**MERESIDE FARM**

**SAFEGUARDING POLICY**

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| Contacts |
| **Designated Safeguarding Lead** | **Terri Carter and Ruth Lowe** |
| **Deputy Designated Safeguarding Lead** | **Christine Hewitt, Jenny Keefe, Claire Smith** |
| **Registered Provider** | **Ruth Lowe** |
| **Setting Manager** | **Terri Carter** |
| **Family Front Door (Children’s Social Care in Worcestershire** | * **01905 822666** Weekdays 9.00 to 5.00pm (4.30 Fridays)
* **01905 768020** (evenings and weekends)
 |
| **Police** | Call **999** in an emergency, e.g. when a crime is in progress, when there is danger to life or when violence is being used or threatened. For less urgent issues call local police on **101**. |
| **Ofsted** | 0300 123 1231 |
| **Worcestershire Children’s first Early Years Team** | 01905 678134 |
| **Babcock Prime Safeguarding support** | Early Years Team – 01905 678134NEF – 01905 678136 |
| **Community Social Workers** | Contact via the Family Front Door on 01905 846057 |
| **Local Authority Designated Officer****(LADO)** | 01905 846 221 (or via the FFD) |
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**Any allegations made about a member of staff must be passed to a DSL immediately (unless it is about the DSL).** The Family front door should be called on the number above and advice sought from the LADO (Local Authority Designated Officer) Ofsted must be informed of all allegations against a staff member.

**If anyone has a concern about a person connected to the setting, they can call Ofsted on 0300 123 1231**

## Mereside Farm Children’s Nursery comes under the jurisdiction of Worcestershire in terms of Safeguarding Policy and procedure. However, we use individual children’s postcodes if reporting concerns to Children’s social care, so would notify Solihull, Birmingham or Worcestershire dependent on this. If unsure call the area you believe to be correct, and they can redirect.

## If you have a safeguarding concern, please call:



* Contact the **Family Front Door** on **01905 822 666** from Monday to Friday 8.30am to 5.00pm (until 4:30pm on a Friday)

## Out of office hours (5.00pm to 8.30am weekdays and all-day weekends and bank holidays) contact the Emergency Duty team on 01905 768020



**Opening hours: Emergency out-of-hours:**
Monday to Friday 9am to 5pm Telephone: **0121 675 4806**
Telephone: **0121 303 1888**



**To report a child or young person at risk call** **0121 788 4300** (Monday to Thursday 8.45am - 5.20pm, Friday 8.45am - 4.30pm).

**If you are calling out of working hours** (Evenings, weekends, or bank holidays) please call

**0121 605 6060**.

**Introduction**

The actions we take as professionals and as a society, to promote the welfare of children and protect them from harm, are referred to as 'safeguarding'.

**Safeguarding** can be defined as:

* Protecting children from maltreatment
* Preventing impairment of children's physical and mental health or development
* Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
* Taking action to enable all children to have the best outcomes.

 *('Working Together to Safeguard Children',* DfE 2018)

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

This policy has been developed in line with the following legislation and guidance:

* [Statutory framework for the early years foundation stage (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974907/EYFS_framework_-_March_2021.pdf)
* [The Children Act 1989 (opens in new window)](http://www.legislation.gov.uk/ukpga/1989/41/contents)
* [The Education Act 2002 (opens in new window)](http://www.legislation.gov.uk/ukpga/2002/32/contents)
* [The Sexual Offences Act 2003 (opens in new window)](https://www.legislation.gov.uk/ukpga/2003/42/part/1/crossheading/abuse-of-position-of-trust)
* [The FGM Act 2003 (opens in new window)](https://www.legislation.gov.uk/ukpga/2003/31/contents)
* [The Children Act (2004) (opens in new window)](http://www.legislation.gov.uk/ukpga/2004/31/contents)
* [The Childcare Act (2006) (opens in new window)](http://www.legislation.gov.uk/ukpga/2006/21/contents)
* [Safeguarding Vulnerable Groups Act (2006) (opens in new window)](http://www.legislation.gov.uk/ukpga/2006/47/contents)
* [The Childcare (Disqualification) Regulations (20090 (opens in new window)](http://www.legislation.gov.uk/uksi/2009/1547/contents)
* [Children and Social Work Act (2017) (opens in new window)](http://www.legislation.gov.uk/ukpga/2017/16/contents/enacted)
* [Education inspection framework (EIF) - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/education-inspection-framework)
* [Inspecting safeguarding in early years education and skills setting (Ofsted 2019) (opens in new window)](https://www.gov.uk/government/publications/inspecting-safeguarding-in-early-years-education-and-skills-from-september-2015) <https://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf>
* <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/398815/SEND_Code_of_Practice_January_2015.pdf>

Our Roles and Responsibilities

Safeguarding is everyone's responsibility and therefore all adults working in the nursery will:

* Take all necessary steps to keep children safe and well
* Promote good health
* Manage behaviour
* Be alert to any issues for concern in the child's life at home or elsewhere
* Meet the requirements of the Statutory Framework for the Early Years Foundation Stage (EYFS 2021)
* Follow the policies and procedures of the setting and notify the relevant person or agency without delay if concerns arise
* Keep appropriate records

In addition, the registered provider ensures that they:

* Have regard to the government's statutory guidance ‘Working Together to Safeguard Children 2018’ and to the ‘Prevent duty guidance for England and Wales 2021’
* Implement the requirements of the Early Years Foundation Stage (2021)
* Create a culture of vigilance where children’s welfare is promoted and where appropriate and timely action is taken when necessary to safeguard children
* Make specific arrangements for children’s safety and wellbeing, including
	+ - the requirements for first aid, policies, and procedures for responding to children who are ill or infectious and those for administering medicines.
		- keeping a written record of accidents or injuries and first aid treatment and informing parents and/or carers of any accident or injury sustained by the child.
		- ensuring the premises are fit for purpose, compliance with health and safety legislation and appropriate risk assessment
		- having an evacuation procedure and suitable fire detection and control equipment
		- ensuring staffing arrangement meet the needs of all children and ensure their safety and implementing a robust key person system
* Notify local child protection agencies and Ofsted of any serious accident, illness, or injury to, or death of, any child while in their care, and of the action taken.
* Only release children into the care of individuals who have been notified to the provider by the parent and ensure that children do not leave the premises unsupervised.
* Take all reasonable steps to prevent unauthorised persons entering the premises
* Record the required information about each child, name, date of birth, who has parental responsibility etc. and the required information about the registered provider and adults in regular contact with children
* Have a complaints procedure and records.
* Keep attendance records
* Notify Ofsted of any changes e.g. a new manager, the address of the premises, the name or address of the provider, any proposal to change the hours during which childcare is provided, etc.

The DSL ensures that they:

* Take lead responsibility for safeguarding children in their setting
* Liaise with local statutory children's services agencies
* Provide support, advice, and guidance to other staff, on any specific safeguarding issues as required.
* Share child protection information with the DSL of any receiving setting or school when children leave the setting.

The role is explicit in the DSL’s job description and they are given sufficient time, resources, and funding to fulfil their role. They attend a training course which enables them to identify, understand and respond appropriately to signs of possible abuse and neglect and renew this bi-annually.

The provider nominates a deputy DSL in order to ensure availability at all times during the hours of operation, but the DSL retains overall responsibility.

**Use of technology**

We use an electronic assessment system called iConnect. Staff complete records while on site using the devices provided by the setting. The setting also provides a mobile phone for outings. Staff are not permitted to use their own devices in the nursery except in the staff room and office where there are no children present. This includes all devices with cameras. Please see Mobile phone and electronic device policy also.

**Safeguarding as part of the curriculum**

We support children’s personal, social, and emotional development, and as part of this we teach children how to keep themselves and others safe. For example, we teach children independence, self-care, and confidence, and we ensure that children understand personal boundaries and acceptable behaviour towards others and themselves. More specifically we support children in understanding healthy and positive relationships and issues of privacy and respect.

**Mental Health Awareness**

We recognise the importance of supporting our young children’s mental health and wellbeing and will do this by:

* Recognising the importance of positive early years experiences – Feelings of attachment, security and positive stimulation within loving and caring relationships help to strengthen a child’s emotional and social systems.
* Ensure appropriate expectations of our children – Using our understanding and knowledge of child development and being ware that all children at times will need support with their behaviour, feelings, thoughts and emotions.
* Ensure children needing more support with recognised emotional issues such as children on the autistic spectrum and those where factors in their home life that may impact their mental health such as domestic abuse, parental mental health concerns and ongoing medical conditions.
* Work with outside agencies wherever appropriate to ensure children are supported in the best ways possible and support parents through these processes.
* Be aware of our own mental health when working with the children and ensure that support is offered and accessed for staff where there are any mental health needs or concerns to ensure they are able to deliver the highest quality care.

Recognising Abuse and Neglect

We recognise that there are many factors which contribute to a child’s well-being, and their development, including the parenting capacity of carers and the family home environment, and we are in a unique position to observe any changes in a child’s behaviour or appearance which might suggest that they are in need of support or at risk of harm.

We understand that abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm which in itself harms a child. Children may be abused in a family or in an institutional or community setting, by those known to them or more rarely by a stranger, for example via the internet. They may be abused by an adult or adults, or another child or children. When the abuser is a child it is important to remember that they may also be at risk and these concerns should be raised with the appropriate agencies too.

Any child could be subject to abuse or maltreatment, but there are groups of children that are considered more vulnerable, these are:

* Children under the age of 1
* Children with additional needs
* Parents with mental health problems
* Families where there is substance misuse
* Families where there is domestic abuse present

**Physical abuse**

A form of abuse which 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.

All children can suffer injuries during their early years as they explore and develop. If an explanation of how a child received their injury doesn’t match the injury itself or if a child’s injuries are a regular occurrence or there is a pattern to their injuries, then you must report your concerns.

**We are alert to possible signs of physical abuse, for example:**

* Multiple bruises in clusters or uniform shapes
* Bruises that carry an imprint such as a hand or belt
* Any bruising or injury to a very young, immobile baby
* Bite marks
* Burn marks
* Bruising or marks in unusual parts of the body such as the back, stomach, shoulders or buttocks
* Injuries not being consistent with the account given
* Fear of going home
* Violence or aggression to peers and aggressive roleplay
* Withdrawing from peers

**Fabricated or induced illness**

Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child. The parent or carer may seek out unnecessary medical treatment or investigation; they may exaggerate a real illness and symptoms or deliberately induce an illness through poisoning with medication or other substances or they may interfere with medical treatments. Fabricated illness is a form of physical abuse and any concerns will be reported, in line with our safeguarding procedures.

**We are alert to possible signs of fabricated or induced illness, for example:**

* Illness that continues for a long period of time with no resolution
* Symptoms are only seen by the parent/carer
* Symptoms only appear when the parent/carer is there
* Symptoms do not seem plausible
* Symptoms do not respond to medication/treatment
* If one illness is said to be resolved, the parent will begin to report another illness
* Symptoms being seen with no cause being found by medical professionals.

**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 a child 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 a child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

**We are alert to possible signs of emotional abuse, for example:**

* Physical, mental and emotional development delays
* Sudden speech disorders
* Overreaction to mistakes
* Extreme fear of any new situation
* Neurotic behaviour (rocking, hair twisting, self-mutilation)
* Extremes of passivity or aggression
* Appear unconfident or lack self-assurance.

Action should be taken if the staff member has reason to believe that there is a severe, adverse effect on the behaviour and emotional development of a child, caused by persistent or severe ill treatment or rejection. Children may also experience emotional abuse through witnessing domestic abuse and alcohol and drug misuse by adults caring for them.

**Softer signs of abuse as defined by National Institute for Health and Care Excellence (NICE) include:**

Emotional states:

* Fearful
* Withdrawn
* Low self-esteem.

Behaviour:

* Aggressive
* Oppositional habitual body rocking.

Interpersonal behaviours:

* Indiscriminate contact or affection seeking
* Over-friendliness to strangers including healthcare professionals
* Excessive clinginess, persistently resorting to gaining attention
* Demonstrating excessively 'good' behaviour to prevent parental or carer disapproval
* Failing to seek or accept appropriate comfort or affection from an appropriate person when significantly distressed
* Coercive controlling behaviour towards parents or carers
* Lack of ability to understand and recognise emotions
* Very young children showing excessive comforting behaviours when witnessing parental or carer distress.

**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.

If a child is being sexually abused you may see both emotional and physical symptoms.

**We are alert to possible signs of possible sexual abuse, for example:**

* Being overly affectionate or knowledgeable in a sexual way inappropriate to the child's age including sexually explicit play
* Personality changes such as becoming insecure or clingy
* Regressing to younger behaviour patterns such as thumb sucking or bringing out discarded cuddly toys and toileting regression
* Sudden loss of appetite or compulsive eating
* Being isolated or withdrawn
* Inability to concentrate.
* Lack of trust or fear of someone they know well, such as not wanting to be alone with a carer
* Unusual compliance
* Becoming worried about clothing being removed
* Suddenly drawing sexually explicit pictures or acting out actions inappropriate for their age
* Using sexually explicit language

**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), or
* Ensure access to appropriate medical care or treatment.

Neglect may also include unresponsiveness to a child's basic emotional needs.

**We are alert to possible signs of possible abuse and neglect, for example**:

* Stealing, scavenging or hoarding food
* Constant hunger and or thirst
* Faltering growth, weight loss and slow development
* Unusual lethargy
* Any sudden uncharacteristic change in behaviour, e.g. child becomes very withdrawn
* Illness or injury that is left untreated
* An accumulation of a number of minor injuries and/or concerns
* A child whose attendance is erratic, or suddenly ceases, without any contact from the family
* Arrangements for the collection of the child give rise to concern
* Lack of attention to child’s basic hygiene needs
* A child who discloses something which may indicate he/she is being abuse
* Failure to attend medical appointments or meet medical needs
* Responsibility for activities that are not age appropriate, such as cooking, ironing or caring for siblings.

**A child may also at any point disclose something which may indicate he/she is being abused**

We are also aware of specific risks and forms of abuse and we ensure that our training includes these, for example:

**Children and the court system -** Children are sometimes required to give evidence in criminal courts, either for crimes committed against them or for crimes they have witnessed.

**Children missing from education –** Children below statutory school age are not required to attend a setting regularly if at all, but once registered most do attend regularly and most parents will let the setting know if they are not going to be present. Therefore, we give consideration to children not attending and seek to assure ourselves that the child’s absence is not a cause for concern.

**Children with family members in prison -** These children are at risk of poor outcomes including poverty, stigma, isolation, and poor mental health.

**Child sexual exploitation (CSE)**

Child exploitation *Keeping Children Safe in Education (2020)* describes CSE as: CSE occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. CSE does not always involve physical contact; it can also occur through the use of technology. CSE can affect any child or young person (male or female) under the age of 18 years, including 16 and 17 year olds who can legally consent to have sex. It can include both contact (penetrative and non-penetrative acts) and non-contact sexual activity and may occur without the child or young person’s immediate knowledge (e.g. through others copying videos or images they have created and posted on social media).

**Signs and indicators may include:**

* Physical injuries such as bruising or bleeding
* Having money or gifts they are unable to explain
* Sudden changes in their appearance
* Becoming involved in drugs or alcohol, particularly if you suspect they are being supplied by older men or women
* Becoming emotionally volatile (mood swings are common in all young people, but more severe changes could indicate that something is wrong)
* Using sexual language that you wouldn’t expect them to know
* Engaging less with their usual friends
* Appearing controlled by their phone
* Switching to a new screen when you come near the computer
* Nightmares or sleeping problems
* Running away, staying out overnight, missing school
* Changes in eating habits
* Talk of a new, older friend, boyfriend or girlfriend
* Losing contact with family and friends or becoming secretive
* Contracting sexually transmitted diseases.

**Child Criminal Exploitation (CCE)**

CCE is where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. CCE does not always involve physical contact; it can also occur through the use of technology.

CCE can include **County lines** where children are used to carry drugs and money from urban to suburban and rural areas, children being forced to work in cannabis factories, being coerced into moving drugs or money across the country forced to shoplift or pickpocket, or to threaten other young people. Exploitation may also be modern slavery and trafficking, which is not always from country to country, sometimes children are trafficked within the local area. Some of the following can be indicators of CCE:

* Children who appear with unexplained gifts or new possessions;
* Children who associate with other young people involved in exploitation;
* Children who suffer from changes in emotional well-being;
* Children who misuse drugs and alcohol;
* Children who go missing for periods of time or regularly come home late; and
* Children who regularly miss school or education or do not take part in education.

**Domestic abuse –** Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse, between those aged 16 or over who are or have been intimate partners or family members, regardless of gender or sexuality. Exposure to domestic abuse can have a serious, long-lasting effect on children and young people.

**Homelessness -** Being homeless or being at risk of becoming homeless presents a real risk to a child’s welfare. Indicators that a family may be at risk of homelessness include household debt, rent arrears, domestic abuse and anti-social behaviour

**So-called ‘honour-based’ abuse -** Encompasses incidents or crimes which have been committed to protect or defend the honour of the family and/or the community, including **female genital mutilation** (FGM), **forced marriage**, and practices such as **breast ironing**. All forms of HBV are abuse (regardless of the motivation) and will be handled and escalated as such.

**Female genital mutilation (FGM)**

FGM can also be known as Female Genital Cutting. FGM is a procedure where the female genital organs are injured or changed and there is no medical reason for this. It is frequently a very traumatic and violent act for the victim and can cause harm in many ways. The practice can cause severe pain and there may be immediate and/or long-term health consequences, including mental health problems, difficulties in childbirth, causing danger to the child and mother; and/or death (definition taken from the Multi-agency Statutory Guidance on Female Genital Mutilation)

The procedure may be carried out shortly after birth and during childhood as well as adolescence, just before marriage or during a woman’s first pregnancy and varies widely according to the community.

FGM is child abuse and is illegal in the UK. It can be extremely dangerous and can cause:

• Severe pain

• Shock

• Bleeding

• Infection such at tetanus, HIV and hepatitis B and C

• Organ damage

• Blood loss and infections

• Death in some cases

**Breast ironing/flattening**

Breast ironing also known as "breast flattening" is the process where young girls' breasts are ironed, massaged and/or pounded down through the use of hard or heated objects in order for the breasts to disappear, or delay the development of the breasts entirely. It is believed that by carrying out this act, young girls will be protected from harassment, rape, abduction and early forced marriage.

Breast Ironing/Flattening is a form of physical abuse and can cause serious health issues such as:

* Abscesses
* Cysts
* Itching
* Tissue damage
* Infection
* Discharge of milk
* Dissymmetry of the breasts
* Severe fever.

**Online safety** – Children are often more adept at using technology than the adults around them, but do not necessarily understand the risks posed by those who they ‘meet’ online. In many cases too parents are not fully aware of the risks and we therefore endeavour to inform and empower parents and carers.

**Peer on peer abuse -** Children can abuse other children. This is generally referred to as peer on peer abuse and can take many forms. This can include (but is not limited to) bullying (including cyberbullying); sexual violence and sexual harassment; physical abuse such as hitting, kicking, shaking, biting, hair pulling, or otherwise causing physical harm; sexting and initiating/hazing type violence and rituals. In such circumstances we would consider the potential needs of the perpetrator as well as the victim.

**Poor mental health** – Poor parental mental health can be a significant risk factor for children, and we would consider this in our assessment of children’s needs. We also acknowledge that children’s own mental health is an important factor in their health and development in both the short and long term, and we therefore work to promote good mental health and consider signs and indicators of poor mental health in children, as part of our safeguarding responsibilities.

**Extremism – the Prevent Duty**

Under the Counter-Terrorism and Security Act 2015 we have a duty to safeguard at risk or vulnerable children under the Counter-Terrorism and Security Act 2015 to have “due regard to the need to prevent people from being drawn into terrorism and refer any concerns of extremism to the police (In Prevent priority areas the local authority will have a Prevent lead who can also provide support).

Children can be exposed to different views and receive information from various sources. Some of these views may be considered radical or extreme. Radicalisation is the way a person comes to support or be involved in extremism and terrorism. It’s a gradual process so young people who are affected may not realise what’s happening.

Radicalisation is a form of harm. The process may involve:

• Being groomed online or in person

• Exploitation, including sexual exploitation

• Psychological manipulation

• Exposure to violent material and other inappropriate information

• The risk of physical harm or death through extremist acts

We have a Prevent Duty and Radicalisation policy in place. Please refer to this for specific details.

**Sexual violence and sexual harassment between children -** Sexual violence and sexual harassment can occur between two children of **any** age and sex. It can also occur through a group of children sexually assaulting or sexually harassing a single child or group of children. It can occur online and offline (both physical and verbal) and are never acceptable.

**Special education needs and disabilities –** Children with SEND are far more likely to be abused or neglected, possibly because of the challenges faced by parents and carers, or because they are particularly vulnerable if they have delayed cognitive and language development, and possibly because signs and symptoms of abuse and neglect can sometimes be attributed to their condition. We acknowledge and understand that unwanted behaviour in particular can be an indicator of trauma as a result of abuse and neglect and would therefore consider all needs holistically in order to determine the right kind out support for the child and family.

Procedures for responding to concerns

Any adult working in the nursery who is concerned about a child or who identifies that a child or family may need extra help and support, will discuss this with the DSL. They may also want to have a discussion with their SENCo and/or a colleague from another agency to get a better understanding of the child and their family, and this will be with the family’s consent.

We also recognise the importance of context, i.e. the family and wider environment in which the child lives.

**Emerging concerns**

We may find that general concern begins to build up around a child’s behaviour, demeanour or presentation. Concerns may include what is seen or heard and may include the way family members relate to the child and/or the setting. Such concerns may not seem to be very significant on their own, but together may indicate a need for family support that should not be ignored. Therefore, concerns are always recorded factually and accurately along with any decisions or action taken in order to support the decision-making process.

**Responding to a disclosure**

A disclosure occurs when a child or young person indicates directly, or through play or drawings for example, that he or she has been or is being abused in some way. Occasionally a disclosure may be very clear and contain specific details about whom, or what was involved, or where and when apparent abuse took place. More commonly disclosure emerges as part of routine activity or conversation.

If a child makes a disclosure we will:

* **Contain our reaction as far as possible –** try not to express shock or disbelief
* **Listen** to the child, accept what they say and communicate to them that we accept it.
* **Not** make any promises to the child about not passing on the information – the child needs to know that someone who will be able to help them will be spoken to
* **Record** the information as accurately and quickly as possible, including the timing, setting and those present, as well as what was said.
* **Discuss with the DSL** to determine the most appropriate course of action.
* **Not interrogate the child**. We may ask for clarification but will not ask leading questions. We will use ‘TED’ questions, i.e. '**Tell** me what happened', 'please **explain** what you mean when you say …..' and 'can you **describe** the person?' or 'can you **describe** the place?'

**Sharing concerns with parents and carers**

Concerns will generally be shared with the child's parents/carers. This can eliminate misunderstandings and can help us better understand the needs of the child and the family situation. It also ensures that our relationship with parents is built on trust and openness. Parents are fully involved in decision making and we seek consent to share information.

However, in some circumstances we would not share information with parents or seek consent to share others, for example if:

* Sexual abuse is suspected
* It is considered that discussing the issue with parents may put the child at further risk of significant harm
* A criminal offence may have been committed
* Organised abuse is suspected
* Fabricated illness is suspected
* An explanation is given by parents/carers which is felt to be inconsistent or unacceptable

We use the WSCP Levels of need guidance to support our understanding of the child’s needs and our decision making. In some circumstances we may be able to offer additional support ourselves. Sometimes we might need to work with another agency or possibly more than one. If possible, we will avoid a formal process, but when a child’s situation becomes more complex or there appears to be increased risk, it may be necessary to draw up more formal plans with the family in order to coordinate the work.

**Level 1** represents children with no identified additional needs. Their needs are met through universal services and possibly housing or voluntary services.

If further support is required practitioners talk to the DSL and to the parents to offer support as appropriate. We would (with the engagement of the family) carry out an Early Help Assessment and seek consent to involve other professionals as appropriate, and/or talk to a community social worker for advice and support.

**Level 2** represents children with extra needs that can be met by providing additional support or straightforward working with one or more partners, such as Speech and Language Therapy.

**Level 3** represents children with more complex or escalating needs. Possibly those professionals working to support the child and family at level 2 are not clear on the best way forward. The parents are advised that practitioners are seeking further advice (unless to share this information would put the child at risk).

**Level 4** represents children who need statutory and/or specialist interventions including both children in need and those in need of protection. A child in need is one who is unlikely to have a reasonable standard of health and development without statutory or specialist service. A child in need of protection is one that is suffering, or is likely to suffer, significant harm.

If a child may be at risk of significant harm, the DSL makes a referral to the Family Front Door, or the relevant child protection department if it is not a child who lives under Worcestershire, without delay. The DSL will do this by telephoning the Family Front Door/and then completing a Referral to Children’s Social Care. If all lines to the FFD are busy, the DSL will complete a Referral to Children’s Social Care and indicate what time the child is likely to be collected from the setting.

* Contact the relevant number for the child’s address (Page 3 of this policy)

However, if the child **needs immediate protection, we contact the Police on 999, and if** a child is brought to us with serious injuries, we telephone for an ambulance

Referral forms are printed and saved in the child’s safeguarding file.

If we are not in agreement with the Family Front Door/child protection department about the level of need and appropriate action, we will use the levels of need guidance to support a professional discussion with the decision maker, and if still unsatisfied we would use the WSCP Escalation policy/escalation policy for the relevant child protection department. In the meantime, we would continue to observe the child and support them and their family. If necessary, we would make another referral.

**Open cases**

If there is new information about a child who already has an allocated social worker, we share this directly with them.

**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. We acknowledge that settings may be the only stable, secure and predictable element in the lives of children who have been abused or who are at risk of harm, and we are aware that research shows that their behaviour may be challenging and defiant or they may be withdrawn.

The nursery will endeavour to support all children by:

* Encouraging self-esteem and self-assertiveness, as well as promoting respectful relationships, challenging bullying and humiliating behaviour
* Promoting a positive, supportive, and secure environment giving children a sense of being valued
* Consistently applying strategies to which are aimed at supporting vulnerable children, and supporting children in understanding that some behaviour is unacceptable but that they are valued and not to be blamed for any abuse which has occurred
* Liaising with other agencies that support the child such as Children’s Social Care and Early Help providers
* Notifying the Family Front Door immediately there is a significant concern and the child could be at risk of significant harm
* Providing continuing support to a child about whom there have been concerns if they leave the setting by ensuring that appropriate information is forwarded under confidential cover to their new setting. A copy of records (which may potentially be required as evidence in the future), will be retained until the child has reached the age of 25 years.

See Behaviour policy also

**Positive Physical Intervention**

Staff only ever use physical intervention as a last resort when managing unwanted behaviour, and it is the minimal force necessary to prevent injury or damage to property. All such incidents of physical intervention are recorded.

Physical intervention of a nature that causes injury or distress to a child may be considered under management of allegations or disciplinary procedures.

We recognise that touch is appropriate in the context of working with children and all adults in the setting have been given safer working practice guidance to ensure they are clear about their professional boundaries.

Record Keeping

**Documenting concerns**

Our records are a factual account of what was seen and heard, containing the child’s own words where appropriate and completed as soon as possible, not later than the end of the

working day. The child is identified by name and date of birth on each page and we do not use abbreviations. Blank spaces or alterations are scored through with a single line, and the original entry remains legible. They are written in permanent black ink, dated, timed, signed and stored securely.

Records describe the care and condition of the child and may include professional opinion which would be clearly indicated. They also include the comments and views of both the child and the parents/carers.

**An individual file chronology** is used as a summary of incidents, concerns and actions, to support monitoring.

**Safety and welfare concerns forms** are used to record specific concerns and are completed by the person identifying the concern. The completed record is given to the DSL immediately, for consideration and/or action.

**A safety and welfare concerns continuation form** is used following the recording of a concern, to record additional information.

An **individual child protection file** is started for a child when:

* There are welfare and or safety concerns
* The child has been referred to the Family Front Door
* There is Children’s Services Social Care involvement with the child/family
* We are participating in multi-agency support

If concerns relate to more than one child from the same family attending the setting a separate file for each child is created and cross referenced to the records of other family members. Common records e.g. child protection conference notes are referenced in each file. Other files relating to the child, for example SEN information, are also cross referenced.

**An individual child protection file includes:**

* Front sheet
* Individual chronology
* All safety and welfare concern forms relating to the child
* Any notes initially recorded
* Records of discussions, telephone calls and meetings (with colleagues, other agencies or services, parents, and children/young people)
* Professional consultations
* Letters sent and received
* Referral forms
* Minutes/notes of meetings (copies for each child as appropriate)
* Formal plans linked to the child (e.g. Child Protection Plan)

**Security, storage, and retention of records**

Individual files are stored securely and separatelyfrom the child's other information so that they are shared only on a need to know basis. The DSL reviews such records regularly so that increasing concerns can be identified and action taken to ensure that needs are met.

Parents have the right to access information held about their child so records are shared with them if they make this request, however there are some exceptions, namely those described previously in the section on sharing information with parents, for example when sharing the information would place the child at risk of significant harm.

All safeguarding records are retained until the child reaches the age of 25 years.

**Transfer of Child Protection records at transition**

Records are transferred at each stage of a child’s education, when they move from one establishment to another, either at normal transfer stage such as moving from nursery to school, or as the result of a move such as a transfer to a different area. They are transferred within 5 days and are passed directly and securely to the safeguarding lead in the receiving establishment. They are transferred by hand if possible or signed for if posted.

In order to safeguard children effectively, when a child moves to a new educational establishment, the receiving establishment is immediately made aware of any current child protection concerns, by telephone prior to the transfer of records.

**Children in more than one setting**

Where children are dual registered (e.g. on roll at a mainstream school, but receiving education in another establishment, such as a Short Stay School or the MET or attending more than one early years setting), any existing child protection records are shared with the new establishment **prior to the child starting**, to enable the new establishment to risk assess appropriately.

We keep a copy of the transfer form along with a copy of the chronology of events and any records pertaining to the establishment (e.g. completed 'Welfare Concern' forms).

**Children subject to a Child Protection (CP) Plan**

If a child is the subject of a Child Protection Plan at the time of transfer we speak to the safeguarding lead of the receiving establishment giving details of the child's key Social Worker from Children's Social Care Services and ensuring the establishment is made aware of the requirements of the child protection plan.

**Receiving establishment unknown**

If a child, subject of a child protection plan leaves and the name of the child’s new education placement is unknown, the DSL will contact the child’s Social Worker to discuss how and when records should be transferred. Where the records are of prior child protection/welfare concerns, and there is not an open case or a social worker involved with the family, the DSL will inform the Family Front Door. Child protection files would be retained by us and transferred to the new setting, once known, or destroyed once the child has reached the age of 25.

Building a Safer Workforce

**Recruiting**

The provider checks the suitability and obtains an enhanced criminal record records disclosure for anyone working directly with children We keep a record of the date and the serial number of the DBS certificate.

Applicants are asked to complete an application form and we obtain two employer’s references, including the most recent employer. If this is not possible, for example if the applicant is applying for their first position, we will obtain character references and complete a risk assessment.

Staff do not take up a post until all checks are completed satisfactorily.

The manager of the setting has completed safer recruitment training and at least one of them is included on every interview panel.

We keep a record of ID checks, right to work in the UK, qualifications (certificates are checked), references obtained and DBS certificate details.

The same processes are used for volunteers and student DBS certificates obtained by their training provider are checked and the details recorded.

**Induction, training, and continued supervision**

All new staff, students and volunteers are given a copy of all policies and procedures and receive induction training which includes:

* an understanding of the settings safeguarding policies and procedure
* behaviour management
* how and when mobile phones and technology can be used in the setting
* how to define and identify possible signs of harm, abuse, and neglect
* what to do if concerns arise
* what to do if concerned about the behaviour or conduct of another adult
* who is the designated safeguarding lead in the setting

All staff complete safeguarding training at least every three years but we always aim for an annual refresher. The DSL, deputy DSL, manager and registered provider complete training at an appropriate level and refresh these every two years. The quality and effectiveness of training is evaluated following each course and Babcock Prime training is used as we are confident that this meets the requirements of the different roles, Ofsted expectations and the recommendations of the WSCP.

Safeguarding is always discussed at staff meetings and all staff are provided with updates at least twice annually.

Supervision meetings take place for all staff regularly. The purpose of this is to foster a culture of mutual support and continuous improvement by providing support, coaching, and training for staff, and encouraging confidential discussion of sensitive issues. The registered provider conducts supervision meetings with the manager.

**Disqualification**

Staff are required to disclose any convictions, cautions, court orders or reprimands and warnings which might affect their suitability to work with children, whether these occur prior to, or during, their employment at the setting. They are asked to confirm this at each supervision meeting.

**Whistleblowing**

If staff have concerns about a colleague, they report them to the manager, registered person as soon as the issue occurs.

All information relating to concerns will be handled in confidence, kept in a locked secure location, and only made available to those who have a right or professional need to see them.

Please see Whistleblowing also.

**Allegations against adults working or volunteering with children**

A complaint is an allegation of abuse if it indicates that someone:

* Has/may have acted in a way that has harmed a child
* Acted in a way which has put a child at risk
* Possibly committed a criminal offence against or related to a child
* Behaved towards a child or children in a way that indicates he/she is unsuitable to work with children

If a complaint (from a parent, child, staff member, member of the public, etc) includes an allegation of abuse, whether made verbally or in writing, the incident would be noted in the record of complaints (with minimal detail to ensure confidentiality) and the registered provider informed. The registered provider will make a record of the allegation.

**We will not investigate an allegation of abuse or discuss with the person involved until we have consulted the LADO.**

The registered provider will inform Ofsted of any allegations of serious harm or abuse whether the allegations relate to harm or abuse committed on the premises or elsewhere.

* Confirmation of the allegation in writing would be sought from the person making the allegation, but action would not be delayed whilst awaiting written confirmation.
* The recipient of the allegation would immediately inform the registered person.
* The Registered Person may delegate responsibility for action to the setting manager, but remains accountable for ensuring that the concern is sharedimmediately with the LADO on 01905 846 221
* The registered person or manager would telephone the LADO and if this is not possible, the Family Front Door.
* If the allegation is against the DSL or manager, it will be necessary to report the concern to the registered person. If this is not possible staff should inform the LADO directly on the telephone number above.
* If the allegation is against the Registered Person, the DSL should inform the LADO immediately and notify Ofsted on 0300 123 1231 (or any relevant childminder agency)
* A note would be made of any actions advised by the LADO or by Ofsted and of the date and time they are implemented.
* The provider would conduct a risk assessment to determine whether the staff member should be suspended and follow the advice from LADO
* Parents/carers would be informed unless to do so could put the child in further danger.

If no further action is recommended, we may still proceed with disciplinary procedures. If there are concerns about the suitability of the member of staff to continue to work with children, we have a statutory duty to refer to the Disclosure and Barring Service (DBS)

In all cases where an allegation against a member of staff is made, we would review all policies and procedures and address identified training/supervision needs.

Records of allegations would be retained until the alleged perpetrator reaches normal retirement age, or for 10 years if that is longer.

Policy review

This policy will be reviewed annually or when an incident occurs or there are new local or national policies and procedures. The review process will be led by the registered provider and the DSL and include all those working in the setting.

**REVIEWED:** May 2022

**REVIEW BY:** May 2023