SAINT JOHN'S

Safeguarding and Child Protection Policy

Autumn 2019

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Introduction

St. John's fully recognises its responsibilities for safeguarding children. Safeguarding incidents could happen anywhere and all staff should be alert to possible concerns. Staff should always act in the best interests of the child and not assume that someone else is taking action.

Our policy applies to all staff, supply staff, governors and volunteers working in the school. There are five main elements to our policy:

- Ensuring we practise safe recruitment in line with Government guidance by using at least one safer recruitment accredited recruiter on all interview panels and by checking the suitability of staff and volunteers to work with children and ensuring any unsuitable behaviour is reported and managed using the Allegations Management procedures.
- 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 by referring to the Children's Helpdesk.
- Supporting pupils who have been abused in accordance with his/her agreed child protection plan.
- Establishing a safe environment in which children can learn and develop.

We recognise that because of the day-to-day contact with children, school staff are well placed to observe the outward signs of abuse. The school will therefore:

- Establish and maintain a safe environment where children feel secure, are encouraged to talk, and are listened to.
- Ensure children know that there are adults in the school whom they can approach if they are worried.
- Ensure that staff are prepared to identify children who may benefit from early help
- Include opportunities in the PSHCE curriculum for children to develop the skills they need to recognise and stay safe from abuse.

Responsibilities

We will follow the procedures set out by the Gloucestershire Safeguarding Children Board and take account of guidance issued by the Department for Education to:

- Ensure we have a designated senior person for child protection who has received appropriate training and support for this role (GSBC multi-agency one day training, renewable every 2 years – http://www.gscb.org.uk/article/113295/Safeguarding-training) :

DSL (Designated Safeguarding Lead)
Juliette Moxham – Headteacher
01242 523786, head@st-johns-pri.gloucs.sch.uk

Deputy DSL
Adrian Brown – Deputy Head
01242 523786
abrown@st-johns-pri.gloucs.sch.uk

- Ensure we have a nominated governor responsible for child protection who has received appropriate training:

Nominated Governor
Matt George
mgeorge@st-johns-pri.gloucs.sch.uk
07825298825

- Ensure every member of staff, (including temporary and supply staff and volunteers) and governing body knows the names of the designated senior person responsible for child protection 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 designated senior person responsible for child protection (*See Appendix 1 Indicators of Harm and Appendix 2 Specific safeguarding issues).*
- Ensure that all staff consider the context within which incidents/behaviours occur, known as contextual safeguarding.
- Ensure that all staff have read and understood part 1 of Keeping Children Safe in Education 2019

All DSLs must undertake the GSCB multi agency training every 2 years. Courses are advertised regularly on the GSCB website and may be booked by filling in and e-mailing the course booking form available online or by contacting the Safeguarding Children Service training section on 01452 583621. For new DSLs, the training is one day (Multi Agency Child Protection Training). For those DSLs who only require a refresher, the training is half a day (Revision and Update).

The DSL is responsible for ensuring that all staff, including non-teaching staff and volunteers, caretakers, secretaries, learning mentors and TAs and all other support staff in the setting undertake whole staff refresher training every 3 years. This training takes the form of a 2 hour twilight session delivered in the educational setting and may be booked by contacting 01452 426994. An up-to-date list of staff safeguarding training is available at the school office.

Ensure that the Governing Body understands its responsibility in relation to Safeguarding arrangements within Extended Services and the importance of working together with appropriate agencies for the safety and well-being of the children.

Ensure that parents have an understanding of the responsibility placed on the school and staff for child protection by setting out its obligations in the school prospectus (welcome booklet).

Notify the relevant social worker if there is an unexplained absence of more than two days of a pupil who has a Child Protection Plan (previously known as being on the child protection register).

Core group meetings are being called before excluding a child on a child protection plan.

Develop effective links with relevant agencies and co-operate as required with their enquiries regarding child protection matters including attendance at child protection conferences and core groups (*Appendix 3, Multi Agency Working*).

Keep written records of concerns about children, even where there is no need to refer the matter immediately (*Appendix 4, Safeguarding Record Log*).
Ensure that the correct procedure is followed when making a referral (*Appendix 5 Referral Procedure*)

Ensure all records are kept securely, separate from the main pupil file, and in locked locations and passed onto any new setting.

Ensure all staff are aware of the local early help process and understand their role in it.

Follow procedures where an allegation is made against a member of staff or volunteer including supply or agency workers, contractors or governors (*Appendix 6, Allegations involving school staff/volunteers)*.

Ensure safe recruitment practices are always followed (*Appendix 7 Safe Recruitment Practices*)[1]. This includes the Headteacher and at least one further member of the Governing Body undertaking the accredited Safe Recruitment Training and the keeping and regular updating of a single Central Record of all staff/volunteers according to current recommended practice. Safer recruitment accreditation is available on-line from Government education website http://www.education.gov.uk and face to face training from GSCB http://www.gscb.org.uk/article/113325/Safeguarding-Recruitment-Accreditation

Our policy has been developed in line with Gloucestershire Safeguarding Children Board Child Protection Procedures (http://www.gscb.org.uk/) and will be reviewed annually.

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 school may be the only stable, secure and predictable element in the lives of children at risk. When at school their behaviour may be challenging and defiant or they may be withdrawn. The school will endeavour to support the pupil through:

- The content of the curriculum.
- The school ethos which promotes a positive, supportive and secure environment and gives pupils a sense of being valued.

- The school behaviour policy which is aimed at supporting vulnerable pupils in the school. The school will ensure that the pupil 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 pupil such as social care, Child and Adult Mental Health Service, education welfare service and educational psychology service.
- Ensuring that, where a pupil who has a Child Protection Plan leaves, their information is transferred to the new school immediately and that the child's social worker is informed.

Confidentiality

We recognise that all matters relating to child protection are confidential. The head teacher or DSLs will disclose any information about a child to other members of staff on a need to know basis only.
All staff will be made aware of their responsibility to share information with other agencies in order to safeguard children.
All staff will be made aware that they cannot promise a child to keep secrets which might compromise the child's safety or wellbeing.
We will always undertake to share our intention to refer a child to social care with their parents/carers unless to do so could put the child at greater risk or impede a criminal investigation. If in doubt we will consult with Gloucestershire Children's help desk 01452 426565.

Supporting Staff

We recognise that staff working in school who have become involved with a child who has suffered harm, or appears likely to suffer from harm may find the situation stressful and upsetting.

We will support such staff by providing an opportunity to talk through their anxieties with the DSL and seek further support if appropriate.

Anti-Bullying

Bullying is behaviour that hurts someone else – such as name calling, hitting, pushing, spreading rumours, threatening or undermining someone.

It can happen anywhere – at school, at home or online. It's usually repeated over a long period of time and can hurt a child both physically and emotionally.

Bullying that happens online, using social networks, games and mobile phones, is often called cyberbullying. A child can feel like there's no escape because it can happen wherever they are, at any time of day or night.

Our school policy on anti-bullying (including cyber bullying) is set out in a separate policy **'Anti-bullying Policy'.**

We keep a record of all bullying incidents. All staff are aware that children with SEND and/or differences/perceived differences are more susceptible to being bullied/victims of child abuse.

Offer of Early Help

St John's Primary school is committed to safeguarding children and promoting their welfare. We ensure that children at risk are identified at the earliest possible stage and that we work with them, their families and outside agencies, in a coordinated manner, to prevent the risk reaching a crisis point.

Children have different Levels of Need at different times across a range of situations and it is important to take all needs into consideration when determining support required and professionals to be involved.

The aim of Early Help is to clearly identify when and how children can be supported and safeguarded to ensure their needs are met at whatever level (*Appendix 8 St. John's Primary School Offer of Early Help)*.

Extended School and off-site arrangements

Where extended school activities are provided by and managed by the school, our own safeguarding and child protection policy and procedures apply. If other organisations provide services or activities on our site we will check that they have appropriate procedures in place, including safer recruitment procedures.

When our children attend off-site activities, we will check that effective child protection arrangements are in place.

Monitoring and Evaluation

Our child protection policy and procedures will be monitored and evaluated by:

Governing body visiting the school
SLT 'drop ins' and discussion with staff
Pupil surveys and questionnaires
Scrutiny of attendance data
Scrutiny of range of risk assessments
Scrutiny of GB minutes
Logs of bullying/racist/behaviour incidents for SLT and GB to monitor
Review of parental concerns
Review of fun club at lunchtime

Additional Reading

This policy should be read in conjunction with the following policies:

Anti-bullying Policy
Attendance
Behaviour Policy
Confidentiality
Equality
Drug Education
E-Safety Policy
Health and Safety Policy
Looked After Children Policy
PSHCE Policy
Pupil Premium Policy
Recruitment and Selection Policy
Transition Policy
Whistle Blowing Policy
Whole school security policy
Young carers Policy
First Aid Policy
E-Safety and Acceptable Use Policy
Safer Recruitment Policy
SEND Policy

Appendix 1: Categories of Abuse and 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 heath, alcohol or drug misuse or domestic violence

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

EMOTIONAL ABUSE

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

It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate.
It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.
Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Indicators in the child

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

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

Indicators in the parent

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

Indicators in the family/environment

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

NEGLECT

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

Once a child is born, neglect may involve a parent or carer failing to:
provide adequate food, clothing and shelter (including exclusion from home or abandonment);
protect a child from physical and emotional harm or danger;
ensure adequate supervision (including the use of inadequate care-givers); or
ensure access to appropriate medical care or treatment.

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 health, alcohol or drug misuse or domestic violence.
History of unexplained death, illness or multiple surgery in parents and/or siblings of the family

Family has a past history of childhood abuse, self harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.
Dangerous or hazardous home environment including failure to use home safety equipment; risk from animals
Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements, inadequate ventilation (including passive smoking) and lack of adequate heating
Lack of opportunities for child to play and learn

SEXUAL ABUSE

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

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

They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).
Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Indicators in the child

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

Emotional/behavioural presentation
Makes a disclosure.
Demonstrates sexual knowledge or behaviour inappropriate to age/stage of development, or that is unusually explicit
Inexplicable changes in behaviour, such as becoming aggressive or withdrawn
Self-harm - eating disorders, self-mutilation and suicide attempts
Poor self-image, self-harm, self-hatred
Reluctant to undress for PE
Running away from home
Poor attention / concentration (world of their own)

Sudden changes in school work habits, 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.

Appendix 2 Specific Safeguarding Issues

Expert and professional organization are best placed to provide up- to-date guidance and practical support on specific safeguarding issues. For example NSPCC offers information for schools and colleges on the TES website and also on its own www.nspcc.org.uk. Schools and colleges can also access broad government guidance on issues listed below via www.GOV.UK

Child Sexual Exploitation (CSE) – also see below
Bullying including cyber bullying
Domestic violence
Drugs
Fabricated or induced illness
Faith abuse
Female genital mutilation (FGM) – also see below
Forced marriage – also see below
Gangs and youth violence
Gender-based violence/violence against women and girls (VAWG)
Gender indentity and sexuality
Mental health
Private fostering
Radicalization and extremism – also see below
Sexting
Teenage relationship abuse
Trafficking

Child Sexual Exploitation (CSE)

Child sexual exploitation involves exploitive situations, contexts and relationships where young people receive something (e.g. food, accommodation, drugs, gifts, money and sometimes simply affection) as a result of engaging in sexual activities. Sexual exploitation takes different forms from a seemingly 'consensual' relationship where sex is exchanged for affection or gifts, to serious organised crime by gangs or groups.
Sexual exploitation involves varying degrees of coercion, intimidation, or enticement including unwanted pressure from peers to have sex, sexual bullying including cyber bullying and grooming.

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.
• 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.

Signs and behaviour seen in children who are 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.
• Change in physical appearance.
• 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.

If CSE is suspected see GSCB CSE screening tool
http://www.gscb.org.uk/CHttpHandler.ashx?id=55517&p=0

Female Genital Mutilation (FGM)

Female Genital Mutilation (FGM) is illegal in the UK.
FGM is a collective term for all procedures which include the partial or total mutilation of the external female genital organs for cultural or other non-therapeutic reasons.
Legislation has been in place for many years. It is known that children are subject to this procedure both in the UK and overseas.
FGM is not an acceptable practice and is a form of child abuse under UK law.
Definition
FGM covers a range of mutilation from the partial to total removal of the external female genital organs.
The World Health Organisation has classified FGM as four different procedures:
FGM Type 1 – Sunna – removal of the hood of the clitoris.
FGM Type 2 – Excision – removal of the clitoris with partial or total excision of the labia minora.

FGM Type 3 – Infibulation – removal of the clitoris, labia minora with narrowing by stitching of the vaginal opening.
FGM Type 4 – Gishiri cuts – all other types including pricking, cutting and piercing, inserting substances with any of the above.

Background

FGM is a tradition practiced in 28 African countries and parts of Asia and Latin American. The communities with the highest prevalence are generally from the Horn of Africa and include countries such as Somalia, Egypt, Mali, Guinea etc (C Momoh (2005) Female Genital Mutilation, Radcliffe, Oxford).
FGM is increasingly found in Western Europe and developed countries. In the UK there are populations of people from countries who practice FGM, they maintain close cultural links to their country of origin. The women and girls in these families are at risk of FGM.
In the UK it has been estimated that up to 100,000 women and up to 10,000 children are at risk.

Justification for FGM

Reason given by communities for practicing FGM includes:
Custom and tradition;
Family honour;
Hygiene and cleanliness;
Preservation of virginity/chastity;
Social acceptance especially for marriage;
The mistaken belief that it is a religious requirement;
A sense of belonging to the group and conversely the fear of social exclusion
In the UK the complexities of the social interactions that surround this practice have led to collusion and secrecy within families when they are planning for FGM. This poses a huge challenge for staff who need to identify these risks and protect girls from FGM.

Short term health implications

Severe pain and shock
Infections
Urine retention
Injury to adjacent tissues
Fracture or dislocation as a result of restraint
Damage to other organs
Behavioural changes and emotional upset
Death

Long term health implications

Recurrent Urinary Tract Infections
Excessive damage to the reproductive system
Uterus, vaginal and pelvic infections
Difficulties in menstruation
Difficulties in passing urine
Increased risk of HIV transmission and Hepatitis B
Infertility
Cysts
Complications in pregnancy and childbirth
Psychological damage
Sexual dysfunction

Signs & indicators

Some indicators that FGM may be about to or has already taken place.
If a family originates from a country that is known to practice FGM and:

A conversation with a child may refer to FGM i.e. she may express anxiety about a 'special procedure', 'pricking', 'pinching my bottom' or an event or celebration that is to take place.
At school following a prolonged absence you may notice a change in the child's behaviour on their return, including a reluctance or inability to take part in physical activity.
A prolonged family trip to the country of origin or countries where FGM is practiced.
A child may spend long periods of time visiting the toilet during the day-perhaps indicating bladder or menstrual problems.
A midwife/obstetrician/gynaecologist/general practitioner/practice nurse may become aware that FGM has occurred when treating a female patient. This should trigger concern for other females in the household.
All agencies have a responsibility to recognise the signs and indicators and share and report information appropriately, but education and health need to be especially vigilant.
For more information see GSCB leaflet 'Female Genital Mutilation/Circumcision – What you need to know' http://www.gscb.org.uk/CHttpHandler.ashx?id=59769&p=0

Forced Marriage (FM)

This is separate issue from arranged marriage. It is a human rights abuse and falls within the Prosecution Service definition of domestic violence. It is a marriage in which one or both spouses do not consent to the marriage and duress is involved. Duress can be physical, psychological, financial, sexual and emotional pressure.

Honour Based Violence (HBV)

Is a collection of practices used to control behaviour within families to protect perceived cultural or religious beliefs and honour. Violence can occur when offenders perceive that a relative has shamed the family or community by breaking their 'code of honour'.
Honour based violence cuts across all cultures and communities: Turkish, Kurdish, Afghani, South Asian, African, Middle Eastern, South and Eastern European. This is not an exhaustive list.

Radicalization and Extremism

The Counter Terrorism and Security Act 2015 places a duty on schools to have 'due regard to the need to prevent people from being drawn into terrorism.' THIS IS THE PREVENT DUTY.

The Prevent strategy was published by the government in 2011 and is part of the Governments overall counter-terrorism strategy known as 'CONTEST'. The aim of the Prevent strategy is to reduce the threat to the UK from terrorism.

Radicalisation is defined in the Prevent Strategy as "the process by which a person comes to support terrorism and forms of extremism leading to terrorism." During the process of radicalisation a vulnerable person will have their vulnerabilities or susceptibilities exploited towards crime or terrorism – most often by a third party with their own agenda.

Extremism is defined in the Prevent Strategy as "vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty

and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces, whether in this country or overseas."

Vulnerabilities

Vulnerabilities or susceptibilities which can be exploited for radicalisation or recruitment to extremism and terrorism can be caused by a wide-range of factors; while there is some overlap these may not always fit our common understanding or perceptions of vulnerabilities for other safeguarding concerns.

Why might a young person be drawn towards extremism or terrorism?

Extremist or terrorist groups can purport to offer a sense of identity, belonging or improved self-esteem

Extremist or terrorist causes can offer a sense of excitement or purpose, often glamorising their activities

Extremist or terrorist groups can manipulate world affairs and political issues to create a strong sense of injustice or grievance

Extremist or terrorist groups are adept at using social media and online platforms to garner support, at times such material may reach young and vulnerable people

Behavioural Changes

Be alert to sudden behavioural changes which may be signs of extremism or radicalisation. Many of the potential behavioural changes will appear similar to other safeguarding concerns, these may include:

Sudden change in peer group

Change in emotional state

Change in use of language, interests, terminology and appearance or dress

Change in routine or hobbies and absence from education or employment

Showing sympathy for extremist causes, glorifying or supporting violence or possession of extremist literature/propaganda

Change in social attitudes towards other members of the community

These are just some of the vulnerabilities or behavioural changes which we should be alert to, in reality the signs of radicalisation or what makes someone vulnerable may be quite different.

If you are concerned about the welfare of a child or member of the community in relation to extremism or radicalization follow the schools safeguarding procedure.

The Department for Education has dedicated a telephone helpline (020 7340 7264) to enable staff and governors to raise concerns relating to extremism directly. Concerns can also be raised by email to counter.extremism@education.gsi.gov.uk.

Domestic Abuse

Domestic abuse is any type of controlling, bullying, threatening or violent behaviour between people in a relationship. But it isn't just physical violence – domestic abuse includes emotional, physical, sexual, financial or psychological abuse.

Abusive behaviour can occur in any relationship. It can continue even after the relationship has ended. Both men and women can be abused or abusers.

Domestic abuse can seriously harm children and young people. Witnessing domestic abuse is child abuse, and teenagers can suffer domestic abuse in their relationships.

If staff become aware that a child or young person is witnessing domestic abuse they should always follow the child protection process.

Private Fostering

A private fostering arrangement is essentially

- one that is made privately (without the involvement of a local authority) for the care of a child under the age of 16 (under 18, if disabled)
- by someone other than a parent or close relative
- With the intention that it should last for 28 days or more.

Private fostering covers a diverse range of situations. Most educational settings will have children who are privately fostered, although the school/setting may not be aware that a child is privately fostered. Asking who has parental responsibility would give an indicator as to whether or not a child is privately fostered. Common private fostering situation include

• African, Asian and Afro Caribbean children with parents or families overseas
• Black and minority ethnic children with parents working or studying in the UK and living with a host family
• Asylum seeking and refugee children
• Trafficked children
• Local children living apart from their families, perhaps because the family has broken down.
• Adolescents estranged from their parents
• Children attending Language Schools
• Children attending independent schools who do not return home for holiday periods
• Children living with host families for a variety of reasons, possibly to learn English or to receive medical treatment in the UK.
• Back door adoptions

If you think a child is being privately fostered, the DSL should make a referral to the Children and Families Helpdesk – 01452 426565. Social care will undertake an assessment of the private fostering arrangement which will include safeguard checks on the carers and contacting the child's parents. A worker will be allocated until the

child is 16 and the arrangement will be monitored and reviewed and the young person visited on a regular basis.

Parental Substance Misuse

Parental substance misuse is not always the only issue within a household- domestic violence and mental health problems often exist alongside substance misuse. Substance misuse may often be a coping strategy for experiences of domestic abuse.
Risks to children are significantly higher where there is substance misuse and domestic abuse or mental health issues.
Mental health problems are more likely to be exacerbated by substance misuse, either because they are triggered by drug or alcohol consumption or because substances are used in response to a psychiatric problem. Either way mental health problems alongside substance misuse are likely to adversely affect a parent's ability to care for their child.

The impact of substance misuse on children can be reduced when information is effectively shared across agencies. Collaboration between professionals is essential in safeguarding children and young people.

See GSCB Gloucestershire Countywide Protocol for Parental Substance Misuse

Sexting

School takes the issue of "Sexting" very seriously. We have consulted with the police on best practice. In the event that the school becomes aware that a pupil may have images on his/her phone (or other electronic device) of an inappropriate nature the school will:

- Take the phone from
- Contact the parents and ask them to collect the phone from school at a time convenient to them
- Ask the parents to not return the phone to the pupil until the parents are confident all images have been wiped and if necessary the phone returned to factory settings.
- We will always liaise closely with the police over issues of sexting the pupil.

Mental Health

Mental health is a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. (World Health Organization)

In an average classroom, three children will be suffering from a diagnosable mental health issue. At school, we aim to promote positive mental health for everyone. We pursue this aim using both universal, whole school approaches and specialised, targeted approaches aimed at vulnerable students.

If you have any concerns contact the Head teacher.

Peer on Peer Abuse

Children are vulnerable to abuse by their peers, including relationship abuse. Such abuse should be taken as seriously as abuse by adults and should be subject to the same child protection procedures. Professionals should not dismiss abusive behaviour as normal between young people and should not develop high thresholds before taking action.

Professionals should be aware of the potential uses of information technology for bullying and abusive behaviour between young people.

If one child or young person causes harm to another, this should not necessarily be dealt with as abuse: bullying, fighting and harassment between children are not generally seen as child protection issues. However, it may be appropriate to regard a young person's behaviour as abusive if:

- There is a large difference in power (for example age, size, ability, development) between the young people concerned; or
- The perpetrator has repeatedly tried to harm one or more other children; or
- There are concerns about the intention of the alleged perpetrator.

If the evidence suggests that there was an intention to cause severe harm to the victim, this should be regarded as abusive whether or not severe harm was actually caused.

If there are any concerns child protection procedures should be followed.

Gender Identity and Sexual Orientation

Gender identity describes the psychological identification of oneself, usually as a boy/man or as a girl/woman. There is a presumption that this sense of identity will evolve along binary lines and be consistent with the sex appearance. However, not everyone will wish to be constrained by that binary form of categorisation. Some people experience a gender identity that is completely inconsistent with their sex appearance, or may be neutral, or may embrace aspects of both man and woman.

Sexual orientation is a separate issue from gender identity. Sexual orientation is associated with the sexual attraction between one person and another. This is quite different from the internal knowledge of one's own identity. Trans people may be gay, straight, bisexual or, occasionally, asexual. Their sexual relationships may remain the same through the transition process, or they may change.

School is committed to valuing, respecting and understanding pupils differing gender identities and sexual orientation, as well as providing continuous support to all pupils. Our Anti-bullying policy will be used to prevent and effectively deal with any homophobic, biphobic and transphobic bullying.

Hate

In extreme cases prejudice-motivated bullying and harassment can be considered a hate crime and is punishable by law.

Appendix 3 Multi Agency working

Child Protection conference/core groups

A child protection conference is convened where agencies involved judge that a child may continue to, or is likely to, suffer significant harm. The initial child protection conference brings together family members and those professionals most involved with child and family. School will be invited to contribute.

The core group is established in response to the child protection conference and is responsible for developing the child protection plan and implementing it. School can contribute significantly to the core group.

MASH (Multi Agency Safeguarding hub)

Is made up of
Gloucestershire County Council (GCC) Children Services
GCC Adult safeguarding Team
GCC Education Services
Gloucestershire Police
Youth Support Services
Gloucestershire health community
Gloucestershire Domestic Abuse Support Services (GDASS)

Referrals are made via existing safeguarding referral routes. MASH allows agencies to share all the available information that they hold in order to make a decision as how to best investigate and offer support.
School may be contacted by the MASH GCC Education Services to share information about a child.

MARAC (Multi Agency Risk Assessment Conference)

MARAC meetings are held regularly to discuss high level incidences of domestic abuse. The purposes of MARACs are to share information to increase the safety, health and well-being of victims – adults and their children, to construct jointly and implement a risk management plan that provides professional support.
Currently education representatives do not attend the MARACs. If the MARAC decides to disclose to the school the health representative will inform the school nurse who will disclose to the DCPO and may offer support directly to the child.

MAPPA (Multi Agency Public Protection Arrangements)

The multi agency public protection arrangements ensure the assessment and management of high risk offenders. The police, probation and prison services are the lead agencies, with other agencies including CYPD/Education settings. There is a statutory duty to cooperate.

Appendix 4: Safeguarding Record Log

Pupil Name	
Date of Birth	
Address	
Incident of concern	
Recorded by	
Date recorded	
Signature	
Named colleagues/professionals Informed	

To be kept securely, separately from the main pupil file

Appendix 5: Referral Procedure

Appendix 6: 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 within their personal, professional or community life.

The person to whom an allegation is first reported should take the matter seriously and keep an open mind. S/he should not investigate or ask leading questions if seeking clarification; it is important not to make assumptions. Confidentiality should not be promised and the person should be advised that the concern will be shared on a 'need to know' basis only.

Actions to be taken include making an immediate written record of the allegation using the informant's words - including time, date and place where the alleged incident took place, brief details of what happened, what was said and who was present. This record should be signed, dated and immediately passed on to the Headteacher.

If the concerns are about the Headteacher, then the Chair of Governors should be contacted. The Chair of Governors in this school is:

NAME: Jonathan Griffiths CONTACT NUMBER: 07397 262333

In the absence of the Chair of Governors, the Vice Chair should be contacted. The Vice Chair in this school is:

NAME: Helen Roach CONTACT NUMBER: 07733055404

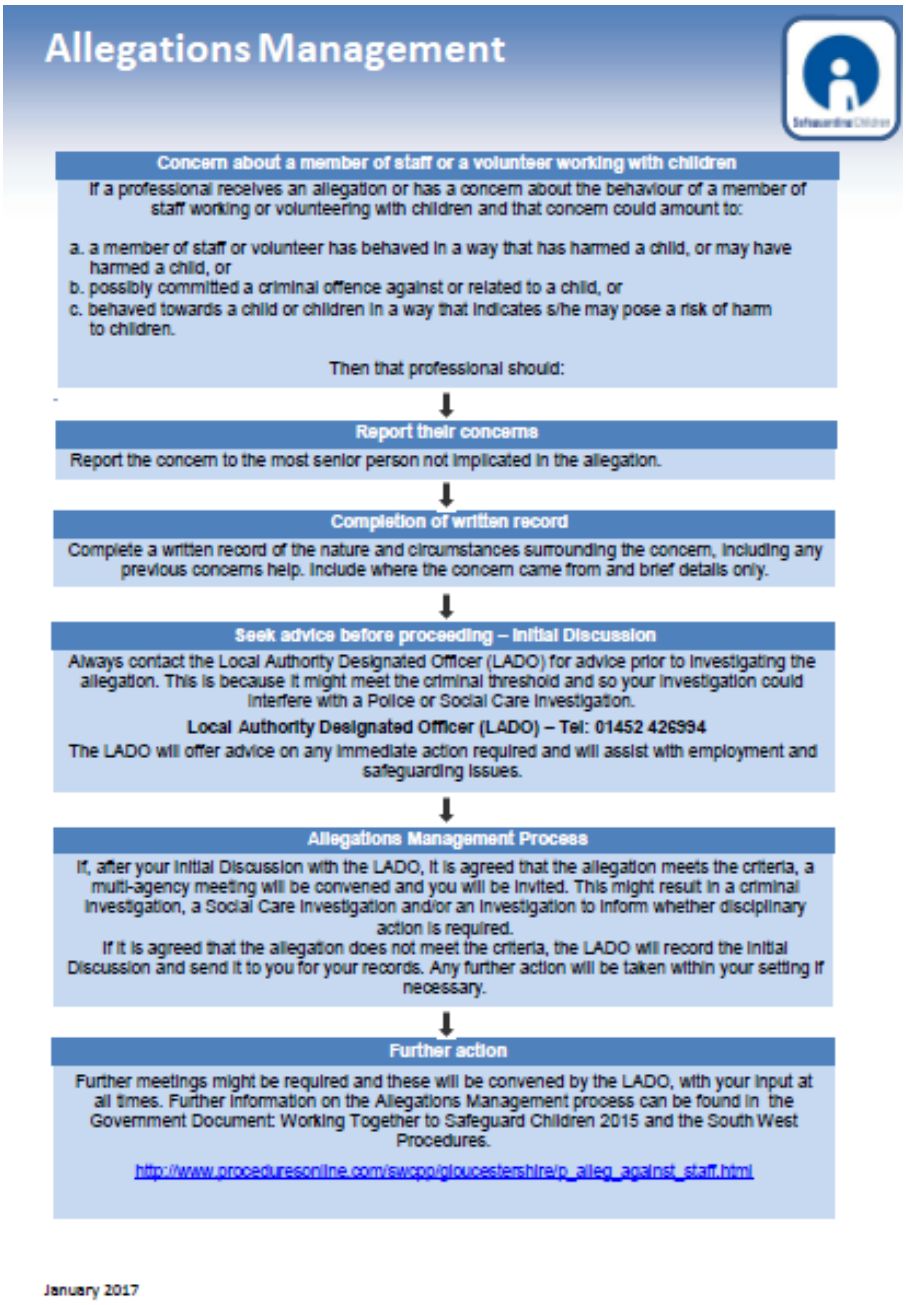
The recipient of an allegation must **not** unilaterally determine its validity, and failure to report it in accordance with procedures is a potential disciplinary matter.

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. If the allegation meets any of the three criteria set out at the start of this section, contact should always be made with the Local Authority Designated Officer without delay.

If it is decided that the allegation meets the threshold for safeguarding, this will take place in accordance with section 4.1 of the Safeguarding Children Board Inter-agency Child Protection and Safeguarding Children Procedures.

If it is decided that the allegation does not meet the threshold for safeguarding, it will be handed back to the employer for consideration via the school's internal procedures.

The Headteacher should, as soon as possible, **following briefing** from the Local Authority Designated Officer inform the subject of the allegation.



Appendix 7: Safe Recruitment Practices

12 steps to safer recruitment

Before you release your post . . .

Ensure that you have an up to date recruitment and selection policy that describes the process and roles before you begin

Ensure that your organisation has a safeguarding policy and that a statement about the organisation's commitment to safeguarding is included in all recruitment and selection materials

Ensure that you have an up to date job description and person specification for the role(s) you wish to recruit to, that have been agreed with the recruiting manager

Ensure that you have an appropriate advertisement prepared that contains all necessary information about the role, timetable for recruitment and your commitment to safeguarding

Ensure that you have compiled a suitable candidate information pack containing all the required information about the organisation, role, recruitment timetable, safeguarding policy/statement and application form

Before you interview…

Ensure that each application received is scrutinised in a systematic way by the shortlisting panel in order to agree your shortlist before sending invitations to interview

Ensure that all appropriate checks have been undertaken on your shortlisted candidates, including references and ISA checks from 2010

Ensure that all shortlisted candidates receive the same letter of invitation to interview, supplying them with all necessary information

Before you select your preferred candidate…

Ensure that a face-to-face interview is conducted for ALL shortlisted candidates based on an objective assessment of the candidate's ability to meet the person specification and job description

Ensure that all specific questions designed to gain required information about each candidate's suitability have been asked, including those needed to address any gaps in information supplied in the application form

Before you formally appoint …

Ensure that you are able to make a confident selection of a preferred candidate based upon their demonstration of suitability for the role

Ensure that your preferred candidate is informed that the offer of employment (including volunteer positions) is conditional on receiving satisfactory information from all necessary checks including prohibition checks and self-declaration of criminal record and other relevant information (childcare disqualification requirements).

Appendix 8: Offer of Early Help

St. John's C of E Primary School Offer of Early Help

The new Children and Families Act 2014 means changes to the law to give greater protection to vulnerable children, better support for children whose parents are separating, a new system to help children with special educational needs and disabilities and help for parents to balance work and family life. Early help is important because it ensures vulnerable children and their families receive the help they need when they need it. It can prevent problems getting worse and requiring specialist intervention from social care, health and the youth justice system.

It is imperative that all children receive appropriate welfare; The United Nations Convention on the Rights of the Child (CRC) provides a child-centred framework within which services to children are located. It spells out the basic human rights that all children have, including *'the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life'.*

The Munro 'Working Together' definition of Early Help is as follows;

Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years.

St. John's C of E Primary School is committed to safeguarding children and promoting their welfare at all levels. We ensure that children who are at risk are identified as soon as possible and that we work with them, their families and any necessary outside agencies to try to ensure that the situation does not reach a crises point. We are aware that children and their families have different levels of needs at different times and as a result of different situations; that all needs need to be taken into account when considering the type of support that would be beneficial and which professionals can help. The aim of early help is to identify which level of help is needed and how we can ensure that the children are safeguarded and that their needs are met. We are fully aware of the importance placed on bespoke care and support being offered to individuals.

The following table identifies that levels of need and the services that the school can offer or signpost to. The information is taken directly from the GSCB website. The list is not exhaustive with the school actively seeking additional/alternative support when needed.

Child needs	School Provision	Community Provision	Other Provision
Universal Services. Children are making good overall	St John's curriculum develops the characteristics that pupils need to	www.glosfamilies.org.uk have services that are accessible	Parentline Plus Citizen's Advice Bureau www.actionforchildren.org.uk

progress in all areas of development. Living in a protected environment where their needs are recognised and met. No additional support needed beyond that which is universally accessible.	develop and thrive as individuals, as part of a family and in the community. The whole child is nurtured through a values led curriculum and particular development of their pastoral needs through our PSHCE curriculum.	without referral or assessment.	www.nhs.uk/Change4Life www.familylives.org.uk - general help and support for parents
Vulnerable: Early Help Services Children needing some additional support which may be related to health, educational or social development. OR A coordinated response through a multi-agency assessment using to assess and address their needs	Attendance Officer monitors attendance and lateness. Class teachers monitor pupil's general behaviour, appearance, engagement, attitude and disposition. Concerns referred to DSL (safeguarding), SENco, PSA, Designated Child in Care Coordinator. Regular meetings regarding pupils highlight pupil needs. Actions will be set ccording to outcomes.	CYPS (children and Young People's Services) Speech and Language Therapy Services School Nurse/Health Visitor/GP Families First Plus Gloucestershire Children's Safeguarding Board GSCB www.gscb.org.uk www.glosfamilies.org.uk	Cheltenham Borough Housing www.youngminds.org.uk - emotional health and wellbeing www.childline.org.uk www.nhs.uk/Livewell - national measurements www.asthma.org.uk www.allergyuk.org.uk www.anaphylaxis.org.uk www.2gether.nhs.uk - mental health services for children www.cafamily.org.uk - support for families with disabled children www.eric.org.uk - continence and bedwetting support
Complex Needs are complex and children are highly vulnerable and living with potential risk. This may lead to	DSL will request Social Care involvement through a Multi Agency Service Request Form MARAC information (Multi-	As Above Children's Social Care Police (Tel:101) Specialist Health Services	As Above www.nspcc.org.uk

an integrated assessment and plan with a lead professional coordinating the support from a range of agencies	agency Risk Assessment Conferences) , children in need plans or child protection plans. The school becomes involved in membership of the core group and attends conferences. SENco represents the child if there are special educational needs with the potential to request an EHC assessment	Advisory Teaching Service (ATS) Educational Psychology Service (EPS) Cheltenham Community Paediatricians Children's Centres Local schools with additional expertise	
Acute Children are at immediate risk of significant harm. This will require immediate referral to social care or intensive specialist care regarding health	DSL requests social care involvement through the Multi Agency Service Request Form emailed directly to GSCB. DSL co-ordinates at school level.	As Above GDASS (Gloucestershire Domestic Abuse Support Service) Police (999) Multi-Agency Safeguarding Hub (MASH) Gloucestershire Children's Helpdesk Emergency Duty Team	As Above www.lucyfaithfull.org.uk - child protection charity www.ncdv.org.uk - National centre for domestic violence www.barnardos.org.uk FGM Helpline 0800 028 3550

Appendix 9: Glossary

CEOP	Child Exploitation and Online Protection Centre
CIN	Children in Need
CP	Child Protection
CSE	Child Sexual Exploitation
CWD	Children with Disabilities
CYPS	Children & Young People's Service (the combined children's services from the former Social Services and Education)
DA	Domestic Abuse
DARP	Domestic Abuse Referral Process
DBS	Disclosure and Barring Service
DOE	Department of Education
DSL	Designated Safeguarding Lead
ESCALATION	Resolution of Professional Differences (Escalation) Policy
FGM	Female Genital Mutilation
GASB	Gloucestershire Adult Safeguarding Board
GDAS	Gloucestershire Domestic Abuse Services
GPPB	Gloucester Public Protection Bureau
GSCB	Gloucestershire Safeguarding Children Board
LA	Local Authority
LADO	Local Authorities Designated Officer
LT	Locality Team (Hub)
MAPPA	Multi Agency Public Protection Arrangements
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
R&AT	Referral and Assessment Teams
SCR	Single Central Record
SCS	Safeguarding Children Service (Previously known as the Child Protection Unit)
Section 17	A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a satisfactory level of health or development, or their health and development will be significantly impaired, without the provision of services; or a child who is disabled.
Section 47	If there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm, to enable a decision to be made to decide whether action should be taken to safeguard and promote the child's welfare.
Section 20	Under Section 20 of the Children Act 1989, the local authority has a duty to accommodate such children in need in their area.
Section 31A	Where a child is the subject of a care order, the local authority, as a corporate parent, must assess the child's needs and draw up a care plan which sets out the services which will be provided to meet the child's identified needs.
Section 175 Section157(for academies/independent schools)	Section 175/157 of the Education Act 2002 came into effect on the 1st June 2004. Section 175/157 requires school governing bodies, local education authorities and further education institutions to make arrangements to safeguard and promote the welfare of children.
TST	Targeted Support Team

Appendix 10: Changes in terms

Previously:	**Now known as:**
Child Protection Register	Child with a Child Protection Plan
Child Protection Unit	Safeguarding Children Service
Area Child Protection Committee	Gloucestershire Safeguarding Children Board
Department for Children, Schools and Families	Department of Education
Criminal Records Bureau	Disclosure and Barring Service
Independent Safeguarding Authority	Disclosure and Barring Service
Designated Child Protection Officer (DCPO)	Designated Safeguarding Lead