PARK GROVE PRIMARY ACADEMY POLICY

Child Protection

INTRODUCTION

This Child Protection Policy forms part of a suite of documents and policies which relate to the safeguarding responsibilities of the school.

Safeguarding and promoting the welfare of children is defined as protecting children from maltreatment, preventing impairment of health and/or development protecting children from the risk of radicalisation and extremism, ensuring that children grow up in the provision of safe and effective care and optimising children's life chances.

Child Protection is a part of safeguarding and promoting welfare. It refers to activity that is undertaken to protect specific children who are suffering, or are likely to suffer, significant harm.

AIM

We aim to ensure that children who are at risk and have suffered or are likely to suffer significant harm are identified, and appropriate action is taken to keep them safe. We will provide a secure, caring environment, highly skilled and aware staff, and a curriculum that nurtures self-esteem and helps children to protect themselves.

OBJECTIVES

- Establish and maintain an environment where children feel secure, are encouraged to talk, and are listened to when they have a worry or concern
- Establish and maintain an environment where school staff and volunteers feel safe, are encouraged to talk and are listened to when they have concerns about the safety and well being of a child
- Ensure children know that there are adults in the school (for example, Children and Family Support workers) whom they can approach if they are worried
- Ensure that children who have been abused will be supported in line with a child protection plan, where deemed necessary by social services.
- Include opportunities in the PSHE curriculum for children to develop the resilience and skills they need to recognise and stay safe from abuse, radicalisation or extremism.
- Contribute to the five outcomes which are key to children's wellbeing:
  - be healthy
  - stay safe
  - enjoy and achieve
  - make a positive contribution
  - achieve economic wellbeing

STATUTORY CONTEXT

In order to safeguard and promote the welfare of children, the school will act in accordance with the following legislation and guidance:

- The Children Acts 1989 and 2004
- Education Act 2002 (section 175)
- Working Together to Safeguard Children (HM Government 2013)
- What to Do if You are Worried a Child is being Abused.(DfES 2006)
- The Education (Pupil Information) (England) Regulations 2005
- Dealing with Allegations of Abuse Against Teachers and Other Staff (DfE 2012)
- Keeping Children Safe in Education (DfE 2014)
- Counter-Terrorism and Security Act 2015 ('Prevent Duty')

GENERAL CONTEXT
School staff and volunteers are particularly well placed to observe outward signs of abuse, changes in behaviour and failure to develop, because they have daily contact with children.

Training
All school staff and volunteers will receive safeguarding children training, so that they are knowledgeable and aware of their role in the early recognition of the indicators of abuse, neglect or risk of radicalisation and of the appropriate procedures to follow. This training will be refreshed every three years. Following good practice, the Designated Safeguarding Lead (the Headteacher) will deliver an annual update to the Governing body.

Temporary staff will be made aware of the safeguarding policies and procedures by the Assistant Headteacher.

Roles and Responsibilities

<u>The Designated Safeguarding Lead</u>

The Designated Safeguarding Lead (DSL) for Child Protection in this school is Joanne Sawyer, Headteacher; in her absence Valerie Steunou, Liz Martindale and Natalie Slater are all Safeguarding Officers (SO)

It is the role of the Designated Safeguarding Lead for Child Protection to:

- Ensure children know that there are Children and Family Support workers in the school whom they can approach if they are worried or in difficulty
- Ensure that he/she receives regular refresher training to keep his or her knowledge and skills up to date
- Ensure that all staff who work with children undertake appropriate training to equip them to carry out their responsibilities for safeguarding children effectively and that this is kept up to date by regular refresher training.
- Ensure that new staff receive a safeguarding children induction within 7 working days of commencement of their contract
- Ensure that temporary staff and volunteers are made aware of the school's arrangements for safeguarding children within 7 working days of their commencement of work
- Ensure that the school operates within the legislative framework and recommended guidance
- Ensure that all staff and volunteers are aware of local inter-agency Child Protection and Safeguarding Children Procedures including how to act on concerns over the risk of radicalisation or extremism. This will include reference to the 'Channel' program if there are sufficient concerns over radicalisation and extremism.
- Develop effective working relationships with other agencies and services
- Decide upon the appropriate level of response to specific concerns about a child e.g. discuss with parents, offer an assessment under the Common Assessment Framework (CAF, locally FEHA Family Early Help Assessment) or refer to Children's social care.
- Liaise and work with Children's social care over suspected cases of child abuse
- Ensure that accurate safeguarding records relating to individual children are kept. Academic files are marked with a red dot where there are any safeguarding concerns and kept in a secure place to which access is limited to a small number of people.
  'Cause for concern' forms are kept securely in the Pupil Support Team (PST) office for the term in which the incident(s) occur. They are then transferred to the academic files.
  Where there are on-going concerns, child protection plans or FEHA's in place the child has a separate safeguarding file in the PST office. Their academic file is marked to indicate the presence of the additional file.

- Ensure the school's attendance at child protection conferences and contribute to decision making and delivery of actions planned to safeguard the child
- Ensure that the school effectively monitors children about whom there are concerns, including notifying Children's social care when there is an unexplained absence of more than two days for a child who is the subject of a child protection plan
- Provide guidance to parents, children and staff about obtaining suitable support
- Discuss with new parents the role of the DSL and the role of safeguarding in the school. Make parents aware of the safeguarding procedures used and how to access the child protection policy

The Governing Body

The Governing Body has overall responsibility for ensuring that there are appropriate measures in place to safeguard the children in the school. In particular the Governing Body must ensure:

- Effective child protection policy and procedures are in place and any deficiencies or weaknesses in safeguarding arrangements are remedied without delay
- Safeguarding policies and procedures are reviewed annually and relevant information provided to the local authority
- Appointment of a DSL who is a senior member of school leadership team
- Relevant safeguarding children training for school staff/volunteers is attended
- Safe management of allegations

A nominated governor will be appointed to take lead responsibility for child protection. The Chair of the Governing Body will be responsible in the event of an allegation of abuse being made against the Headteacher.

Staff

If any member of staff is concerned about a child they must inform the DSL or one of the SO's and record information regarding the concerns on the same day. The recording must be a clear, precise, factual account of the observations. A Cause for Concern form should be used.

The DSL/SO will decide whether the concerns should be referred to Children's Social care. If it is decided to make a referral this will be discussed with the parent/carer, unless it is an emergency or to do so would place the child at further risk of harm.

Particular attention will be paid to the attendance and development of any child about whom the school has concerns, or who has been identified as being the subject of a child protection plan or FEHA and a written record will be kept.

If a pupil who is/or has been the subject of a child protection plan or FEHA changes school, the DSL will inform the lead practitioner responsible for the case and transfer the appropriate records to the DSL at the receiving school, in a secure manner, and separate from the child's academic file.

When To Be Concerned

The main categories of abuse are: Physical abuse; Emotional abuse; Sexual abuse; Neglect, female genital mutiliation, radicalisation and/or extremist behaviour*. All staff and volunteers should be concerned about a child if s/he presents with indicators of possible significant harm – **see Appendix 1 for details**.

*The SO has access to additional information regarding Extreme Right Wing and Affiliated Groups

Dealing with A Disclosure

The recipient of an allegation must not unilaterally determine its validity and failure to report it in accordance with procedures is a potential disciplinary matter for members of staff.

If a child discloses that s/he has been abused in some way, the member of staff / volunteer will make a written record (see Record Keeping) and pass the information to the DSL or an SO without delay.

The member of staff / volunteer should:

- Accept what is being said and listen without displaying shock or disbelief or criticising the alleged perpetrator, allowing the child to talk freely, only asking questions when necessary to clarify
- Reassure the child, but not make promises which it might not be possible to keep. For example, not promising confidentiality as it might be necessary to refer to Children's Social care or other agency.
- Reassure the child that what has happened is not his or her fault and stressing that it was the right thing to tell
- Explain what has to be done next and who has to be told

Record Keeping
When a child has made a disclosure, the member of staff/volunteer should:

- Make brief notes as soon as possible after the conversation. Use the school Cause For Concern form wherever possible
- Not destroy the original notes in case they are needed by a court
- Record the date, time, place and any noticeable non-verbal behaviour and the words used by the child
- Draw a diagram to indicate the position of any injuries
- Record statements and observations rather than interpretations or assumptions

All records must be given to the DSL/SO promptly, no copies should be retained by the member of staff / volunteer.

Support
Dealing with a disclosure from a child, and safeguarding issues can be stressful. The member of staff/volunteer should, therefore, consider seeking support for him/herself and discuss this with the DSL.

Allegations Involving School Staff/Volunteers
An allegation is any information which indicates that a member of staff/volunteer may have:

- Behaved in a way that has, or may have harmed a child
- Possibly committed a criminal offence against/related to a child
- Behaved towards a child or children in a way which indicates s/he would pose a risk of harm if they work regularly or closely with children

This applies to any child the member of staff/volunteer has contact with in their personal, professional or community life, not just children in this school.

The Headteacher will not investigate the allegation itself, or take written or detailed statements, but will assess whether it is necessary to refer the concern to the Local Authority Designated Officer. The Headteacher will act in accordance with Guidance issued by the Department for Education.

Allegations involving the Headteacher

If an allegation is made against the Headteacher, the matter will be reported immediately to the Chair of Governors who will refer the allegation to the Local Authority Designated Officer for consideration of further action.

Parents Unfit to Accompany a Child
The school will not allow parents / carers to take responsibility for a child when they are not considered capable of safely supervising them due to alcohol, drugs or illness.

If a parent / carer arrives at school in the morning, in what a member of staff considers to be an unfit state, then the matter should be reported to the DSL as soon as reasonably possible.

If a parent / carer arrives to collect a child and the member of staff feels they are not in a fit state to take safe responsibility for the child, then the adult and child should be brought to the office and the matter handed over to the DSL who will then decide on the safest course of action. This may involve contacting another member of the family, the child protection authorities or the police, as appropriate in the circumstances.

Confidentiality
Safeguarding children raises issues of confidentiality that must be clearly understood by parent/carers and staff/volunteers in schools.

The school has a duty to safeguard and promote the welfare of its pupils. This responsibility means the school may need to share information and work in partnership with other agencies when there are concerns about a child's welfare.

Staff/volunteers who receive information about children and their families in the course of their work should share that information only within appropriate professional contexts.

However, all staff in schools, both teaching and non-teaching staff, also have a responsibility to share relevant information about the protection of children with other professionals, particularly the investigative agencies (Children's Social Care and the Police).

Communication with Parents/Carers
We will undertake appropriate discussion with parents/carers prior to involvement of another agency unless to do so would place the child at further risk of harm.

MONITORING & EVALUATION
The Headteacher is responsible for the day to day monitoring of this policy and if any changes are required will consult with the Governing Body to effect those changes promptly. The policy will be evaluated and reviewed annually by the governing body.

LINKED POLICIES
This policy should be read in conjunction with the school's other policies on Safeguarding, Intimate Care, Safer Recruitment, Behaviour, Physical Intervention, Anti-Bullying and Whistleblowing .

APPROVED BY: The Full Governing Body

DATE: February 2016

NEXT REVIEW: February 2017

Appendix 1 Indicators of Harm

PHYSICAL ABUSE

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

Indicators in the child
Bruising

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

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

Fractures

Fractures may cause pain, swelling and discolouration over a bone or joint. It is unlikely that a child will have had a fracture without the carers being aware of the child's distress.

If the child is not using a limb, has pain on movement and/or swelling of the limb, there may be a fracture.

There are grounds for concern if:

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

Rib fractures are only caused in major trauma such as in a road traffic accident, a severe shaking injury or a direct injury such as a kick.

Skull fractures are uncommon in ordinary falls, i.e. from three feet or less. The injury is usually witnessed, the child will cry and if there is a fracture, there is likely to be swelling on the skull developing over 2 to 3 hours. All fractures of the skull should be taken seriously.

Mouth Injuries

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

Poisoning

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

Fabricated or Induced Illness

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

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

Bite Marks

Bite marks can leave clear impressions of the teeth when seen shortly after the injury has been inflicted. The shape then becomes a more defused ring bruise or oval or crescent shaped. Those over 3cm in diameter are more likely to have been caused by an adult or older child.

A medical/dental opinion, preferably within the first 24 hours, should be sought where there is any doubt over the origin of the bite.

Burns and Scalds

It can be difficult to distinguish between accidental and non-accidental burns and scalds. Scalds are the most common intentional burn injury recorded.

Any burn with a clear outline may be suspicious e.g. circular burns from cigarettes, linear burns from hot metal rods or electrical fire elements, burns of uniform depth over a large area, scalds that have a line indicating immersion or poured liquid.

Old scars indicating previous burns/scalds which did not have appropriate treatment or adequate explanation. Scalds to the buttocks of a child, particularly in the absence of burns to the feet, are indicative of dipping into a hot liquid or bath.

The following points are also worth remembering:

- A responsible adult checks the temperature of the bath before the child gets in.
- A child is unlikely to sit down voluntarily in a hot bath and cannot accidentally scald its bottom without also scalding his or her feet.
- A child getting into too hot water of his or her own accord will struggle to get out and there will be splash marks

Scars

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

Emotional/behavioural presentation

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

Indicators in the parent

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

Indicators in the family/environment

- Marginalised or isolated by the community
- History of mental health, alcohol or drug misuse or domestic violence

- History of unexplained death, illness or multiple surgery in parents and/or siblings of
- the family
- Past history of childhood abuse, self harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.

EMOTIONAL ABUSE

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person.

It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate.

It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Indicators in the child

- Developmental delay
- Abnormal attachment between a child and parent/carer e.g. anxious, indiscriminate or no attachment
- Aggressive behaviour towards others
- Child scapegoated within the family
- Frozen watchfulness, particularly in pre-school children
- Low self esteem and lack of confidence
- Withdrawn or seen as a 'loner' - difficulty relating to others
- Over-reaction to mistakes
- Fear of new situations
- Inappropriate emotional responses to painful situations
- Neurotic behaviour (e.g. rocking, hair twisting, thumb sucking)
- Self harm
- Fear of parents being contacted
- Extremes of passivity or aggression
- Drug/solvent abuse
- Chronic running away
- Compulsive stealing
- Low self-esteem
- Air of detachment – 'don't care' attitude

- Social isolation – does not join in and has few friends
- Depression, withdrawal
- Behavioural problems e.g. aggression, attention seeking, hyperactivity, poor attention
- Low self esteem, lack of confidence, fearful, distressed, anxious
- Poor peer relationships including withdrawn or isolated behaviour

Indicators in the parent

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

Indicators of in the family/environment

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

NEGLECT

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

health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.

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

- provide adequate food, clothing and shelter (including exclusion from home or abandonment);
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate care-givers); or
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Indicators in the child
Physical presentation

- Failure to thrive or, in older children, short stature
- Underweight

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

Development

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

Emotional/behavioural presentation

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

Indicators in the parent

- Dirty, unkempt presentation
- Inadequately clothed
- Inadequate social skills and poor socialisation
- Abnormal attachment to the child .e.g. anxious
- Low self esteem and lack of confidence
- Failure to meet the basic essential needs e.g. adequate food, clothes, warmth, hygiene
- Failure to meet the child's health and medical needs e.g. poor dental health; failure to attend or keep appointments with health visitor, GP or hospital; lack of GP registration; failure to seek or comply with appropriate medical treatment; failure to address parental substance misuse during pregnancy
- Child left with adults who are intoxicated or violent

- Child abandoned or left alone for excessive periods
- Wider parenting difficulties, may (or may not) be associated with this form of abuse

Indicators in the family/environment

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

SEXUAL ABUSE

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening.

The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).

Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Indicators in the child
Physical presentation

- Urinary infections, bleeding or soreness in the genital or anal areas
- Recurrent pain on passing urine or faeces
- Blood on underclothes
- Sexually transmitted infections
- Vaginal soreness or bleeding
- Pregnancy in a younger girl where the identity of the father is not disclosed and/or there is secrecy or vagueness about the identity of the father
- Physical symptoms such as injuries to the genital or anal area, bruising to buttocks, abdomen and thighs, sexually transmitted disease, presence of semen on vagina, anus, external genitalia or clothing

Emotional/behavioural presentation

- Makes a disclosure.
- Demonstrates sexual knowledge or behaviour inappropriate to age/stage of development, or that is unusually explicit
- Inexplicable changes in behaviour, such as becoming aggressive or withdrawn
- Self-harm - eating disorders, self mutilation and suicide attempts
- Poor self-image, self-harm, self-hatred
- Reluctant to undress for PE
- Running away from home
- Poor attention / concentration (world of their own)
- Sudden changes in school work habits, become truant
- Withdrawal, isolation or excessive worrying
- Inappropriate sexualised conduct
- Sexually exploited or indiscriminate choice of sexual partners
- Wetting or other regressive behaviours e.g. thumb sucking
- Draws sexually explicit pictures
- Depression
- Indicators in the parents
- Comments made by the parent/carer about the child.
- Lack of sexual boundaries
- Wider parenting difficulties or vulnerabilities
- Grooming behaviour
- Parent is a sex offender

Indicators in the family/environment

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

FEMALE GENITAL MUTILIATION

There are a range of potential indicators that a child may be at risk of FGM which individually may not indicate risk but if there are two or more indicators present this could signal a risk to the child.

Specific risk factors:

- The position of the family and the level of integration into UK society. It is believed that communities less integrated into British society are more likely to carry out FGM

- Any girl born to a woman who has been subjected to FGM must be considered to be at risk of FGM herself.
- Any girl who has a sister who has already undergone FGM must be considered to be at risk of FGM herself.
- Any girl withdrawn from PSHE/SRE may be at risk as a result of her parents wishing to keep her uninformed about her body and rights.

Indications that FGM may be about to take place soon:

The age at which FGM takes place varies widely but it is thought that the majority of cases take place when the child is between the ages of 5 and 8.

- Parents state that they will take the child out of the country for a prolonged period.
- A girl may talk about a long holiday to her country of origin.
- A girl may confide that she is to have a 'special' procedure or attend a special occasion to 'become a woman'
- A girl talks about a special visitor from abroad – possibly

Indications that FGM may already have taken place:

- A prolonged absence from school with noticeable behaviour changes on her return.
- A girl may talk about pain or discomfort between her legs.or may ask for help but not be explicit about the problem due to embarrassment or fear.
- Prolonged or repeated absences from school.
- A girl may spend longer than normal in the bathroom and spend periods of time away from the classroom during the day.