Springfield Primary School
SAFEGUARDING POLICY

Date agreed by Governors: **September 2016**
Date for renewal: **Spring 2018**

'Every Child Matters'

Principles
Section 175 of the Education Act 2002 gives maintained schools a statutory duty to promote and safeguard the welfare of children, and have due regard to the guidance 'Keeping Children Safe in Education DFE 2015

Child Protection Policy Statement

Aims
Springfield Primary School recognises that it has a duty to ensure arrangements are in place for safeguarding and promoting the welfare of children and we will carry out this duty through our teaching and learning, pastoral care and extended school activities. All members of the school community (including volunteers and governors) will at all times establish and maintain a safe and stimulating environment where children feel secure, are encouraged to talk to adults they can trust and are listened to. We also adopt an ethos where staff and pupils can talk freely about concerns, are listened to and appropriate action taken.
Through monitored on line training, all staff (teaching and non-teaching) will be able to recognise the signs of abuse and understand their responsibilities when a child may be at risk of harm. Training of all staff will be updated annually.

The school will ensure that it provides written referrals on the correct form and recognises the importance of attendance at all meetings called when there is a concern regarding the safeguarding of a pupil.

When to be concerned

All staff and volunteers should be aware that the main categories of abuse are:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect

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

Staff recruitment
In line with the guidance 'Safer Recruitment', the Head Teacher and Chair of Governors have completed Safer Recruitment training. All staff including volunteers who have access to children in our school have been carefully selected and screened and all have had an

enhanced Disclosure and Barring Service and the new Staff Disqualification Declaration prior to commencing work.

Designated member of staff
The designated member of staff for safeguarding in this school is:

Jill Lowery

Assisted by:

Marianne Allen and Deb Brown

Our designated member of staff is fully trained and regularly receives updated training as necessary. All staff, including the DSL, undergo online safeguarding training annually. The School office keeps copies of their certificates.

Governors

Governors are required to have an enhanced Disclosure and Barring Service (DBS).

Reporting and Recording Concerns

All staff need to be aware of the early help process and be prepared to identify children and families that may benefit. All staff are responsible for filling in course for concern sheets which are collated by the designated person who ensures these confidential records are kept securely. It is the responsibility of the designated member of staff to have discussions with MASH (Multi-Agency Support Hub and/or Social Care when concerns arise regarding the safety of a pupil in this school. All such pupils are closely monitored, including attendance, and where extra concerns arise these are passed on to the appropriate agencies. Any liaison with outside agencies is subject to confidentiality and will only be discussed with the DSL. Advice and support are offered to other members of staff dealing with a pupil for whom there are concerns. Staff need to be aware of the difference between a 'concern' about a child and 'immediate danger of risk or harm'. If they are unsure, then they will approach the DSL for advice and guidance. All concerns, discussions and decisions are recorded in writing and a copy given to the DSL. This will be kept in a secure place.
There are regular meetings with the Early Help advisor for Springfield Lower School.
The designated member of staff has had Prevent Training and is qualified to train members of staff within the school. Teaching staff have all undertaken Prevent training, which will be updated on a regular basis. The Local Prevent Officer from the Police is James Marshall.

Designated Governor
Our school has a designated safeguarding governor who will act as the link person between the governing body and the designated officer. The governor will review safeguarding procedures/practices including access to training. The governors will ensure that sufficient time is given to carry out the duties including accessing training. Where safeguarding concerns arise regarding a member of staff, the governor will liaise with the Chair of Governors.

The designated governor for safeguarding children is:

Anna Goddard

Children with Education and Health Care Plans.
We recognise that statistically children with behavioural difficulties and disabilities are most vulnerable to abuse. Through regular training, all staff who support these pupils will be fully aware of the need for vigilance for signs of abuse.

Allegations of abuse made against other children
As a Value based school we promote tolerance and respect for each other. We do recognise that children are capable of abusing their peers. Peer on peer allegations are taken very seriously and will be investigated and dealt with as soon as possible (see anti-bullying policy).

Parents
This school believes in working closely with parents and in most cases where we have a concern about a pupil, the parents will be informed. This policy is available to parents on request.

Allegations against a member of staff
Where there is a concern that a member of staff may have behaved inappropriately the Head Teacher will discuss the matter with the Allegations Manager as laid down in the Bedfordshire LSCB procedures and the Chair of Governors will be informed. However, where the allegation made concerns the Head Teacher, the Chair of Governors will liaise with the Allegations Manager. The school will not attempt to investigate unless authorised to do so.
The policy will be implemented, monitored and evaluated on a yearly basis by designated governor, designated member of staff and Head Teacher.

The school will adhere to the DfE Statutory guidance: Dealing with Allegations of Abuse against Teachers and Other Staff including adhering to legislation as set out in the Education Act 2011 relating to the retention of anonymity of a teacher who is subject to an allegation of a criminal offence made by, on behalf of, a registered pupil at the school.

Online Safety

In an increasingly digital age, Springfield takes online safety very seriously. We have an online safety policy that outlines the measures we take. These include:

- Appropriate Broadband filters and monitoring systems (provided by Schools' Broadband)
- Regular internet safety lessons and activities
- Pupils are not allowed to bring mobile phones to school
- Mobile devices used in the classroom are subject to the same filtering as the computers.

This policy links to other school's policies on:
PSHCE
Health and Safety
Behaviour and Attendance
Sex and Relationships Education
Bullying
Confidentiality
Internet Safety
Visits
Looked After Children

Legislation relating to this policy:
Children Act 1989, 2004
Education Act 1996, 2002 (Section 175) 2011 Chapter 21

School Standards and Framework act 1998
Keeping Children Safe in Education Statutory Guidance for Schools and Colleges September 2016

Manuals kept in school

Working Together to Safeguard Children 2015
Promoting the Educational Attainment of Children who are Looked After (CLA) in Schools 2014
Personal Education Plans for Children who are Looked After 2013
Working Together to Safeguard Children 2015
Statutory Guidance on Promoting the Health and Well-being of Looked After Children 2015
Safeguarding Children in whom illness is fabricated or induced 2008
Guidance for Schools on Developing Emotional Health and Wellbeing 2015
Safeguarding Children and Safer Recruitment in Education 2012
Bedfordshire Safeguarding Inter-Agency Procedures 2015
Staff health and wellbeing 2012
The Roles and Responsibilities of the Designated teacher for Looked after Children 2012
Safer working practice – DfE Guidance 2013
Dealing with Abuse against Teachers and Other Staff 2012
Keeping Children Safe in Education Statutory Guidance for Schools and Colleges July 2015

APPENDIX 1 - INDICATORS OF HARM

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 of, or deliberately induces, illness in a child.

Indicators in the child

Bruising

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

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

Fractures

Fractures may cause pain, swelling and discolouration over a bone or joint. It is unlikely that a child will have had a fracture without the carers being aware of the child's distress.
If the child is not using a limb, has pain on movement and/or swelling of the limb, there may be a fracture.

There are grounds for concern if:

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

Rib fractures are only caused in major trauma such as in a road traffic accident, a severe shaking injury or a direct injury such as a kick.
Skull fractures are uncommon in ordinary falls, i.e. from three feet or less. The injury is usually witnessed, the child will cry and if there is a fracture, there is likely to be swelling on the skull developing over 2 to 3 hours. All fractures of the skull should be taken seriously.

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

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

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

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

Bite Marks
Bite marks can leave clear impressions of the teeth when seen shortly after the injury has been inflicted. The shape then becomes a more defused ring bruise or oval or crescent shaped. Those over 3cm in diameter are more likely to have been caused by an adult or older child.
A medical/dental opinion, preferably within the first 24 hours, should be sought where there is any doubt over the origin of the bite.

Burns and Scalds
It can be difficult to distinguish between accidental and non-accidental burns and scalds. Scalds are the most common intentional burn injury recorded.
Any burn with a clear outline may be suspicious e.g. circular burns from cigarettes, linear burns from hot metal rods or electrical fire elements, burns of uniform depth over a large area, scalds that have a line indicating immersion or poured liquid.
Old scars indicating previous burns/scalds which did not have appropriate treatment or adequate explanation. Scalds to the buttocks of a child, particularly in the absence of burns to the feet, are indicative of dipping into a hot liquid or bath.
The following points are also worth remembering:

- A responsible adult checks the temperature of the bath before the child gets in.
- A child is unlikely to sit down voluntarily in a hot bath and cannot accidentally scald its bottom without also scalding his or her feet.

- A child getting into too hot water of his or her own accord will struggle to get out and there will be splash marks.

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

Emotional/behavioural presentation
Refusal to discuss injuries
Admission of punishment which appears excessive
Fear of parents being contacted and fear of returning home
Withdrawal from physical contact
Arms and legs kept covered in hot weather
Fear of medical help
Aggression towards others
Frequently absent from school
An explanation which is inconsistent with an injury
Several different explanations provided for an injury

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

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

EMOTIONAL ABUSE
Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.
It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate.

It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.
It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.
Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Indicators in the child

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

Indicators in the parent

Domestic abuse, adult mental health problems and parental substance misuse may be features in families where children are exposed to abuse.
Abnormal attachment to child e.g. overly anxious or disinterest in the child
Scapegoats one child in the family
Imposes inappropriate expectations on the child e.g. prevents the child's developmental exploration or learning, or normal social interaction through overprotection.
Wider parenting difficulties, may (or may not) be associated with this form of abuse.

Indicators in the family/environment

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

NEGLECT

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

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

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

Indicators in the child

Physical presentation

Failure to thrive or, in older children, short stature
Underweight
Frequent hunger
Dirty, unkempt condition
Inadequately clothed, clothing in a poor state of repair
Red/purple mottled skin, particularly on the hands and feet, seen in the winter due to cold
Swollen limbs with sores that are slow to heal, usually associated with cold injury
Abnormal voracious appetite
Dry, sparse hair
Recurrent / untreated infections or skin conditions e.g. severe nappy rash, eczema or persistent head lice / scabies/ diarrhoea
Unmanaged / untreated health / medical conditions including poor dental health
Frequent accidents or injuries

Development

General delay, especially speech and language delay
Inadequate social skills and poor socialization

Emotional/behavioural

Attachment disorders
Absence of normal social responsiveness
Indiscriminate behaviour in relationships with adults
Emotionally needy
Compulsive stealing
Constant tiredness
Frequently absent or late at school
Poor self esteem
Destructive tendencies
Thrives away from home environment
Aggressive and impulsive behaviour
Disturbed peer relationships
Self harming behaviour

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

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

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

Indicators in the child
Physical presentation
Urinary infections, bleeding or soreness in the genital or anal areas
Recurrent pain on passing urine or faeces
Blood on underclothes
Sexually transmitted infections
Vaginal soreness or bleeding
Pregnancy in a younger girl where the identity of the father is not disclosed and/or there is secrecy or vagueness about the identity of the father

Physical symptoms such as injuries to the genital or anal area, bruising to buttocks, abdomen and thighs, sexually transmitted disease, presence of semen on vagina, anus, external genitalia or clothing

Emotional/behavioural presentation
Makes a disclosure.
Demonstrates sexual knowledge or behaviour inappropriate to age/stage of development, or that is unusually explicit
Inexplicable changes in behaviour, such as becoming aggressive or withdrawn
Self-harm - eating disorders, self mutilation and suicide attempts
Poor self-image, self-harm, self-hatred
Reluctant to undress for PE
Running away from home
Poor attention / concentration (world of their own)
Sudden changes in school work habits, absences
Withdrawal, isolation or excessive worrying
Inappropriate sexualised conduct
Wetting or other regressive behaviours e.g. thumb sucking
Draws sexually explicit pictures
Depression

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

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