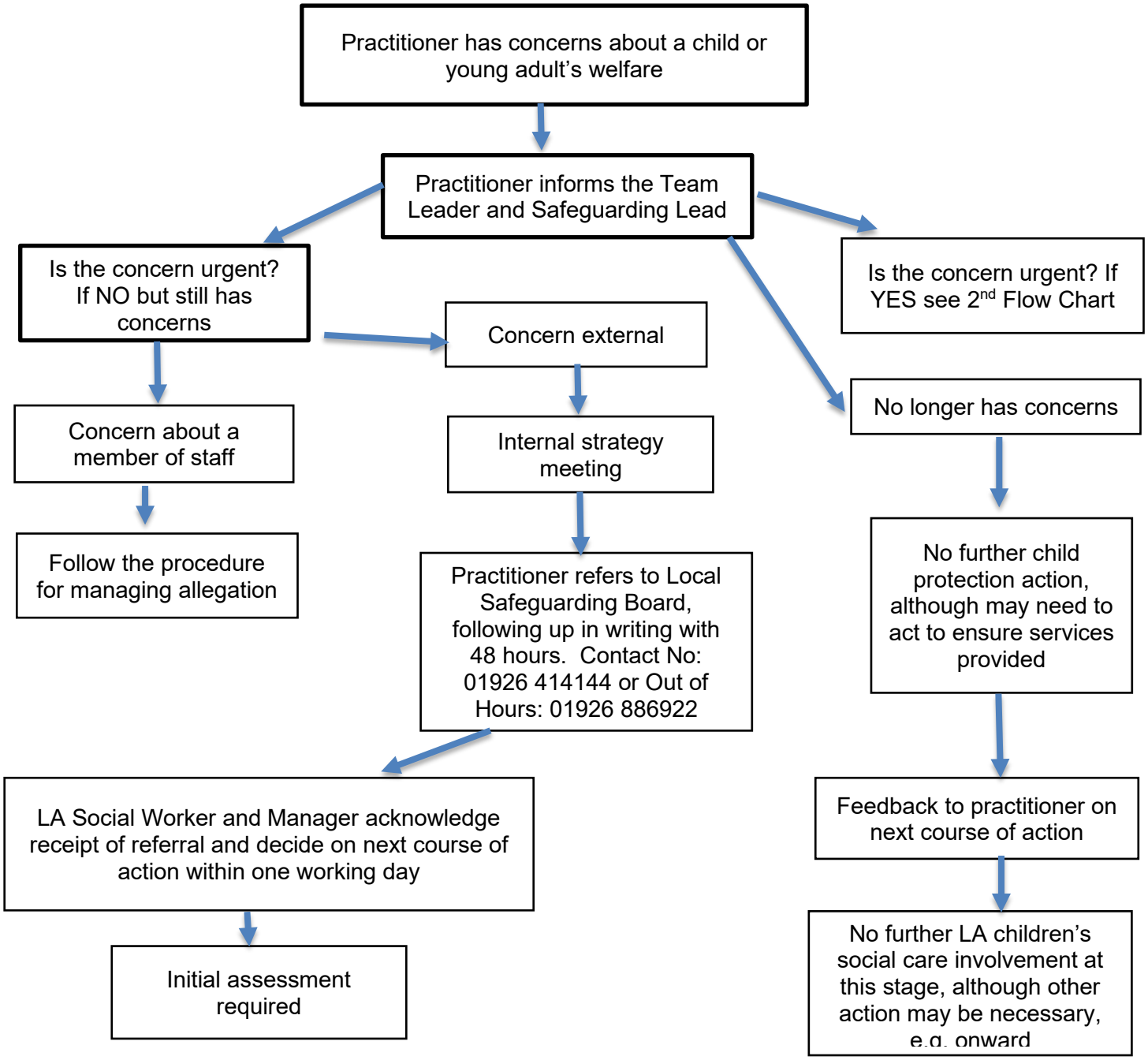
Safeguarding Children Policy

Abbreviations

Local Safeguarding Children Board (LSCB)
Department for Children, Schools and Families (DCSF)

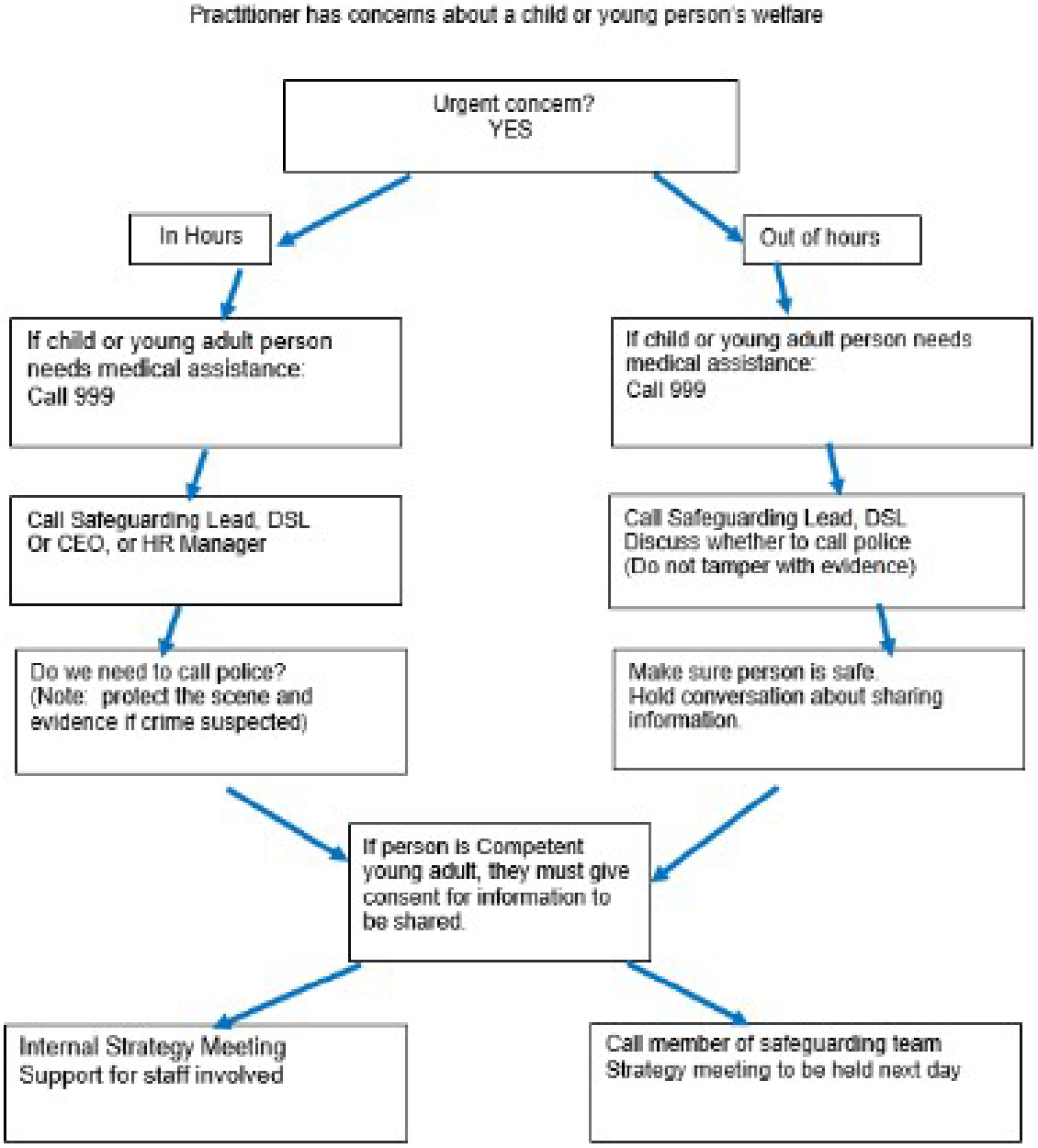
1. Responding to concerns and reporting flowchart



Contacts:

Head of Clinical Services	07900 404 838
Chief Executive Officer	07917 970 769
Human Resources Manager	07780 329 545

2. Responding to Urgent Concerns and Reporting Flowchart



3. Introduction

The Shakespeare Hospice fully recognises its responsibilities for safeguarding children. Our policy applies to all staff, trustees and volunteers working in the hospice.

There are five main elements to our policy:

- Ensuring we practice safer recruitment in checking the suitability of staff, trustees and volunteers to work with children;
- Raising awareness of child protection issues and equipping children with the skills needed to keep them safe;
- Developing and then implementing procedures for identifying and reporting cases, or suspected cases, of abuse;
- Supporting children who have been abused in accordance with his/her agreed child protection plan;
- Establishing a safe environment in which children can achieve their potential and develop.

4. Procedures

We will follow the procedures set out by the Local Safeguarding Children Board (LSCB) and take account of guidance issued by the Department for Children, Schools and Families (DCSF).

The Hospice will:

- Ensure it has a Designated Senior Member of Staff (DSMS) who will undertake regular, appropriate training for this role; (DSMS – Head of Clinical Services)
- Ensure it has a member of staff who will act in the absence of the DSMS;
- Ensure it has a nominated trustee responsible for safeguarding children;
- Ensure every member of staff (including temporary, agency staff and volunteers) and the Board of Trustees know the name of the DSMS and their role;
- Ensure all staff and volunteers understand their responsibilities in being alert to the signs of abuse and responsibility for referring any concerns to the DSMS;
- Ensure that parents understand the responsibility placed on the hospice and staff for child protection by setting out its obligations in the hospice's literature;
- Develop effective links with relevant agencies and co-operate as required with their enquiries regarding safeguarding matters, including attendance at strategy meetings, initial case conferences, core group and child in need review meetings;
- Ensure that the duty of care towards children and staff is promoted by raising awareness of illegal, unsafe and unwise behaviour and assist staff to monitor their own standards and practice;
- Be aware of and follow procedures set out by Children's Services and the LSCB where an allegation is made against a member of staff, trustee or volunteer;
- Ensure safer recruitment practices are always followed.

Our procedures will be reviewed annually and up-dated in accordance with current legislation.

When staff, trustees and volunteers join our hospice they will be informed of the safeguarding children arrangements in place. They will be given a copy of this policy and told who the DSMS is and who acts in their absence.

The induction programme will include basic safeguarding information relating to signs and symptoms of abuse, how to manage a disclosure from a child, when and how to record a concern about the welfare of a child.

All volunteers and regular visitors to our hospice will be told where our policy is kept and given the name of the DSMS.

The Shakespeare Hospice will adopt the guidelines within the documents What to do if you are worried a child is being abused (2006) and Working Together to Safeguard Children (2018).

5. Responsibilities

- The Board of Trustees has a proactive duty and responsibility to safeguard and promote the welfare of children and to protect their rights to receive the Hospice's services in safety, free from abuse and neglect.
- The Board of Trustees is responsible for ensuring that there is an organisational culture where safeguarding is a priority, a golden thread that runs through everything.
- The Board of Trustees will nominate a member to be responsible for Safeguarding Children and liaise with the DSMS in matters relating to Safeguarding. It will ensure that Safeguarding Policies and procedures are in place, available to parents and reviewed annually.
- The Chief Executive Officer will ensure that the Safeguarding Policies and procedures are fully implemented and followed by all staff (including temporary, agency and volunteers) and that sufficient resources are allocated to enable the DSMS and other staff to discharge their responsibilities with regard to Safeguarding.
- The DSMS will co-ordinate action on safeguarding and promoting the welfare of children within the hospice ensuring that all staff, volunteers and visitors to the hospice know who the DSMS is and who acts in his/her absence, they are aware of their responsibilities in being alert to the signs of abuse and of their responsibility to report and record any concerns. No one can delegate their duty of care.

6. Managing a Disclosure

Staff in hospices are in a unique position to observe children's behaviour over time and often develop close and trusting relationships with them. If a child discloses directly to a member of staff, the following procedures will be followed:

- Listen carefully to what is said.
- Ask only open questions such as:
    - 'How did that happen?'
    - 'What was happening at the time?'
    - 'Anything else you want to tell me?'
- Do not ask questions which may be considered to suggest what might have happened, or who has perpetrated the abuse, e.g. 'Did your Dad hit you?'
- Do not force the child to repeat what he/she said in front of another person.

Following a disclosure, the member of staff should talk immediately to the DSMS and complete a written record.

7. Information Sharing & Confidentiality

- We recognise that all matters relating to Child Protection are confidential.
- The CEO or DSMS will disclose any information about a child to other members of staff on a need to know basis only.
- All staff must be aware that they have a professional responsibility to share information with other agencies to safeguard children.

- All staff must be aware that they cannot promise to a child to keep secrets.

We are committed to protecting the privacy of the young people that engage with us through our website and at fundraising events as detailed in the TSH Privacy Policy. Fundraising events also request specific information about the age of participants.

Anyone under the age of 16 must obtain parental or guardian consent before participating in an event organised by The Shakespeare Hospice. Children aged under 13 must obtain the consent of a parent or guardian before providing any personal information.

8. Record Keeping

Any member of staff receiving a disclosure of abuse from a child or young person, or noticing signs or symptoms of possible abuse, will make notes as soon as possible (within the hour, if possible) writing down exactly what was said, using the child's own words as far as possible. All notes should be timed, dated and signed, with name printed alongside the signature. Concerns should be recorded using the hospice's safeguarding children recording system.

All records of a child protection nature should be passed to the DSMS including case conference minutes and written records of any concerns.

9. Supporting Children

We recognise that children who are abused or witness violence may find it difficult to develop a sense of self-worth. They may feel helplessness, humiliation and some sense of blame. The hospice may be the only stable, secure and predictable element in the lives of children at risk. When at the Hospice their behaviour may be challenging and defiant or they may be withdrawn. The Hospice will endeavour to support the child through:

- The content of the curriculum in the day centre;
- The Hospice's ethos which promotes a positive, supportive and secure environment and gives children a sense of being valued;
- The Hospice's behaviour policy which is aimed at supporting vulnerable children in the Hospice. The Hospice will ensure that the child knows that some behaviour is unacceptable, but they are valued and not to be blamed for any abuse which has occurred;
- Liaison with other agencies that support the child such as Children's Services, Child and Adult Mental Health Service (CAMHS), education service, education welfare service and educational psychology service and those agencies involved in the safeguarding of children;
- Notifying Children's Social Care immediately there is a significant concern. The Local Safeguarding Board Contact No: 01926 414144 – Out of Hours: 01926 886922
- Providing continuing support to a child about whom there have been concerns who leaves the hospice by ensuring that appropriate information is forwarded under confidential cover to the child's new hospice.

10. Supporting Staff

We recognise that staff working in the hospice who have become involved with a child who has suffered harm, or appears to be likely to suffer harm, may find the situation stressful and upsetting. We will support such staff by providing an opportunity to talk through their anxieties with the DSMS and to seek further support as appropriate.

11. Safer Recruitment and Selection of Staff

'This hospice is committed to safeguarding and promoting the welfare of children and young people and expects all staff, trustees and volunteers to share this commitment.'

The hospice has a written recruitment and selection policy statement and procedures linking explicitly to this policy. The statement (see above) is included in all job advertisements, publicity material, recruitment websites, and candidate information packs.

The recruitment process is robust in seeking to establish the commitment of candidates to support the hospice's measures to safeguard children and to deter, reject or identify people who might abuse children or are otherwise unsuited to work with them.

The Head of Human Resources holds a Single Central Register regarding the issue of Disclosure and Barring Service certificates, for all Volunteers, Staff and Trustees.

12. Allegations against staff

We understand that a child may make an allegation against a member of staff.

If such an allegation is made, the member of staff receiving the allegation will immediately inform the Head of Clinical Services or, in their absence the Chief Executive Officer or Head of Human Resources.

The CEO on all such occasions will discuss the content of the allegation with the Local Safeguard Board's Senior Adviser for Safeguarding Children. Local Safeguarding Board Contact: 01926 414144 - Out of Hours: 01926 886922. If the allegation made to a member of staff concerns the CEO, the designated Member of staff will immediately inform the Chair of Trustees who will consult with the Local Safeguarding Board – Contact No: 01926 414144 – Out of Hours:01926 886922.

The Hospice will follow the appropriate Disciplinary Policy, a copy of which is readily available in the Hospice.

13. Whistleblowing

We recognise that children cannot be expected to raise concerns in an environment where staff fail to do so. All staff should be aware of their duty to raise concerns, where they exist, about the attitude or actions of colleagues.

14. Complaints or Concerns expressed by Children, Parents, Staff, Trustees or Volunteers

We recognise that listening to children is an important and essential part of safeguarding them against abuse and neglect. To this end any expression of dissatisfaction or disquiet in relation to an individual child will be listened to and acted upon to safeguard his/her welfare.

We will also seek to ensure that the child or adult who makes a complaint is informed not only about the action the hospice will take but also the length of time that will be required to resolve the complaint. The hospice will also endeavour to keep the child or adult regularly informed as to the progress of his/her complaint.

15. Prevention

We recognise that the hospice plays a significant part in the prevention of harm to children by providing them with good lines of communication with trusted adults, supportive friends and an ethos of protection.

The hospice will therefore:

- Establish and maintain an environment where children feel secure, are encouraged to talk, and are always listened to;
- Ensure children know that there are adults in the hospice whom they can approach if they are worried or in difficulty;
- Include in the day centre curriculum opportunities that equip children with the skills they need to recognise and stay safe from abuse.
- In order to meet our safeguarding compliance , and to safeguard our own staff and volunteers, young people under the age of 18 volunteering can only work in Hospice Departments with a member of staff who has a clear DBS (Standard) certificate and passed the e-learning Children's Safeguarding level 1 and 2 course. A volunteer can only work with a young person when a member of staff is present.

16. Physical Intervention

Our policy on positive handling is set out in a separate policy and acknowledges that staff must only ever use physical intervention as a last resort, and that always it must be the minimal force necessary to prevent injury or damage to property.

We understand that physical intervention of a nature that causes injury or distress to a child may be considered under safeguarding children or disciplinary procedures.

17. Abuse of Trust

We recognise that as adults working in the Hospice, we are in a relationship of trust with the children in our care and acknowledge that it is a criminal offence to abuse that trust.

We acknowledge that the principle of equality embedded in the legislation of the Sexual Offenders Act 2003 applies irrespective of sexual orientation: neither homosexual nor heterosexual relationships are acceptable within a position of trust.

We recognise that the legislation is intended to protect young people who are over the age of consent but under 18 years of age.

18. Racist Incidents

Our policy on racist incidents is set out in a separate policy and acknowledges that repeated racist incidents or a single serious incident may lead to consideration under safeguarding children procedures.

19. Bullying

Our policy on bullying is set out in a separate policy and acknowledges that to allow or condone bullying may lead to consideration under safeguarding children procedures.

20. E-safety

Our Acceptable Use policy recognises that internet safety is a whole hospice responsibility (staff, trustees, volunteers, children, parents).

Children and young people may expose themselves to danger, whether knowingly or unknowingly, when using the internet and other technologies. Additionally, some young people may find themselves involved in activities which are inappropriate or possibly illegal.

We therefore recognise our responsibility to educate our children, teaching them the appropriate behaviours and critical thinking skills to enable them to remain both safe and legal when using the internet and related technologies.

21. Health & Safety

Our Health & Safety policy, set out in a separate document, reflects the consideration we give to the safeguarding of our children both within the hospice environment and when away from the hospice when undertaking fundraising, trips and visits.

22. Other Relevant Policies

The Board of Trustees' legal responsibility for safeguarding the welfare of children goes beyond basic child protection procedures. The duty is now to ensure that safeguarding permeates all activity and functions. This policy therefore complements and supports a range of other policies, for instance:

- Managing Allegations and Concerns Against Staff, Trustees and Volunteers
- Complaints Procedure
- First aid and the administration of medicines
- Health and Safety
- Equal Opportunities
- Safer Recruitment and Employment Standards.

The above list is not exhaustive but when undertaking development or planning of any kind the hospice will need to consider safeguarding matters.

Contacts: - Accountability

Internal: -

Chief Executive Officer
Designated Senior Member of Staff for Child Protection /The Head of Clinical Services

People who act in the absence of the Designated Senior Member of Staff
The Safeguarding Team: - Lead Nurse Quality
Transitional Care Nurse Lead; Y& C Co-ordinator or Y &C Support Co-ordinator

External: -

Multi-Agency Safeguarding Hub (MASH)	01926 414144
Out of Hours Emergency Duty Team	01926 886922

Warwickshire Safeguarding Children Board	01926 410410
Police Public Protection Unit:	101/ 999
NSPCC Helpline	0808 800 5000
www.help@nspcc.org.uk Child Line	800 1111

www.childline.oeg.uk

Child Exploitation and Online Protection Agency (CEOP) www.ceop.police.uk/

23. Training

Shakespeare Hospice Staff, Volunteers and Trustees will be trained in accordance with the safeguarding competences outlined below.

Safeguarding competences are the set of abilities that enable staff to effectively safeguard, protect and promote the welfare of children and young people. They are a combination of skills, knowledge, attitudes and values that are required for safe and effective practice.

Different staff groups require different levels of competence depending on their role and degree of contact with children, young people and families, the nature of their work, and their level of responsibility. In response to the Laming Report and other evidence, there has been recognition of the importance of the level of competence of some practitioner groups, for example GPs and paediatricians.

This Framework identifies six levels of competence and gives examples of groups that fall within each of these. The levels are as follows:

- Level 1: Non-clinical staff working in health care settings
- Level 2: Minimum level required for clinical staff who have some degree of contact with children and young people and/or parents/carers
- Level 3: Clinical staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns
- Level 4: Named professionals
- Level 5: Designated professionals
- Level 6: Expert

Reference:

Safeguarding Children and Young people: roles and competences for health care staff – September 2015

APPENDIX A

Safeguarding Children Policy contains the following forms:

Form 1: Logging a Concern about a Child's Safety and Welfare – all staff, trustees and visitors

Form 2: Front Sheet: Child Protection Record

Form 3: Checklist for handling and recording allegations or complaints made against a member of staff or volunteer

Please photocopy the forms and use as required.

APPENDIX A – FORM 1

Logging a Concern about a Child's Safety and Welfare – all staff and visitors

<table>
<tr><td colspan="3">Child's Name: d.o.b.</td></tr>
<tr><td colspan="2">Date:</td><td>Time:</td></tr>
<tr><td colspan="2">Name:

.....……
Print</td><td>

.....…….
Signature</td></tr>
<tr><td colspan="3">Position:</td></tr>
<tr><td colspan="3">Note the reason(s) for recording the incident.</td></tr>
<tr><td rowspan="4">Record the following factually:</td><td colspan="2">Who?</td></tr>
<tr><td colspan="2">What?</td></tr>
<tr><td colspan="2">Where?</td></tr>
<tr><td colspan="2">When?</td></tr>
<tr><td colspan="3">Offer an opinion where relevant (how and why might this have happened?)</td></tr>
<tr><td colspan="3">Substantiate the opinion. Note action taken, including names of anyone to whom your information was passed.</td></tr>
</table>

Check to make sure your report is clear now - and will also be clear to a stranger reading it next year.

PLEASE PASS THIS FORM TO YOUR DESIGNATED PERSON FOR CHILD PROTECTION

APPENDIX A – FORM 2

FRONT SHEET: CHILD PROTECTION RECORD

Date file started .....

Name of child .....

Any other names by which child known, if relevant .....

.....

Date of birth .....

Address .....

.....

..... Postcode .....

Other family members (include full name, relationship e.g. mother, stepfather etc. For U18s, include age, if known).

Are any other child protection files held in the hospice relating to this child or another child closely connected to him/her? YES/NO

If yes, which files are relevant?

.....

.....

Name and contact number of key worker (Social Care), if known

.....

Name and contact number of GP, if known

.....

APPENDIX A – FORM 3

Checklist for handling and recording allegations or complaints made against a member of staff, trustee or volunteer.

1. Name and position of member of staff who is subject of allegation/complaint:

.....
2. Is the complaint written or verbal? .....
3. Complaint made by: ..... Relationship to child: .....
4. Name of child: ..... Age and d.o.b.: .....
5. Parents'/Carers' name and address: .....
.....

.....
6. Date of alleged incident/s: .....
7. Did the child attend on this/these dates? .....
8. Nature of the complaint (continue on a separate sheet if necessary): .....
.....

.....

.....

.....

.....

.....

.....

9. Other relevant information:
.....

.....

.....

APPENDIX A – FORM 3

10. Senior Adviser for Safeguarding contacted: ..... Date: .....…….
11. Further actions advised by Children's Services: .....……

.....……..

.....…….

.....…….

.....…….

Checklist Yes No

- Do you have details (either a written account or notes from a verbal account) of the alleged incident, signed and dated?
- Have you checked the incident could actually have taken place?
  (i.e. was the child in the hospice; was the member of staff on duty in the hospice on that day)?
- Is there evidence of significant harm – e.g. a visible injury?
- Has a criminal offence taken place – e.g. has excessive force been used, that could be classed as an assault?
- Has the incident been reported to anyone else – e.g. the Police?
- Were there any witnesses to the incident – if so have you made a note of names?
- Are parents aware of the allegation?
- Is the member of staff aware of the allegation?
- Have you reported the allegation to the Senior Adviser for Safeguarding Children?

Remember, do not attempt to investigate the allegation yourself.

Your name and position: …….

Signature:…….. Date: …….

APPENDIX B

Effects of domestic abuse on children and young people

The impact of domestic abuse on the quality of a child's or young person's life is very significant. Children and young people who live with domestic abuse are at increased risk of behavioural problems, emotional trauma, and mental health difficulties in adult life.

The impact of domestic abuse on children and young people can be wide-ranging and may include effects in any or all the following areas:

Physical: Children and young people can be hurt either by trying to intervene and stopping the violence or by being injured themselves by the abuser. They may develop self-harming behaviour or eating disorders. Their health could be affected, as they may not be being cared for appropriately. They may have suicidal thoughts or try to escape or blank out the abuse by using drugs, alcohol or by running away.

Sexual: There is a high risk that children and young people will be abused themselves where there is domestic abuse. In homes where living in fear is the norm, and situations are not discussed, an atmosphere of secrecy develops, and this creates a climate in which sexual abuse could occur. In addition to this, children and young people may sometimes be forced to watch the sexual abuse of their mother/carer. This can have long-lasting effects on the sexual and emotional development of the child/young person.

Economic: The parent or carer of the child or young person may have limited control over the family finances. Therefore, there might be little or no money available for extracurricular activities, clothing or even food, impacting on their health and development.

Emotional: Children and young people will often be very confused about their feelings – for example, loving both parents/carers but not wanting the abuse to continue. They may be given negative messages about their own worth, which may lead to them developing low self- esteem. Many children and young people feel guilty, believing that the abuse is their fault. They are often pessimistic about their basic needs being met and can develop suicidal thoughts. Some children and young people may internalise feelings and appear passive and withdrawn or externalise their feelings in a disruptive manner.

Isolation: Children and young people may become withdrawn and isolated; they may not be allowed out to play; and if there is abuse in the home they are less likely to invite their friends round. Attendance at the hospice may be disrupted in many ways, and this may contribute to their growing isolation. They may frequently be absent from the hospice as they may be too scared to leave their mother alone. They may have to move away from existing friends and family – e.g. into a refuge or other safe or temporary accommodation.

Threats: Children and young people are likely to have heard threats to harm their mother/father. They may have been directly threatened with harm or heard threats to harm their pet. They also live under the constant and unpredictable threat of violence, resulting in feelings of intimidation, fear and vulnerability, which can lead to high anxiety, tension, confusion and stress.

This clearly highlights that living with domestic abuse has a significant impact on a child's ability to achieve the five outcomes as outlined in Every Child Matters agenda:

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

APPENDIX B

What you might see in the Hospice

- Unexplained absences or lateness – either from staying at home to protect their parent or hide their injuries, or because they are prevented from attending the hospice;
- Children and young people attending hospice when ill rather than staying at home;
- Children and young people making constant excuses, because of what is happening at home;
- Children and young people who are constantly tired, on edge and unable to concentrate through disturbed sleep or worrying about what is happening at home;
- Children and young people displaying difficulties in their cognitive performance;
- Children and young people whose behaviour and personality changes dramatically;
- Children and young people who become quiet and withdrawn and have difficulty in developing positive peer relations;
- Children and young people displaying disruptive behaviour or acting out violent thoughts with little empathy for victims;
- Children and young people who are no trouble at all.

This list is not exhaustive – this is intended to give you an idea of some of the types of behaviour that could be presented.

What hospices can do

Hospices can create an environment which both promotes their belief and commitment that domestic abuse is not acceptable, and that they are willing to discuss and challenge it.

For many victims, the hospice might be the one place that they visit without their abusive partner.

It would help if the Hospice displayed posters or had cards/pens available with information about domestic abuse and contact details for useful agencies: for example, NSPCC 0808 800 5000 and ChildLine 0800 11 11; Parent line 0808 800 2222; Warwickshire's Forum Against Domestic Abuse (WFADA) 24 hr. helpline; website; Warwickshire Constabulary - Police Domestic Abuse Units .

Research shows that the repeated use of physical, sexual, psychological and financial abuse is one of the ways in which male power is used to control women. The underlying attitudes which legitimate and perpetuate violence against women should be challenged by the hospice as part of the whole hospice ethos.

Hospices can support individual children and young people by:

- Introducing a whole-hospice philosophy that domestic abuse is unacceptable;
- Responding to disclosures and potential child protection concerns; recognising that domestic abuse and forced marriage may be a child protection concern; policies and procedures must include domestic abuse;
- Giving emotional support – the child or young person might need referral to a more specialist service or need additional support to complete coursework, exams etc;
- Facilitating a peer support network – children and young people can become isolated but often welcome talking to friends about their problems;
- Offering practical support – if children or young people are new to the hospice they may need financial help with extra-curricular activities, or they may be unfamiliar with the area, where to hang out, etc;
- Providing somewhere safe and quiet to do their homework or just to sit and think;

APPENDIX B

- Improving the self esteem and confidence of children and young people by:
  - offering them opportunities to take on new roles and responsibilities;
  - offering tasks which are achievable and giving praise and encouragement;
  - monitoring their behaviour and setting clear limits;
  - criticising the action, not the person;
  - helping them to feel a sense of control in their lives;
  - involving them in decision making;
  - helping them to be more assertive;
  - respecting them as individuals;
  - encouraging involvement in extra-curricular activities.

From the Expect Respect Education Toolkit – Women's Aid

Advice for hospices on receiving notification of a Domestic Abuse incident

Background

Following a call to a domestic abuse incident where children are involved, Police will notify Social Care and Health. The notification is then classified 'high, medium or low' depending on the risk to children. If the risk is medium or high, the hospice DSMS will receive a letter informing them that an incident has taken place.

Hospice action

On receiving this information, the DSMS should:

- Log the information and keep the record separately, along with other CP records. This will allow the hospice to recognise any pattern and/or frequency of notifications and take appropriate action.
- Inform any staff of notification on a 'need to know' only basis – e.g. physiotherapist.
- Alert all staff who care for the child with minimum of information – e.g. 'This child may need extra support.
- Monitor child behaviour in hospice (including attendance) and should concerns arise which may be attributed to the impact of the incident, consult with Social Care through the Access Centre as the concerns may be significant and lead to new safeguarding action, or to seek advice on how to proceed.
- Provide appropriate support, if required – do not question child about the incident.
- If in doubt, consult with either the Local Safeguarding Board – Contact No : 01926 414144 – Out of Hours: 01926 886922.

Bear in mind

- Victim of incident may not be aware hospice has been informed.
- Notification does not give details as to which parent is the perpetrator/victim – any disclosure to the 'wrong' parent could heighten risk.
- Need to be aware who is 'connected' to the child – e.g. day centre supervisor may be child's relative / friend of the family.
- Inappropriate sharing of information could heighten the risk for the victim and/or the child.

APPENDIX C

Private Fostering and the role of Hospices

What is Private Fostering?

Private Fostering is an arrangement made, usually, between a child's parent and the private foster carer who becomes responsible for caring for the child.

Many children are cared for by people who are not their parents. The Children Act 1989 sets out which of these are private foster carers. By law, any person who is thinking of privately fostering a child must notify the local authority at least 6 weeks before the child comes to live with them.

If a child comes in an emergency, Children's Services must be notified within 48 hours.

When is a Child Privately Fostered?

- If the child is under 16 (or 18 if the child is disabled).
- If the child is living with someone who is not a close relative or someone with parental responsibility. A close relative is a grandparent, aunt or uncle, or sibling. A great aunt or cousin would be private fostering.
- If there is an intention to care for the child for longer than 28 days.

Some Examples of Private Fostering:

- A teenager moves in with a friend's family because they are not getting on with their own family.
- A young person's family move out of the area and the young person moves in with a neighbour to stay at the same school.
- A child lives with their father and his partner who are not married. The father leaves the home (for example is imprisoned), and the child stays with the partner.
- A young person stays with a host family while at language school.

Why should Hospices be aware of Private Fostering?

Following the death of Victoria Climbié (who was privately fostered), the Children Act 2004 tightened the legislation around privately fostered children to make local authorities more pro-active in their efforts to keep privately fostered children safe.

Private fostering comes within the remit of the Safeguarding Board and the Act places a duty on all agencies to keep children safe.

In Warwickshire, most children that are privately fostered are teenagers and the arrangement is made in an emergency because of difficulties at home. Hospices are in a good position to pick up on a child's change of address and carer.

What should a Hospice do if they think a child is Privately Fostered?

Both parents and private foster carers have a legal duty to notify Children's Services. Very often it doesn't happen because they don't know of the requirement, so the first step is to remind them of their duty.

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If you think that they will not do this, the hospice has a duty to notify Children's Services. It would be good practice, anyway, for a hospice to check with Children's Services to see if they know about an arrangement. Phoning would result in an answer!

What do Children's Services do?

A social worker must visit the child within 7 days and an assessment is made of the private foster carers, including an enhanced CRB. A senior manager signs off the arrangement and the child has to be visited every 6 weeks by a social worker.

It is possible to prohibit a carer from privately fostering.

Children's Services do not support the arrangement financially, but carers can apply for Child Benefit, tax credits, etc.

Conclusion:

Many of the children who are privately fostered come from complex backgrounds and have experienced loss. The families they live with vary between providing a high standard of care to care that is barely "good enough".

They are a particularly vulnerable group of children, and that is why it's important for hospices to be involved in keeping them safe by checking that Children's Services have been notified.
Senior Social Worker Private Fostering Children's Services,

APPENDIX D

Allegations against and concerns about Foster Carers

WHAT IS AN ALLEGATION?

1. An allegation against a foster carer is a statement to a professional (often a social worker but may be a member of hospice staff) which gives information about treatment of a child which may constitute child abuse and is not consistent with the standards of care expected. Anyone can make an allegation against a foster carer, for example the fostered child, their parent(s), a neighbour.

2. An allegation can relate to one of the following categories:
   - neglect – e.g. not enough proper food, dirty clothes
   - emotional abuse – e.g. constant criticism, insufficient attention
   - physical abuse – e.g. any form of punishment which involves hitting, slapping, shaking
   - sexual abuse – e.g. inappropriate touching or behaviour.

3. A member of the hospice staff may hear about or witness an action which they believe may indicate abuse; in such a situation they would be making the allegation by passing the information on correctly.

4. If a member of staff in a hospice is told about an allegation against a foster carer or has information which gives rise to concern that the actions of a foster carer may constitute child abuse, that person must inform, or ensure that another member of staff informs, the child's social worker immediately. The Designated Member of Staff for Looked After Children must also be informed as soon as possible.

5. Such an allegation can also be made against an adult member of the fostering household or the child of the foster carers and would be investigated in the same way.

6. If an allegation is made against another foster child in the home this would be managed through child protection procedures and not as an allegation against a foster carer. If it became clear during this investigation that there were issues concerning the care offered by the foster carer this would then be managed as a standards of care issue.

7. We expect high standards of care from foster carers and therefore actions by them may result in an allegation of abuse whilst the same action by a parent may not result in child protection procedures being followed. For example, a smack by a parent may not be investigated through child protection procedures; however, a smack by a foster carer is contrary to the regulations governing fostering and if an allegation is made there must be an investigation.

8. It is the responsibility of the Warwickshire County Council Children's Services Directorate to ensure that all allegations of abuse by foster carers are looked into quickly and thoroughly in order to safeguard the child/ren. This process will be carried out internally if the foster carer is registered to Warwickshire County Council or in conjunction with another fostering services provider if the carer is registered elsewhere. In either case a swift and thorough response is important to ensure that we also deal fairly with the foster carer.

9. As soon as the child's social worker becomes aware of an allegation against a foster carer they will inform their manager, the Family Assessment and Support Team manager. It is the responsibility of the FAST manager to manage the process of the child protection investigation.

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10. The social care staff involved will need to decide whether it is safe for the child to continue to be placed with the foster carer.

11. It is essential therefore that information concerning an allegation is passed to the social worker immediately (i.e. within one hour) the concern is noted. In this way social care staff will have the maximum possible time to manage initial enquiries and where necessary decide to move the child/ren.

12. It is not acceptable to wait until the end of the day to pass on information concerning an allegation.

13. Many allegations against foster carers are ‘unfounded’, or ‘unsubstantiated’ (i.e. one person’s word against another’s). In very few cases it can be demonstrated that foster carers have acted abusively towards a child/ren. Foster carers find the process of having an allegation made against them very stressful and the fostering service (or Independent Fostering Agency if the carers are not registered to the local authority) offers them independent support. A full investigation will then be carried out to reach a conclusion as to whether they should continue to foster.

14. Staff working in hospices may have concerns about the behaviour of a foster carer which does not relate to a particular child, but which gives rise to concern about their suitability to act as foster carers.

15. In this case the child's social worker should be informed (as above). The child's social worker will then ensure that this information is passed on to the fostering service provider holding the registration of the carers, i.e. either to Warwickshire County Council's fostering service or to an Independent Foster Agency or other local authority.

16. The fostering service provider will then have a duty to investigate the concerns with the foster carer and act as appropriate.

APPENDIX E

Protecting Students on Work Placements

Detailed advice on child protection issues in relation to work placements is contained in DfES document 'Safeguarding Children and Safer Recruitment in Education', 2006. See Annex A and Appendix 14.

For long term placements (periods of several months or longer) and for placements that are part of an FE course and under 16 Young Apprenticeships, additional safeguards will be needed where one or more of the following apply:

- Placement is more than one day per week
- Placement is longer than one term
- Placement is aimed at vulnerable children (with special needs or aged under 16)
- Where someone has substantial unsupervised access to the student because of the nature of the business (e.g. sole trader)
- Where there is a residential component

If any of these conditions apply, the following safeguards should be in place:

- Training in child protection for staff arranging, vetting and monitoring placements
- Endorsement by the employer of child protection policy or statement of principles
- CRB check of employees whose are responsible for looking after, supervising or training a child throughout the placement
- Child protection training for the supervising etc employee in the placement
- Advice to students on child protection contacts at hospice etc
- Appropriate local authority policies to support and respond as necessary
- Ensure child is suitable for the placement (if working with younger children)

The rationale behind any decision not to have a CRB check should be recorded.

If there is a concern or an allegation made about a person who works with children and young people, they need to contact the Children's Services LADO (Local Authority Designated Officer).

Child protection

A Hospice does not only have responsibilities in relation to standard health and safety issues, but also in relation to the safeguarding of young people from harm, including ensuring that other adults with whom they come into contact behave appropriately and are not a risk to their welfare. Measures which should be taken in relation to work experience include:

- The work experience coordinator (or equivalent) should have a basic awareness of child protection issues.
- Employers should be made aware of how to proceed if they encounter a child protection issue.
- If an adult at a work placement is likely to have 'regular or significant unsupervised access to young people' then CRB checks should be conducted before the placement commences.

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If the hospice is involved in long-term work placements, then there are additional child protection requirements. These are:

- Endorsement by the employer of a child protection policy or statement of principles.
- DBS checking of ‘any person whose normal duties will include regularly caring for, training, looking after or supervising a child in the workplace’

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Supporting Documents; - Available on the web: -

Practitioner's Guide to Safeguarding and Promoting the Welfare of Children – Warwickshire Safeguarding Children Board: -

- Single Assessment Strategy, Children & Families Workforce - April 2018
- Warwickshire Thresholds for Service Meeting the Needs of Children & Young People in Warwickshire - April 2017
- The Children Acts 1989 and 2004
- Working Together to Safeguard Children – July 2018
- What to do if you're Worried a Child is Being Abused – DfES December 2006
- Safeguarding Children & Young People: roles & competences for health care staff INTERCOLLEGIATE DOCUMENT - September 2015
- Guidance for Safe Working Practice for the Protection of Children and Staff in Education Settings – IRSC September 2006
- Signposts to Safety: Teaching e-safety at Key Stages 1 & 2 / Key Stages 3 & 4 – April 2007
- Safeguarding Children online – a guide for school leaders – January 2008

APPENDIX G

Recognition & Identification of Abuse
Taken from Working Together to Safeguard Children 2018.

What is abuse?
Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting, by those known to them or, more rarely, by a stranger for example, via the internet. They may be abused by an adult or adults, or another child or children.

Indicators of Abuse
Caution should be used when referring to lists of signs and symptoms of abuse. Although the signs and symptoms listed below may be indicative of abuse there may be alternative explanations. In assessing the circumstances of any child any of these indicators should be viewed within the overall context of the child's individual situation including any disability.

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 cyber-bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Emotional abuse is difficult to:
- define
- identify/recognise
- prove.

Emotional abuse is chronic and cumulative and has a long-term impact. Indicators may include:
- Physical, mental and emotional development lags
- Sudden speech disorders
- Continual self-depreciation ('I'm stupid, ugly, worthless, etc.')
- Overreaction to mistakes
- Extreme fear of any new situation
- Inappropriate response to pain ('I deserve this')
- Unusual physical behaviour (rocking, hair twisting, self-mutilation) - consider within the context of any form of disability such as autism
- Extremes of passivity or aggression
- Children suffering from emotional abuse may be withdrawn and emotionally flat. One reaction is for the child to seek attention constantly or to be over-familiar. Lack of self- esteem and developmental delay are again likely to be present
- Babies – feeding difficulties, crying, poor sleep patterns, delayed development, irritable, non-cuddly, apathetic, non-demanding
- Toddler/Pre-School – head banging, rocking, bad temper, 'violent', clingy. From overactive to apathetic, noisy to quiet. Developmental delay – especially language and social skills

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- School age – Wetting and soiling, relationship difficulties, poor performance at school, non-attendance, antisocial behaviour. Feels worthless, unloved, inadequate, frightened, isolated, corrupted and terrorised
- Adolescent – depression, self-harm, substance abuse, eating disorder, poor self- esteem, oppositional, aggressive and delinquent behaviour
- Child may be underweight and/or stunted
- Child may fail to achieve milestones, fail to thrive, experience academic failure or under achievement
- Also consider a child's difficulties in expressing their emotions and what they are experiencing and whether this has been impacted on by factors such as age, language barriers or disability

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

There are occasions when nearly all parents find it difficult to cope with the many demands of caring for children. But this does not mean that their children are being neglected. Neglect involves ongoing failure to meet a child's needs.

Neglect can often fit into six forms which are:

- Medical – the withholding of medical care including health and dental.
- Emotional – lack of emotional warmth, touch and nurture
- Nutritional – either through lack of access to a proper diet which can affect in their development.
- Educational – failing to ensure regular school attendance that prevents the child reaching their full potential academically
- Physical – failure to meet the child’s physical needs
- Lack of supervision and guidance – meaning the child is in dangerous situations without the ability to risk assess the danger.1

1 Source: Horwath, J (2007): Child neglect: identification and assessment: Palgrave Macmillan

Common Concerns:

- The child’s development in all areas including educational attainment
- Cleanliness
- Health
- Children left at home alone and accidents related to this
- Taking on unreasonable care for others
- Young carers

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Neglect can often be an indicator of further maltreatment and is often identified as an issue in panel reviews as being present in the lead up to the death of the child or young person. It is important to recognise that the most frequent issues and concerns regarding the family in relation to neglect relate to parental capability. This can be a consequence of:

- Poor health, including mental health or mental illness
- Disability, including learning difficulties
- Substance misuse and addiction
- Domestic violence

Hospice staff need to consider both acts of commission (where a parent/carer deliberately neglects the child) and acts of omission (where a parent's failure to act is causing the neglect).

Many of the signs of neglect are visible. However, hospice staff may not instinctively know how to recognise signs of neglect or know how to respond effectively when they suspect a child is being neglected. All concerns should be recorded and reflected upon, not simply placed in a file.

Here are some signs of possible neglect:

Physical signs:

- Constant hunger
- Poor personal hygiene
- Constant tiredness
- Emaciation
- Untreated medical problems
- The child seems underweight and is very small for their age
- The child is poorly clothed, with inadequate protection from the weather
- Neglect can lead to failure to thrive, manifest by a fall away from initial centile lines in weight, height and head circumference. Repeated growth measurements are crucially important
- Signs of malnutrition include wasted muscles and poor condition of skin and hair. It is important not to miss an organic cause of failure to thrive; if this is suspected, further investigations will be required
- Infants and children with neglect often show rapid growth catch-up and improved emotional response in a hospital environment
- Failure to thrive through lack of understanding of dietary needs of a child or inability to provide an appropriate diet; or may present with obesity through inadequate attention to the child's diet
- Being too hot or too cold – red, swollen and cold hands and feet or they may be dressed in inappropriate clothing
- Consequences arising from situations of danger – accidents, assaults, poisoning
- Unusually severe but preventable physical conditions owing to lack of awareness of preventative health care or failure to treat minor conditions
- Health problems associated with lack of basic facilities such as heating
- Neglect can also include failure to care for the individual needs of the child including any additional support the child may need as a result of any disability

Behavioural signs:

- No social relationships
- Compulsive scavenging
- Destructive tendencies

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- If they are often absent from school for no apparent reason
- If they are regularly left alone, or in charge of younger brothers or sisters
- Lack of stimulation can result in developmental delay, for example, speech delay, and this may be picked up opportunistically or at formal development checks
- Craving attention or ambivalent towards adults, or may be very withdrawn
- Delayed development and failing at school (poor stimulation and opportunity to learn)
- Difficult or challenging behaviour

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.

When dealing with concerns regarding physical abuse, refer any suspected non-accidental injury to the Designated Safeguarding Lead without delay so that they are able to seek appropriate guidance from the police and/or Children's Services in order to safeguard the child.

Staff must be alert to:

- Unexplained recurrent injuries or burns; improbable excuses or refusal to explain injuries;
- Injuries that are not consistent with the story: too many, too severe, wrong place or pattern, child too young for the activity described.

Physical signs:

- Bald patches
- Bruises, black eyes and broken bones
- Untreated or inadequately treated injuries
- Injuries to parts of the body where accidents are unlikely, such as thighs, back, abdomen
- Scalds and burns
- General appearance and behaviour of the child may include:
    - Concurrent failure to thrive: measure height, weight and, in the younger child, head circumference;
    - Frozen watchfulness: impassive facial appearance of the abused child who carefully tracks the examiner with his eyes.
- Bruising:
    - Bruising patterns can suggest gripping (finger marks), slapping or beating with an object.
    - Bruising on the cheeks, head or around the ear and black eyes can be the result of non-accidental injury.
- Other injuries:
    - Bite marks may be evident from an impression of teeth
    - Small circular burns on the skin suggest cigarette burns
    - Scalding inflicted by immersion in hot water often affects buttocks or feet and legs symmetrically
    - Red lines occur with ligature injuries
    - Retinal haemorrhages can occur with head injury and vigorous shaking of the baby
    - Tearing of the frenulum of the upper lip can occur with force-feeding. However, any injury of this type must be assessed in the context of the explanation given, the child's developmental stage, a full examination and other relevant investigations as appropriate.
    - Fractured ribs: rib fractures in a young child are suggestive of non-accidental injury
    - Other fractures: spiral fractures of the long bones are suggestive of non-accidental injury

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Behavioural signs:

- Wearing clothes to cover injuries, even in hot weather
- Refusal to undress
- Chronic running away
- Fear of medical help or examination
- Self-destructive tendencies
- Fear of physical contact - shrinking back if touched
- Admitting that they are punished, but the punishment is excessive (such as a child being beaten every night to 'make him study')
- Fear of suspected abuser being contacted
- Injuries that the child cannot explain or explains unconvincingly
- Become sad, withdrawn or depressed
- Having trouble sleeping
- Behaving aggressively or be disruptive
- Showing fear of certain adults
- Having a lack of confidence and low self-esteem
- Using drugs or alcohol
- Repetitive pattern of attendance: recurrent visits, repeated injuries
- Excessive compliance
- Hyper-vigilance

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 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.

Sexual abuse is usually perpetrated by people who are known to and trusted by the child –
e.g. relatives, family friends, neighbours, people working with the child in school or through other activities.

Characteristics of child sexual abuse:

- It is usually planned and systematic – people do not sexually abuse children by accident, though sexual abuse can be opportunistic;
- Grooming the child – people who abuse children take care to choose a vulnerable child and often spend time making them dependent. This can be done in person or via the internet through chat-rooms and social networking sites;
- Grooming the child's environment – abusers try to ensure that potential adult protectors (parents and other carers especially) are not suspicious of their motives. Again, this can be done in person or via the internet through chat-rooms and social networking sites.

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In young children behavioural changes may include:

- Regressing to younger behaviour patterns such as thumb sucking or bringing out discarded cuddly toys
- Being overly affectionate - desiring high levels of physical contact and signs of affection such as hugs and kisses
- Lack of trust or fear of someone they know well, such as not wanting to be alone with a babysitter or child minder
- They may start using sexually explicit behaviour or language, particularly if the behaviour or language is not appropriate for their age
- Starting to wet again, day or night/nightmares

In older children behavioural changes may include:

- Extreme reactions, such as depression, self-mutilation, suicide attempts, running away, overdoses, anorexia
- Personality changes such as becoming insecure or clinging
- Sudden loss of appetite or compulsive eating
- Being isolated or withdrawn
- Inability to concentrate
- Become worried about clothing being removed
- Suddenly drawing sexually explicit pictures
- Trying to be 'ultra-good' or perfect; overreacting to criticism
- Genital discharge or urinary tract infections
- Marked changes in the child's general behaviour. For example, they may become unusually quiet and withdrawn, or unusually aggressive. Or they may start suffering from what may seem to be physical ailments, but which can't be explained medically
- The child may refuse to attend school or start to have difficulty concentrating so that their schoolwork is affected
- They may show unexpected fear or distrust of a particular adult or refuse to continue with their usual social activities
- The child may describe receiving special attention from a particular adult, or refer to a new, "secret" friendship with an adult or young person
- Children who have been sexually abused may demonstrate inappropriate sexualised knowledge and behaviour
- Low self-esteem, depression and self-harm are all associated with sexual abuse

Physical signs and symptoms for any age child could be:

- Medical problems such as chronic itching, pain in the genitals, venereal diseases
- Stomach pains or discomfort walking or sitting
- Sexually transmitted infections
- Any features that suggest interference with the genitalia. These may include bruising, swelling, abrasions or tears
- Soreness, itching or unexplained bleeding from penis, vagina or anus
- Sexual abuse may lead to secondary enuresis or faecal soiling and retention
- Symptoms of a sexually transmitted disease such as vaginal discharge or genital warts, or pregnancy in adolescent girls

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Sexual Abuse by Young People

The boundary between what is abusive and what is part of normal childhood or youthful experimentation can be blurred. The determination of whether behaviour is developmental, inappropriate or abusive will hinge around the related concepts of true consent, power imbalance and exploitation. This may include children and young people who exhibit a range of sexually problematic behaviour such as indecent exposure, obscene telephone calls, fetishism, bestiality and sexual abuse against adults, peers or children.

Developmental Sexual Activity encompasses those actions that are to be expected from children and young people as they move from infancy through to an adult understanding of their physical, emotional and behavioural relationships with each other. Such sexual activity is essentially information gathering and experience testing. It is characterised by mutuality and of the seeking of consent.

Inappropriate Sexual Behaviour can be inappropriate socially, inappropriate to development, or both. In considering whether behaviour fits into this category, it is important to consider what negative effects it has on any of the parties involved and what concerns it raises about a child or young person. It should be recognised that some actions may be motivated by information seeking, but still cause significant upset, confusion, worry, physical damage, etc. it may also be that the behaviour is “acting out” which may derive from other sexual situations to which the child or young person has been exposed.

If an act appears to have been inappropriate, there may still be a need for some form of behaviour management or intervention. For some children, educative inputs may be enough to address the behaviour.

Abusive sexual activity includes any behaviour involving coercion, threats, aggression together with secrecy, or where one participant relies on an unequal power base.

Assessment

In order to more fully determine the nature of the incident the following factors should be given consideration. The presence of exploitation in terms of:

- Equality – consider differentials of physical, cognitive and emotional development, power and control and authority, passive and assertive tendencies
- Consent – agreement including all the following:
    - Understanding that is proposed based on age, maturity, development level, functioning and experience
    - Knowledge of society’s standards for what is being proposed
    - Awareness of potential consequences and alternatives
    - Assumption that agreements or disagreements will be respected equally
    - Voluntary decision
    - Mental competence
- Coercion – the young perpetrator who abuses may use techniques like bribing, manipulation and emotional threats of secondary gains and losses that is loss of love, friendship, etc. Some may use physical force, brutality or the threat of these regardless of victim resistance.

In evaluating sexual behaviour of children and young people, the above information should be used only as a guide.

APPENDIX H

Child Sexual Exploitation (CSE)

Child sexual exploitation is a form of abuse which involves children (male and female, of different ethnic origins and of different ages) receiving something in exchange for sexual activity.

'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.' (DfE – February 2017)

The definition and further guidelines can be found in the DfE document : Child sexual exploitation - Definition and a guide for practitioners

Who is at risk?

Child sexual exploitation can happen to any young person from any background. Although the research suggests that the females are more vulnerable to CSE, boys and young men are also victims of this type of abuse.

The characteristics common to all victims of CSE are not those of age, ethnicity or gender, rather their powerlessness and vulnerability. Victims often do not recognise that they are being exploited because they will have been groomed by their abuser(s). As a result, victims do not make informed choices to enter into, or remain involved in, sexually exploitative situations but do so from coercion, enticement, manipulation or fear. Sexual exploitation can happen, face to face and it can happen online. It can also occur between young people. In all its forms, CSE is child abuse and should be treated as a child protection issue.

WARNING SIGNS AND VULNERABILITIES CHECKLIST 1
The evidence available points to several factors that can increase a child's vulnerability to being sexually exploited. The following are typical vulnerabilities in children prior to abuse:

- Living in a chaotic or dysfunctional household (including parental substance use, domestic violence, parental mental health issues, parental criminality)
- History of abuse (including familial child sexual abuse, risk of forced marriage, risk of 'honour'-based violence, physical and emotional abuse and neglect)
- Recent bereavement or loss
- Gang association either through relatives, peers or intimate relationships (in cases of gang-associated CSE only)
- Attending school with young people who are sexually exploited
- Learning disabilities
- Unsure about their sexual orientation or unable to disclose sexual orientation to their families

1 The Office of the Children's Commissioner (2012) Interim Report - Inquiry into Child Sexual Exploitation in Group and Gangs.

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- Friends with young people who are sexually exploited
- Homeless
- Lacking friends from the same age group
- Living in a gang neighbourhood
- Living in residential care
- Living in hostel, bed and breakfast accommodation or a foyer
- Low self-esteem or self-confidence
- Young carer

The following signs and behaviour are generally seen in children who are already being sexually exploited:

- Missing from home or care
- Physical injuries
- Drug or alcohol misuse
- Involvement in offending
- Repeat sexually-transmitted infections, pregnancy and terminations
- Absent from school
- Evidence of sexual bullying and/or vulnerability through the internet and/or social networking sites
- Estranged from their family
- Receipt of gifts from unknown sources
- Recruiting others into exploitative situations
- Poor mental health
- Self-harm
- Thoughts of or attempts at suicide

Evidence shows that any child displaying several vulnerabilities from the above lists should be considered to be at high risk of sexual exploitation.

All hospices should ensure that there is a dedicated lead person with responsibility for implementing local guidance in respect of child sexual exploitation. This would normally be the DSL.

The DSL must ensure that all staff are aware of signs and symptoms of CSE and know that these must be reported and recorded as child protection concerns.

APPENDIX I

Forced Marriage – a form of Domestic Abuse

Forced Marriage should be recognised as a human rights abuse – and should always invoke child protection procedures.

A forced marriage is a marriage conducted without the full consent of both parties, and one where duress is a factor. A forced marriage is not the same as an arranged marriage – in an arranged marriage the families take a leading role in choosing the marriage partner. The marriage is entered into freely by both people.

Warning signs

Warning signs can include a sudden drop in performance, truancy from school and conflicts with parents over continuation of the student's education.
There may be excessive parental restrictions and control, a history of domestic abuse within the family, or extended absence through sickness or overseas commitments. Young people may also show signs of depression or self-harming, and there may be a history of older siblings leaving education early to get married.

The justifications

Most cases of forced marriage in the UK involve South Asian families. This is partially a reflection of the fact that there is a large established South Asian population in the UK. It is clear, however, that forced marriage is not a solely South Asian phenomenon — there have been cases involving families from East Asia, the Middle East, Europe and Africa.

Some forced marriages take place in the UK with no overseas element, while others involve a partner coming from overseas, or a British citizen being sent abroad. Parents who force their children to marry often justify it as protecting them, building stronger families and preserving cultural or religious traditions. They may not see it as wrong.

Forced marriage can never be justified on religious grounds: every major faith condemns it and freely given consent is a pre-requisite of Christian, Jewish, Hindu, Muslim and Sikh marriage.
Culture

Often parents believe that they are upholding the cultural traditions of their home countries, when in fact practices and values there have changed. Some parents come under significant pressure from their extended families to get their children married.

The law

Sexual intercourse without consent is rape, regardless of whether this occurs within the confines of a marriage. A girl who is forced into marriage is likely to be raped and may be raped until she becomes pregnant.
In addition, the Forced Marriage (Civil Protection) Act (2007) makes provision for protecting children, young people and adults from being forced into marriage without their full and free consent through Forced Marriage Protection Orders. Breaching a Forced Marriage Protection Order is a criminal offence.

The Anti-Social Behaviour, Crime and Policing Act 2014 makes it a criminal offence, with effect from 16th June 2014, to force someone to marry. This includes:

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Taking someone overseas to force them to marry (whether or not the marriage takes place);
Marrying someone who lacks the mental capacity to consent to the marriage (whether they're pressured into it or not).

What to do if a young person seeks help

- The young person should be seen immediately in a private place, where the conversation cannot be overheard.
- The young person should be seen on her own, even if she attends with others.
- Develop a safety plan in case the young person is seen i.e. prepare another reason why you are meeting.
- Explain all options to the young person and recognise and respect her wishes. If the young person does not want to be referred to Children's Services, you will need to consider whether to respect her wishes — or whether her safety requires further action to be taken. If you take action against the young person's wishes you must inform her.
- Establish whether there is a family history of forced marriage — i.e. siblings forced to marry.
- Advise the young person not to travel overseas and discuss the difficulties she may face.
- Seek advice from the Forced Marriage Unit.
- Liaise with Police and Children's Services to establish if any incidents concerning the family have been reported.
- Refer to the local Police Child Protection Unit if there is any suspicion that there has been a crime or that one may be committed.
- Refer the young person with her consent to the appropriate local and national support groups, and counselling services.

What to do if the young person is going abroad imminently

The Forced Marriage Unit advises professionals to gather the following information if at all possible — it will help the unit to locate the young person and to repatriate her:

- a photocopy of the young person's passport for retention — encourage her to keep details of her passport number and the place and date of issue
- as much information as possible about the family (this may need to be gathered discretely)
- full name and date of birth of the girl under threat
- girl's father's name
- any addresses where the young person may be staying overseas
- potential spouse's name
- date of the proposed wedding
- the name of the potential spouse's father if known
- addresses of the extended family in the UK and overseas

Specific information

It is also useful to take information that only the young person would know, as this may be helpful during any interview at an embassy or British High Commission — in case another person of the same age is produced pretending to be the young person.
Professionals should also take details of any travel plans and people likely to accompany the young person.

Note also the names and addresses of any close relatives remaining in the UK and a safe means to contact the young person — a secret mobile telephone, for example, that will function abroad.

APPENDIX I

Forced marriage: what professionals should NOT do

- treat such allegations merely as domestic issues and send the young person back to the family home
- ignore what the young person has told you or dismiss the need for immediate protection
- approach the young person's family or those with influence within the community, without the express consent of the young person, as this will alert them to your concern and may place the young person in danger
- contact the family in advance of any enquires by the Police, Children's Services or the Forced Marriage Unit, either by telephone or letter
- share information outside child protection information sharing protocols without the express consent of the young person
- breach confidentiality except where necessary in order to ensure the young person's safety
- attempt to be a mediator

E-mail: fmu@fco.gov.uk Website: www.fco.gov.uk/forcedmarriage
FMU publication: 'Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage' June 09
See also: 'The Right to Choose – Multi-Agency Guidance in relation to Forced Marriage' Government Office - November 2008 and Interagency Guidance on Forced Marriage on the WSCB website.
Ref: WSCB regional procedures 'Forced Marriage' and Warwickshire's Forced Marriage, Honour-Based Violence and Female Genital Mutilation Protocol – January 2016.

APPENDIX J

Female Genital Mutilation (FGM) – a form of Human Rights Abuse

What is FGM?
FGM includes procedures that intentionally alter or injure the female genital organs for non- medical reasons. There are four known types of FGM, all of which have been found in the UK:

Type 1 – clitoridectomy: partial or total removal of the clitoris and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris)
Type 2 – excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are the 'lips' that surround the vagina)
Type 3 – infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris
Type 4 – other: all other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping and cauterising the genital area.

FGM is sometimes known as 'female genital cutting' or female circumcision. Communities tend to use local names for this practice, including 'Sunna'.

Why is FGM carried out?

It is believed that:

- It brings status and respect to the girl and that it gives a girl social acceptance, especially for marriage.
- It preserves a girl's virginity/chastity.
- It is part of being a woman as a rite of passage.
- It upholds the family honour.
- It cleanses and purifies the girl.
- It gives the girl and her family a sense of belonging to the community.
- It fulfills a religious requirement believed to exist.
- It perpetuates a custom/tradition.
- It helps girls and women to be clean and hygienic.
- It is cosmetically desirable.
- It is mistakenly believed to make childbirth safer for the infant.

Religion is sometimes given as a justification for FGM. For example, some people from Muslim communities argue that the Sunna (traditions or practices undertaken or approved by the prophet Mohammed) recommends that women undergo FGM, and some women have been told that having FGM will make them 'a better Muslim'. However, senior Muslim clerics at an international conference on FGM in Egypt in 2006 pronounced that FGM is not Islamic, and the London Central Mosque has spoken out against FGM on the grounds that it constitutes doing harm to oneself or to others, which is forbidden by Islam.

Within which communities is FGM known to be practised?

According to the Home Office it is estimated that up to 24,000 girls under the age of 15 are at risk of FGM. UK communities that are most at risk of FGM include Kenyan, Somali, Sudanese, Sierra Leoni, Egyptian, Nigerian and Eritrean, as well as non-African communities including Yemeni, Afghani, Kurdish, Indonesian and Pakistani.

Obviously, this not to say that all families from the communities listed above practise FGM, and many parents will refuse to have their daughters subjected to this procedure. However, in some communities a great deal of pressure can be put on parents to follow what is seen as a cultural or religious practice.

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Is FGM harmful?

FGM is extremely harmful and is often described as brutal because of the way it is carried out, and its short- and long-term effects on physical and psychological health.

FGM is carried out on children between the ages of 0 and 15, depending on the community in which they live. It is often carried out without any form of sedation and without sterile conditions. The girl or young woman is held down while the procedure of cutting takes place and survivors describe extreme pain, fear and feelings of abandonment.

Where the vagina is cut and then sewn up, only a very small opening may be left. This is often seen as a way to ensure that when the girl enters marriage, she is a virgin. In some communities the mother of the future husband and the girl's own mother will take the girl to be cut open before the wedding night.

Repeat urinal tract infections are a common problem for women who have undergone FGM, and for some, infections come from menstruation being restricted. Many women have problems during pregnancy and childbirth. The removal of the clitoris denies women physical pleasure during sexual activity and some groups will practise complete removal to ensure chastity.

Is it illegal?

FGM is internationally recognised as a violation of the human rights of girls and women and is illegal in most countries – including the UK. The Female Genital Mutilation Act 2003 came into force in 2004:

The act makes it illegal to:

- practise FGM in the UK
- take girls who are British nationals or permanent residents of the UK abroad for FGM, whether or not it is lawful in that country
- aid and abet, counsel or procure the carrying out of FGM abroad.

The offence carries a penalty of up to 14 years in prison, and/or a fine.

Signs, symptoms and indicators

The following list of possible signs and indicators are not diagnostic but are offered as a guide as to what kind of things should alert professionals to the possibility of FGM.

Things that may point to FGM happening:

- a child talking about getting ready for a special ceremony
- a family arranging a long break abroad
- a child's family being from one of the 'at-risk' communities for FGM (see above)
- knowledge that an older sibling has undergone FGM
- a young person talks of going abroad to be 'cut' or get ready for marriage. Things that may indicate a child has undergone FGM:
- prolonged absence from school or other activities
- behaviour change on return from a holiday abroad, such as the child being withdrawn and appearing subdued
- bladder or menstrual problems
- finding it difficult to sit still, and looking uncomfortable
- complaining about pain between their legs

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- mentioning something somebody did to them that they are not allowed to talk about
- secretive behaviour, including isolating themselves from the group
- reluctance to take part in physical activity
- repeated urinal tract infection
- disclosure.

What should the Hospice do?

Where a hospice has a concern about a child, they should contact Children's Social Care Services. If the concerns are based on more concrete indicators – i.e., the young person says this is going to happen to them, or disclosure that it has happened to them or to an older sister – the hospice should make a child protection referral and inform the Police as required by the mandatory reporting duty.

The Hospice should not:

- contact the parents before seeking advice from children's social care;
- make any attempt to mediate between the child/young person and parents.

It is important to keep in mind that the parents may not see FGM as a form of abuse; however, they may be under a great deal of pressure from their community and or family to subject their daughters to it. Some parents from identified communities may seek advice and support as to how to resist and prevent FGM for their daughters, and education about the harmful effects of FGM may help to make parents feel stronger in resisting the pressure of others in the community. Remember that religious teaching does not support FGM.

The 'one chance' rule

In the same way that we talk about the 'one chance rule' in respect of young people coming forward with fears that they may be forced into marriage, young people disclosing fears that they are going to be sent abroad for FGM are taking the 'one chance', of seeking help.
It is essential that we take such concerns seriously and act without delay. Never underestimate the determination of parents who have decided that it is right for their daughter to undergo FGM. Attempts to mediate may place the child/young person at greater risk, and the family may feel so threatened at the news of their child's disclosure that they bring forward their plans or take action to silence her.

Mandatory Reporting Duty

Where FGM has taken place, since 31 October 2015 there has been a mandatory reporting duty placed on health professionals. 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 health professionals in England and Wales, to personally 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. Those failing to report such cases will face disciplinary sanctions. Further information on when and how to make a report can be found in the following Home Office guidance: 'Mandatory Reporting of Female Genital Mutilation - procedural information' (October 2015).

APPENDIX K

SEXTING

What is sexting?

Sexting is the exchange of self-generated sexually explicit images, through mobile picture messages or webcams over the internet.

Sexting is often seen as flirting by children and young people who think that it's part of normal life.

Often, incidents of sexting are not clear-cut or isolated; Hospices may encounter a variety of scenarios. Sexting incidents can be divided into two categories – aggravated and experimental2:

Aggravated incidents of sexting involve criminal or abusive elements beyond the creation of an image. These include further elements, adult involvement or criminal or abusive behaviour by minors such as sexual abuse, extortion, threats, malicious conduct arising from personal conflicts, or creation or sending or showing of images without the knowledge or against the will of a minor who is pictured.

Experimental incidents of sexting involve youths taking pictures of themselves to share with established boy or girlfriends, to create romantic interest in other youth, or for reasons such as attention seeking. There is no criminal element (and certainly no criminal intent) beyond the creation and sending of the images and no apparent malice or lack of willing participation.

The consequences of sexting can be devastating for young people. In extreme cases it can result in suicide or a criminal record, isolation and vulnerability. Young people can end up being criminalised for sharing an apparently innocently image which may have, in fact, been created for exploitative reasons.

Because of the prevalence of sexting, young people are not always aware that their actions are illegal. In fact, sexting as a term is not something that is recognised by young people and the 'cultural norms' for adults can be somewhat different. Some celebrities have made comments which appear to endorse sexting – 'it's okay, as long as you hide your face' - giving the impression that sexting is normal and acceptable. However, in the context of the law it is an illegal activity and young people must be made aware of this.

The Law - Much of the complexity in responding to youth produced sexual imagery is due to its legal status. Making, possessing and distributing any imagery of someone under 18 which is 'indecent' is illegal. This includes imagery of yourself if you are under 18. 'Indecent' is not defined in legislation. For most purposes, if imagery contains a naked young person, a topless girl, and/or displays genitals or sex acts, including masturbation, then it will be considered indecent. Indecent images may also include overtly sexual images of young people in their underwear.

The law criminalising indecent images of children was created long before mass adoption of the internet, mobiles and digital photography. It was also created to protect children and young people from adults seeking to sexually abuse them or gain pleasure from their sexual abuse. It was not intended to criminalise children.

Despite this, young people who share sexual imagery of themselves, or peers, are breaking the law.
The National Police Chiefs Council (NPCC) has made clear that incidents involving youth produced sexual imagery should primarily be treated as safeguarding issues. Hospices may respond to incidents without involving the police. Where the police are notified of incidents of youth produced sexual imagery they are obliged, under the Home Office Counting rules and National Crime Recording Standards, to record the incident on their crime systems. The incident will be listed as a 'crime' and the young person involved will be listed as a 'suspect.' This is not the same as having a criminal record.

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Every 'crime' recorded on police systems has to be assigned an outcome from a predefined list of outcome codes. As of January 2016, the Home Office launched a new outcome code (outcome 21) to help formalise the discretion available to the police when handling crimes such as youth produced sexual imagery. This means that even though a young person has broken the law and the police could provide evidence that they have done so, the police can record that they chose not to take further action as it was not in the public interest.

Action to take in the case of an incident of sexting

Step 1 – Disclosure by a child / young person

Sexting disclosures should follow the normal safeguarding practices and protocols. A young person is likely to be very distressed especially if the image has been circulated widely and if they don't know who has shared it, seen it or where it has ended up. They will need pastoral support during the disclosure and after the event. They may even need immediate protection or a referral to Social Care.

The following questions will help decide upon the best course of action:

- Is the young person disclosing about themselves receiving an image, sending an image or sharing an image?
- What sort of image is it? Is it potentially illegal or is it inappropriate?
- Are the hospice child protection and safeguarding policies and practices being followed? For example, has the DSL been consulted and is their advice and support available?
- How widely has the image been shared and is the device in their possession?
- Is it a hospice device or a personal device?
- Does the young person need immediate support and or protection?
- Are there other children and or young people involved?
- Do they know where the image has ended up?

This situation will need to be handled very sensitively. Whatever the nature of the incident, ensure hospice safeguarding and child protection policies and practices are adhered to.

Step 2 – Searching a device

It is highly likely that the image will have been created and potentially shared through mobile devices. The image may not be on one single device but may be on a website or on a multitude of devices; it may be on either a hospice-owned or personal device. It is important to establish the location of the image but be aware that this may be distressing for the young person involved, so be conscious of the support they may need.

When searching a mobile device, the following conditions should apply:

- The action is in accordance with the hospice's child protection and safeguarding policies
- The search is conducted by the head CEO or a person authorised by them
- A member of the safeguarding team is present
- The search is conducted by a member of the same sex

If any illegal images of a child are found, you should consider whether to inform the police. As a general rule it will almost always be proportionate to refer any incident involving "aggravated" sharing of images to the police, whereas purely "experimental" conduct may proportionately be dealt with without such referral, most particularly if it involves the child sharing images of themselves.

Any conduct involving, or possibly involving, the knowledge or participation of adults should always be referred to the police.

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If an “experimental” incident is not referred to the police, the reasons for this should be recorded in writing. Always put the child first. Do not search the device if this will cause additional stress to the young person whose image has been distributed.

If there is an indecent image of a child on a website or a social networking site, then you should report the image to the site hosting it. In the case of a sexting incident involving a child or young person where you feel that they may be at risk of abuse then you should report the incident directly to CEOP www.ceop.police.uk/ceop-report, so that law enforcement can make an assessment, expedite the case with the relevant provider and ensure that appropriate action is taken to safeguard the child.

Step 3 – What to do and not do with the image

If the image has been shared across a personal mobile device:

- Confiscate and secure the device;
- Don't view the image unless there is a clear reason to do so;
- Don't send, share or save the image anywhere;
- Don't allow students to view images or send, share or save them anywhere.

If the image has been shared across a social network, or website:

- Block the network to all users and isolate the image;
- Don't send or print the image;
- Don't move the material from one place to another;
- Don't view the image outside of the protocols of your safeguarding policies and procedures.

Step 4 – Who should deal with the incident?

Whoever the initial disclosure is made to must act in accordance with the hospice’s safeguarding policy, ensuring that the DSL or a senior member of staff is involved in dealing with the incident.

The DSL should always record the incident. Senior management should also always be informed. There may be instances where the image needs to be viewed and this should be done in accordance with protocols. The best interests of the child should always come first; if viewing the image is likely to cause additional stress, staff should make a judgement about whether or not it is appropriate to do so.

Step 5 - Deciding on a response

There may be a multitude of reasons why a young person has engaged in sexting – it may be a romantic/sexual exploration scenario, or it may be due to coercion.

It is important to remember that it won’t always be appropriate to inform the police; this will depend on the nature of the incident. However, as a hospice it is important that incidents are consistently recorded. It may also be necessary to assist the young person in removing the image from a website or elsewhere.

If indecent images of a child are found:

- Act in accordance with your child protection and safeguarding policy, e.g. notify DSL
- Store the device securely
- Carry out a risk assessment in relation to the young person (see Appendix B of the Safeguarding Children in Education Guidance for a Sexting Risk Assessment pro-forma and flow chart)
- Make a referral if needed
- Contact the police (if appropriate)

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- Put the necessary safeguards in place for the child, e.g. they may need counselling support, immediate protection and parents must also be informed.
- Inform parents and/or carers about the incident and how it is being managed.

Step 6 – Contacting other agencies (making a referral)

If the nature of the incident is high-risk, consider contacting Children's Social Care. Depending on the nature of the incident and the response you may also consider contacting local police or referring the incident to CEOP. Understanding the nature of the incident, whether experimental or aggravated, will help to determine the appropriate course of action.

Step 7 – Containing the incident and managing reaction

Sadly, there are cases in which victims of sexting have had to leave areas because of the impact the incident has had on them. The young person will be anxious about who has seen the image and where it has ended up. They will seek reassurance regarding its removal from the platform on which it was shared. They are likely to need support from the hospice, their parents and their friends. Education programmes can reinforce to all young people the impact and severe consequences that this behaviour can have.

Other staff may need to be informed of incidents and should be prepared to act if the issue is continued or referred to by other young people. Everyone should be on high alert, challenging behaviour and ensuring that the victim is well cared for and protected. The young peoples' parents should usually be told what has happened so that they can keep a watchful eye over their child, especially when they are online at home. Creating a supportive environment for young people in relation to the incident is very important.

Step 8 – Reviewing outcomes and procedures to prevent further incidences

As with all incidents, a review process ensures that the matter has been managed effectively and that the hospice has the capacity to learn and improve its handling procedures. Incidents of sexting can be daunting for a hospice to manage, especially if the image has been widely shared between young people.

Further information is available from the NSPCC

APPENDIX L

RADICALISATION AND EXTREMISM

What is Prevent?

Prevent is the Government's strategy to stop people becoming terrorists or supporting terrorism, in all its forms. Prevent works at the pre-criminal stage by using early intervention to encourage individuals and communities to challenge extremist and terrorist ideology and behaviour.

The Counter-Terrorism and Security Act (2015), places a duty on specified authorities, including health, to have due regard to the need to prevent people from being drawn into terrorism ("the Prevent duty"). The Prevent duty reinforces existing duties placed upon establishments for keeping children safe by:

- Assessing the risk of young people being drawn into extremist views;
- Ensuring safeguarding arrangements by working in partnership with local authorities, police and communities;
- Training staff to provide them with the knowledge and ability to identify children / young people at risk;
- Keeping patients safe online, using effective filtering and usage policies.

Warning Signs/Indicators of Concern

There is no such thing as a "typical extremist": those who become involved in extremist actions come from a range of backgrounds and experiences, and most individuals, even those who hold radical views, do not become involved in violent extremist activity.

Children / young people may become susceptible to radicalisation through a range of social, personal and environmental factors. It is vital that hospice staff are able to recognise those vulnerabilities. However, this list is not exhaustive, nor does it mean that all young people experiencing the above are at risk of radicalisation for the purposes of violent extremism.

Factors which may make children / young people more vulnerable may include:

- Identity Crisis: the child / young person is distanced from their cultural/religious heritage and experiences discomfort about their place in society.
- Personal Crisis: the young person may be experiencing family tensions; a sense of isolation; low self-esteem; they may have dissociated from their existing friendship group and become involved with a new and different group of friends; they may be searching for answers to questions about identity, faith and belonging.
- Personal Circumstances: migration; local community tensions and events affecting the young person's country or region of origin may contribute to a sense of grievance that is triggered by personal experience of racism or discrimination or aspects of Government policy.
- Unmet Aspirations: the young person may have perceptions of injustice; a feeling of failure; rejection of civic life.
- Experiences of Criminality: involvement with criminal groups, imprisonment, poor resettlement or reintegration.
- Special Educational Need: young people may experience difficulties with social interaction, empathy with others, understanding the consequences of their actions and awareness of the motivations of others.

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Children / young people who are vulnerable to radicalisation may also be experiencing:

- Substance and alcohol misuse
- Pressure
- Influence from older people or via the Internet
- Bullying
- Domestic violence
- Race/hate crime

Behaviours which may indicate a child is at risk of being radicalised or exposed to extremist views could include:

- Being in contact with extremist recruiters and/or spending increasing time in the company of other suspected extremists;
- Loss of interest in other friends and activities not associated with the extremist ideology, group or cause;
- Young person accessing extremist material online, including through social networking sites;
- Possessing or accessing materials or symbols associated with an extremist cause;
- Using extremist narratives and a global ideology to explain personal disadvantage;
- Young person voicing opinions drawn from extremist ideologies and narratives, this may include justifying the use of violence to solve societal issues;
- Graffiti symbols, writing or art work promoting extremist messages or images;
- Significant changes to appearance and/or behaviour increasingly centred on an extremist ideology, group or cause;
- Changing their style of dress or personal appearance to accord with the group;
- Attempts to recruit others to the group/cause;
- Using insulting to derogatory names for another group;
- Increase in prejudice-related incidents committed by that person – these may include:
    - physical or verbal assault
    - provocative behaviour
    - damage to property
    - derogatory name calling
    - possession of prejudice-related materials
    - prejudice related ridicule or name calling
    - inappropriate forms of address
    - refusal to co-operate
    - attempts to recruit to prejudice-related organisations
    - condoning or supporting violence towards others
    - Parental reports of changes in behaviour, friendship or actions and requests for assistance;
    - Partner professionals, local authority services, and police reports of issues affecting young people in other institutions.

Referral Process

All concerns about young people vulnerable to radicalisation should be referred to the DSL in the first instance. The DSL will follow safeguarding procedures including:

- Talking to the young person about their behaviour/views/on-line activity/friends etc.;
- Discussion with parents/carers about the concerns;
- Checking out on-line activity, including social media if possible;
- Providing in-house support, if available;
- Providing Early Help targeted support if necessary.

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If concerns persist, then the DSL should complete the Channel Referral Form (available from the WSCB website) normally with the knowledge and consent of the young person.

The referral will then be subject to a triage process to decide whether or not it meets the threshold for a referral to Channel. If it does, the DSL should be prepared to attend the Channel Panel meeting to share the concerns and help identify any intervention required. Further feedback to the Channel Panel will be expected following intervention to decide whether there are still concerns.

Further information can be found in the WSCB regional procedures.

APPENDIX M

The Shakespeare Hospice code of behaviour for working with Children and Adults at risk (VULNERABLE ADULTS)

- Do treat everyone with dignity and respect.
- Do make careful judgements about how to act to safeguard and promote a child or young adult's welfare.
- Do be aware of professional boundaries, for example do not visit a child or young adult in their own home in your own time or without the knowledge of your line manager.
- Do not invite children or young adults to your home.
- Do treat all children and young adults equally – show no favouritism
- Do respect a child or young adult's right to privacy
- Do not get involved in unacceptable situations within a relationship of trust e.g. an intimate relationship with a young adult over the age of consent.
- Do allow children and young adults to talk about their concerns that they have and do share this with a senior member of staff.
- Do document any concerns that are voiced to you.
- Do take any allegations or concerns of abuse seriously and refer immediately.
- Do not engage in inappropriate contact either physical, verbal or sexual.
- Do not text, phone or email a child or young adults in your own time or on your own equipment.
- Avoid where possible spending excessive time alone with children and young adults away from others.
- Do not take a child or young adult alone in a car journey without the authorisation of a senior member of staff.
- If you find yourself in a vulnerable position or if you contravene the code of behaviour inform a senior member of staff as soon as possible.