

The CHAUNCY SCHOOL

CHILD PROTECTION POLICY

November
2010

Policy Review

This policy will be reviewed in full by the Governing Body on an annual basis.

The policy was last reviewed and agreed by the Governing Body in November 2010.

It is due for review in November 2011

Signature Head Teacher Date

Signature Chair of Governors Date

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1. INTRODUCTION

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

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

In particular this policy should be read in conjunction with the Safer Recruitment Policy, Behaviour Policy and Anti-bullying Policy.

Purposes of a Child Protection Policy

To inform staff, parents, volunteers and governors about the school's responsibilities for safeguarding children.
To enable everyone to have a clear understanding of how these responsibilities should be carried out.

Hertfordshire Safeguarding Children Board Child Protection Procedures

The school follows the procedures established by the Hertfordshire Safeguarding Children Board, a guide to procedure and practice for all agencies in Hertfordshire working with children and their families.

School Staff & Volunteers

All school staff and volunteers are particularly well placed, because they have daily contact with children, to observe outward signs of abuse, changes in behaviour and failure to develop.
All school staff and volunteers will receive child protection training, so that they are knowledgeable and aware of their role in the early recognition of the signs and symptoms of abuse or neglect and of the appropriate procedures to follow. This training is refreshed every three years.

Mission Statement

- 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 that children know that there are adults in the school 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.
- Include opportunities in the PSHE curriculum for children to develop the skills they need to recognise, and stay safe from, abuse.
- Contribute to the five Every Child Matters outcomes:
 - Be healthy
 - Stay safe
 - Enjoy and achieve
 - Make a positive contribution
 - Achieve economic well-being

2. STATUTORY FRAMEWORK

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

The Children Act 1989

The Children Act 2004

Education Act (2002), section 175

HSCB Inter-agency Child Protection and Safeguarding Children Procedures (2010)

DfES guidance Safeguarding Children and Safer Recruitment in Education (2006)

HM Government 'Working Together to Safeguard Children' (2010)

HM Government 'Working Together to Safeguard Children' (2010) requires all schools to follow the procedures, established by the Hertfordshire Safeguarding Children Board, for protecting children from abuse. Schools are also expected to ensure that they have appropriate procedures in place for responding to situations in which they believe that a child has been abused or is at risk of abuse - these procedures should also cover circumstances in which a member of staff is accused, or suspected, of abuse.

DfES guidance Safeguarding Children and Safer Recruitment in Education (2006) places the following responsibilities on all schools:

- Schools should be aware of and follow the procedures established by the Hertfordshire Safeguarding Children Board
- Staff should be alert to signs of abuse and know to whom they should report any concerns or suspicions
- Schools should have procedures (of which all staff are aware) for handling suspected cases of abuse of pupils, including procedures to be followed if a member of staff is accused or suspected of abuse
- A Designated Senior Person should have responsibility for co-ordinating action within the school and liaising with other agencies
- Staff with designated responsibility for Child Protection should receive appropriate training

DfES guidance Safeguarding Children and Safer Recruitment in Education (2006) also states that "All parents need to understand that schools and FE colleges have a duty to safeguard and promote the welfare of children who are their pupils or students, that this responsibility necessitates a child protection policy and procedures, and that a school or FE college may need to share information and work in partnership with other agencies when there are concerns about a child's welfare."

3. THE DESIGNATED SENIOR PERSON

The Designated Senior Person for Child Protection in this school is:

Sara Mead

The Deputy Designated Senior Person for Child Protection in this school is:

Steve Walton

It is the role of the Designated Senior Person for Child Protection to:

- Ensure that he/she receives refresher training at two yearly intervals 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 effectively their responsibilities for child protection and that this training is kept up to date at three yearly intervals. The DSP holds the training record.
- Ensure that newly appointed staff receive a child protection induction within seven working days of commencement of their contract
- Ensure that temporary staff and volunteers are made aware of the school's arrangements for child protection
- Ensure that the school operates within the legislative framework and recommended guidance
- Ensure that all staff and volunteers are aware of the Hertfordshire Safeguarding Children Board Child Inter-agency Child Protection and Safeguarding Children Procedures
- Ensure that the Head Teacher is kept fully informed of any concerns
- 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) or refer to Children, Schools and Families social care
- Liaise with CSF social care teams over suspected cases of child abuse
- Ensure that accurate records relating to individual children are kept separate from the academic file in a secure place and marked 'Strictly Confidential' and that these records are passed securely should the child transfer to a new provision

- Submit reports to, and 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 CSF 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

4. THE GOVERNING BODY

The Governing Body has overall responsibility for ensuring that there are sufficient measures in place to safeguard the children in their establishment.

The nominated governor to take lead responsibility for Child Protection is:
Posy Williams

In particular the Governing Body must ensure:

- That child protection policy and procedures are in place
- That safe recruitment procedures are in place
- The appointment of a DSP or Deputy DSP who is a senior member of school leadership team
- That relevant child protection training for school staff/volunteers is attended
- That allegations are managed safely
- That deficiencies or weaknesses in child protection arrangements are remedied without delay
- That a member of the Governing Body (usually the Chair) is nominated to be responsible in the event of an allegation of abuse being made against the Head Teacher
- That safeguarding policies and procedures are reviewed annually and that information provided to the local authority about them and about how the above duties have been discharged

5. SCHOOL PROCEDURES

If any member of staff is concerned about a child he or she must inform the Designated Senior Person.

The member of staff must record information regarding the concerns on the same day. The recording must be a clear, precise, factual account of the observations. A pro forma is available in the DSP's pigeon hole.

The Designated Senior Person will decide whether the concerns should be referred to CSF social care. If it is decided to make a referral to social care, CSF this will be done with prior discussion with the parents, unless 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, and a written record will be kept.

If a pupil who is or has been the subject of a child protection plan changes school, the Designated Senior Person will inform the social worker responsible for the case and transfer the appropriate records to the Designated Senior Person at the receiving school, in a secure manner, and separate from the child's academic file.

6. WHEN TO BE CONCERNED

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

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect

[Self-harm can cause significant physical damage and could be an indicator of another type of abuse. Staff should follow guidelines in 'Safeguarding Essentials for Staff', of which everyone has a copy.]

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

Generally, in an abusive relationship the child may:

- Appear frightened of the parent(s) or other household members e.g. siblings or others outside the home
- Act in a way that is inappropriate to her/his age and development (full account needs to be taken of different patterns of development and different ethnic groups)
- Display insufficient sense of 'boundaries' and/or lack stranger awareness

- Appear wary of adults and display 'frozen watchfulness'

7. DEALING WITH A DISCLOSURE

If a child discloses that he or she has been abused in some way, the member of staff / volunteer should:

- Listen to what is being said without displaying shock or disbelief
- Accept what is being said
- Allow the child to talk freely
- Reassure the child, but not make promises which it might not be possible to keep
- Not promise confidentiality – it might be necessary to refer to Children Schools and Families
- Reassure him or her that what has happened is not his or her fault
- Stress that it was the right thing to tell
- Listen, only asking questions when necessary to clarify
- Not criticise the alleged perpetrator
- Explain what has to be done next and who has to be told
- Make a written record (see Record Keeping)
- Pass information to the Designated Senior Person without delay

Support

Dealing with a disclosure from a child is likely to be stressful. The member of staff/volunteer should, therefore, consider seeking support for him/herself and discuss this with the Designated Senior Person.

8. CONFIDENTIALITY

Child Protection raises issues of confidentiality that must be clearly understood by all staff/volunteers in schools.

- All staff in schools, both teaching and non-teaching, have a responsibility to share relevant information about the protection of children, with other professionals, particularly the investigative agencies (CSF social care and the Police).

- If a child confides in a member of staff/volunteer and requests that the information is kept secret, it is important that the member of staff/volunteer tell the child in a manner appropriate to the child's age/stage of development that he/she cannot promise complete confidentiality – instead he/she must explain that he/she may need to pass information to other professionals to help keep the child or other children safe.
- 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.

9. COMMUNICATION WITH PARENTS

Chauncy School will:

Undertake appropriate discussion with parents prior to the involvement of another agency, unless to do so would place the child at further risk of harm.

Ensure that parents have a understanding of the responsibilities placed on the school and on staff for safeguarding children

10. 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, on pro forma
- Preserve 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 bruising or other injury
- Record statements and observations rather than interpretations or assumptions

All records need to be given to the Designated Senior Person promptly. No copies should be retained by the member of staff or volunteer

11. 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 toward a child in a way which indicates she/he is unsuitable to work with children

This applies to any child that the member of staff/volunteer has contact with in personal, professional or community life.

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

Actions to be taken include making a written record of the allegation using the disloser/informant's words – including the time, date and place where the alleged incident happened, what was said and whether anyone else was present. This record should be signed, dated and immediately passed 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:

Bob Watson

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

Lucy Bailey

The recipient of an allegation must **not** unilaterally determine its validity, and failure to report it in accordance with procedures is potentially a 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 CSF social care in consultation with the Local Authority Designated Officer (07920 283106 or 07995 288271 or 01992 556986)

If it is decided that the allegation meets the threshold for further action through HSCB Inter-agency Child Protection and Safeguarding Children Procedures, the Head Teacher must immediately make a referral to CSF social care on 0300 123 4043 SO THAT THE ALLEGATION CAN BE INVESTIGATED IN ACCORDANCE WITH SECTION 10 OF THE HERTFORDSHIRE SAFEGUARDING CHILDREN BOARD CHILD PROTECTION PROCEDURES).

If it is decided that the allegation does not meet the threshold for referral to CSF social care, the Headteacher and Local Authority Designated Officer will consider the appropriate course of action e.g. joint evaluation meeting, internal investigation.

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

For further information see:

- HSBC Inter-agency Safeguarding children and Child Protection Procedures (2010)
- Section 4.1.1. Managing Allegations against Adults who work with Children and Young People

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 of bruises, 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 indicate 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 diffused ring bruise or an oval or crescent shape. 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 are of concern. 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 his/her bottom without also scalding his or her feet.
- A child getting into too hot water of his or her own accord will struggle to

Scars

A large number of scars of different sizes or ages, or on different parts of the body, or unusual in shape, 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
- Failure to seek medical help/unexplained delay in seeking treatment
- Reluctance to give information or mention previous injuries
- Absence 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
- Attempts 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

- 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 in so far as they meet the needs of another person.

It may include the failure to give the child opportunities to express his/her 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
- Scapegoating of one child in the family

- Imposition of inappropriate expectations on the child e.g. the prevention of 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.
- Marginalisation or isolation 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 caregivers)
- 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
- Frequent absence or lateness at school
- Poor self esteem
- Destructive tendencies
- Thriving 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
- 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
- Reluctance to undress for PE
- Running away from home
- Poor attention / concentration (world of their own)
- Sudden changes in school work habits, truancy
- 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
- Drawing of 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 may (or may not) be associated with this form of abuse
- 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.