutions. Now, where ritual killings take place children are selected on the assumption that they are innocent and therefore represent a perfect sacrifice.

There is no apparent way of determining what kind of children would be at risk of Witchcraft Abuse. However, in the past, the following groups of children are known to have been accused of being witches and have experienced untold abuse and harm as a result

 • Children with disability including autism, epilepsy, downs syndrome and dyslexia

 • Children living away from home in private fostering situations as well as in domestic servitude situations

 • Children living with a step parent, with one of the natural parents absent or dead

 • Children whose parents have been branded as witches

 • Children who are “naughty”, rude or have challenging behaviour or involved in delinquent activity

• Children with learning disabilities or mental health problems

 • Left handed children

• Children who are geniuses or exceptionally bright

• Children living in broken families

Once a child has been branded as a witch, a catalogue of abusive actions follows in response to what people believe is a way of countering evil. The form of abuse experienced is usually two-fold:

**Within Families and in the community This involves:**

• The subsequent psychological and emotional abuse experienced in the form of verbal abuse, curses, and the knowledge by the child that he or she is hated by everyone because she is a witch. The self-torture that accompanied the belief that one is a witch responsible for wicked acts on people can be very damaging.

• Physical abuse: to beat the devil out, but also to punish. Many children accused of witchcraft experience severe physical abuse including beating with heavy implements, stamping on stomachs, kicking, punching, starving in the form of fasting which can go on for days on end.

• Neglect: The child can be isolation and ostracised from other members of the family and friends. They are not cared for and are denied any form of attention, including medical attention. Sometimes children miss education or are not able to concentrate at school because of the abuses highlighted above.

• Sexual Abuse: In some cases, the isolation makes victims prone to additional sexual abuse in the hands of opportunists, since no one cares what happens to them.

**Within Faith Organisations In many instances**, the accusation of witchcraft is made by the church (mainly the Pastor) who also professes solutions to this. This is usually in the form of deliverance or exorcism by the pastor or other high ranking members of the church. Less dramatic but equally hindering children’s well-being are the following practices which occur in attempts to exorcise or deliver the child:

• Shouting over a child while praying for him or her in a group which can cause a lot of emotional trauma

• Long prayers (vigil prayers) that do not give a child enough time to play and sleep thus having a negative impact on his/her health and the ability to concentrate on their studies at home and in school

• Traumatising a child with threats of hell if they do not repent from their witch craft or evil deed.

**What are the signs of witchcraft abuse?**

In many instances, many of the indicators that can alert other people to the fact that a child is being abused because he or she is believed to be a witch are no different from other signs of abuse. While some of the signs below might not in themselves be indicators of witchcraft abuse, taken together, they should arouse suspicion and induce further inquiry:

 • Unexplained bruises or marks on the body

• Incision marks on the body

• Says he or she will go to hell or is a bad person

• Does not go to school or does not go to school regularly

• Has limited freedom of movement

• Is malnourished or steals food

• Claims to be fasting for many days at a time

• Is not taken to hospital when ill

• Looks unkempt and uncared for

• Looks sad, miserable and lonely

• Does not have any friends or is ignored by other children

*Witches bear different names in different parts of Africa. In the Congo, they are Ndoki. In parts of Tanzania they are called the evil eye or “djinn”. In Nigeria, among the Yoruba, they are “Aje”. In Igboland they are called “Ogbanjé” or “Amozu”. In Rwanda, they are known as “Abazimu”. And in Uganda they are called “Emandwa”.*

**Preventing radicalisation**

From the 1st July 2015, all Early Years providers must have due regard to the need to prevent people from being drawn into terrorism and extremist ideas. This is known as “The Prevent Duty” and falls under section 26 of the Counter-Terrorism and Security Act 2015. Any signs of concerning behaviour displayed by a child, parent or staff member in nursery will be recorded and reported as necessary. Cause for concern could include changes in behaviour, change of appearance, concerning home life, religious conversion, or being a victim or witness to race or hate crimes. (See Preventing Extremism and Radicalisation Policy).

* Protecting children from the risk of radicalisation should be seen as part of nurseries’ wider safeguarding duties, and is similar in nature to protecting children from other forms of harm and abuse. During the process of radicalisation it is possible to intervene to prevent vulnerable people being radicalised.
* Radicalisation refers to the process by which a person comes to support terrorism and forms of extremism (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 and beliefs.). There is no single way of identifying an individual who is likely to be susceptible to an extremist ideology. It can happen in many different ways and settings. Specific background factors may contribute to vulnerability which are often combined with specific influences such as family, friends or on-line, and with specific needs for which an extremist or terrorist group may appear to provide an answer. The internet and the use of social media in particular has become a major factor in the radicalisation of young people.
* As with other safeguarding risks, staff should be alert to changes in children’s behaviour which could indicate that they may be in need of help or protection. Staff should use their judgement in identifying children who might be at risk of radicalisation and act proportionately which may include making a referral to the Channel programme.
* The Counter-Terrorism and Security Act (Feb 2015) places a duty on specified authorities, including local authorities and childcare, education and other children’s service providers, in the exercise of their functions, to have due regard to the need to prevent people from being drawn into terrorism **(“the Prevent duty”).**
* The statutory ‘Revised Prevent duty guidance: for England & Wales’ (for schools) summarises the requirements on schools in terms of four general themes:
* Risk Assessment –settings are expected to assess the risk of children being drawn into terrorism, including support for extremist ideas that are part of terrorist ideology. This means being able to demonstrate both a general understanding of the risks affecting children and young people in the area and a specific understanding of how to identify individual children who may be at risk of radicalisation and what to do to support them.
* Working in Partnership – the setting’s safeguarding arrangements and procedures are built on Sefton Local Safeguarding Children Board policies and procedures. As a setting we work closely with families and advise and assist any families who raise concerns in relation to radicalisation. Any concerns that we may have in this regard will be discussed with parents in line with safeguarding policies and procedures unless there is reason to believe that to do so would be putting the child at risk.
* Staff Training – is key to ensure that staff are equipped to identify children at risk of being drawn into terrorism and to challenge extremist ideas. Training on Prevent awareness will be included in regular Safeguarding Training Updates.
* Any concerns should be logged and reported to the Designated Safeguarding Lead for appropriate action which may include referral to the MASH Team and the Channel programme.
* Referral form can be accessed as noted in policy.
* Merseyside Police Special Branch

Contact Anti Terrorist Hotline: Tel: 0800 789 321 Or 101

Merseyside Police Prevent Tel: 0151-777-8311

Email msoc.prevent@merseyside.police.uk

twitter @merpolprevent

* Referral form can be accessed from Sefton LA website following the link <https://www.sefton.gov.uk/schools-learning/attendance-and-welfare/prevent-duty-guidance-for-schools-and-child-care-providers-settings.aspx>.
* Sefton LSCB strategy ‘Supporting Individuals Vulnerable to Violent Extremism Procedure’ can be accessed by following the link <http://www.seftonlscb.co.uk/media/9718/Section-18-CHANNEL-Procedure-Sept-15.pdf>.
* Due Diligence & Counter-Extremism Group DDCEG dedicated and confidential telephone helpline (020 7340 7264)for schools
* Confidential Terrorist hotline -0800 789 321

Appendix 2: Safeguarding Procedure to follow in case of an allegation

DSO’s will contact MASH to ask for advice and follow their recommendations.

0151 934 4481/4013

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Refer to Children’s Services on

<http://www.seftonlscb.co.uk/>

0345 1400845

0151 934 3737

You should receive a response within 3 days. If not, follow up.

Out of hrs 934 3555

Discuss with Parent/carers.

Report incident to Designated Safeguarding Officers Alex/ Bev/ Sandra

Document as accurately as possible (following safeguarding procedures)

Allegation arises due to suspicious circumstances, e.g. injury, comments by children or their play

1st Steps Safeguarding Children Procedures

What to do if an allegation occurs.

Incident will be reported to

DO

0151 934 3783

Ofsted

**0300 123 1231.**

Investigations will follow, staff will be suspended where necessary awaiting their instruction.

Report incident to Designated Safeguarding Officers Alex/ Bev/ Sandra

Incident will be assessed

Document as accurately as possible (follow safeguarding procedures)

Allegation towards member of staff, i.e. physical/emotional form a parent, child or other staff member.