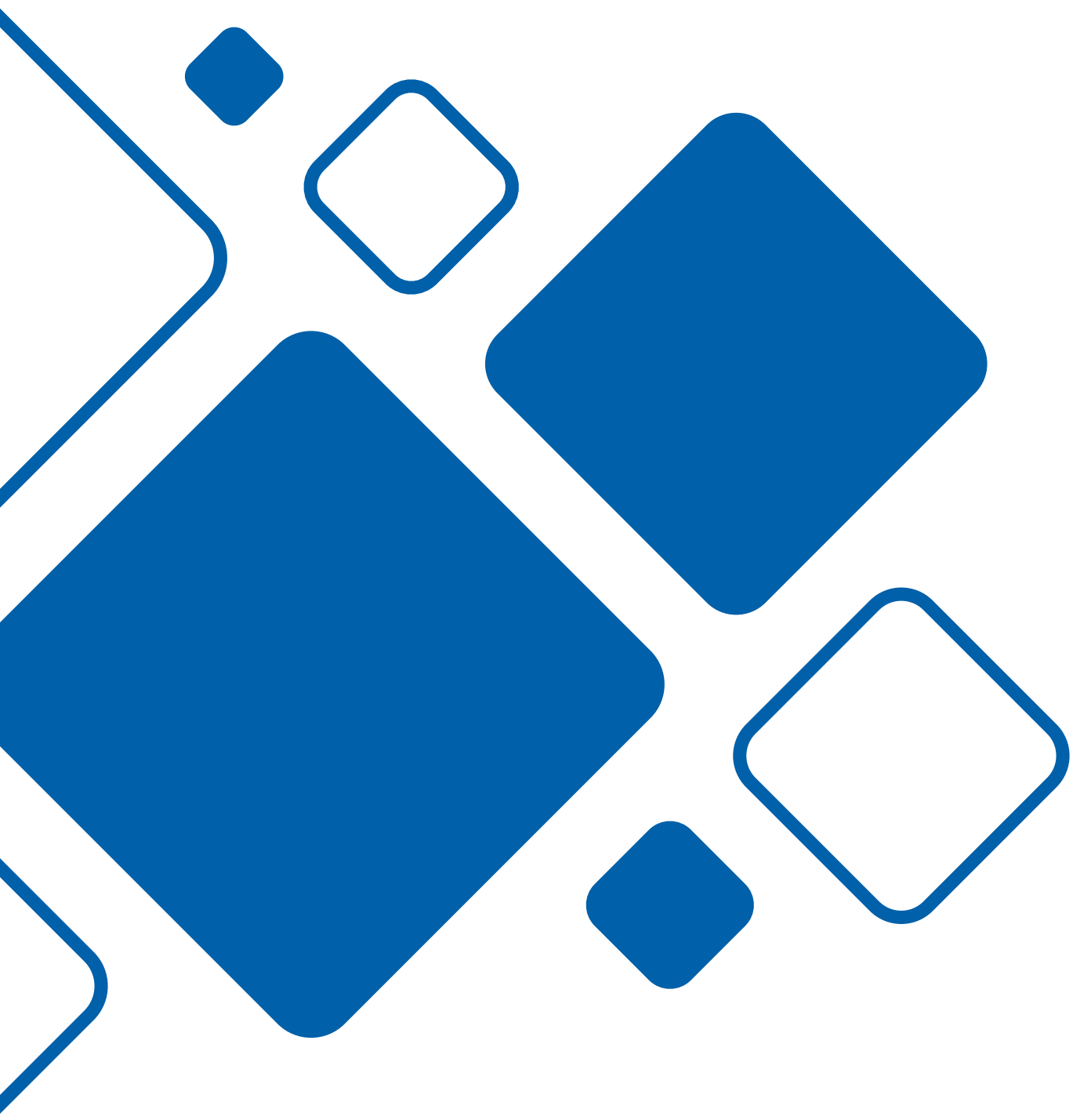
NURSDOC

POLICY NUMBER: **97**

POLICY TITLE: **CHILD PROTECTION**

WHO MUST ABIDE BY THIS POLICY? **ALL NURSDOC WORKERS**



CHILD PROTECTION POLICY

Relevant Legislation
- Children and Families Act 2014
- Counter-Terrorism and Border Security Act 2019
- Counter- Terrorism and Security Act 2015
- The Young Carers' (Need Assessment) Regulations 2015
- Chronically Sick and Disabled Persons Act (CSDPA) 1970
- Children and Social Work Act 2017
- Female Genital Mutilation Act 2003
- Children and Young Persons Act 1933
- Serious Crime Act 2015
- Borders, Citizenship and Immigration Act 2009
- Adoption and Children's Act 2002
- Digital Economy Act 2017
- Modern Slavery Act 2015
- United Nations Convention Rights of the Child 1989
- The Sexual Offences Act 2003
- The Police Act 1997
- The Care Act 2014
- Children Act 1989
- Children Act 2004
- Equality Act 2010
- Human Rights Act 1998
- Public Interest Disclosure Act 1998
- Safeguarding Vulnerable Groups Act 2006
- General Data Protection Regulation 2016
- Data Protection Act 2018

EQUALITY IMPACT ASSESSMENT

This statement is a written record that demonstrates that we have shown due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations with respect to the characteristics protected by equality law.

Purpose
The purpose of a Child Protection Policy and Procedure is to ensure that appropriate action is taken when a young person (up to the age of 18 years) is suspected of either being abused or at risk from parents, guardians, carers, adult visitors, other responsible adults or other young people.

The Child Protection Policy at Nursdoc recognises that the safety and protection of children is paramount and has priority over all other interests. The purpose of this policy is to protect any children or young adults who receive our services. It also includes the children or child relatives of adults who may be receiving our services. We recognise that everyone working with children has a responsibility for keeping them safe and we have a statutory duty to ensure that robust procedures are in place.

This policy refers to all children up to 18 years of age (including the unborn), regardless of nationality, culture or religion. If the child has 'learning disabilities' or is a care leaver, their needs may extend to their 21st birthday (Section 9 Children Act 2004). The term 'children' will be used throughout this policy to refer to children and young people.

To support Nursdoc in meeting the following Key Lines of Enquiry:

RESPONSIVE	R2: How are people's concerns and complaints listened and responded to and used to improve the quality of care?
SAFE	S1: How do systems, processes and practices keep people safe and safeguarded from abuse?
SAFE	S2: How are risks to people assessed and their safety monitored and managed so they are supported to stay safe and their freedom is respected?
WELL-LED	W4: How does the service continuously learn, improve, innovate and ensure sustainability?
WELL-LED	W5: How does the service work in partnership with other agencies?

SCOPE

2.1 The following roles may be affected by this policy:
- All staff
- Anyone working on behalf of our organisation
- Senior Management including Directors
- Students, Trainees, Apprentices, Work Experience
- Contractors
- Agency Staff

2.2 The following Service Users may be affected by this policy:
- Service Users
- Children

2.3 The following stakeholders may be affected by this policy:
- Family
- Commissioners
- External health professionals
- Local Authority
- NHS

OBJECTIVES

The objective of Nursdoc is to have a coordinated approach to child protection and to ensure that the procedures at Nursdoc are in line with policies and procedures published in local areas where Nursdoc delivers services.

To ensure that the voice of the child is heard and that a child-centred approach is taken.

POLICY

Statement of Intent
Nursdoc recognises the vulnerability of children and believes that it is always unacceptable for a child or young person to experience abuse of any kind. It wholly supports the principle that the welfare of the child is paramount and accepts the United Nations Declaration of the Rights of the Child.

Nursdoc understands that children can be under threat, and/or abused by parents/family, other children and young people, carers, staff and others and that everyone who works with children has a responsibility for keeping them safe.

Nursdoc will ensure that it works in partnership with other agencies, children and their families so that they receive the right help, at the right time; further,with everyone who comes into contact with children, understands that they all have a role to play in identifying concerns, sharing information and taking prompt action.

Additionally, Nursdoc believes that all children, regardless of ethnicity, gender, culture, sexual orientation, disability, faith or religious belief, have a right to equal protection from all types of harm or abuse.

Nursdoc recognises that deaf and disabled children and those with complex health needs are at increased risk of abuse. Furthermore, it understands that some children have increased vulnerability because of the impact of previous experiences, their level of dependency, their communication needs, or other issues; and that threats can take a variety of different forms including sexual, physical and emotional abuse, neglect, exploitation by criminal gangs and organised crime groups, trafficking, online abuse, sexual exploitation and the influences of extremism leading to radicalisation. All necessary steps will be taken to ensure that the rights of all children are respected and that opportunities for abuse to occur are minimised.

Nursdoc will seek to keep children and young people safe by:

- Empowering children, listening, respecting and responding in a compassionate but effective way.
- Ensuring a child-centred approach to service planning and delivery and keeping the child in focus when making decisions about their lives.
- Ensuring that all staff read and understand this policy.
- Providing child protection training to staff to enable them to recognise signs of abuse and follow appropriate procedures when dealing with child protection concerns.
- Adopting safe staff recruitment, selection and vetting procedures.
- Sharing information about child protection and good practice with staff, volunteers, parents, carers and relevant agencies.

- Requiring all staff to follow the reporting and recording procedures in every case of suspected abuse or disclosed abuse.
- Ensuring that all staff with responsibility for, or contact with children, will be provided with appropriate policies, guidance, training and support to enable them to implement this policy.
- Providing effective management and support systems for all staff so that staff know who to contact within Nursdoc in the event of child protection concerns arising.
- Working within the relevant Local Safeguarding Partners' guidance and procedures.
- Ensuring that policy and practice remains current and up to date and in line with local procedures.

Information Sharing and Confidentiality
Good communication is essential for any organisation. In Nursdoc, every effort will be made to assure individuals that, should they have concerns, they will be listened to and taken seriously. It is the responsibility of the management and staff to ensure that information is available to, and exchanged between, all those involved in this organisation and its activities.

Children and young people have a right to information, especially any information that could make life better and safer for them. Nursdoc will act to ensure that they have information about how, and with whom, they can share their concerns, complaints and anxieties.

When sharing information, staff will be sensitive to the level of understanding and maturity, as well as to the level of responsibility of the people with whom they are sharing.

We understand that some information is confidential and will only be shared on a strictly need-to-know basis. Nursdoc will ensure that staff follow the guidelines: Information Sharing Advice for Practitioners Providing Safeguarding Services to Children, Young People, Parents and Carers (July 2018).

Nursdoc will ensure that staff understand that the General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights legislation are not barriers to justified information sharing, but provide a framework to ensure that personal information about living individuals is shared appropriately.

Safe Recruitment
Nursdoc will adopt a consistent and thorough process of safe recruitment in order to ensure that those recruited are suitable. This includes ensuring that safe recruitment and selection procedures are adopted which deter, reject or identify people who might abuse children or are otherwise unsuitable to work with them. Nursdoc will not sub-contract to any organisation which has not been part of a safe recruitment process.

Nursdoc will ensure that the level of DBS check required for the role will be confirmed. The recruiting manager will ensure that clearance is obtained before the applicant commences employment. As an employer of staff in a 'regulated activity', Managers must report concerns to the Local Authorities, CCG's and other service users Child Protection Team.

Best practice, Accountabilities and responsibilities
Nursdoc will adhere to HM Government's 'Working Together to Safeguard Children (2018)' and will follow, within the scope of its role and responsibilities, NICE guidance NG76 and C G89 in addition to other best practice documents cited in this policy and procedure.

The Leadership Team at Nursdoc will:
- Be responsible for the effectiveness of this policy and related procedures and for ensuring that sufficient resources are available to support its implementation
- Appoint a nominated individual to ensure that this policy is agreed, implemented and reviewed within the clinical governance framework.
- Delegate responsibility for ensuring that this policy is integrated into the governance structure of Nursdoc and reviewed.
- Appoint a designated Safeguarding Lead(s) to undertake a lead role for safeguarding, including being involved in Serious Case Reviews with Local Safeguarding Partners and agreeing action plans for shortfalls or improvements in process and working with the local operational team.
- The Safeguarding Lead will review concerns identified, standardise process and learning and report to the committee responsible for reviewing safeguarding incidents, ensuring that the CQC is informed.

The Director of Nursing will ensure that Nursdoc will:
- Notify the designated Safeguarding Lead, if it is someone other than themselves, of any safeguarding concerns.
- Notify the designated Safeguarding Lead of the outcome of any safeguarding meetings not attended by the Lead.
- Ensure that they remain up to date on child protection processes in their own locality.
- Notify the CQC in line with CQC notification reporting requirements.

All managers are responsible for:
- Ensuring that all staff are aware of their responsibilities in accordance with this policy and associated documents.
- Monitoring compliance with this policy within their area of responsibility.
- Providing support to staff involved in any children welfare incidents.
- Ensuring that staff complete approved safeguarding training.

COVID-19
Nursdoc recognises that during the coronavirus pandemic, children are at increased risk due to limited interaction outside of their household and social distancing measures. Nursdoc will ensure that it continues to be vigilant in relation to child protection and adheres to the steps outlined in this policy.

Recognising Children who May Need Early Help
Nursdoc will ensure that staff understand that they must be alert to the potential need for early help as stated in 'Working Together to Safeguard Children' (2018) for a child who:

- Is disabled and has specific additional needs.
- Has special educational needs (whether or not they have a statutory Education, Health and Care Plan).
- Is a young carer.
- Is showing signs of being drawn into anti-social or criminal behaviour, including gang involvement and association with organised crime groups.
- Is frequently missing/goes missing from care or from home.
- Is at risk of modern slavery, trafficking or exploitation.
- Is at risk of being radicalised or exploited.
- Is in a family circumstance presenting challenges for the child, such as drug and alcohol misuse, adult mental health issues and domestic abuse.
- Is misusing drugs or alcohol themselves.
- Has returned home to their family from care.
- Is a privately fostered child.

Additionally, staff must be aware of any new or emerging threats which include online abuse, grooming, sexual exploitation and radicalisation as well as having the ability to identify symptoms and triggers of abuse or neglect.

Local Procedures
All staff, including contracted or agency staff working with children, will familiarise themselves with the local child safeguarding policies, procedures and guidelines and work within them. Nursdoc will ensure that all staff within Nursdoc are aware and understand their local child protection policies and the localised reporting procedures for Local Authorities, CCG's and other service users. Nursdoc will identify a member of staff responsible for safeguarding.

Responding When a Child Discloses Abuse
Keep the following considerations in mind when talking to a child who is disclosing abuse:

- Help the child feel comfortable.
- Reassure the child that it is not their fault. Let them know that they have not done anything wrong.
- Do not react with shock, anger, disgust. Be calm.
- Do not force a child to talk. Give the child time. Let him/her talk to you at their own pace.
- Do not force a child to show injuries.
- Use terms and language that the child can understand.
- Do not 'interview' the child.
- Ask appropriate questions.
- Do not ask 'why' questions.
- Do not teach the child new terms or words. This is important in relation to the court and law.
- Find out what the child wants from you.
- Be honest with the child.
- Confirm the child's feelings. Be supportive.
- Remember that the safety of the child is most important. Keep in mind that a child might be further abused if they report that they have spoken to someone about the abuse. If you feel that the child is in danger, you must act immediately.

Reporting Concerns
- If the child requires immediate medical attention call an ambulance and inform the control room staff that there is a child protection concern.

- Call 999 if in immediate danger.
- Report incident/concerns to the relevant line manager who will support you to complete a report form.
- Report to the Local Authorities, CCG's and other service users Child Social Care Team.

Management of Allegations Against People in Positions of Trust
Nursdoc, when working with children and families, must have clear policies for dealing with allegations against people who work with children. Nursdoc will make a clear distinction between an allegation, a concern about the quality of care or practice and a complaint. An allegation may relate to a person who works with children who 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 they may pose a risk of harm to children If an allegation arises it will:
- Be reported immediately to a Senior Manager within Nursdoc.
- Be addressed as quickly as possible with a consistent and a fair and thorough investigation. Where it appears that a criminal offence may have been committed, the Police will be contacted immediately by the appropriate Senior Manager.
- Local Authorities, CCG's and other service users Children's Social Care Team must be informed within one working day of all allegations that come to the attention of Nursdoc or that are made to the Police regarding an employee or someone in a position of trust working with, or on behalf of, or who is known to Nursdoc who may have caused harm to a child. It is the responsibility of the Director of Nursing to ensure that the Local Authority, CCG or the service users Children's Social Care Team is notified.

5.2 SAFEGUARDING DISABLED CHILDREN

Research suggests that disabled children are at increased risk of abuse, and that the presence of multiple disabilities appears to increase the risk of both abuse and neglect. A child could be considered to be disabled if he or she has significant problems with communication, comprehension, vision, hearing or physical functioning. A failure to recognise disabled children's human rights can lead to abusive situations and practices. Organisational culture and 'custom and practice' can contribute to institutional abuse or harm.

- Nursdoc will not underestimate how poor practice can become pervasive in influencing staff to behave inappropriately.
- Nursdoc will ensure that its services will readily seek the views of young people, parents and other professionals in reviewing their practice.

Particular attention will be paid to promoting a high level of awareness of the risks of harm, to high standards of practice, and to strengthening the ability of children and families to help themselves.

- Make it common practice to enable disabled children to make their wishes and feelings known in respect of their care and treatment.
- Make sure that all disabled children know how to raise concerns and give them access to a range of adults with whom they can communicate. This could mean using interpreters and facilitators who are skilled in using the child's preferred method of communication.
- Recognise and utilise key sources of support, including staff in schools such as support workers, friends and family members where appropriate.
- Ensure that there is an explicit commitment to, and an understanding of, disabled children's safety and welfare among all providers of services used by disabled children.
- Develop the safe support services that families want, and a culture of openness and joint working with parents and carers on the part of services.
- Provide guidelines and training for staff on good practice in intimate care; working with children of the opposite sex; managing behaviour that challenges families and services; issues around consent to treatment; anti-bullying and inclusion strategies; sexuality and safe sexual behaviour among young people; monitoring and challenging placement arrangements for young people living away from home.
- Where a child is unable to tell someone of the abuse, they may convey anxiety or distress in some other way, e.g. behaviour or symptoms, and the Temporary worker must be alert to this.

Child Sexual Exploitation (CSE)
As a result of nationwide cases CSE has become a national priority for health and social care. Staff have a significant contribution to make in identifying children and young people at risk of sexual exploitation.

Where there are concerns about the welfare of a child, Nursdoc

- Remember the child or young person's welfare is of paramount importance.
- Make sure the Temporary Worker is alert to the signs of Child Sexual Exploitation.
- The Temporary Worker will seek immediate advice from their manager, and Nursdoc will refer to Children's Social Care or the Police if there is a suspicion that a child is at risk of harm or is in immediate danger.
- Nursdoc will ensure that staff and temporary Workers know and understand the organisational and multi-agency safeguarding arrangements and processes.
- Information must be shared on a need-to-know basis.

Domestic Violence and Abuse
There is a strong link between domestic abuse and all types of significant harm to children and young people. Witnessing domestic violence is a form of emotional abuse to a child/young person which may result in long-lasting implications for their future well-being.

The Temporary Worker must follow local child protection reporting procedures if they are concerned that a child is witnessing domestic violence, is at risk of being harmed or is being harmed as a result of domestic violence or abuse.

5.3 FORCED MARRIAGE AND HONOUR BASED ABUSE/ VIOLENCE

Children and young people can be subjected to domestic abuses perpetrated in order to force them into marriage or to 'punish' them for 'bringing dishonour on the family'. Duress cannot be justified on religious or cultural grounds, and forced marriage is an abuse of human rights. Whilst honour-based violence can culminate in the death of the victim, this is not always the case.

The child or young person may be subjected, over a long period, to a variety of different abusive and controlling behaviours ranging in severity. The abuse is often carried out by several members of a family including mothers, and female relatives/community members and may, therefore, increase the child's sense of powerlessness and be harder for professionals to identify and respond to.

Forced marriages of children must be regarded as a child protection issue. Nursdoc must not contact the parents in this situation and must make a referral direct to the local Safeguarding Team and follow local reporting procedures. Further advice can be obtained from the Forced Marriage Unit here:
www.gov.uk/stop-forced-marriage

If Staff is at Risk
Contact the Forced Marriage Unit (FMU) if staff know someone who has been taken abroad to be forced into marriage. Give as many details as possible, for example:

- Where the person has gone
- When they were due back
- When you last heard from them

The FMU will contact the relevant Embassy. If the person is a British National, the Embassy will try to contact the person and help them get back to the UK, if that is what they want.

Female Genital Mutilation (FGM)
FGM is an illegal practice which affects a girl's genital area, and which can impact on their emotional or physical well-being. FGM is a criminal offence and carries a maximum penalty of 14 years imprisonment.

- If a Temporary worker is aware of any Service User who has had FGM or of any female children who are at risk of FGM, they must discuss this with their manager or the Local Authorities, CCG's and other service users Safeguarding Team.
- If there is an immediate risk the police must be contacted.
- Staff must understand their responsibilities to report concerns. Free E-Learning training is available through the Home Office

Contextual Safeguarding
Nursdoc will ensure that staff training includes Contextual Safeguarding. Nursdoc will ensure that staff understand that, as well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation from outside their families. These extra-familial threats might arise at school and other educational establishments, from within peer groups, or more widely from within the wider community and/or online. These threats can take a variety of different forms and children can be vulnerable

to multiple threats, including: exploitation by criminal gangs and organised crime groups such as county lines; trafficking; online abuse; sexual exploitation and the influences of extremism leading to radicalisation. Training must highlight that extremist groups make use of the Internet to radicalise and recruit and to promote extremist materials. Any potential harmful effects to individuals identified as vulnerable to extremist ideologies or being drawn into terrorism must also be considered and Nursdoc will ensure that staff know how to refer any concerns to local safeguarding partners and that they have an understanding of Channel referrals and processes.

Whistle-blowing
Safeguarding children is complex and can frequently be under review. It is important to remember that safeguarding is everyone's responsibility, and a culture must be promoted where staff are able to raise concerns and whistle-blow without fear.

Training
Safeguarding Children and Young People should be included within the mandatory induction and include familiarisation with child protection responsibilities and the procedures to be followed should anyone have any concerns about a child's safety or welfare.

Consent
Where Nursdoc needs to share special category personal data, Nursdoc will be aware that the Data Protection Act 2018 includes 'safeguarding of children and individuals at risk' as a condition that allows practitioners to share information without consent.

Information can be shared legally without consent if Nursdoc is unable to or cannot be reasonably expected to gain consent from the individual, or if to gain consent could place a child at risk.

DEFINITIONS

Domestic Violence and Abuse
• The UK's cross-government definition of domestic abuse is:

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 abuse can encompass but is not limited to:

- 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, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Safeguarding
- Safeguarding is a term which is broader than 'child protection' and relates to the action taken to promote the welfare of children and protect them from harm. Safeguarding is everyone's responsibility.

Statutory guidance says that safeguarding means:

- 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.
- Taking action to enable all children to have the best outcomes.

Child or Young Person
- Under the Children Acts 1989 and 2004 respectively, a child (or young person) is anyone who has not yet reached their 18th birthday. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital, in prison or in a Young Offenders Institution does not change his or her status or entitlement to services or protection under the Children Act 1989.

Staff
- Employment context: A person working under the control or direction of another, under a contract of employment in return for a wage or salary.

Volunteer
- The Disclosure and Barring Service (DBS) defines a 'volunteer' as: "A person who is engaged in any activity which involves spending time, unpaid (except for travelling and other approved out of pocket expenses), doing something which aims to benefit someone (individuals or groups) other than, or in addition to close relatives.

Child Sexual Exploitation
- 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.

Safeguarding Partners
- Local Safeguarding Children Boards (LSCBs) are being replaced by "Safeguarding Partners." Under the new legislation, three safeguarding partners (Local Authorities, Chief Officers of Police, and Clinical Commissioning Groups) must make arrangements to work together with relevant agencies (as they consider appropriate) to safeguard and protect the welfare of children in the area.
- The geographical footprint for the new arrangements is based on local authority areas. Every Local Authority, Clinical Commissioning Group and Police Force must be covered by a local safeguarding arrangement.

Contextual Safeguarding
- Contextual Safeguarding is an approach to understanding, and responding to, young people's experiences of significant harm beyond their families. It recognises that the different relationships that young people form in their neighbourhoods, schools and online can feature violence and abuse. Parents and carers have little influence over these contexts, and young people's experiences of extra- familial abuse can undermine parent-child relationships.

GDPR
- The General Data Protection Regulation (GDPR) (EU) 2016/679 is a regulation in EU law on data protection and privacy for all individuals within the European Union (EU) and the European Economic Area (EEA). The General Data Protection Regulation (GDPR) is a legal framework that sets guidelines for the collection and processing of personal information of individuals within the European Union (EU).
- The GDPR forms part of the data protection regime in the UK, together with the new Data Protection Act 2018 (DPA 2018). The main provisions of this applied like the GDPR, from 25 May 2018 Special Category Personal Data.
- Under GDPR, special categories of personal data means data revealing health, racial or ethnic origin, political opinions, religious or philosophical beliefs, trade union membership, etc.

PROFESSIONALS

Professionals providing this service should be aware of the following:

- The welfare of the child is paramount, with safeguarding being everyone's responsibility.
- Whether you deliver children's services or not you must ensure that your staff have received child protection training and understand local reporting procedures.
- Nursdoc will promote a culture where staff can freely raise concerns.

People affected by the service
People affected by this service should be aware of the following:

- You have a right to equal protection from all types of harm or abuse.
- Nursdoc will seek your consent to share information about you. However, if we think you are at risk we will respond in your best interests. We will only share information on a need-to-know basis.

APPENDIX 1

Categories and Indicators of Child Abuse and Neglect
The following definitions will assist staff to recognise whether a child is suffering or is likely to suffer significant harm. Where abuse is suspected, a referral must always be made to the Local Authorities, CCG's and other service users Child Protection Team using local reporting procedures.

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

Emotional Abuse:
Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent effects on the child's emotional development and may involve: Conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person; Imposing age or developmentally inappropriate expectations on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction; Seeing or hearing the ill-treatment of another e.g. where there is domestic violence and abuse; Serious bullying, causing children frequently to feel frightened or in danger; Exploiting and corrupting children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual Abuse:
Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (e.g. rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. Sexual abuse includes non-contact activities, such as involving children in looking at pornography, including online and with mobile phones, or in the production of pornographic materials, watching sexual activities or encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

In addition, sexual abuse includes abuse of children through sexual exploitation. Penetrative sex, where one of the partners is under the age of 16, is illegal although prosecution of similar age, consenting partners is not usual. However, where a child is under the age of 13 it is classified as rape under Section 5 of the Sexual Offences Act 2003.

Neglect:
Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development.

Neglect may occur during pregnancy as a result of maternal substance misuse, maternal mental ill health or learning difficulties or a cluster of such issues. Where there is domestic abuse and violence towards a carer, the needs of the child may be neglected. Once a child is born, neglect may involve a parent 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)
- Ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to a child's basic emotional, social and educational needs

Domestic Abuse:
Included in the four categories of child abuse and neglect above, are a number of factors relating to the behaviour of the parents and carers which have significant impact on children, such as domestic violence. Research analysing Serious Case Reviews has demonstrated a significant prevalence of domestic abuse in the history of families with children who are the subject of Child Protection Plans. Children can be affected by seeing, hearing and living with domestic violence and abuse as well as being caught up in any incidents directly, whether to protect someone or as a target. It should also be noted that the age group of 16 and 17 year olds has been found in recent studies to be increasingly affected by domestic violence in their peer relationships.

The cross-government definition of domestic violence and abuse is:

Any incident or pattern of incidents of controlling, coercive, 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. The abuse can encompass, but is not limited to:

- Psychological
- Physical
- Sexual
- Financial
- Emotional

Controlling Behaviour:
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.

Signs of Abuse
Recognising child abuse is not easy. It is not your responsibility to decide whether child abuse has taken place or if a child is at risk of harm from someone. You do, however, have both a responsibility and duty to act in order that the appropriate agencies can investigate and take any necessary action to protect a child. The following information should help you to be more alert to the signs of possible abuse:

Physical Abuse
Most children will collect cuts and bruises as part of the rough and tumble of daily life. Injuries should always be interpreted considering the child's medical and social history, developmental stage and the explanation given. Most accidental bruises are seen over bony parts of the body e.g. elbows, knees, skins, and are often on the front of the body. Some children, however, will have bruising that is more than likely inflicted rather than accidental. Important indicators of physical abuse are bruises or injuries that are either unexplained or inconsistent with the explanation given, or visible on the 'soft' parts of the body where accidental injuries are unlikely e.g. cheeks, abdomen, back and buttocks. A delay in seeking medical treatment when it is obviously necessary is also a cause for concern, although this can be more complicated with burns, as these are often delayed in presentation due to blistering taking place. The physical signs of abuse may include:

- Unexplained bruising, marks or injuries on any part of the body.
- Multiple bruises – in clusters, often on the upper arm, outside of the thigh.
- Unexplained bruising in babies or non-mobile children.
- Cigarette burns.
- Human bite marks.
- Scalds, with upward splash marks.
- Multiple burns with a clearly demarcated edge.

Changes in behaviour which can also indicate physical abuse:

- Fear of parents being approached for an explanation
- Aggressive behaviour or severe temper outbursts
- Flinching when approached or touched
- Reluctance to get changed, for example in hot weather
- Depression
- Withdrawn behaviour
- Running away from home
- Fear of medical help or examination

Emotional Abuse
Emotional abuse can be difficult to measure, as there are often no outward physical signs. There may be a developmental delay due to a failure to thrive or grow, although this will usually only be evident if the child puts on weight in other circumstances, for example when hospitalised or away from their parents' care. Even so, children who appear well cared for may nevertheless be emotionally abused by being taunted, put down or belittled. They may receive little or no love, affection or attention from their parents or carers. Emotional abuse can also take the form of children not being allowed to mix or play with other children. Changes in behaviour which can indicate emotional abuse include:

- Neurotic behaviour e.g. sulking, hair twisting, rocking.
- Sudden speech disorders.
- Fear of making mistakes.
- Being unable to play.
- Self-harm.
- Fear of parent being approached regarding their behaviour.
- Developmental delay in terms of emotional progress.
- Extremes of passivity or aggression.

Sexual Abuse
Adults or other children who use children to meet their own sexual needs, abuse both girls and boys of all ages, including infants and toddlers. Usually, in cases of sexual abuse, it is the child's behaviour

that may cause you to become concerned, although physical signs can also be present. In all cases, children who tell about sexual abuse do so because they want it to stop. It is important, therefore, that they are listened to and taken seriously.

The physical signs of sexual abuse may include:

- Pain or itching in the genital area.
- Bruising or bleeding near the genital area.
- Sexually transmitted disease.
- Vaginal discharge or infection.
- Stomach pains.
- Discomfort when walking or sitting down.
- Pregnancy.

Changes in behaviour which can also indicate sexual abuse include:

- Sudden or unexplained changes in behaviour e.g. becoming aggressive or withdrawn.
- Fear of being left with a specific person or group of people.
- Having nightmares.
- Running away from home.
- Sexual knowledge which is beyond their age, or developmental level.
- Sexual drawings or language.
- Bed-wetting/daytime soiling.
- Sudden loss of appetite or compulsive eating.
- Self-harm or mutilation, sometimes leading to suicide attempts.
- Saying they have secrets they cannot tell anyone about.
- Substance or drug misuse.
- Suddenly having unexplained sources of money or gifts.
- Not allowed to have friends (particularly in adolescence).
- Acting in a sexually explicit way towards adults or other children/peers.

Neglect
Neglect can be a difficult form of abuse to recognise yet has some of the most lasting and damaging effects on children. The physical signs of neglect may include:

- Constant hunger, sometimes stealing food from other children.
- Poor personal hygiene – constantly dirty or 'smelly'.
- Loss of weight, or being constantly underweight.
- Inappropriate clothing for the conditions.
- Poor parental engagement for school/health needs.

Changes in behaviour which can also indicate neglect may include:

- Complaining of being tired all the time.
- Not requesting medical assistance and/or failing to attend appointments.
- Having few friends.
- Mentioning being left alone or unsupervised.

NB: These definitions and indicators are not meant to be definitive, but only serve as a guide to assist you. It is important too, to remember that many children may exhibit some of these indicators at some time, and that the presence of one or more should not be taken as proof that abuse is occurring. There may well be other reasons for changes in behaviour such as a death, or the birth of a new baby in the family or relationship problems between parents/carers. In assessing whether indicators are related to abuse or not, the authorities will always want to understand them in relation to the child's development and context.

Abuse and Neglect - General Indicators:
The risk of maltreatment is recognised as being increased when there is:

- Parental or carer drug or alcohol abuse.
- Parental or carer mental ill health.
- Intra-familial violence or history of violent offending.
- Previous child maltreatment in members of the family.
- Known maltreatment of animals by the parent or carer.
- Vulnerable and unsupported parents or carers.
- Pre-existing disability in the child.

(NICE CG89: When to suspect Child Maltreatment, July 2009)

Babies Under 1 Year
All babies need to be safe, nurtured and able to thrive. The early care they receive provides the essential foundations for all future physical, social and emotional development. Whilst most parents do provide the love and care their babies need, sadly too many babies suffer abuse and neglect. The emotional abuse, neglect or physical harm of babies is particularly shocking both because babies are totally dependent on others and because of the relative prevalence of such maltreatment.

- 45 percent of serious case reviews in England relate to babies under the age of 1 year

In England and Wales, babies are eight times more likely to be killed than older children. An original analysis conducted for this report estimates, for the first time, the numbers of babies living in vulnerable and complex family situations:

- 19,500 babies under 1 year old are living with a parent who has used Class A drugs in the last year.
- 39,000 babies under 1 year old live in households affected by domestic violence in the last year.
- 93,500 babies under 1 year old live with a parent who is a problem drinker.
- 144,000 babies under 1 year old live with a parent who has a common mental health problem (All babies count campaign, NSPCC, executive summary. Nov 2011

WHAT IS CHILD SEXUAL EXPLOITATION?

Sexual exploitation of children and young people has been identified throughout the UK, in both rural and urban areas, and in all parts of the world. It affects boys and young men as well as girls and young women from any and of any ethnicity. It is a type of Sexual Abuse and can have a serious impact on every aspect of the lives of children involved. Child sexual exploitation (CSE) is the organised and deliberate exploitation of a child purely for the sexual gratification of adults.

The sexual exploitation of children is described in the Government's guidance as "involving exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) because of their performing, and/or another or others performing on them, sexual activities. It can occur using technology without the child's immediate recognition; e.g. being persuaded to post sexual images on the internet/mobile phones without immediate payment or gain. In all cases, those exploiting the child have power over them by their age, gender, intellect, physical strength and/or economic or other resources. Violence, coercion and intimidation are common, involvement in exploitative relationships being characterised in the main by the child's limited availability of choice resulting from their social/economic and/or emotional vulnerability."

Sexual exploitation results in children and young people suffering harm and causes significant damage to their physical and mental health. It can also have profound and damaging consequences for the child's family. Parents and carers are often traumatised and under severe stress. Siblings can feel alienated and their self-esteem affected. Family members can themselves suffer serious threats of abuse, intimidation and assault at the hands of perpetrators.

There are strong links between children involved in sexual exploitation and other behaviours such as running away from home or care, bullying, self-harm, teenage pregnancy, truancy and substance misuse. In addition, some children are particularly vulnerable, for example, children with special needs, those in residential or foster care, those leaving care, migrant children, unaccompanied asylum-seeking children, forced marriage and those involved in gangs.

Many sexually exploited children are hidden from public view. They are unlikely to be loitering or soliciting on the streets. Research and practice has helped to move the understanding away from a narrow view of seeing sexual exploitation as a young person standing on a street corner selling sex.

There is also often a presumption that children are sexually exploited by people they do not know. However, evidence shows that this is often not the case and children are often sexually exploited by people with whom they feel they have a relationship, e.g. a boyfriend/girlfriend.

Due to the nature of the grooming methods used by their abusers, it is very common for children and young people who are sexually exploited, not to recognise that they are being abused. Staff should be aware that, particularly young people aged 17 and 18, may believe themselves to be acting voluntarily and will need support to work with them so they can recognise that they are being sexually exploited.

Types of CSE
There are three main types of CSE:

• **Inappropriate Relationships**
This usually involves one perpetrator who has inappropriate power or control over a young person. There is often a significant age gap and the victim may believe they are in a loving relationship.

• **'Boyfriend' Model**
The perpetrator befriends and grooms the young person into a 'relationship' and then convinces or forces them to have sex with friends or associates. This is sometimes associated with gang activity.

• **Organised Sexual Exploitation**
Young people are passed through networks where they are forced into sexual activity with multiple men. This often occurs at 'sex parties' and the young people may be used to recruit others into the network Child Sexual Exploitation (CSE) can also take place over the internet.

Know the Signs
Even something that seems like normal teenage behaviour could be a sign that a child is being sexually exploited. Some of the visible signs include:

- Change in physical appearance - new clothes, more/less makeup, poor self-image, weight gain/loss.
- Having increased health/sexual health-related problems.
- Having marks or scars on their body which they try to conceal by refusing to undress or uncover parts of their body.
- Expressions of despair (self-harm, overdose, eating disorder, challenging behaviour, aggression, appearing drunk or under the influence of drugs/alcohol, suicidal tendencies, looking tired or ill, sleeping during the day).
- Sexually transmitted infections/pregnancy.
- Multiple miscarriages or terminations.
- Indicators of CSE in conjunction with chronic alcohol and drug use.
- Indicators of CSE alongside serious self-harming behaviour.
- Being defensive about where they have been and what they have been doing.
- Volatile/criminal behaviour.
- Use of the internet that causes concern including possible use of web cams.
- Becoming involved in criminality/repeat offending.
- Exclusion and/or unexplained absences from school or not engaged in education or training. Non-school attendance or excluded due to behaviour.
- Sexualised risk-taking including on the Internet and mobile phone.
- 'Sexting' (the act of sending sexually explicit messages or photographs, primarily between mobile phones).
- Increased use of online gaming including Xbox.
- Association with gangs.
- Removed from known 'red light' district by professionals due to suspected CSE.
- Child under 16 meeting different adults and exchanging or selling sexual activity.
- Being hostile or physically aggressive in their relationship with parents/carers or other family members.
- Getting into cars with unknown adults or associating with known CSE adults.
- Child under 13 engaging in penetrative sex with another over 15 years.
- Associating/developing a sexual relationship with older men or women.
- Reports of being involved in CSE through being seen in hotspots (i.e. in certain flats, recruiting grounds, cars or houses and maybe in the company of known CSE adults).
- Becoming disruptive at home or school or using offensive language.
- Being secretive or withdrawn.
- Older 'boyfriend/girlfriend' or relationship with a controlling adult.
- Physical or emotional abuse by that 'boyfriend/girlfriend' or controlling adult.
- Associating with other sexually exploited children.
- Regularly coming home late or going missing overnight or longer.
- Returning home after long intervals but appearing well cared for.
- Being a victim of honour-based violence.
- Unsuitable or inappropriate accommodation (including street homelessness, staying with adults known to be involved in CSE and living in a place where needs are not met).
- Being involved in witchcraft.
- Isolated from peers and social networks; not mixing with their usual friends.
- Lack of positive relationship with a protective, nurturing adult.
- Living independently and failing to respond to attempts by workers to keep in touch.
- Unusual association with taxi drivers/firms.
- Breakdown of residential placements due to behaviour.
- Having money, mobile phones, credit for mobile phones, sim cards, clothes, jewellery or other items without a plausible explanation and not given by parents/carers.
- Having multiple mobile phones, sim cards or use of a mobile phone that causes concern; multiple callers, more texts than usual.
- Overtly sexualised dress.
- Disclosure of physical/sexual assault and then refusing to make or withdrawing a complaint.
- Having possession of hotel keys/key cards or keys to unknown premises.
- Receiving rewards of money or goods for recruiting peers into CSE or just introducing peers to known adults.
- Knowledge of towns and cities they have no previous connection with.
- Being taken to clubs and hotels by adults and engaging in sexual activity.
- Disappearing from the 'system' with no contact or support.
- Being taken abroad by family members (forced marriage).
- Abduction and forced imprisonment.
- Being bought/sold for sexual acts.

Possible Indicators Specific to Boys and Young Men are:

• **Health**
Physical symptoms (e.g. bruising or sexually transmitted infections); drug or alcohol misuse; self-harm or eating disorders.

• **Education**
Truancy, deterioration of school work or part-time timetable.

• **Emotional and Behavioural Development**
Secretive e.g. about internet use; anti-social behaviour; sexualised language; sexually offending behaviour.

• **Family and Social Relationships**
Associating with other children and young people at risk of sexual exploitation; missing from home or staying out late; getting into cars of unknown people; contact with adults outside normal social group.

• **Identity**
Low self-esteem, poor self-image or lack of confidence.

• **Social Presentation**
Wearing an unusual amount of clothing.

• **Income**
Social activities with no explanation of how it has been funded; possession of abnormal amounts of money, gifts, new mobile phones, credit on mobile phone, number of SIM cards.

• **Social Integration**
Frequenting known high-risk areas or going to addresses of concern; seen at public toilets known for cottaging; seen at adult venues.

What are the Vulnerabilities?
The warning signs and vulnerabilities are indicated below:

Once engaged, offenders are likely to employ a series of sequential steps to erode the free will of the victim and trap them into a lifestyle which is not a choice but to which they can see no alternative as it has become all they know. These incremental steps may take the form of:

• **Chilling**
Generally associating with the child, supplying them with drink or drugs, listening to them, making them feel good and appearing to be the only one who understands them. Commonly, this phase may extend for a protracted period e.g. 12 months.

• **Presents**
The victim will be provided with gifts e.g. jewellery, electronic items or money.

• **Physical**
The offender will begin to ask for them to enter a sexual relationship.

• **Pestering**
Whether they have had a sexual relationship to date the pressure to do so or to expand it will be increased.
• **Threats**
To the victim and/or other people e.g. their family.

• **Orders**
The victim is essentially challenged to refuse what is being demanded of them.

• **Force**
Whether they consent the victim is physically forced to engage in sexual acts.

The Significance of Attachment
Victims often do not see themselves as such and may defend their abuser. Some will avoid contact with the Police and can be the hardest victims to gain the confidence of and protect. If a child or a young person presents with an indicator of CSE, action is required; the earlier the intervention, the better the chances for success.

Attachment between the victim and offender is the key to CSE occurring and continuing, and breaking that attachment is the most effective way to tackle the issue, safeguard the victim and deal with the offender. Attachment arises from the grooming/indoctrination process as the offender creates the cognitive distortions of the victim. They erode pre-existing relationships and bonds and replace them with their own, making them the single most important person in the victim's life. In doing so, they create a position whereby the victim is more likely to give in to their demands and less likely to report them due to the natural processes of the brain. Attachment also explains why the victim will repeatedly return to the offender even after making complaints about them; refuse to pursue complaints that have been made and give false details about persons involved or acts that have occurred.

Important Information About CSE
Sexual exploitation can take many forms, from the seemingly 'consensual' relationship where sex is exchanged for attention, accommodation or gifts, to serious organised crime and child trafficking.

What marks out exploitation is an imbalance of power within the relationship. The perpetrator always holds power over the victim, increasing the dependence of the victim as the exploitative relationship develops.

Technology can play a part in sexual abuse, for example, through its use to record abuse and share it with other like-minded individuals or as a medium to access children and young people to groom them. A common factor in all cases is the lack of free economic or moral choice.

Sexual exploitation has strong links with other forms of 'crime', for example, domestic violence and abuse, online and offline grooming, the distribution of abusive images of children and child trafficking. Many adults involved in prostitution describe difficult childhood experiences that include domestic violence and abuse, neglect, emotional abuse, disrupted schooling and low educational attainment.

The perpetrators of sexual exploitation are often well organised and use sophisticated tactics. They are known to target areas where children and young people gather without much adult supervision, e.g. parks or shopping centres or sites on the Internet.

REFERRAL

As in all cases, concerns that a child may be at risk of sexual exploitation should be discussed with a manager and/or designated professional for safeguarding, and a decision made as to whether there should be a referral to Children's Social Care.
The wishes and feelings of the child or young person should be obtained when deciding how to proceed, but staff should be aware that perpetrators may have groomed the child's responses and that the child may be denying what is happening. Where a member of staff is fearful of losing the engagement of a child or young person by reporting their concern to Children's Social Care, the manager should discuss this with Children's Social Care to agree a way forward. Any decision not to share information or refer a child should be recorded with a full explanation of the rationale behind that decision and the prevailing circumstances at that time. This will assist in the future if there is a review of the case and the decision-making processes.

A child or young person who is suspected of suffering or being at risk of suffering sexual exploitation will be a child who may be a Child in Need under the Children Act 1989 and should be referred to Children's Social Care using the relevant local child protection referral procedures.

The Local Safeguarding Partnership will consult and share information concerning incidents or suspicions of sexual exploitation within 24 hours. A decision should be made whether a criminal offence has been committed against a child or young person.

The child's individual needs and circumstances must be carefully assessed, including issues of ethnicity, gender, culture, disability, religion and sexual orientation.

POLICY OWNER: ROBERT STIFF

POSITION: CEO

SIGNATURE: Robert Stiff

DATE: 01/11/2020

REVIEW: 01/11/2023

NURSDOC