Child Protection Policy

Recommended by:

Resources & People Committee: **Date: 21 November 2018**

Adopted at Full Governing Body Meeting: **Date: 12 December 2018**

Signed by A Titley, Chair of Governors:

Review date: Autumn Term 2019 (earlier if any legislative change)

4 January 2019

ISSUED TO ALL STAFF

Please sign and return this form as soon as possible, and keep the attached document for future reference

To: Mr S Jones, Acting Headteacher

I confirm that I have received a copy of the Child Protection Policy, which was adopted by the Full Governing Body on 12 December 2018.

Signed: .....

Name: .....
(Block Capitals)

Date: .....

Child Protection Policy 2018-19

Updated: September 2018
Reviewed at Resources & People Committee: 21 November 2018
Adopted at Full Governing Board Meeting: 12 December 2018

This policy will be made available to all staff and volunteers, and placed on the School website and T:\Staff Resources\Policies and Procedures drive

1. Contacts

Headteacher	Mr Simon Jones
Leadership Team Designated Safeguarding Lead:	Mrs C Hankin, Assistant Headteacher 01296 688264
Additional Safeguarding Lead:	Miss E Phillips, LINC Manager
Additional Safeguarding Officers:	Mr P Cropper, Assistant Head of Sixth Form
	Mrs N Brimmell, Wellbeing Officer
	Mr S Jones, Headteacher
Looked After Children Officer:	Mr R Peel, Assistant Headteacher

Any Child Protection matter should be brought to the attention of one of the Safeguarding Team

CP and Safeguarding Governor:	Mr K Adamson	
Whistleblowing Governor:	Mr A Titley	email: atitley@cottesloe.bucks.sch.uk Mobile: 07876 747252
Trained CP Trainer:	Mrs C Hankin	
Chair of Governors:	Mr A Titley	email: atitley@cottesloe.bucks.sch.uk Mobile: 07876 747252

Contacts in County

- Education Safeguarding Advisory Service 01296 382912
- Education Safeguarding Advisor 01296 382732
- Local Authority Designated Officer (LADO): 01296 382070
- First Response Team (including Early Help, Channel referrals) 01296 383962
- Children's Services, Out of Hours: 0800 999 7677
- Thames Valley Police 101 (999 in case of emergency)
- Local Safeguarding Children Board www.bucks-lscb.org.uk
  for procedures, policies and practice guidelines
- Family Information Service 0845 688 4944
- Bucks County Council Schools Web https://schoolsweb.buckscc.gov.uk/schools.index.asp
  - School Bulletin, Safeguarding links, A-Z guide to information and services
- Buckinghamshire Grid for Learning e-Safety www.bucksgfl.org.uk/course/view
- RU Safe (Barnados – Child Sexual Exploitation Service) 01494 461112
- Equalities Manager/Management of Bullying/Prevent Lead for schools 01296 382461

Other contacts

- NSPCC 0800 800 5000
- Childline 0800 11 11
- Kidscape Bullying Helpline 0845 1205 204
- Female Genital Mutilation (FGM) 0800 0283550
  Email: fgmhelp@nspcc.org.uk
- Samaritans 0845 790 9090
- CEOP (Child Exploitation and Online Protection) www.ceop.gov.uk
- Foreign and Commonwealth Office (Forced Marriages Section) 0207 008 0151
- Crimestoppers 0800 555 111

Please see the school website safeguarding section for more contacts

2. Introduction

At The Cottesloe School, we believe a child centred approach is fundamental to safeguarding and promoting the welfare of every student. A child centred approach means we strive always to keep the child in focus when making decisions about their lives and working in together with them, their families as well as partner agencies. All staff are expected to be vigilant to the needs of our students.

2.1 This policy has been developed in accordance with the principles established by the Children Acts 1989 and 2004; and in line with the following:

"Working Together to Safeguard Children 2018".

"Keeping Children Safe in Education"- statutory guidance for schools and further education colleges, September 2018

Buckinghamshire Multi-Agency Information Sharing for Children, Young People & Families – Code of Practice for sharing personal information, March 2015 .

Children Missing Education; Statutory Guidance for Local Authorities Sept 2016

Statutory Guidance issued under section 29 of the Counter-Terrorism and Security Act 2015.

Sexual Violence and Sexual Harassment between Children – May 2018

The Equality Act 2010

The United Nations Convention on the Rights of the Child (UNCRC)

It should be read in conjunction with the following Cottesloe School guidance documents (copies attached to this Policy):

- Female Genital Mutilation
- Forced Marriage
- Honour Based Violence
- Children Fasting
- Prevent Duty
- Self Harm
- Breast Ironing

2.2 We believe clear governance and leadership is central to embedding a safeguarding culture The Governing Board takes seriously its responsibility under section 175 of the Education Act 2002 to safeguard[1] and promote the welfare of children; and to work together with other agencies to ensure adequate arrangements within our school to identify, assess, and support those children who are suffering harm or whose welfare may be in question. Governors will ensure all staff at the school have read and understood their responsibilities pertaining to Part 1, Part 5 and Annex A of Keeping Children Safe in Education, September 2018 and have

[1] Safeguarding (as defined in the Joint Inspector's Safeguarding report is taken to mean "All agencies working with children, young people and their families take all reasonable measures to ensure that the risk of harm to children's welfare are minimised" and "where there are concerns about children and young people's welfare, all agencies take all appropriate actions to address those concerns, working to agree local policies and procedures in full partnership with other agencies"

an auditable system in place to evidence this. In addition all staff are required to read and adhere to the Staff Code of Conduct which governs behaviours expected of them as well as having an understanding of the Behavioural Policy for children and our Attendance Policy.

2.3 We recognise all staff[2] and Governors have a full and active part to play in protecting our students from harm and actively promoting their welfare and that the child's welfare is our paramount concern.

2.4 All staff believe that our school should provide a safe, caring, positive and stimulating environment that promotes the social, physical and moral development of the individual child.

2.5 School recognises that as well as threats to the welfare of children from within their families, children may be vulnerable to abuse or exploitation outside their homes and from other children staff will remain vigilant and alert to these potential risks

2.6 The aims of this policy are:

2.6.1 To support students' development in ways that foster security, confidence and resilience free from discrimination.

2.6.2 To provide an environment in which children and young people feel safe, secure, valued and respected and feel confident that they know how to approach adults if they are in difficulties.

2.6.3 To ensure all teaching and non-teaching staff, are aware of the need to safeguard and promote the wellbeing of children identifying the need for support early to promote well-being and promptly reporting cases of actual or suspected abuse.

2.6.4 To provide a systematic means of monitoring children known or thought to be at risk of harm and ensure we, the school, contribute to assessments of need and support plans for those children.

2.6.5 To acknowledge the need for effective and appropriate communication between all members of staff in relation to the safeguarding of pupils, ensuring staff know how and when to share information to protect children in a way that is legal and ethical.

2.6.6 To ensure our school has a clear system for communicating concerns and a model for open communication between children, teachers, parents and other adults working with children.

2.6.7 To underpin a structured procedure within the school, which will be followed by all members of the school community in cases of suspected abuse.

2.6.8 To ensure the school have robust systems in place which accurately records safeguarding and child protection concerns, which are clearly understood by staff and adhered to. Actions taken to address concerns and outcome achieved are clearly and accurately recorded and these records are appropriately stored.

2.6.9 To develop effective working relationships, guided by the Threshold document, with all other agencies involved in safeguarding and promoting the needs of children at our school.

2.6.10 To ensure that all staff appointed within our school, have been through the safer recruitment process and understand the principles of safer working practices as set out in our Staff Code of Conduct, which stipulates their duty to challenge and report where behaviours of

[2] "Staff" covers ALL adult staff on site, including temporary, supply and ancillary staff, and volunteers working with children

colleagues may have stepped outside of agreed safe practices.

2.6.11 To provide clarity to other community users of our facilities with regard to our expectations of how they should maintain a safe environment which supports children's welfare and development.

3. Responsibilities

3.1 All staff at our school understand that safeguarding children is **everyone's responsibility**. Any member of staff, volunteer or visitor to the school who receives a disclosure of abuse, an allegation or suspects that abuse may have occurred should report it immediately to the DSL (see contacts sheet) or, in their absence, to another Additional DSL (see contacts sheet) using the systems and processes our school has designed for this purpose. In the absence of any of the above, the matter should be brought to the most senior member of staff on site. Staff understand if there is an immediate risk of harm then they call the police or First Response directly and update the DSL at the earliest opportunity. (See Flow chart attached Appendix One).

- Staff will ensure the child is in a safe place and in receipt of support should this be needed
- Staff will initially make a verbal report to the DSL to alert them to the safeguarding/child protection concern arising
- Staff will then follow this up, making a written report using the school record keeping process
- All concerns must be logged on the 'Safeguard' system that is used in school. This can be found via the school website, the school computer desktop or by google.
- This must be recorded as soon as possible after the event.
- Staff will ensure the **time and date** of the incident is recorded
- A factual account of the incident including **who** was involved, **what** was said/seen/heard, **where** the incident took place, any preceding information which may have prompted the event
- The DSL will record when the report was passed to them and what action was taken alongside any outcomes achieved. An automatic response will be sent to the person who has logged a concern, as soon as it is read by a member of the safeguarding team.

3.2 The **Governing Board** understands and fulfils its safeguarding responsibilities. It will:

3.2.1 Ensure that that the school has a robust Child Protection Policy that reflects the unique features of the community it serves and the needs of the students attending its provision and that this is reviewed at least annually.

3.2.2 Monitor and evaluate the effectiveness of the Child Protection Policy and be satisfied that it is being complied with.

3.2.3 Appoint a Designated Safeguarding Lead (DSL) and Additional Safeguarding Lead and Safeguarding Officers who are trained to the same level of the DSL The roles and responsibilities of the DSL and Additional Safeguard Leads are made explicit in the post-holders' job descriptions.

3.2.4 Recognise the importance of the role of the Safeguarding team, ensuring they have sufficient time, training skills and resources, as necessary to be effective.

3.2.5 Ensure measures are in place to have oversight of how schools delivery on its responsibilities are exercised and evidenced, following up with the Headteacher any identified gaps in practice or where procedures may not have been followed

3.2.6 Ensure cover is provided when needed, appreciating the additional duties taken on by the member of staff when carrying out this role especially when there are on-going child protection issues.

3.2.7 Recognise the contribution the school can make to helping children and young people keep safe, through incorporation of safeguarding within the curriculum.

3.2.8 Ensure that there are safe and effective recruitment policies and disciplinary procedures in place, which adhere to *Keeping Children Safe in Education (KCSiE) 2018* and legislation referred to therein.

3.2.9 Ensure the needs of pupils for early intervention and Child Protection, are fully understood and resources allocated to meet identified needs.

3.2.10 Supports the DSL to complete an Annual Safeguarding Report for Governors, demonstrating how our school is meeting its statutory responsibilities for safeguarding and promoting the welfare of children, ensuring a copy of this report is shared with the Education Safeguarding Advisory Service (ESAS) within the recommended time frame.

3.3 It will be the duty of the **Chair of Governors** Mr Adrian Titley to liaise with relevant agencies if any allegations are made against the Headteacher. If there are concerns that issues are not being progressed in an expedient manner, staff /student/parents should escalate concerns directly to the Local Authority Designated Officer (LADO telephone 01296 382070).

3.4 The **Nominated Governor** for child protection will be familiar with Buckinghamshire LSCB procedures, Local Authority procedures and guidance issued by the Department for Education.

The Nominated Governor will:

3.4.1 Work with the Designated Safeguarding Lead to produce the Child Protection Policy.

3.4.2 Undertake the training available for Nominated Governors.

3.4.3 Ensure Child Protection is, as a minimum, an annual agenda item for the Governing Board.

3.4.4 Meet regularly with the DSL to review and monitor schools delivery on its safeguarding responsibilities.

3.5 We have a Designated Safeguarding Lead (DSL) who along with members of the safeguarding team are responsible for:

3.5.1 Creating a culture of safeguarding where children are protected from harm. Ensuring children receive the right help at the right time using the Threshold Document to inform plans for support or protection (see Appendix Two for definitions of the categories of abuse).

3.5.2 Ensuring referrals to partner agencies, are followed up in writing, within 24 hrs of initial contact.

3.5.3 Establishing and imbedding a policy and process for recording and storing information about child protection concerns and outcomes achieved, enabling records to be reviewed and an overview gained, to support timely interventions and allowing prompt follow up, if it is felt the needs of the student are not being met. This includes use of the Escalation Process found on the BSCB website.

3.5.4 Ensuring records are up to date, and staff are supported to differentiate between fact, opinion and hearsay, and are maintained in accordance with data protection.

3.5.5 Ensuring records are stored safely and securely and remain confidential, the DSL will share information on a 'need to know' basis only and in accordance with the confidentiality policy. All Child Protection files are held separately from student records, with a front sheet listing dates and brief entry to provide a chronology.

3.5.6 Creating a culture of safeguarding and vigilance within the school, beginning with ensuring that all staff receive an appropriate level of induction and training to support them to be professionally curious, to question behaviours and to "think the unthinkable" if they have concerns for a student.

3.5.7 Acting as a focal point for staff to be able to discuss and share their concerns, supporting staff to formulate their thinking and be part of planning to address issues raised, liaising with other agencies and professionals to achieve change.

3.5.8 Being available or ensuring the Additional Safeguarding Lead or Safeguarding Officers are available, in their absence, to staff during school hours and term time for consultation and advice on safeguarding concerns raised. (The DSL, the Additional Safeguarding Lead and Safeguarding Officers are all trained to the same level within our school).

3.5.9 Ensuring arrangements are in place to support staff outside of these times if students are off site and accompanied by staff.

3.5.10 Contributing effectively to multiagency working for the purpose of safeguarding and promoting the welfare of students who have suffered or are likely to suffer significant harm, attending Child Protection Case Conferences and submitting reports to the conference, which have been shared in advance, with the parents. Contributing effectively to core group meetings, or other multi-agency planning meetings and contributing to the Framework for Assessments process.

3.5.11 Providing the Headteacher with an annual report for the Governing Board, detailing how school delivers on its safeguarding responsibilities and any child protection issues within the school. The Governing Board will use this report to fulfil its responsibility to provide the LA with information about their Safeguarding policies and procedures.

3.5.12 Meeting regularly (suggest minimum of once a term) with the Nominated Governor, to share oversight of safeguarding provision within the school, monitoring performance and developing plans to rectify any gaps in delivery noted.

3.5.13 to Meeting the statutory requirement to keep up to date with knowledge, enabling them to fulfil their role, including attending relevant training.

3.5.14 Referring, to the Police any cases where a criminal offence may have been committed or risk of harm is imminent.

3.5.15 Retaining responsibility for the safeguarding of students although tasks may be delegated to other members of the safeguarding team at the school.

4. Procedures

4.1 Our school procedures for safeguarding and protecting children from harm children will be in line with Buckinghamshire County Council and Buckinghamshire Safeguarding Children Board Child Protection Procedures, "Working Together to Safeguard Children 2018" and "Keeping Children Safe in Education 2018" and statutory guidance issued under section 29 of the Counter-Terrorism and Security Act 2015.

4.2 We will ensure that:

4.2.1 We have a Designated Safeguarding Team which includes members of the Senior Leadership Team who have all undertaken appropriate training for the role, as recommended by BSCB. Our Safeguarding Team will update their training following the agreed Learning Pathway agreed by the LSCB.

4.2.2 We have five members of staff within the Safeguarding Team who are all able to act in the Designated Safeguarding Lead's absence who have also received the same level of training for the role of DSL and who will have been briefed in the role.

4.2.3 All adults (including supply teachers and volunteers) new to our school are made aware of the school's policy and procedures for child protection, the name and contact details of the DSL, their role and responsibilities under Keeping Children Safe in Education 2018 and the booklet "What to do if You're Worried a Child is Being Abused", and have these explained, as part of their induction into the school.

4.2.4 All members of staff are required to attend annual training opportunities arranged or delivered by the DSL in order to develop their understanding of the signs and indicators of abuse, how to respond to a pupil who discloses abuse and the procedure to be followed to promote a child's welfare. Staff are supported to further develop their understanding as mechanisms are in place to enhance this via team meetings, newsletters and email updates.

4.2.5 All parents/carers are made aware of the school's responsibilities in regard to child protection procedures through publication of the school's Child Protection Policy and reference to it in our prospectus/brochure and home school agreement.

4.2.6 Through our Attendance Policy, we have in place a robust system for monitoring attendance and will act to address absenteeism with parents and pupils promptly to effect change and identify any safeguarding issues arising.

4.2.7 All children attending our school are required to have a minimum of two identified emergency contact, this is to support prompt communication in the event of a serious incident or a child missing from school

4.2.8 Any student that has been marked absent during morning registration and subsequent lessons, where parents have not notified school, will receive a telephone call or email from our attendance officer before 11am to ask about their whereabouts.

4.2.9 Any pupil absent for ten school days, where it has not been possible to make contact with a parent/carer, will be reported as a Child Missing in Education using the CME Protocol.

4.2.10 Any absence of two consecutive school days, without satisfactory explanation, of a pupil currently subject to a child protection plan is immediately referred to their social worker.

4.2.11 Parents must inform school if there are any changes to where a student will be living. School has a mandatory duty to inform the local authority via the First Response Team, if a child under the age of 16 years, lives with someone other than their parent, step-parent, aunt, uncle or grandparent for a period of more than 28 days. This is defined as being a private fostering arrangement

4.2.12 All staff, parents/carers and children are aware of the school's escalation process, which can be activated in the event of concerns not being resolved after the first point of contact. We acknowledge an individual's safeguarding responsibility does not end once they have informed a member of the Safeguarding Team of any concerns, although specific details of further actions may be appropriately withheld by the Safeguarding Team as information will only be shared on a need-to-know basis.

4.2.13 Our lettings policy reflects the on-going responsibility the school has for safeguarding those using the site outside of normal school hours, ensuring the suitability of adults working with children on school sites at any time. This includes the purpose of the letting when for religious or political reasons.

4.2.14 Community users organising activities for children are made aware of and required to demonstrate their understanding of the need for compliance with the school's child protection guidelines and procedures, as part of their use of our facilities.

4.2.15 The school operates Safe Recruitment practices including ascertaining the suitability of employed staff and volunteers in regulated activities. Checks will be made through the Disclosure and Barring Service, and the Department for Education's Teacher Services (Employers Checks) Prohibition List, as recommended by Buckinghamshire County Council and in line with current legislation.

4.2.16 We apply the same level of scrutiny to staff employed as supply, via an agency, ensuring their identities, qualification and suitability to work safely with children.

4.2.17 Allegations against members of staff are referred to the Local Authority Designated Officer (LADO). There are procedures in place to make a referral to the Disclosure and Barring Service (DBS) if a person in regulated activity has been dismissed or removed due to safeguarding concerns or would have been had they not resigned. The school recognises that this is a legal duty and a failure to refer when the criteria are met is a criminal offence.

4.2.18 Our procedures are reviewed and updated annually as a minimum.

4.2.19 The name of the Designated Safeguarding Lead will be clearly displayed around the school in appropriate locations including Reception and the staff room, with a statement explaining the school's role in referring and monitoring cases of suspected abuse. The DSL will be available during school hours and term time to support safeguarding within our school.

5 Prevention

5.1 We recognise that the school plays a significant part in the prevention of harm to our students by providing students with effective lines of communication with trusted adults, supportive friends and an ethos of protection. We include within this the emotional wellbeing of our students and recognise the role school plays identifying vulnerability and preventing the political indoctrination of students, either by self-radicalisation or through exposure to extremist views.

5.2 We are aware of the Prevent Duty to protect young people from radicalisation and extremism At our school we view this as a safeguarding matter like any other and these processes will be

applied to support children and their families where vulnerabilities are identified, invariably this will require us to work with partner agencies to support and protect the vulnerable student. Concerns regarding the conduct or behaviour of a student, where it is believed they are vulnerable to extremism will follow the same process of reporting as with any other safeguarding concern. A referral will be made to the First Response Team and passed by them to the Channel Co-ordinator.

5.3 All school staff are required to attend training to support them to identify a range of safeguarding and child protection matters, helping them to recognise and respond appropriately should concerns arise, supporting them to act on or escalate concerns.

5.4 Whilst a central part of our work with students is to support them to stay safe whilst on-line, we also have in place appropriate web filtering systems so that young people cannot view potentially extreme material, which we also monitor.

5.5 We recognise some students because of their life experiences or additional needs including SEN, may be disproportionally affected by the behaviours of their peers or vulnerable to the influence of others. We will work in partnership with colleagues in other agencies to promote the wellbeing of this cohort of students.

5.6 The school community will therefore:

5.6.1 Establish and maintain a safeguarding ethos, which is understood by all staff, enabling students to feel secure. Ensuring all students know there are staff in the school whom they can approach if they are worried or in difficulty. Encouraging students to share their worries knowing that they will be listened to.

5.6.2 Receive focused annual training to support learning and understanding of the changing landscape of safeguarding which is underpinned by legislation and includes issues such as FGM, themes of exploitation and management of sexual violence and sexual harassment.

5.6.3 Understand safeguarding and protection of students has to be view within the context of the students lived experience and the factors around him/her which may impact on this; friends, family school and their community.

5.6.4 Provide, across the curriculum, opportunities which equip children with the skills they need to stay safe from both physical and emotional harm and to know to whom they should turn for help.

5.6.5 Ensure that staff will work effectively with partner agencies to seek advice support and guidance, drawing on multi agency expertise, knowledge and experience to support students at risk of harm including emotional and intellectual harm via social media and use of the internet.

5.6.6 Be sensitive and alert to the possibility of the risk some children's behaviours may pose to their peers. Staff will be supported by the DSL to assess and act on concerns highlighted to ensure school remains a safe place to learn.

6 Supporting Children

6.1 We recognise the young minds of our students can be vulnerable and exploited by others, therefore Staff will be alert to the signs of vulnerability and / or susceptibilities to violent extremism or grooming or indoctrination and report concerns via our child protection procedures.

6.2 We recognise that the school may provide the only stability in the lives of children who have been abused or who are at risk of harm we therefore take our responsibilities seriously.

6.3 We accept that research shows that the behaviour of a child in these circumstances may range from that which is perceived to be normal to aggressive or withdrawn. Research also tells us that children with special needs are at an increased risk of abuse. Changes in mood, patterns of behaviour, injury and responses to stimulus around them may be wrongly attributable to their disability. Staffs are therefore trained to **question behaviours** and be **professionally curious** about changes noted, all staff are required to be prepared to "think the unthinkable", raise the concern and ensure safeguards are in place. We recognise children with communication difficulties may be especially vulnerable and for this reason we link behaviour with safeguarding, "listening to behaviours" acknowledging not all children will be able to verbalise what may be troubling them

6.4 Staff understand the need for a culture of vigilance to be present in the school to support safeguarding. This includes awareness and sensitivity to changes in the attitudes of students, which may indicate they are at risk of radicalisation.

6.5 The changing landscape of safeguarding and protecting children from harm requires staff to be aware of children being trafficked both from abroad and locally as part of ongoing exploitation, financial or sexual. Our admissions process will therefore ask for proof of identification and who has parental responsibility for a student – if parents go through County this process will have been initiated by them. We will however ask parents/carers to update contact details and alert us to changes of address or care arrangements within 48 hours.

6.6 Through training, staff are aware that children's behaviours may pose a risk to their peers, behaviours may range from bullying to those which are sexually abusive.

- Staff are trained to be vigilant and report any concerns to the Head of Year and/or the DSL in a wide range of per on peer behaviours including online, 1:1 group and issues related to gender/sexuality.

- Allegations are investigated by the Pastoral Team and overseen by the DSL who line manages them.

- Victims and families are supported by the Pastoral Team and outside agencies where necessary.

- Appropriate sanctions are put in place in line with the Behaviour Policy. Support is also offered to the perpetrators in order to minimise the risk of repeated behaviours.

The safeguarding team are aware of the need for sensitivity and care when dealing with all such incidents of bullying.

The school use many different strategies to make students aware of the seriousness of the different forms of peer on peer abuse. These include, but are not limited to:

- Assemblies
- The PSHE Curriculum
- The School's Healthy Relationship agenda
- Protective Behaviours

Any incidents of peer on peer abuse are investigated by the student's Head of Year by taking statements from the victim, alleged perpetrator and witnesses where appropriate. With any online abuse, screen shots taken by the victim (or others) will be used.

CCTV footage can also be used, as can reports received via the 'Share it' button.

We can support all parties in many ways, these include, but are not limited to:

- Restorative justice
- Conflict resolution
- Mediation
- Counselling
- Referring students to outside agencies
- Parental meetings

6.7 Our school will support all students by:

6.7.1 Encouraging the development of self-esteem, resilience and critical thinking in every aspect of school life including through the curriculum.

6.7.2 Promoting a caring, safe and positive environment within the school.

6.7.3 Monitoring all absences from school and promptly addressing concerns about irregular attendance with the parent/carer.

6.7.4 Liaising and working together with all other support services and those agencies involved in the safeguarding of children and using the expertise and resources of colleagues in other service areas to promote the welfare of students.

6.7.5 Ensuring staff work with Prevent Officers and the Channel Panel to support and safeguard if a student is thought to be vulnerable to or espousing radical political ideologies.

6.7.6 Liaising with the parent/carer, GP and/or school nurse to ensure that an appropriate care plan is in place if a pupil has medical needs.

6.7.7 Developing a good working knowledge of the Threshold Document and how it can be used to safeguard and promote the wellbeing of students, informing the notification to Social Care (First Response) as soon as there is a significant concern.

6.7.8 Ensuring that a named teacher is designated for Looked after Children (LAC) and that an up to date list of children who are subject to a Care Order or are accommodated by the County Council is regularly reviewed and updated. We will work with the Virtual Schools Team to support the educational attainment for children looked after at our school.

6.7.9 Staff are sensitive to the needs of children who are "looked after", recognising they are likely to have encountered difficulties and challenges which may mean they are disproportionately affected by the behaviours of their peers, e.g. teasing, bullying or when negotiating relationships.

6.7.10 Seeking appropriate advice, support and guidance to enable us to critically evaluate safeguarding information and concerns, and to act on them appropriately.

6.7.11 Providing continuing support to a student (about whom there have been concerns) who leaves the school by ensuring that such concerns and school medical records are forwarded under confidential cover to the Designated Safeguarding Lead at the student's new school as a matter of urgency/within the first term.

6.8 We are aware of our responsibilities for the safeguarding of pupils who are educated off site or who are in alternative provision and work with Bucks County Council to monitor and review this.

6.9 At our school we work hard to understand the impact on children of living in families experiencing difficulties relating to mental ill-health and/or substance misuse and/or domestic violence and know that the child/ren might experience abuse or neglect as a result of these difficulties.

6.10 The DSL along with the rest of our staff have received training to recognise and respond appropriately should suspicions arise. Ensuring signs and indicators are progressed to inform plans of support.

6.11 Pupils are encouraged to seek help and support and are provided with information about how to access this, if they are encountering problems at home.or elsewhere.

6.12 Whilst we strive to work together with families, staff understand that sharing information with parents may not be appropriate and ensure that decisions of this nature are made in partnership with Children's Social Care or the police.

7 Confidentiality

7.1 We recognise that all matters relating to child protection are confidential.

7.2 The Headteacher or Designated Safeguarding Lead will disclose personal information about a student to other members of staff on a need to know basis only. This will be governed by BSCB Information Sharing Protocols.

7.3 All staff are aware that they have a professional responsibility to share information with other agencies in order to safeguard children.

7.4 Staff will not keep duplicate or personal records of child protection concerns. All information will be reported to the Safeguarding Team and securely stored only in the designated location within the school, separate from the student educational records.

7.5 Provision is in place for the information to be accessed in the absence of the DSL in an emergency.

7.6 All staff are aware that they cannot promise a child to keep secrets which might compromise the child's safety or well-being or that of another. Staff will however reassure the child that information will only be shared with those people who will be able to help them and therefore need to know.

7.7 We will always undertake to share our intention to refer a child to Social Care (First Response) with their parents/carers unless to do so could put the child at greater risk of harm, or impede a criminal investigation. If in doubt, we will consult with the Education Safeguarding Advisory Service (ESAS) or Social Care on this point.

7.8 In the event of a child disclosing abuse staff will:

- Listen to the child. Allowing the child to tell what has happened in their own way, and at their own pace. Staff will not interrupt a child who is freely recalling significant events.
- Remain calm. Be reassuring and supportive but will endeavour to not respond emotionally.
- Not ask leading questions. Staff are reminded to ask questions only when seeking clarification about something the child may have said. Staff are trained to use TED; Tell, Explain, Describe.
- Make an accurate record of what they have seen/heard using the schools record keeping processes, recording: times, dates or locations mentioned, using as many words and expressions used by the child as possible. Staff will not substitute anatomically correct names for body part names used by the child. Any words which are unclear to the staff member will be spelt phonetically
- Reassure the child that they did the right thing in telling someone, they will reassure the child that they have not done anything wrong.
- Staff will explain to the child what will happen next and the need for the information to be shared with the DSL
- In the unlikely event of the DSL and other safeguarding officers not being available, staff are aware they must ring First Response for advice.

If there is immediate risk of harm to a child staff will NOT DELAY, and will ring 999

- The child will be monitored/accompanied at all times following a disclosure, until a plan is agreed as to how best they can be safeguarded.

8 Supporting staff

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

8.2 We will support such staff by providing an opportunity to talk through their anxieties with a member of the Safeguarding Team and to seek further support if necessary. This could be provided by the Headteacher or another trusted colleague, Occupational Health, and/or a representative of a professional body or trade union, as appropriate.

8.3 In consultation with all staff, we have adopted a Code of Conduct for Staff at our school. This forms part of staff induction and can be found on the T:\Policies and Procedures drive or from the Headteacher's PA. We understand that staff should have access to advice on the boundaries of appropriate behaviour in order to define and underpin the safe working practices adhered to within our school.

8.4 All staff are required to sign that they have read, understood and agree to comply with the agreed standards of practice set out in the staff Code of Conduct.

8.5 We recognise that our Designated Safeguarding Lead(s) should have access to support (as in 8.2 above) and appropriate workshops, courses or forums as organised by the County Council.

9 Allegations against staff

9.1 All school staff should take care not to place themselves in a vulnerable position with a child. It is always advisable for interviews or work with individual children or parents to be conducted in view of other adults (see also 8.3 above). There should be no 1:1 contact between staff and students which is not "open to the casual observer". Staff are made aware of safe working practice on the staff induction. It is also documented in the Staff Code of Conduct.

9.2 All staff should be aware of the school's Behaviour/Discipline Policy. This can be found on the T:\Policies and Procedures drive and on the school's website.

9.3 We understand that a student may make an allegation against a member of staff. If such an allegation is made, the member of staff receiving the allegation will immediately inform the Headteacher or the most senior teacher if the Headteacher is not present.

9.4 The Headteacher/senior teacher on all such occasions should immediately discuss the content of the allegation with the Local Authority Designated Officer (LADO). The purpose of an initial discussion is for the LADO and the case manager to consider the nature, content and context of the allegation and agree a course of action.

9.5 The Head Teacher/Senior Teacher will:

9.5.1 Follow all advice given by the LADO throughout the investigation process, including how to manage the staff member or volunteer against whom the allegation is made, as well as supporting other staff and volunteers within the workplace.

9.5.2 Follow all advice given by the LADO relating to supporting the child or young person making the allegation, as well as other children and young people connected to the organisation.

9.5.3 Ensure feedback is provided to the LADO about the outcome of any internal investigations within your agency.

9.6 If the allegation made to a member of staff concerns the Headteacher, the person receiving the allegation will immediately inform the Chair of Governors who will consult the LADO (as in 9.4 above) without notifying the Headteacher first.

9.7 The school will follow the County Council's procedures for managing allegations against staff, a copy of which can be found on the T:\Policies and Procedures drive or from the Headteacher's PA.

9.8 Suspension of the member of staff against whom an allegation has been made needs careful consideration, and we will consult (as in 9.4 above) in making this decision, as well as being guided by HR.

9.9 If a suspension is made (as in 9.8 above) restrictions will apply to all staff regarding contact whilst suspended including the use of social media such as, but not restricted to, Facebook and Twitter.

9.10 Our lettings agreement for other users requires that the organiser will follow County Council procedures for managing allegations against staff and, where necessary, the suspension of adults from school premises.

10. Transfer of Risk

10.1 Should an individual staff member or volunteer be involved in child protection, other safeguarding procedures or Police investigations in relation to abuse or neglect, they must inform their manager of employer. In these circumstances, the organisation will need to assess whether there is any potential for risk to transfer to the workplace and the individual's own work with children or young people.

11 Whistleblowing

11.1 We recognise that children cannot be expected to raise concerns in an environment where staff fail to do so. For this reason we have a separate Whistleblowing Policy which can be found T:\Policies and Procedures drive or from the Headteacher's PA. Staff are required to familiarise themselves with this document during their induction period.

11.2 All staff should be aware of their duty to raise concerns about the attitude or actions of colleagues. If necessary, they should speak to the delegated 'Whistleblowing' Governor or the Local Authority Designated Officer (LADO). See flowchart attached Appendix One

11.3 A tool to support safeguarding concerns to be reported can be found on our website which has the Department for Education "Report a concern" button

12 Physical intervention/Positive handling

12.1 Our policy on physical intervention/positive handling by staff is set out separately, as part of our Behaviour Policy. It complies with the Department for Education Guidance, 'The Use of Reasonable Force, and Advice for Headteachers, Staff and Governing Bodies' July 2013. This policy states that staff may only use 'reasonable force', meaning no more force than is needed, to prevent students from hurting themselves or others, from damaging property, or from causing disorder. It is always unlawful to use force as a punishment.

12.2 Headteachers and authorised staff can use such force as is reasonable given the circumstances to conduct a search for the following 'prohibited items': knives and weapons, alcohol, illegal drugs, stolen items, cigarettes and tobacco, fireworks, pornographic images, or any article that has been or is likely to be used to commit an offence, cause personal injury or damage property.

12.3 If the use of force is necessary, reasonable adjustments for disabled children and children with special educational needs will be made.

12.4 Any use of force or restraint, should be recorded and signed by a witness. The parent/carer will be informed of the incident.

12.5 Staff who are likely to need to use physical intervention should be appropriately trained.

12.6 We understand that physical intervention of a nature which causes injury or unnecessary distress to a child may be considered under child protection or disciplinary procedures.

13 Anti-Bullying

13.1 At our school, we have an agreed definition of bullying '*There is no legal definition of bullying. But it is usually defined as repeated behaviour which is intended to hurt someone either emotionally or physically, and is often aimed at certain people because of their race, religion, gender or sexual orientation or any other aspect such as appearance or disability*' which is understood by pupils, staff, parents and carers.

13.2 We have an Anti-Bullying Policy and measures in place to prevent and respond to all forms of bullying, which acknowledges that to allow or condone bullying may lead to consideration under child protection procedures.

13.3 This policy is available to all staff, parents and carers and pupils. The policy is written in language that is accessible to pupils and a child-friendly version is made available to all pupils.

13.4 Staff, pupils and parents are made aware of how mobile technologies are increasingly being used to bully children both in and outside of the school environment. Cyber bullying is therefore referenced within our Anti-Bullying Policy.

14 Racist Incidents

14.1 Our Equalities and Cohesion policy references how racist incidents will be dealt with and acknowledges the serious nature of these events and their impact on the individual/group of students involved including those who may witness the incident. All incidents will be taken seriously and consideration will be given as to whether a multi-agency approach using child protection procedures in required.

15 Health and Safety

15.1 We recognise the importance of safeguarding pupils throughout the school day. Our Health & Safety policy reflects the consideration we give to the protection of our children both physically within the school environment and in relation to internet use and when away from the school when undertaking school trips and visits

15.2 Part of the safeguarding measures we have in place include the safe dropping off and collection of pupils at the start and end of the school day. We would therefore ask all parents to deliver their children to the coach park in the morning, using the area by the shelter as a drop off point. Please be vigilant in the fact that this is being used in the morning by school buses. The collection point at the end of the day is also from the coach park. Parents are not permitted to enter the coach park before 3.10pm as the school buses will be collecting students. Collection or drop off of students throughout the school day, due to appointments or sickness will remain at the front of the school. Parents are expected to inform us via reception if there is to be a change in the arrangement of collection for their children.

15.3 Pupils who leave the site during the school day do so only with the written permission of a parent and are collected by an authorised adult where appropriate. School should be notified by the parents regarding whom they have authorised for this task. Year 12 and 13 students are able to leave site only at break time and lunchtime and students must sign out/in in the Sixth Form block or at the attendance office.

15.4 Students that arrive to school either by bus or by car are dropped off on the coach park at the rear of the school. Students should then stay on school site until the end of the school day. Students that attend afterschool clubs or fixtures should be collected by parents at the agreed time given. Staff that organise these clubs/fixtures should stay in school until the last student is collected.

15.5 All staff are aware of potential 'hotspots' in the school where areas of potential vulnerability may exists. 2-way radios are used to communicate with key staff members.

15.6 In the event of a student going missing during the course of the school day we will carry out immediate checks to ensure the student is not on site, staff will then make contact with the student's parents and inform the police

16 E-Safety

16.1 All staff should be aware of the school policy on e-Safety which sets out our expectations relating to:

- Creating a safer online learning environment.
- Giving everyone the skills, knowledge and understanding to help children and young people stay safe online, question the information they are accessing and support the development of critical thinking.
- Inspiring safe and responsible use and behaviour of mobile technologies, to combat behaviours on line which may make students vulnerable including sexting.
- Use of mobile technology both within school and on school trips/ outings.
- Use of camera equipment, including camera phones.
- What steps to take if there are concerns and where to go for help
- Staff use of social media as set out in the Staff Code of Conduct.

16.2 Cyber-bullying by children, via texts, social media and emails, will be treated as seriously as any other type of bullying and will be managed through our anti-bullying procedures This includes sexting and image exchange under threat or use of coercion

16.3 Students, staff and parents are supported to understand the risks posed by the **CONTENT** accessed by students – their **CONDUCT** on line – and who they have **CONTACT** with in the digital world.

16.4 We have a separate mobile phone policy which sets out the acceptable use of mobile technologies by pupils whilst onsite. This includes sanctions which will be applied when these boundaries are not adhered to.

16.5 Visitors to our school are respectfully requested to turn all mobile devices off. This is a safeguarding measure for our students.

16.6 Staff's use of mobile technology whilst on site is set out in the Staff Code of Conduct.

17 Sexting

17.1 'Sexting', also referred to as 'youth produced sexual imagery', is one of a number of 'risk-taking' behaviours associated with the use of digital technologies, social media or the internet. It is accepted that young people experiment and challenge boundaries and therefore the risks associated with 'online' activity can never be completely eliminated.

17.2 Staff, pupils and parents are supported via training to understand the creation and sharing of sexual imagery, such as photos or videos, of under 18s is illegal. This includes imagery of pupils themselves if they are under the age of 18.

17.3 Any youth produced sexual imagery disclosures will follow the normal safeguarding practices and protocols for our school. We will also use the guidelines for responding to incidents, as set out in the publication 'Sexting in Schools and Colleges' produced by the UK Council for Child Internet Safety. A copy of which can be found T:drive\Safeguarding/Documents/Other/Sexting-in-schools-and-colleges-UKCCIS-August-2016.pdf. This requires us to share reports of sexting with the police and/or First Response.

18 Cultural Issues

As a school we are aware of the cultural diversity of the community around us and seek to work sensitively to address the unique culture of our students and their families as they relate to safeguarding. This includes children at risk of harm from abuse linked to a belief in spirit possession on the part of their parent, carer or wider community.

18.1 Our guidance on the following are set out in separate documents (attached):

- female genital mutilation;
- breast ironing;
- forced marriage;
- honour based violence;
- children fasting.

18.2 As a staff team we are aware of the harm to children that can be caused by practices linked to culture, faith and beliefs. We promote awareness through training and access to resources.

18.3 Staff will report concerns about abuse linked to culture, faith and beliefs in the same way as other child protection concerns.

18.4 We support students, via targeted sessions and delivery through our curriculum, to understand that some aspects of cultural or religious practice and beliefs could cause harm and they should turn to someone they trust or an organisation such as ChildLine for help and support.

18.5 We make links with local services, community organisations and faith leaders to provide support and helpful information on what is safe and unsafe practice within the culture/faith, groups of our school community.

18.6 At our school we are aware of a range of practices and belief which can be classified as honour based violence, we include within this female genital mutilation, forced marriage and breast ironing. Whilst this may be a part of a long held tradition within communities we categorise this as child abuse and will act according to our child protection processes to safeguard the pupil concerned.

18.7 Teachers at our school understand there is a legal duty to report known cases of FGM to the police and they will do this with the support of the DSL https://www.gov.uk/government/publications/mandatory-reporting-of-female-genital-mutilation-procedural-information

18.8 At our school we are aware of the need to respond to concerns relating to forced marriage and understand that it is illegal, a form of child abuse and a breach of children's rights. We recognise some students due to capacity or additional learning needs may not be able to give an informed consent and this will be dealt with under our child protection processes.

18.9 We recognise that both male and female pupils may be subject to honour based abuse e.g. where young people's cultural background are at odds with their behaviours such as homosexuality, under-age sex, relationships or life style choices.

18.10 We promote awareness through training and access to resources, ensuring that the signs and indicators are known and recognised by staff, any suspicions or concerns for forced marriage are reported to the DSL and the Forced Marriage Bureaux as well as First Response.

18.11 Staff understand that whilst we try always to work in partnership with families, sharing information with a parent or member of the family is not appropriate in these instances where

there may be cultural differences of opinion on abuse. Staff will report concerns to the DSL who will liaise with Children's Social Care, the police or the Forced Marriage Unit and follow advice given regarding protective strategies to safeguard the pupil.

19 Retention of Records

19.1 When a disclosure of abuse, or an allegation against a member of staff or volunteer, has been made, our school will have a record of this. These records will be maintained in a way that is confidential and secure, in accordance with our Record Keeping Policy and Data Protection Legislation.

19.2 There is a statutory requirement for our school to pass any child protection records to the child's next school. We are also required to retain these records securely and confidentially until the child concerned reaches the age of 25 years. These records will be stored securely.

19.3 If an allegation is made against a member of staff, a comprehensive, confidential summary of the allegation will be kept on their personnel file. This record will be kept by the school until normal retirement age, or 10 years after the allegation if longer. This record will include a clear outcome, including when cases have been investigated and found to be without substance.

19.4 For cases in which an allegation has been proven to be false, unsubstantiated or malicious, the allegation will not be included in employer references, even if that person has been the subject of repeated allegations.

19.5 In the instance or repeated allegations however our school retains the right in the interest of safeguarding students to retain a record of concern[3].

19.6 We have a system for reviewing our archiving of information held and will only retain information for the agreed time span. All information will thereafter be disposed of via confidential waste management

20 Use of Photography

20.1 We will often use photographs and film to capture achievements, monitor a child development and help promote successes within our school. We like to have a record of all the wonderful activities our students take part in. Via our website we like to be able to share these events with parents. We are however mindful of the safety of our students and will seek the permissions of both parents and student before taking or sharing any images.

20.2 As confirmed in the Data Protection Act, our school will ensure written consent is sought from the parent or carer of any child under the age of 18 before any photographs are taken. If consent is given, we will make a clear agreement with the parent or carer as to how the image will be used (for example, in a school brochure or website) and how widely (as part of a schools bulletin for all parents, on the child's individual development record etc). Our agreement with parents and students includes how images will be stored, how long they will be stored for and how they will be disposed of.

20.3 Due consideration will be given to the appropriate of clothing and posture, and details such as a child's name or age will not be shared unless integral to the use of the image (such as the acceptance of an award) in particular when additional identifiers (i.e. a school or uniform logo) are being shared.

[3] Safeguarding Children: dealing with low-level concerns about adults – Farrer & Co Adele Eastman and Katie Rigg, May 2017

20.4 We acknowledge the right of parents and students to withhold or with draw consent at any point in time of the duration the student is at the school

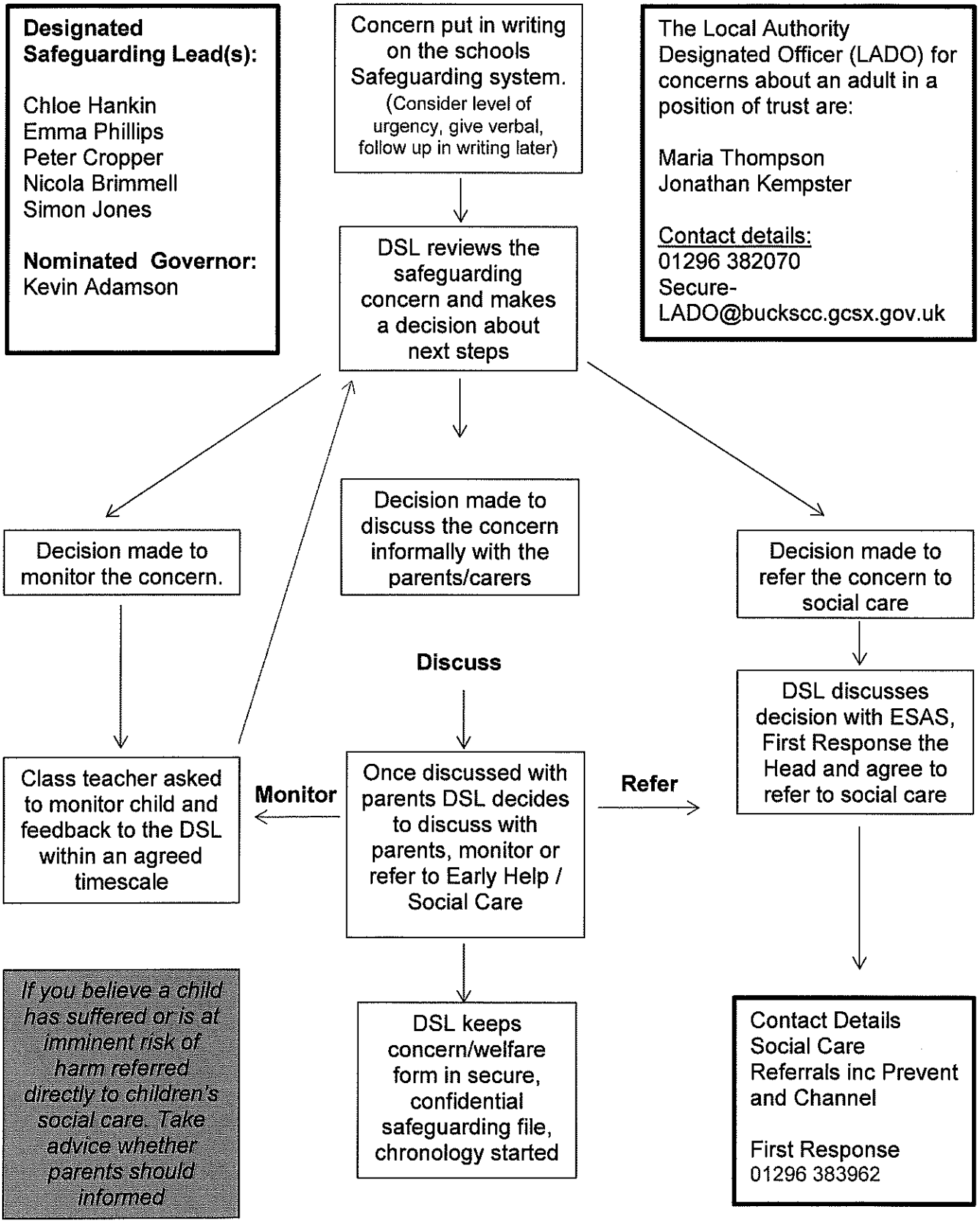
21 Policy Review

21.1 The Governing Board of our school is responsible for ensuring the annual review of this policy, and for reporting back to the County Council. The date the next review is due is on the front cover.

September 2018

Appendix One

FLOW CHART FOR RAISING SAFEGUARDING CONCERNS ABOUT A CHILD



Child Protection

Everyone who works with children has a duty to safeguard and promote the welfare of children. They should be aware of the signs and indicators of abuse and know what to do and to whom to speak if they become concerned about a child or if a child discloses to them.

The following is intended as a reference for school staff and parents/carers if they become concerned that a child is suffering or likely to suffer significant harm. This should be read along with KCSiE 2018 Part 1 and Annex A of the same document

The Children Act 1989 defines abuse as when a child is suffering or is likely to suffer 'significant harm'. Harm means ill treatment or the impairment of health or development. Four categories of abuse are identified.

Categories of Abuse

Child abuse is a form of maltreatment. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children.

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). If a child is observed scavenging for food at school, the possibility of inadequate feeding at home should be considered as a priority;
- protect a child from physical and emotional harm or danger;
- ensure adequate supervision (including the use of inadequate or inappropriate care-givers);
- ensure access to appropriate medical care or treatment.

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

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.

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 feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill treatment of another. It may involve serious bullying (including cyber bullying), causing children to feel frightened and 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.

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including exploitative relationships, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts (e.g. masturbation, kissing, rubbing and touching outside of clothing). They may include non-contact activities, such as involving children in looking at, or in the production of, sexual images (including on-line images), watching sexual activities, or 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.

Exploitation

Exploitation is a form of child abuse and may take a number of forms

Child Sexual Exploitation

Sexual abuse may involve physical contact, including assault by penetration (for example, rape or oral sex) or nonpenetrative acts such as masturbation, kissing, rubbing and touching outside clothing. It may include non-contact activities, such as involving children in the production of sexual images, forcing children to look at sexual images or watch sexual activities, encouraging children to behave in sexually inappropriate ways or grooming a child in preparation for abuse (including via the internet).

The definition of child sexual exploitation is as follows:

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology

https://www.gov.uk/government/publications/child-sexual-exploitation-definition-and-guide-for-practitioners

Extremism

Extremism goes beyond terrorism and includes people who target the vulnerable – including the young – by seeking to sow division between communities on the basis of race, faith or denomination; justify discrimination towards women and girls; persuade others that minorities are inferior; or argue against the primacy of democracy and the rule of law in our society. Extremism is defined in the Counter Extremism Strategy 2015 as the vocal or active opposition to our fundamental values, including the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. We also regard calls for the death of members of our armed forces as extremist.

County Lines

As set out in the Serious Violence Strategy (see link below), published by the Home Office, a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

Child Criminal Exploitation

As set out in the Serious Violence Strategy https://www.gov.uk/government/publications/serious-violence-strategy published by the Home Office, where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 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. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology.

Taken from "Working Together" 2018

https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

September 2018

Female Genital Mutilation: Safeguarding Girls and Women

Guidance and Procedure

Last updated: January 2017

RELATED POLICIES AND PROCEDURES

- What to do if you have a Concern about a Child in Buckinghamshire
- BSCB Information Sharing Code of Practice

1. Introduction

1.1. Female Genital Mutilation (FGM) is considered child abuse in the UK and is a grave violation of the human rights of girls and women. It has intolerable long-term physical and emotional consequences for the survivors and has been illegal in the UK for over 30 years. It is estimated that 137,000 girls and women in the UK are affected by this practice,[i] but this is likely to be an underestimation.[ii]

1.2. This multi-agency FGM guidance and procedure is relevant for agencies working with both children and adults. It has been produced to support agencies in Buckinghamshire to work effectively together to tackle FGM. **Agencies should continue to refer to relevant specialist professional guidance alongside this document.**

1.3. This document should also be read in conjunction with:

- Government Statutory Guidance on Female Genital Mutilation. This should be read and followed by all professionals who are working to safeguard and promote the welfare of children and vulnerable adults.
- BSCB Thresholds document and procedure for what to do if you are concerned about a child in Bucks
- The government's procedural information for professionals subject to the FGM mandatory reporting duty

2. Key Principles

2.1. All agencies/services should be alert to the possibility of FGM, and their approach should include a preventative strategy that focuses upon education, as well as the protection of girls / women at risk of significant harm.

2.2. The following principles should be adhered to:

- The safety and welfare of the girl / woman is paramount.
- All agencies/services and staff, including volunteers, should act in the interest of the rights of the girl / woman, as stated in the UN Convention on the Rights of the Child (1989)
- All decisions or plans for the girl / woman should be based on thorough assessments which have a sensitive approach to the issues of age, race, culture, gender, religion. Stigmatisation of the girl / woman or their specific community should be avoided.
- Buckinghamshire's agencies/services should work in partnership with members of affected local communities, to develop support networks and appropriate education programme.

3. Legal Status

3.1. The momentum to end FGM has grown significantly in the last four years due to various campaigners raising awareness of the issue and the government strengthening its stance on FGM.[iii] The UK government is committed to eradicating this harmful practice within a generation[iv] and has strengthened the legal framework to help achieve this.

Mandatory Reporting Duty (October 2015): Introduced under Section 5B of the 2003 Female Genital Mutilation Act, the duty requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s to the police which they identify in the course of their professional work. See Section 12 of this guidance for further details

Serious Crime Act (2015): This strengthened the 2003 Female Genital Mutilation Act with the following measures:
1) **Created a new offence** of failing to protect a girl from FGM. Anyone with parental responsibility for a girl under 16 who was mutilated will be potentially liable if they did not take steps to prevent it.
2) **Granted** life-long anonymity for persons against whom a female genital mutilation offence is alleged to have been committed.
3) **Enabled** a court to grant an "FGM protection order" for the purposes of:
   a) protecting a girl against the infliction of a genital mutilation offence, or
   b) protecting a girl against whom any such offence has been committed.

Female Genital Mutilation Act (2003): This replaced the 1985 Act in England, Wales and Northern Ireland.[1]

Made the following an offence:
1) To aid, abet, counsel or procure a person who is not a UK national or permanent UK resident to undertake a relevant act of FGM outside the UK.
2) To aid, abet, counsel or procure a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris.
On conviction of indictment: a fine, or imprisonment for a term not exceeding 14 years, or both.

Prohibition of Female Circumcision Act (1985): It became an offence for any person:
a) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person.
b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body.
On conviction or indictment: a fine or imprisonment for a term not exceeding 14 years or both.

4. Definition and Types of Female Genital Mutilation

4.1. The World Health Organisation (WHO) defines female genital mutilation as: "*all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons*".

4.2. FGM has been classified by the WHO into four types:

- **Type 1 - Clitoridectomy:** Partial or total removal of the clitoris and, rarely, the prepuce (the fold of skin surrounding the clitoris) as well.
- **Type 2 - Excision:** Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are 'the lips' that surround the vagina).
- **Type 3 - Infibulation:** Narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner and sometimes outer labia, with or without removal of the clitoris. This is the most extreme form of FGM.
- **Type 4 - Other:** All other harmful procedures to the female genitalia for non-medical purposes for example, pricking, piercing, tattooing, incising, scraping and cauterising the genital area. Type 4 is noted by professionals to be common among practising communities. However, it is also the type that often goes unnoticed and therefore not recorded.

4.3. FGM is known by a number of names, including female genital cutting or circumcision. The names 'FGM' or 'cut' are increasingly used at the community level, although they are still not always understood by individuals in practicing communities, largely because they are English terms. Appendices B and C provide further information to help professionals talk about FGM with different communities, including the various names that may be used for FGM across different communities.

4.4. Those who are affected by FGM may be born to parents from FGM practising communities or women resident in the UK who were born in countries that practice FGM. These may include (but are not limited to) immigrants, refugees, asylum seekers, overseas students or the wives of overseas students.

4.5. The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out at any time, including when the girl is newborn, during childhood, adolescence, at marriage or during the first pregnancy. However, in the majority of cases FGM takes place between the ages of 5-8 and therefore girls within that age bracket are at a higher risk.

5. Prevalence

5.1. The Buckinghamshire Strategy for Tackling FGM contains more detailed information on the prevalence of FGM at an international, national and local level. A summary of key points is listed below.

5.2. The International Picture

- Globally 100 – 140 million women and girls have undergone FGM and a further 3 million girls undergo FGM every year in Africa. [v]
- Most of the females affected live in 28 African countries, with some also from parts of the Middle East and Asia. In Somalia, Sudan, Djibouti, Egypt, Guinea and Sierra Leone, FGM prevalence rates are over 90%.

5.3. The National Picture

5.3.1. The prevalence of FGM in the UK is difficult to estimate because of its hidden nature. However, a report published in July 2014[vi] estimated that as of 2011:

- Approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM;
- Approximately 103,000 women aged 15-49 and approximately 24,000 women aged 50 and over who have migrated to England and Wales are living with the consequences of FGM. In addition, approximately 10,000 girls aged under 15 who have migrated to England and Wales are likely to have undergone FGM;
- Combining the figures for the three age groups, an estimated 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011.

5.4. The Local Picture

5.4.1. There is an uneven distribution of cases of FGM around the country, with more occurring in those areas of the UK with larger communities from the practising countries. Whilst this would not make Buckinghamshire an area of high FGM prevalence, there are some areas close by that are likely to have far more cases such as Oxford, Reading, Slough and Milton Keynes.

5.4.2. The Buckinghamshire Joint Strategic Needs Assessment (JNSA) has used 2011 census data to estimate the number of women aged 15-49 years in Buckinghamshire and within each of the four Districts who may have undergone FGM.[vii]

- Approximately 792 (0.16% of the total population) Buckinghamshire resident women aged 15-49 years may have undergone FGM. In addition there will also be women aged 50 and over who have undergone FGM who are not included in these estimates.

- The highest number of women aged 15-49 estimated to have undergone FGM live in Wycombe District Council, although the proportion of the total population is slightly higher in South Bucks than in other Districts.
- In Wycombe District Council there are estimated to be 257 women (0.15% of total residents) who have had FGM, 238 (0.14% of total residents) in Aylesbury Vale District Council, 161 (0.24% of total residents) in South Bucks District Council, and 136 (0.15% of total residents) in Chiltern District Council.

5.4.3. Since the mandatory reporting duty was implemented in October 2015 (see section 12), no cases of FGM in Buckinghamshire have been reported to Thames Valley Police that could be recorded as a crime under Home Office Counting Rules.

5.4.4. Data on FGM prevalence can also be derived from The Female Genital Mutilation (FGM) Enhanced Dataset (see section 13). This is a repository for individual level data collected by healthcare providers in England. As of September 2016, all statistical releases relating to Buckinghamshire have data suppressed for statistical reasons, indicating between 0 and 4 reported cases for each reporting period.

5.4.5. **It is important professionals understand how to follow relevant reporting procedures so that we have an accurate picture of the prevalence of FGM in Buckinghamshire. Professionals should also be aware that as the demographics of our community shift over time, it is possible that we will see an increase in residents from those countries where FGM is prevalent.**

6. Cultural Context

6.1. The procedure is often carried out by an older woman in the community, who may see conducting FGM as a prestigious act.

6.2. The procedure can involve the girl / woman being held down on the floor by several women. It is often carried out without medical expertise, attention to hygiene or an anaesthetic. Instruments used have been known to include un-sterilised household knives, razor blades, broken glass and stones. The girl / woman may undergo the procedure unexpectedly, or it may be planned in advance.

6.3. The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. Increasingly, however, FGM is being performed by health care providers.[viii]

6.4. The WHO cites a number of reasons for the continuation of FGM, such as:

- Custom and tradition
- A mistaken belief that FGM is a religious requirement
- Preservation of virginity/chastity
- Social acceptance, especially for marriage
- A belief that it will increase marriageability
- Hygiene and cleanliness
- Increasing sexual pleasure for the male
- Family honour
- A sense of belonging to the group and conversely the fear of social exclusion
- Enhancing fertility

6.5. Religion and FGM

6.5.1. Muslim scholars and faith leaders, including the Muslim Council of Britain, have condemned the practice and are clear that FGM is an act of violence against women. Further, scholars and clerics have stressed that Islam forbids people from inflicting harm on others and therefore the practice of FGM is counter to the teachings of Islam.

6.5.2. The Bible does not support this practice nor is there any suggestion that FGM is a requirement or condoned by Christian teaching and beliefs.

7. Signs and Indicators

7.1. Specific factors that may heighten a child's risk of being subjected to FGM include:

- Girl's mother has undergone FGM
- Other family members have undergone FGM
- Father comes from a community known to practice FGM
- Mother / family have limited contact with people outside of her family
- Parents have poor access to information about FGM and do know about the harmful effects of FGM or UK law
- Girl/family has limited level of integration within UK community
- Girl/women repeated fail to attend or engage with health and welfare services
- A family elder such a grandmother is very influential within the family and is / will be involved in the care of the girl

7.2. Indications that FGM may be about to take place include:

- Parents say they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would be more likely to lead to a concern
- Girl has spoken about a long holiday to her country of origin / another country where the practice is prevalent

- Girl has attended a travel clinic or equivalent for vaccinations / anti-malarials
- FGM is referred to in conversation by the child, family or close friends of the family (see Appendix C for traditional and local terms) – the context of the discussion will be important
- Girl withdrawn from PHSE lessons or from learning about FGM at school
- Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girls has talked about going away 'to become a woman' or to 'become like my mum and sister'
- The girl or a sibling may ask for help
- A parent or family member expresses concern that FGM may be carried out on a child

7.3. Indications that FGM may have already taken place include:

- Girl is reluctant to undergo any medical examination
- Girl spends long periods of time in the bathroom / toilet / away from the classroom
- Girl has spoken about having been on a long holiday to her country of origin / another country where the practice is prevalent
- Increased emotional and psychological needs such as withdrawal, depression or significant changes in behaviour
- Girl presents to GP or A&E with frequent urine, menstrual or stomach problems
- Girl talks about pain or discomfort between her legs
- Girl has difficulty walking, sitting or standing and looks uncomfortable
- Girl finds it hard to sit still for long periods of time, which was not a problem previously
- Girl is avoiding physical exercise or requiring to be excused from PE lessons without a GP letter
- A child may ask for help or confides in a professional that FGM has taken place
- Mother of family member discloses that FGM has taken place

8. Health Implications of FGM

8.1. Short term consequences of FGM may include:[ix]

- Severe pain during the procedure and healing
- Shock, which may be caused by pain and / or haemorrhage
- Excessive bleeding
- Difficulty in passing urine and faeces due to swelling and pain
- Infections or septic shock are common, particularly as the procedure can be carried out in unhygienic conditions and/or with instruments that are not sterilised.

- Psychological consequences due to the pain, shock and use of physical force by those performing the procedure
- Death can be caused by haemorrhage or infections
- Blood born viruses (for example Hepatitis B and C and HIV) and Tetanus are also a potential risk due to non-sterile equipment being used.

8.2. Long term consequences may include:

- Chronic pain
- Infections, particularly of the reproductive and urinary tracts
- Abscesses, painful cysts or keloids (excessive scar tissue formed at the site of the cutting)
- Menstrual problems
- Birth complications such as prolonged labour, recourse to caesarean section, postpartum haemorrhage and tearing
- Danger to the new-born, with high death rates and reduced Apgar scores
- Increased risk of HIV infection and transmission in adulthood due to an increased risk of bleeding during intercourse
- Psychological consequences such as fear of sexual intercourse, post-traumatic stress disorder, anxiety, depression and memory loss
- Loss of pleasure in sex and / or loss of ability to experience orgasm

8.3. Results from research in practicing African communities are that women who have undergone FGM have the same levels of Post-Traumatic stress Disorder as adults who have been subject to early childhood abuse. Research also indicates that the majority of the women (80%) suffer from affective (mood) or anxiety disorders.[x]

9. Procedure for responding to FGM

9.1. The following circumstances relating to FGM require identification and intervention:

- It is known that an adult woman has undergone FGM and there are no children or pregnant women in the household
- It is known that an adult woman has undergone FGM and there is an unborn child / female child(ren) in the family or household. However, FGM has not been identified in them and there are no signs that FGM is imminent
- It is known that an adult woman has undergone FGM, there is a female child / children in the family or household and there is suspicion FGM has occurred or may be imminent
- A female child / children have been subjected to FGM and this is confirmed by a disclosure or evident on examination.

9.2. Please refer to the following flow diagram to guide you through the procedure in Buckinghamshire for each of these circumstances.

Multi-Agency FGM Pathway

FGM / risk of FGM is identified or suspected, for example through

- Routine enquiry
- Disclosure
- Physical findings during examination
- Girl talks about attending 'special celebration' in high prevalence country of origin

See Section 7 of Multi-Agency FGM Guidance for further detail on potential signs and indicators of FGM

Explore consequences of FGM for the woman / girl (physical / psychological / legal) and any ongoing risk of FGM for any children / unborn children in the household. Avoid using a family member as an interpreter.

- Complete most relevant FGM screening tool (See Appendix A of Multi-Agency FGM Guidance)
- Provide information on the illegal status of FGM in the UK
- Inform that you will need to share information with the GP and any other relevant professional involved in the girl / woman's care (e.g. Health Visitor, midwife)
- Provide and discuss leaflet on FGM in appropriate language (see section 13 of the FGM Guidance for suggested leaflets) and advise on available support

Adult female identified as FGM victim and no female children or pregnant women in the family / household.

Treat as **LOW / FUTURE risk**

- Discuss with woman
- Ongoing preventative work with woman & family recommended
- Refer to services to manage psychological / physical / legal impact

- Inform GP with consent
- Flag internal records

Adult female identified as FGM victim and unborn child / female child(ren) in family / household. No FGM or signs of imminent FGM identified in them.

Treat as **LOW / FUTURE risk**

- Discuss with family **if safe to do so**
- Ongoing preventative work with woman & family recommended
- Refer to services to manage psychological / physical / legal impact

- Inform GP & other relevant services (eg midwife, social worker, health visitor). If consent is not given professionals may wish to reconsider risk level risk
- Flag internal records

Female child(ren)/ vulnerable adult* in family/ household and:

- Suspicion FGM has occurred
- Signs of possible procedure suspected
- Signs procedure is planned / imminent

Treat as **HIGH / IMMEDIATE risk**

- Refer child to Children's Social Care using Multi-Agency Referral Form (MARF)
- Refer vulnerable adult to Adult Social Care
- Call Police on 999 if immediate action required

Female child(ren) / vulnerable adult* in family / household already subjected to FGM – confirmed by disclosure or evident upon examination.

Treat as **HIGH / IMMEDIATE risk**

- Refer child to Children's Social Care using MARF. Agencies subject to **Mandatory Reporting Duty** must also report to Police on 101
- Consider referring vulnerable adult to Adult Social Care
- Call Police on 999 if immediate action required

For child: Multi-agency strategy discussion led by Children's Social Care

- Legal advice may sought and action taken
- Consider if medical examination at SARC (Sexual Assault Referral Centre) is required
- Section 47 Enquiry which may lead to Child Protection Conference and Plan
- If Child Protection Plan is not keeping girl safe from harm, Children's Social Care will consider legal proceedings including FGM Prevention Order, Supervision Order or Care Order.

For vulnerable adult: Multi-agency response to be agreed in-line with local safeguarding procedures.

9.3. All professionals are encouraged to complete a risk screening tool for any case of FGM, whether it is known or suspected. This will help with the assessment of the situation, decision making and record keeping. A screening tool is provided at Appendix A.

9.4. **In all cases, professionals should consider dialling 999 if immediate Police action is needed.**

9.5. In cases where it is **known that a child has undergone FGM** (if a professional has seen evidence of it or heard about it directly from the child) professionals must make a referral to Children's Social Care using the Multi Agency Referral Form (MARF). Regulated professionals working within health or social care, and teacher, must also act in accordance with the FGM Mandatory Reporting Duty (see section 12) by reporting the case without delay to the police on 101.

9.6. If there are reasons to **suspect that a child has been abused through FGM**, (for example, see signs and symptoms listed in Section 7), the professional or the Safeguarding Lead from the organisation should make a referral to Children's Social Care using the MARF.

9.7. In cases where it is **known or suspected that a vulnerable adult has undergone FGM**, the professional should consider making a referral to Adult Social Care. Consideration should be given to how recently the FGM was undertaken and the impact on the individual. If there are any doubts about whether a referral should be made, the professional can ring the Multi-Agency Safeguarding Hub (MASH) for advice on 0800 137 915.
* In this content, a vulnerable adult is defined as someone who has care and support needs.[1]

9.8. If there is a perception that **a child may be at risk of FGM in the future** it is important to determine whether this risk is high and immediate, or low and future. All professionals should complete an FGM risk screening tool (see Appendix A) to help with the assessment of the situation, decision making and record keeping.

9.9. If there is concern that a **vulnerable adult may be at risk of FGM in the future** it is important to determine whether this risk is high and immediate, or low and future. All professionals should complete an FGM risk screening tool (see Appendix A) to help with the assessment of the situation, decision making and record keeping.
* In this content, a vulnerable adult is defined as someone who has care and support needs.[2]

[1] The Care Act 2014 sets out a minimum threshold in term of adult care and support needs: www.legislation.gov.uk/ukpga/2014/23/contents/enacted

9.10. An example of a high/immediate level of risk is if a girl is talking about a 'special' ceremony, going on a long holiday, or if a woman who has had FGM and gave birth to a girl admits to be supporting the practice.

9.11. An example of a low/future level of risk is when a woman who has had FGM and gave birth to a girl speaks against cutting her daughter.

9.12. Professionals should see to undertake a holistic assessment of the family given the pressure to undertake FGM can come from other members of the family such as female family elders.

9.13. In all cases the risk to other female children in the family and extended family must be considered, and all parents/carers should be given information on FGM explaining that it is illegal to carry it out in the UK or to take their child abroad and they have a statutory responsibility to protect their child from this practice.

9.14. If it has been determined that the risk is high/immediate it is important to act quickly – before the child is abused by being subjected to FGM in the UK, or taken abroad to undergo the procedure.

9.15. Every attempt should be made to work with parents to prevent abuse of FGM occurring. All professionals should ensure that parental co-operation is achieved wherever possible, including the use of community organisations and / or community leaders to facilitate the work with parents / family.

9.16. However, if it is not possible to reach an agreement and if the parents cannot guarantee that they will not proceed with the mutilation, the first priority is protection of the girl / woman and appropriate measures should be taken such as an Emergency Protection Order, Police Protection or an FGM Prevention Order should be sought.

9.17. There may be cases where the risk is determined as low at the time of the assessment, for example if a mother who has had FGM speaks against mutilating her daughter. However, as the child is growing up the risk might change from low to high and it is important that all agencies follow their internal procedures, and complete and attach an appropriate risk screening tool to the child's health records for future reference.

9.18. Regardless of the age of the girl or woman, or when the procedure took place, all professionals should make appropriate referrals to support those suffering from the physical or emotional consequences of FGM.

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[2] The Care Act 2014 sets out a minimum threshold in term of adult care and support needs: www.legislation.gov.uk/ukpga/2014/23/contents/enacted

9.19. There is no requirement for automatic referral of other adult women with FGM to adult social services or the police. Healthcare professionals should be aware that any disclosure may be the first time that a woman has ever discussed her FGM with anyone. Referral to the police must not be introduced as an automatic response when identifying adult women with FGM, and each case must continue to be individually assessed. Healthcare professionals should seek to support women by offering referral to specialist organisations that can provide support, and for possible clinical intervention or other services as appropriate. The wishes of the woman must be respected at all times.

10. Health professionals

10.1. Health professionals in GP surgeries, sexual health clinics and maternity services are the most likely to encounter a girl or woman who has been subjected to FGM. A question about FGM should be incorporated when the routine patient history is being taken and professionals should consider the advice provided in Section 13 about talking to a child or woman about FGM.

11. Information Sharing

11.1. As with any form of child abuse, when FGM / risk of FGM is identified it is important that information is shared appropriately with relevant professionals. This will help ensure the right measures are put in place to safeguard against the risk of FGM or to meet the physical and psychological needs of those who have undergone FGM.

11.2. You should discuss openly with the girl / woman and, where possible, with the parents of a girl, how, why and with whom information will be shared and seek their consent. **However, be aware that by alerting a girl's family, you may place her at increased risk of harm.** Professionals should take this into account and remember that consent for information sharing is not required where there is evidence the child is suffering or at risk of suffering significant harm, or in order to prevent a criminal offence from taking place.

11.3. The risk of FGM can change over time and if information has been shared then professionals who are in contact with a child in the future may be in a good position to spot signs of imminent or actual FGM. For example, if a midwife has shared information with a GP that a mother has had FGM, when her daughter attends the GP Practice with urine and stomach problems this may prompt early questioning about possible FGM.

11.4. Information should always be shared in line with the BSCB Information Sharing Code of Practice and the Government's information sharing advice for safeguarding practitioners.

11.5. The multi-agency pathway diagram provides further guidance on information sharing in relation to FGM. However, if you are unsure whether you can share information, then please refer to the BSCB Information Sharing Code of Practice and the government guidance. If you are in doubt, speak to your designated safeguarding lead as soon as possible.

11.6. For known cases of FGM, those agencies subject to the Mandatory Reporting Duty must share information in order to make a report (see below). Whilst it is good practice to discuss that you will need to share information to make a report, consent is not required. In cases where mandatory reporting has taken place, this does not negate the need to share information with other relevant professionals.

12. Mandatory Reporting

12.1. On the 31st October 2015 a new duty was introduced that requires all regulated professionals working within health or social care, and teachers, to report 'known' cases of FGM in girls aged under 18 to the police. This is an individual rather than a corporate duty.

12.2. 'Known' cases are those where either a girl discloses that FGM has been carried out on her, or where a professional observes physical signs on a girl appearing to show that FGM has been carried out. For example, if a doctor sees that a girl aged under 18 has had FGM they will need to make a report to the police. Similarly if a girl tells her teacher that she has had FGM, the teacher will need to report this to the police.

12.3. To make a report you should call the Police on 101 and state you wish to make a report under the FGM mandatory reporting duty. Reports should be made as soon as possible after the FGM is discovered, and best practice is to complete the report by the close of the next working day.

12.4. All agencies should ensure relevant frontline staff understand this duty and how to make a report. The professional consequences for failing to report a known case of FGM in a child are very serious.

12.5. Professionals subject the duty and their employers should refer to the government guidance on mandatory reporting. This includes a list of those professionals covered by the report and more detail on how to make a report.

12.6. The government has also published additional information on the mandatory duty for health care professionals in England

13. The FGM Enhanced Dataset

13.1. Some agencies will also need to submit data on FGM to the FGM Enhanced Dataset.

13.2. This dataset was set up to collect information on the prevalence of FGM from across the NHS in order to support a response to FGM that is based on an understanding of need. The Information Standard (SCC 12026 FGM Enhanced Dataset) requires clinicians across all NHS healthcare settings to record in clinical notes when patients with FGM are identified, and what type it is.

13.3. It became mandatory for all acute trusts to collect and submit the FGM Enhanced Dataset from 1st July 2015 and all mental health trusts and GPs from 1st October 2015. Community services within mental health trusts can participate. Sexual Health and GUM clinics do not need to submit FGM information but the legal obligation to appropriately share information for safeguarding purposes still applies.

13.4. All relevant agencies should ensure their staff are familiar with these requirements. Further information on the dataset can be found at www.digital.nhs.fgm.

14. Talking to women and children

14.1. Professionals discussing FGM with a child or woman suspected to be abused through FGM should tailor their response appropriately, including:

- Arranging for an interpreter if this is necessary and appropriate (avoid using a family member as an interpreter)
- Creating an opportunity for the child / woman to disclose, seeing the child / woman on their own
- Using simple language and asking straightforward questions
- Giving the opportunity to be accompanied by someone they know and trust
- Using terminology that the child / woman will understand, e.g. the child / woman may not view the procedure as abusive
- Being sensitive to the fact that the child / woman will be loyal to their parents
- Being willing to listen and giving the child / woman time to talk
- Getting accurate information about the urgency of the situation, if the child is at risk of being subjected to the procedure
- Giving the message that the child / woman can come back to you again
- Being sensitive to the intimate nature of the subject
- Making no assumptions

- Being non-judgemental (condemning the practice, but not blaming the girl/woman)
- Understanding how she may feel in terms of language barriers, culture shock, that she, her partner, her family are being judged
- 'Circumcised' is not medically correct and although 'mutilation' is the most appropriate term, it might not be understood or it may be offensive to a woman from a practising community who does not view FGM in that way. Different terminology will be appropriate to the different cultures (see Appendix C)
- Giving a clear explanation that FGM is illegal and that the law can be used to help the family avoid FGM if / when they have daughters
- Carrying out Mental Capacity Assessment as necessary

14.2. Professionals can refer to 'Key questions for interviewing women with FGM' (Appendix B) to start a conversation on FGM. The following leaflets may also be useful for practitioners who are discussing FGM with women and children:

- FGM: The Facts (Home Office)
- More about FGM (Department of Health) – available in several different languages
- A guide on FGM for young people (Forward UK)

15. Requests for re-infibulation

15.1. After childbirth, a girl / woman who has been deinfibulated (a surgical procedure to open up the scar tissue to restore the normal vaginal opening, commonly called a 'reversal') may request re-infibulation. All girls / women who have undergone FGM (and their partners or husbands) must be told that re-infibulation is against the law and will not be done under any circumstances. Each woman should be offered counselling to address how things will be different for her afterwards.

15.2. If a woman continues to request re-infibulation this should be treated as a potential child protection concern, as the girl / woman's apparent reluctance to comply with UK law, may have implications for her own children if they are female. Professionals should consult with their agency's designated safeguarding lead and make a referral to Children's Social Care using the MARF.

16. Interpreters and Independent Mental Capacity Advocates

16.1. Wherever possible, a professional female interpreter should be used for a girl / woman known to have limited English. This will reduce misunderstanding, increase the likelihood of identification of FGM and any additional physical, psychological and social concerns. Use of family

members is not advised as they may influence decisions and inhibit true expression of the woman's feelings.

16.2. Always brief / debrief the interpreter, explain the purpose of the meeting, ensure they understand the issue and are happy to talk about FGM. We must remain aware that the interpreter may have experienced FGM, hence may have difficulty discussing it. Alternatively, they may view FGM as a valuable practice, hindering the interpretation process.

16.3. Always check that the girl / woman is happy to continue with the chosen interpreter, as communities affected by FGM are often small and therefore interpreters may be known socially by the girl / woman. The importance of confidentiality should be stressed to all parties involved.

16.4. In the case of an adult with care and support needs, it may be necessary to appoint an Independent Mental Capacity Advocate (IMCA) to support them with decision making. Further information, including how to book n IMCA can be found at: www.pohwer.net/buckinghamshire

Appendix A FGM Screening Tool / Risk Assessment

This section provides 4 short risk assessments that can be used by relevant professionals in the following scenarios:

1. **Child under 18 years old:** Use when considering whether a child has had FGM

2. **Child under 18 years old:** Use when considering whether a child may be at risk of FGM or whether there are other children in the family for whom a risk assessment may be required.

3. **Non-Pregnant woman over 18 years old:** Use when considering whether any female children are at risk of FGM, whether there are any other children in the family for whom a risk assessment may be required, or whether the woman herself is at risk of further harm in relation to FGM.

4. **Pregnant woman:** Use when considering whether the unborn child, or other female children in the family are at risk of FGM or whether the woman herself is at risk of further harm in relation to FGM.

NB, all of these assessments tools can also be used for adults with care and support needs.

FGM Risk Assessment Tool for Child or Young Adult (under 18)

Please use this tool when considering whether a child has had FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Girl is reluctant to undergo any medical examination			
Girl has difficulty walking, sitting or standing or looks uncomfortable			
Girl finds it hard to sit still for long periods of time, which was not a problem previously			
Girl presents to GP or A&E with frequent urine, menstrual or stomach problems			
Increased emotional and psychological needs eg. withdrawal, depression, or significant change in behaviour			
Girl avoiding physical exercise or requiring to be excused from PE Lessons without a GP's letter			
Girl has spoken about having been on a long holiday to her country of origin/another country where the practice is prevalent			
Gil spends a long time in the bathroom/toilet/long periods of time away from the classroom			
HIGH OR IMMEDIATE RISK			
Girl asks for help			
Girl confides in a professional that FGM has taken place			
Mother/family member discloses that female child has had FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to Children's Social Care

Name _____
DOB _____
NHS number _____
Completed by _____
Initial/ On-going assessment

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

FGM Risk Assessment Tool for Child or Young Adult (under 18)

Please use this tool when considering whether a child is at risk of FGM, or whether there are other children in the family for whom a risk assessment may be required.

Indicator	Yes	No	Details
CONSIDER RISK			
Child's mother has undergone FGM			
Other female family members have had FGM			
Father comes from a community known to practice FGM			
A Family Elder such as Grandmother is very influential within the family and is/will be involved in the care of the girl			
Mother/Family have limited contact with people outside of her family			
Parents have poor access to information about FGM and do not know about the harmful effects of FGM or UK law			
Parents say that they or a relative will be taking the girl abroad for a prolonged period – this may not only be to a country with high prevalence, but this would more likely lead to a concern			
Girl has spoken about a long holiday to her country of origin/another country where the practice is prevalent			
Girl has attended a travel clinic or equivalent for vaccinations/anti-malarials			
FGM is referred to in conversation by the child, family or close friends of the child (see Appendix Three for traditional and local terms) – the context of the discussion will be important			
Sections missing from the Red book. Consider if the child has received immunisations, do they attend clinics etc			
Girl withdrawn from PHSE lessons or from learning about FGM - School Nurse should have conversation with child			
Girls presents symptoms that could be related to FGM – continue with questions in part 3			
Family not engaging with professionals (health, school, or other)			
Any other safeguarding alert already associated with the Always check whether family are already known to social care			

Name _____
DOB _____
NHS number _____
Completed by _____
Initial/ On-going assessment

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Indicator	Yes	No	Details
HIGH OR IMMEDIATE RISK			
A child or sibling asks for help			
A parent or family member expresses concern that FGM may be carried out on the child			
Girl has confided in another that she is to have a 'special procedure' or to attend a 'special occasion'. Girl has talked about going away 'to become a woman' or 'to become like my mum and sister'			
Girl has a sister or other female child relative who has already undergone FGM			
Family/child are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to Children's Social Care.

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

High or immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

FGM Risk Assessment Tool for Non-Pregnant Women (over 18)

Name _____
DOB _____
NHS number _____
Completed by _____
Initial/ On-going assessment

Please use this tool to help decide whether any female children are at risk of FGM, whether there are other children in the family for whom a risk assessment may be required or whether the woman herself is at risk of further harm in relation to her FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Woman already has daughters who have undergone FGM – who are over 18 years of age			
Husband/partner comes from a community known to practice FGM			
Grandmother (maternal or paternal) is influential in family or female family elder is involved in care of children			
Woman and family have limited integration in UK community			
Woman's husband/partner/other family member may be very dominant in the family and have not been present during consultations with the woman			
Woman/family have limited/ no understanding of harm of FGM or UK law			
Woman's nieces (by sibling or in-laws) have undergone FGM Please note:– if they are under 18 years you have a professional duty of care to refer to social care			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment			
Family are already known to social services – if known, and you have identified FGM within a family, you must share this information with social services			
HIGH OR IMMEDIATE RISK			
Woman/family believe FGM is integral to cultural or religious identity			
Woman already has daughters who have undergone FGM – who are under 18 years of age			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be triggered if she is found to have FGM			

Please remember: any child under 18 who has undergone FGM should be referred to Children's Social Care.

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

High or Immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

FGM Risk Assessment Tool for Pregnant Women

Please use this tool to help you make a decision as to whether the unborn child (or other female children in the family) are at risk of FGM or whether the woman herself is at risk of further harm in relation to her FGM.

Indicator	Yes	No	Details
CONSIDER RISK			
Woman comes from a community known to practice FGM			
Woman has undergone FGM herself			
Husband/partner comes from a community known to practice FGM			
A female family elder is involved/will be involved in care of children/unborn child or is influential in the family			
Woman/family has limited integration in UK community			
Woman and/or husband/partner have limited/ no understanding of harm of FGM or UK law			
Woman's nieces of siblings and/or in-laws have undergone FGM			
Woman has failed to attend follow-up appointment with an FGM clinic/FGM related appointment.			
Woman's husband/partner/other family member are very dominant in the family and have not been present during consultations with the			
Woman is reluctant to undergo genital examination			
HIGH OR IMMEDIATE RISK			
Woman already has daughters have undergone FGM			
Woman requesting reinfibulation following childbirth			
Woman is considered to be a vulnerable adult and therefore issues of mental capacity and consent should be considered if she is found to have			
Woman says that FGM is integral to cultural or religious identity			
Family are already known to social care services – if known, and you have identified FGM within a family, you must share this information with social services			

Please remember: any child under 18 who has undergone FGM should be referred to Children's Social Care

Name _____
DOB _____
NHS number _____
Completed by _____
Initial/ On-going assessment

ACTION

Ask more questions – if one indicator leads to a potential area of concern, continue the discussion in this area.

Consider risk – if one or more indicators are identified, you need to consider what action to take. If unsure whether the level of risk requires referral at this point, discuss with your named/ designated safeguarding lead.

High or immediate risk – if you identify one or more high or immediate risks, or the other risks are, by your judgement, sufficient to be considered serious, you should refer to Children's Social Care in line with the BSCB multi-agency FGM pathway

Any action taken should reflect the urgency of the situation. Where emergency measures are required consider calling the Police on 999.

Professionals subject to the mandatory reporting duty must report 'known' cases of FGM to the Police on 101.

In all cases:–

- Share information of any identified risk with the patient's GP
- Document in notes
- Discuss the health complications of FGM and the law in the UK

Appendix B: 3 Key Questions for discussing FGM with women

This is an amended version of the document developed by the Oxfordshire Safeguarding Children Board.

1. **Known FGM women:** Read any existing information you have relating to the woman and determine whether you need to go through screening tool again.

Start with a short discussion and introduction

As [health visitor/GPs/midwives] we are informed of a woman's medical history. I understand that you were cut/circumcised when you were a child. I understand that this is a sensitive subject/difficult for you. I know you have spoken about this previously to [health visitor/midwife/GP] but I would like to discuss this with you.

- *Is there anything I can help you with in this?*
- *Do you feel your daughter/s are at risk of being cut?*
- *Do you need any help or support for your own experience of being cut?*

Do FGM screening tool if this has not already been done by previous health professional. If not done and there is YES to any questions follow BSCB procedure

2. Not known if mother had FGM and her or partner from country/cultural background were FGM is significant risk.

Start with a short discussion and introduction

You / your partner are from [name country] where a high number of women are cut / circumcised when they are young girls. Women who have experienced this can find this traumatic. It affects their physical health, emotional health, childbirth and sexual relations. I would like to ask you a few questions. I appreciate this is a sensitive subject to talk about

- *Is this something that has happened to you? Have you been cut/circumcised when you were young?*
- *Has anyone in your family or partner's family been cut?*
- *Are there any influences/reasons why would you ever consider having your daughter cut/circumcised? (if yes, follow BSCB guidance)*
- *Do you feel that your daughter/s are at risk of being cut/circumcised by anyone in your family or in your circle of friends?*

If there is YES answered to any of the following, the FGM risk assessment tool should be done and BSCB procedure followed.

3. Universal

In some cultural backgrounds women are cut / circumcised when they are young girls. Women who have experienced this can find this traumatic. It affects their physical health, emotional health, childbirth and sexual relations.

- *Is this something you have knowledge or experience of?*
- *Do you need any further information?*
- *Do you need any further help or support?*

Appendix C Terms for FGM in different languages

Country	Term used for FGM	Language	Meaning
EGYPT	Thara	Arabic	Deriving from the Arabic word 'tahar' meaning to clean / purify
	Khitan	Arabic	Circumcision – used for both FGM and male circumcision
	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
ETHIOPIA	Megrez	Amharic	Circumcision / cutting
	Absum	Harrari	Name giving ritual
ERITREA	Mekhnishab	Tigregna	Circumcision / cutting
KENYA	Kutairi	Swahili	Circumcision – used for both FGM and male circumcision
	Kutairi was ichana	Swahili	Circumcision of girls
NIGERIA	Ibi / Ugwu	Igbo	The act of cutting – used for both FGM and male circumcision
	Sunna	Mandingo	Religious tradition / obligation – for Muslims
SIERRA LEONE	Sunna	Soussou	Religious tradition / obligation – for Muslims
	Bondo	Temenee	Integral part of an initiation rite into adulthood – for non Muslims
	Bondo / Sonde	Mendee	Integral part of an initiation rite into adulthood – for non Muslims
	Bondo	Mandingo	Integral part of an initiation rite into adulthood – for non Muslims
	Bondo	Limba	Integral part of an initiation rite into adulthood – for non Muslims
SOMALIA	Gudniin	Somali	Circumcision – used for both FGM and male circumcision
	Halalays	Somali	Deriving from the Arabic word 'halal' i.e. 'sanctioned' – implies purity. Used by Northern & Arabic speaking Somalis
	Qodiin	Somali	Stitching / tightening / sewing refers to infibulation
SUDAN	Khifad	Arabic	Deriving from the Arabic word 'khafad' meaning to lower (rarely used in everyday language)
	Tahoor	Arabic	Deriving from the Arabic word 'tahar' meaning to clean / purify
CHAD – the Ngama	Bagne		Used by the Sara Madjingaye
Sara subgroup	Gadja		Adapted from 'ganza' used in Central African Republic
GUINEA-BISSAU	Fanadu di Mindjer	Kriolu	Circumcision of girls

	Fanadu di Omi	Kriolu	Circumcision of boys
GAMBIA	Niaka	Mandinka	Literally to 'cut / weed clean'
	Kuyango	Mandinka	Meaning 'the affair' but also the name for the shed built for initiates
	Musolula Karoola	Mandinka	Meaning 'the womens side' / 'that which concerns women'

[i] http://www.nhs.uk/conditions/female-genital-mutilation/pages/introduction.aspx
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf
[ii] http://about-fgm.co.uk/about-fgm/world-prevalence/uk-prevalence/
http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/20105.htm
[iii]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/383075/Mandatory_Reporting_for_FGM_Consultation_Framework_v6.pdf
[iv] https://www.gov.uk/government/news/pm-hosts-girl-summit-2014-a-future-free-from-fgm-and-child-and-forced-marriage
[v] United Nations Children's Fund (2013). Female Genital Mutilation / Cutting: A Statistical overview and exploration of the dynamics of change. UNICEF, New York.
[vi] Equality Now and City University
[vii] Around 11,747 people (male and female, all ages) were recorded in the 2011 census as born in a country where FGM is practised. Approximately half of these residents were females and 61% of the population from the Black African/Caribbean ethnic group were in the 15-49 age group. Applying these proportions to the total residents who were born in a country where FGM is practised, the total number of females aged 15-49 were estimated by country of birth for Buckinghamshire and for each of the four Districts. The total number of women aged 15-49 years who may have had FGM was estimated by applying the FGM country specific prevalence to the above estimated number of women residents aged 15-49 who were born in a country where FGM is practised.
viii (World Health Organisation 2010)
ix Female genital mutilation fact sheet 2009
x (Behrendt A et al, 2005)

Buckinghamshire
BSCB
Safeguarding
Children Board

Buckinghamshire Safeguarding Children Board
BSCB Procedure: Forced Marriage
August 2015

Version Control			
Version number	**Date**	**Author**	**Comments and nature of update**
V1.0	June 2011		Original Document
V2.0	August 2015		Revised by Policies and Procedures Sub Group
V3.0	October 2015	Sandra Parsons	Updated section 6.1 National Guidance and Advice

These procedures are based on 'Multi-Agency Practice Guidelines: **Handling Cases Of Forced Marriage'**, Foreign & Commonwealth Office 2009 and 'Forced Marriage and Learning Disabilities: **Multi-Agency Practice Guidelines'**, Foreign & Commonwealth Office 2010 and are focused on aspects of safeguarding children.

A 'forced' marriage (as distinct from a consensual 'arranged' marriage) is a marriage in which one or both spouses do not and/or cannot consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure. Duress cannot be justified on religious or cultural grounds.

Honour Based Violence (HBV) may be a feature of forced marriage and the BSCB has produced further guidance which is also available on the website.

1. POSSIBLE CONSEQUENCES OF FORCED MARRIAGE

1.1 Taking of dowry, forced repatriation, female genital mutilation, acid attacks, blood feuds, honour killings, abduction and homicide.

1.2 Many of these acts fall within the definition of domestic abuse.

1.3 Forced marriages of children may involve non-consensual and/or underage sex, emotional and possibly physical abuse and should be regarded as a child protection issue and referred to children's social care.

1.4 National guidance states that 85% of those seeking help concerning forced marriage are women and so this issue is primarily, but not exclusively, an issue of violence against girls and young women.

1.5 Whilst the majority of cases encountered in the UK involve South Asian families, partly reflecting the composition of the UK population, there have been cases involving families from East Asia, the Middle East, Europe, Norway and Africa. Some forced marriages take place in the UK with no overseas element, whilst others involve a partner coming from overseas or a British citizen being sent abroad.

2. FORCED MARRIAGE AND CHILDREN WITH LEARNING DISABILITIES

2.1 Research also indicates that the forced marriage of children and adults with learning disabilities is likely to be vastly underreported and can differ from the way in which forced marriage presents generally.

Person without a learning disability	**Person with a learning disability**
Duress always a factor	Duress may manifest itself differently, the person may even appear happy about the forthcoming marriage as they may not appreciate the consequences.
Person without a learning disability	**Person with a learning disability**

Victim often reports themselves that they may be or have been forced into marriage.	May report themselves or may need support to report. May be reliant on others to recognise what is happening and report or take action. By far the majority of cases come to the attention of statutory agencies through a third party.
More females than males reported to be forced into marriage. Most support services for forced marriage focused on meeting needs of females.	In the case studies identified through this research, proportions of males and females with learning disabilities being forced into marriage are similar. Services need to address needs of males and females.
Capacity to give or withhold informed consent to marriage.	May lack capacity to give consent to marriage. May not understand they are being forced into marriage. May be more easily coerced into marriage.
May be able to obtain support themselves if leave family or community (to find work, apply for benefits, housing, medical needs and so on), though they are often supported in accessing accommodation and other support services, particularly in the short term.	Often need ongoing support from a range of professionals in order that daily living needs are met (may include personal care, helping to eat, shopping, finances, social and leisure activities, work and so on). May need specific and specialist support if placed in a refuge. Males may find it difficult to obtain place of safety given limited availability of refuges to meet needs of males with or without a learning disability.

2.2 There are additional factors which may make someone with a learning disability more vulnerable. Some key motives for forcing people with learning disabilities to marry include:

- Obtaining a carer for the person with a learning disability.
- Obtaining physical assistance for ageing parents.
- Obtaining financial security for the person with a learning disability.
- Believing the marriage will somehow "cure" the disability.
- A belief that marriage is a "rite of passage" for all young people.
- Mistrust of the "system", mistrust of external (e.g. social care/health) carers.
- A fear that younger siblings may be seen as undesirable if older sons or daughters are not already married.
- The marriage being seen as the only option or the right option (or both) – no alternative.

3. LEGAL ASPECTS

3.1 **The Anti-social Behaviour, Crime and Policing Act (2014)** makes it a criminal offence to force someone to marry This includes:

- Taking someone overseas to force them to marry (whether or not the forced marriage takes place)
- Marrying someone who lacks the mental capacity to consent to the marriage (whether they're pressured to or not)
- Breaching a Forced Marriage Protection Order is also a criminal offence
- The civil remedy of obtaining a Forced Marriage Protection Order through the family courts will continue to exist alongside the new criminal offence, so victims can choose how they wish to be assisted

Forcing someone to marry can result in a sentence of up to 7 years in prison. Disobeying a Forced Marriage Protection Order can result in a sentence of up to 5 years in prison

3.2 In addition to the specific offences of forced marriage, there are still a number of other offences that may be committed. Perpetrators – usually parents or family members - may also be prosecuted for offences including threatening behaviour, assault, kidnap, abduction, theft (of passport), threats to kill, imprisonment and murder. For those under 16 other criminal offenses including cruelty to persons under 16 and child abduction may also be involved. The Crown Prosecution Service is responsible for making the decision for which offences(s) the perpetrator(s) should be prosecuted. Sexual intercourse without consent is rape, regardless of whether this occurs within a marriage or not. A woman who is forced into marriage is likely to be raped and may be raped until she becomes pregnant (WTSC 2010).

3.3 **The Forced Marriage Act (2007)** was brought in to protect those forced into marriage, whether children, teenagers or adults - and irrespective of background, gender, race or religion. The Act gives the courts a wide discretion to deal flexibly and sensitively with the circumstances of each individual case, employing civil remedies that will offer protection to victims without criminalising members of their family.

3.4 The Act gives victims the power to get Forced Marriage Protection Orders from the courts in whatever circumstances they find themselves. Under the Act, the court can order those forcing another into marriage to stop; or impose requirements upon them. If a person fails to comply with the court order they could be sent to prison for contempt of court.

3.5 Not all victims will be able to apply personally to the courts for protection. Some might not want to take court action against members of their own family. Where this happens the intention is that other people or organisations can step in on their behalf.

3.6 **The Mental Capacity Act 2005** aims to empower people to make decisions about their own lives where possible and protects those who lack capacity. If a person does not consent or lacks capacity to consent to a marriage, that marriage must be viewed as a forced marriage whatever the reason for the marriage taking place. www.legislation.gov.uk/ukpga/2005/9

4. RECOGNITION

4.1 Victims of existing or prospective forced marriages may be fearful of discussing their worries with friends and teachers; however they may come to the attention of professionals, those working in community groups or in a voluntary capacity due to various behaviours or circumstances consistent with distress. These may include factors relating to:

Education

- Absence and persistent absence
- Request for extended absence and failure to return from visits to country of origin
- Fear about forthcoming school holidays
- Surveillance by siblings or cousins at school
- Decline in behaviour, engagement, performance or punctuality
- Being withdrawn from school by those with parental responsibility
- Removal from a day centre of a person with a physical or learning disability
- Not allowed to attend extra curricular activities
- Sudden announcement of engagement to a stranger
- Prevented from going on to further/higher education

Health

- Accompanied to doctor's or clinics
- Self harm
- Attempted suicide
- Eating disorders
- Depression
- Isolation
- Substance misuse
- Early/unwanted pregnancy
- Female genital mutilation

Police

- Victim or other siblings within the family reported missing
- Reports of domestic abuse, harassment or breaches of the peace at the family home
- Female genital mutilation
- The victim reported for offences e.g. shoplifting or substance misuse
- Threats to kill and attempts to kill or harm
- Reports of other offences such as rape or kidnap
- Acid attacks

Family History

- Siblings forced to marry
- Early marriage of siblings
- Self harm or suicide of siblings
- Death of a parent
- Family disputes
- Running away from home
- Unreasonable restrictions e.g. kept at home by parents ("house arrest") & financial restrictions

5. RESPONSE

5.1 The "One Chance" Rule

You may only have one chance to speak to a potential victim and thus may only have one chance to save a life. This means that all practitioners working within statutory agencies, community workers and volunteers need to be aware of their responsibilities and obligations when they identify potential forced marriage cases. If the victim is allowed to walk out of the door without support being offered, that one chance might be wasted. Everyone working with victims of forced marriage and honour-based violence need to be aware of the "one chance" rule.

5.2 First Steps in all cases

- See them immediately in a secure and private place where the conversation cannot be overheard.
- See them on their own – even if they attend with others
- Recognise and respect their wishes

- Contact, as soon as possible, the Forced Marriage Unit based at the Foreign and Commonwealth Office fmu@fco.gov.uk, www.fco.gov.uk/forcedmarriage, 020 7008 0151, or 020 7008 1500 if out of hours. They produce useful information leaflets and posters which are available to download or order from the publications link on their website.
- If the young person is under 18 years of age, refer them to the designated person with responsibility for safeguarding children and activate local safeguarding procedures
- Reassure them about confidentiality i.e. practitioners will not inform their family
- Establish a way of contacting them discreetly in the future
- Consider the need for immediate protection and placement away from the family.

5.3 DO NOT:

- Send them away
- Approach members of their family or the community unless they expressly ask you to do so
- Share information with anyone without their express consent Breach confidentiality unless it is with the information sharing protocol
- Attempt to be a mediator

5.4 Additional Steps

- If necessary, record any injuries and arrange a medical examination
- Give them personal safety advice
- Develop a safety plan in case they are seen i.e. prepare another reason why you are meeting
- Establish if there is a family history of forced marriage, e.g. siblings forced to marry.
- Other indicators may include domestic violence, self-harm, family disputes, unreasonable restrictions (e.g. withdrawal from education or "house arrest") or missing persons within the family
- Advise them not to travel overseas. Discuss the difficulties they may face Identify any potential criminal offences and refer to the police if appropriate
- Give them advice on what service or support they should expect and from whom
- Ensure that they have the contact details for the trained specialist
- Maintain a full record of the decisions made and the reason for those decisions
- Information from case files and database files should be kept strictly confidential and preferably be restricted to named members of staff only
- Refer them, with their consent, to appropriate local and national support groups, counselling services and women's groups that have a history of working with survivors of domestic abuse and forced marriage.
- Anyone threatened with forced marriage or forced to marry against their will can apply for a Forced Marriage Protection Order. Third parties, such as relatives, friends, voluntary workers and police officers, can also apply for a protection order with the leave of the court. Fifteen county courts deal with applications and make orders to prevent forced marriages. Local authorities can now seek a protection order for vulnerable adults and children without leave of the court. Guidance published by the Ministry of Justice explains how local authorities can apply for protection orders and provides information for other agencies. www.justice.gov.uk/guidance/forced-marriage.htm
- Where a case of forced marriage has resulted in the serious harm of a child or young person, practitioners should also consider undertaking a Serious Case Review.

5.5 Remember

- Circumstances may be more complex if the young person is lesbian, gay, bisexual or transgender.
- British Embassies and High Commissions can only help British nationals or, in certain circumstances EU or Commonwealth nationals. This means that if a non-British national leaves the UK to be forced into marriage overseas, the British Embassy or High Commission will not be able to assist them.
- If in doubt, ask the Forced Marriage Unit for advice.

6. NATIONAL GUIDANCE & ADVICE

6.1 Professionals working in this field should be familiar with:

- **The Right to Choose:** Multi-agency statutory guidance for dealing with forced marriage (HM Government, 2014): www.gov.uk/government/uploads/system/uploads/attachment_data/file/322310/HMG_Statutory_Guidance_publication_180614_Final.pdf

- Multi-Agency Practice Guidelines: **Handling Cases Of Forced Marriage** (HM Government, 2014): www.gov.uk/government/uploads/system/uploads/attachment_data/file/322307/HMG_MULTI_AGENCY_PRACTICE_GUIDELINES_v1_180614_FINAL.pdf

- Forced Marriage And Learning Disabilities: **Multi-Agency Practice Guidelines** (HM Government, 2010) www.gov.uk/government/uploads/system/uploads/attachment_data/file/141824/Forced_Marriage_and_learning_disabilities_guidelines_FINAL.PDF

- The Forced Marriage Unit (FMU) is Government's central unit dealing with forced marriage casework, policy and projects. The FMU provides confidential information and assistance to potential victims and concerned professionals: www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage/

- The FMU guide for LGBT people: http://www.bucks-lscb.org.uk/wp-content/uploads/Professionals_Protocol_and_Guidance_Forced_Marriage/Leaflet_for_LGBT.pdf

- The FMU Survivors Handbook: http://www.bucks-lscb.org.uk/wp-content/uploads/Professionals_Protocol_and_Guidance_Forced_Marriage/Survivors_Handbook.pdf

- The FMU e-learning training package complements the multi-agency practice guidelines for professionals. You can access the course on the Forced marriage eLearning website

6.2 FMU staff can offer advice and assistance to individuals who:

- Fear they will be forced into a marriage (in UK or overseas)

- Fear for a friend or relative who may be forced into a marriage (in the UK or overseas)
- Have been forced into a marriage and do not want to support their spouse's visa application

Buckinghamshire

BSCB

Safeguarding Children Board

Buckinghamshire Safeguarding Children Board
BSCB Procedure: Honour Based Violence
September 2013

Version Control			
Version number	Date	Author	Comments and nature of update
V1.0	May 2011		Original Document
V2.0	September 2013		Revised by Policies and Procedures Sub Group

1. Introduction

1.1 Honour based violence is the term used to describe murders in the name of so-called honour, sometimes called 'honour killings'. These are murders in which predominantly women are killed for perceived immoral behaviour, which is deemed to have breached the honour code of a family or community, causing shame.

1.2 The Police definition of so-called honour based violence is: 'a crime or incident, which has or may been committed to protect or defend the honour of the family and/or community'.

1.3 Professionals should respond in a similar way to cases of honour violence as with domestic violence and forced marriage (i.e. in facilitating disclosure, developing individual safety plans, ensuring the child's safety by according them confidentiality in relation to the rest of the family, completing individual risk assessments etc). See BSCB procedures for Domestic violence and Forced marriage.

1.4 Victims from black or ethnic minority groups, where the violence is perpetrated by extended family members or relate to forced marriage issues, may be more isolated due to religious and/or cultural pressures, language barriers, having no recourse to public funds or fear of bringing shame to their 'family honour'.

Procedures

These procedures should be read in conjunction with BSCB procedures for Domestic Violence, and where appropriate, BSCB procedures for Forced Marriage.

2. Recognition

2.1 A child who is at risk of honour based violence is at significant risk of physical harm (including being murdered) and/or neglect, and may also suffer significant emotional harm through the threat of violence or witnessing violence directed towards a sibling or other family member.

2.2 Honour based violence cuts across all cultures and communities, and cases encountered in the UK have involved families from Turkish, Kurdish, Afghani, South Asian, African, Middle Eastern, South and Eastern European communities. This is not an exhaustive list.

2.3 The perceived immoral behaviour which could precipitate a murder include:

- Inappropriate make-up or dress;
- The existence of a boyfriend;
- Kissing or intimacy in a public place;
- Rejecting a forced marriage;
- Pregnancy outside of marriage;
- Being a victim of rape;
- Inter-faith relationships;
- Leaving a spouse or seeking divorce.

2.4 Murders in the name of 'so-called honour' are often the culmination of a series of events over a period of time and are planned. There tends to be a degree of premeditation, family conspiracy and a belief that the victim deserved to die.

2.5 Incidents, in addition to those listed above, which may precede a murder include:

- Physical abuse;
- Emotional abuse, including:
  - house arrest and excessive restrictions
  - denial of access to the telephone, internet, passport and friends
  - threats to kill
- Pressure to go abroad. Victims are sometimes persuaded to return to their country of origin under false pretences, when in fact the intention could be to kill them.

2.6 Children sometimes truant from school to obtain relief from being controlled at home by relatives. They can feel isolated from their family and social networks and become depressed, which can on some occasions lead to self-harm or suicide.

2.7 Families may feel shame long after the incident that brought about dishonour occurred, and therefore the risk of harm to a child can persist. This means that the young person's new boy/girlfriend, baby (if pregnancy caused the family to feel 'shame'), associates or siblings may be at risk of harm.

3. Disclosure and response

3.1 When receiving a disclosure from a child, professionals should recognise the seriousness / immediacy of the risk of harm.

3.2 For a child to report to any agency that they have fears of honour based violence in respect of themselves or a family member requires a lot of courage, and trust that the professional / agency they disclose to will respond appropriately. Specifically, under no circumstances should the agency allow the child's family or social network to find out about the disclosure, so as not to put the child at further risk of harm.

3.3 Authorities in some countries may support the practice of honour-based violence, and the child may be concerned that other agencies share this view, or that they will be returned to their family. The child may be carrying guilt about their rejection of cultural / family expectations. Furthermore, their immigration status may be dependent on their family, which could be used to dissuade them from seeking assistance.

3.4 Where there is a disclosure of suspicion of honour based violence, staff in all agencies/organisations should respond immediately by referring to Social Care First Response Team, or where there is imminent risk, directly to the Police.

3.5 Referring agencies should make an assessment of risk of harm using a dedicated assessment tool e.g. DASH (http://www.caada.org.uk/)

3.6 The Social Care and Police response should include:

- Seeing the child immediately in a secure and private place;
- Seeing the child on their own;
- Explaining to the child the limits of confidentiality;
- Asking direct questions to gather enough information to make a referral to LA children's social care and the police, including recording the child's wishes;
- Encouraging and/or helping the child to complete a personal risk assessment

- Developing an emergency safety plan with the child;
- Agreeing a means of discreet future contact with the child;
- Explaining that a referral to children's social care and the police will be made (See Individual Case Management Procedures – Section 5)
- Record all discussions and decisions (including rationale if no decision is made to refer to children's social care).

3.7 Professionals should not approach the family or community leaders, share any information with them or attempt any form of mediation. In particular, members of the local community should not be used as interpreters.

3.8 All multi-agency discussions should recognise the police responsibility to initiate and undertake a criminal investigation as appropriate.

3.9 Multi-agency planning should consider the need for providing suitable safe accommodation for the child, as appropriate.

3.10 If a child is taken abroad, the Foreign and Commonwealth Office may assist in repatriating them to the UK.

https://www.gov.uk/government/organisations/foreign-commonwealth-office

Islamic Rules for Children Fasting in UK Primary and Secondary Schools

1. In Islamic law, children are not required to fast during Ramadan: they are only required to fast when they become adults.

2. a) The age of adulthood is disputed: some traditional views look at only biological factors, i.e. puberty. This usually equates to 12-15 years old for boys and 9-15 years old for girls (depending on when their periods start).

b) The stronger traditional view is that emotional and intellectual maturity is also required for adulthood, ie 15-20 years old for both sexes. [This view is found in all four of the main Sunni schools of law - cf. Sheikh Wahba Zuhayli's *Al-Fiqh al-Islami wa adillatuhu* (Islamic Jurisprudence and its Evidential Bases); the age of 18 or 19 was often mentioned classically as true adulthood.]

3. In Islamic tradition, children are often encouraged to fast, even though it is not a legal requirement, in order to prepare them for adulthood. The situation here is analogous to that of prayer (5 times a day), which is also expected of adults. For prayer, the ages of 7-10 are traditionally when they begin. Hence, many parents introduce their children to fasting at a similar age.

4. In Islamic law, the health of an individual is the first priority after their faith. This is why adults are exempt from fasting if they are sick or face other hardships that make fasting too difficult, eg travelling or unduly laborious or safety-critical work, e.g. medical surgeons or airline pilots.

5. In Islamic law, the decisions of relevant authorities in disputed matters are upheld and respected, eg court judgments or school policy.

6. Hence, if a school has a policy on fasting in the best interest of children, with input from Muslim parents, governors and leaders, parents are obliged by Islamic law to abide by that policy, even if it goes against their wishes.

7. Violation of such a policy by parents would entail going against their religion in two ways:

(i) by breaking their agreement with the school to abide by its policy and rules; and

(ii) by mistreating their child, since the school policy and Islamic law have the same purpose, ie to safeguard the health and education of the child.

8. a) Since social services have the same aim as Islamic law also, ie to safeguard children, a school's referral to them would also be in accordance with Islam.

b) Such a step is not ideal, of course, because of the status and importance of parents and the parent-child relationship in both Islam and UK society, and all attempts should be made to reach agreement such that a referral is not necessary.

Sheikh Dr. Usama Hasan – London, July 2013 (Ramadan 1434)

HM Government

Revised *Prevent* Duty Guidance: for England and Wales

Guidance for specified authorities in England and Wales on the duty in the Counter-Terrorism and Security Act 2015 to have due regard to the need to prevent people from being drawn into terrorism.

Originally issued on 12th March 2015 and revised on 16th July 2015

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A. Status and Scope of the Duty

Statutory guidance issued under section 29 of the Counter-Terrorism and Security Act 2015.

1. Section 26 of the Counter-Terrorism and Security Act 2015 (the Act) places a duty on certain bodies ("specified authorities" listed in Schedule 6 to the Act), in the exercise of their functions, to have "due regard to the need to prevent people from being drawn into terrorism". This guidance is issued under section 29 of the Act. The Act states that the authorities subject to the provisions must have regard to this guidance when carrying out the duty.

2. The list of specified authorities subject to the provisions can be found in Schedule 6 to the Act. Further details can be found in the sector-specific sections of this guidance.

3. The duty applies to specified authorities in England and Wales, and Scotland. Counter terrorism is the responsibility of the UK Government. However, many of the local delivery mechanisms in Wales and Scotland, such as health, education and local government, are devolved. We will ensure close cooperation with the Scottish and Welsh Governments in implementing the Prevent duty where there are interdependencies between devolved and non-devolved elements. There is separate guidance for specified authorities in Scotland.

4. The duty does not confer new functions on any specified authority. The term "due regard" as used in the Act means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions. This purpose of this guidance is to assist authorities to decide what this means in practice.

B. Introduction

5. The Prevent strategy, published by the Government in 2011, is part of our overall counter-terrorism strategy, CONTEST. The aim of the *Prevent* strategy is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. In the Act this has simply been expressed as the need to "prevent people from being drawn into terrorism".

6. The 2011 *Prevent* strategy has three specific strategic objectives:

- respond to the ideological challenge of terrorism and the threat we face from those who promote it;
- prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support; and
- work with sectors and institutions where there are risks of radicalisation that we need to address.

7. Terrorist groups often draw on extremist ideology, developed by extremist organisations. Some people who join terrorist groups have previously been members of extremist organisations and have been radicalised by them. The Government has defined extremism 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".

8. The *Prevent* strategy was explicitly changed in 2011 to deal with all forms of terrorism and with non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists then exploit. It also made clear that preventing people becoming terrorists or supporting terrorism requires challenge to extremist ideas where they are used to legitimise terrorism and are shared by terrorist groups. And the strategy also means intervening to stop people moving from extremist (albeit legal) groups into terrorist-related activity.

9. Our *Prevent* work is intended to deal with all kinds of terrorist threats to the UK. The most significant of these threats is currently from terrorist organisations in Syria and Iraq, and Al Qa'ida associated groups. But terrorists associated with the extreme right also pose a continued threat to our safety and security.

10. Islamist extremists regard Western intervention in Muslim-majority countries as a 'war with Islam', creating a narrative of 'them'and'us'. Their ideology includes the uncompromising belief that people cannot be both Muslim and British, and that Muslims living here should not participate in our democracy. Islamist extremists specifically attack the principles of civic participation and social cohesion. These extremists purport to identify grievances to which terrorist organisations then claim to have a solution.

11. The white supremacist ideology of extreme right-wing groups has also provided both the inspiration and justification for people who have committed extreme right-wing terrorist acts.

12. In fulfilling the duty in section 26 of the Act, we expect all specified authorities to participate fully in work to prevent people from being drawn into terrorism. How they do this, and the extent to which they do this, will depend on many factors, for example, the age of the individual, how much interaction they have with them, etc. The specified authorities in Schedule 6 to the Act are those judged to have a role in protecting vulnerable people and/or our national security. The duty is likely to be relevant to fulfilling other responsibilities such as the duty arising from section 149 of the Equality Act 2010.

13. This guidance identifies best practice for each of the main sectors and describes ways in which they can comply with the duty. It includes sources of further advice and provides information on how compliance with the duty will be monitored. Sector-specific guidance for Further Education and Higher Education institutions subject to the Prevent duty has been published separately and should be read alongside this guidance.

C. A risk-based approach to the *Prevent* duty

14. In complying with the duty all specified authorities, as a starting point, should demonstrate an awareness and understanding of the risk of radicalisation in their area, institution or body. This risk will vary greatly and can change rapidly; but no area, institution or body is risk free. Whilst the type and scale of activity that will address the risk will vary, all specified authorities will need to give due consideration to it.

15. There are three themes throughout the sector-specific guidance, set out later in this document: effective leadership, working in partnership and appropriate capabilities.

Leadership

16. For all specified authorities, we expect that those in leadership positions:

- estalish or use existing mechanisms for understanding the risk of radicalisation;
- ensure staff understand the risk and build the capabilities to deal with it;

- communicate and promote the importance of the duty; and
- ensure staff implement the duty effectively.

Working in partnership

17. Prevent work depends on effective partnership. To demonstrate effective compliance with the duty, specified authorities must demonstrate evidence of productive co-operation, in particular with local Prevent co-ordinators, the police and local authorities, and co-ordination through existing multi-agency forums, for example Community Safety Partnerships.

Capabilities

18. Frontline staff who engage with the public should understand what radicalisation means and why people may be vulnerable to being drawn into terrorism as a consequence of it. They need to be aware of what we mean by the term "extremism" and the relationship between extremism and terrorism (see section B, above).

19. Staff need to know what measures are available to prevent people from becoming drawn into terrorism and how to challenge the extremist ideology that can be associated with it. They need to understand how to obtain support for people who may be being exploited by radicalising influences.

20. All specified authorities subject to the duty will need to ensure they provide appropriate training for staff involved in the implementation of this duty. Such training is now widely available.

Sharing information

21. The *Prevent* programme must not involve any covert activity against people or communities. But specified authorities may need to share personal information to ensure, for example, that a person at risk of radicalisation is given appropriate support (for example on the Channel programme). Information sharing must be assessed on a case-by-case basis and is governed by legislation. To ensure the rights of individuals are fully protected, it is important that information sharing agreements are in place at a local level. When considering sharing personal information, the specified authority should take account of the following:

- necessity and proportionality: personal information should only be shared where it is strictly necessary to the intended outcome and proportionate to it. Key to determining the necessity and proportionality of sharing information will be the professional judgement of the risks to an individual or the public;
- consent: wherever possible the consent of the person concerned should be obtained before sharing any information about them;
- power to share: the sharing of data by public sector bodies requires the existence of a power to do so, in addition to satisfying the requirements of the Data Protection Act 1998 and the Human Rights Act 1998;
- Data Protection Act and the Common Law Duty of Confidentiality: in engaging with non-public bodies, the specified authority should ensure that they are aware of their own responsibilities under the Data Protection Act and any confidentiality obligations that exist.

22. There may be some circumstances where specified authorities, in the course of *Prevent*-related work, identify someone who may already be engaged in illegal terrorist-related activity. People suspected of being involved in such activity must be referred to the police.

D. Monitoring and enforcement

23. All specified authorities must comply with this duty and will be expected to maintain appropriate records to show compliance with their responsibilities and provide reports when requested.

Central support and monitoring

24. The Home Office currently oversees *Prevent* activity in local areas which have been identified as priorities for this programme, and will provide central monitoring for the new duty. The Home Office shares management (with local authorities) of local *Prevent* co-ordinator teams.

25. The Home Office will:

- draw together data about implementation of Prevent from local and regional Prevent co-ordinators (including those in health, further and higher education), the police, intelligence agencies and other departments and inspection bodies where appropriate;
- monitor and assess Prevent delivery in up to 50 Prevent priority areas;
- maintain contact with relevant departments and escalate issues to them and inspectorates where appropriate;
- support the *Prevent* Oversight Board, chaired by the Minister for Immigration and Security, which may agree on further action to support implementation of the duty.

26. Where a specified body is not complying with the duty, the *Prevent* Oversight Board may recommend that the Secretary of State use the power of direction under section 30 of the Act. This power would only be used when other options for engagement and improvement had been exhausted. The power would be used only to ensure the implementation and delivery of the *Prevent* duty. It is also capable of being exercised in respect of Welsh specified authorities, and would be used following consultation with Welsh Ministers.

Inspection regime in individual sectors

27. Central support and monitoring will be supported by existing inspection regimes in specific sectors. Not every specified authority has a suitable inspection regime and in some areas it may be necessary to create or enhance existing regimes.

28. We will work with the Welsh Government on *Prevent* monitoring arrangements and provide support to Welsh inspection regimes as required.

E. Sector-specific guidance

Local authorities

29. With their wide-ranging responsibilities, and democratic accountability to their electorate, local authorities are vital to *Prevent* work. Effective local authorities will be working with their local partners to protect the public, prevent crime and to promote strong, integrated communities.

Specified local authorities

30. The local authorities that are subject to the duty are listed in Schedule 6 to the Act. They are:

- a county council or district council in England;
- the Greater London Authority;
- a London borough council;
- the Common Council of the City of London in its capacity as a local authority;
- the Council of the Isles of Scilly;
- a county council or county borough council in Wales; and
- a person carrying out a function of an authority mentioned in section 1 (2) of the Local Government Act 1999 by virtue of a direction made under section 15 of that Act.

31. Other local authorities, including stand-alone fire and rescue authorities, are not listed in the Act and are not subject to the duty, but it is anticipated, considering their wider prevention role, that in many areas they will be partners in local efforts to prevent people from being drawn into terrorism.

32. In fulfilling the new duty, local authorities, including elected members and senior officers should be carrying out activity in the following areas.

Partnership

33. Local authorities should establish or make use of an existing local multi-agency group to agree risk and co-ordinate *Prevent* activity. Many local authorities use Community Safety Partnerships but other multi-agency forums may be appropriate.

34. It is likely that links will need to be made to other statutory partnerships such as Local Safeguarding Children Boards Safeguarding Adults Boards, Channel panels and Youth Offending Teams.

35. It will be important that local or regional *Prevent* co-ordinators have access to senior local authority leadership to give advice and support.

36. We expect local multi-agency arrangements to be put in place to effectively monitor the impact of *Prevent* work.

37. *Prevent* work conducted through local authorities will often directly involve, as well as have an impact on local communities. Effective dialogue and coordination with community-based organisations will continue to be essential.

Risk assessment

38. We expect local authorities to use the existing counter-terrorism local profiles (CTLPs), produced for every region by the police, to assess the risk of individuals being drawn into terrorism. This includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit. Guidance on CTLPs is available here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118203/counter-terrorism-local-profiles.pdf

39. This risk assessment should also be informed by engagement with Prevent co-ordinators, schools, registered childcare providers, universities, colleges, local prisons, probation services, health, immigration enforcement Youth Offending Teams and others, as well as by a local authority's own knowledge of its area.

40. We would expect local authorities to incorporate the duty into existing policies and procedures, so it becomes part of the day-to-day work of the authority. The duty is likely to be relevant to fulfilling safeguarding responsibilities in that local authorities should ensure that there are clear and robust safeguarding policies to identify children at risk. This guidance should be read in conjunction with other relevant safeguarding guidance, in particular Working Together to Safeguard Children (https://www.gov.uk/government/publications/working-together-to-safeguard-children).

Action plan

41. With the support of co-ordinators and others as necessary, any local authority that assesses, through the multi-agency group, that there is a risk should develop a Prevent action plan. This will enable the local authority to comply with the duty and address whatever risks have been identified.

42. These local action plans will identify, prioritise and facilitate delivery of projects, activities or specific interventions to reduce the risk of people being drawn into terrorism in each local authority. Many of these projects and activities will be community based.

Staff training

43. Local authorities will be expected to ensure appropriate frontline staff, including those of it's contractors, have a good understanding of Prevent are trained to recognise vulnerability to being drawn into terrorism and are aware of available programmes to deal with this issue.

44. Local authority staff will be expected to make appropriate referrals to Channel (a programme which provides support to individuals who are at risk of being drawn into terrorism which is put on a statutory footing by Chapter 2 of Part 5 of the Counter-Terrorism and Security Act 2015) and ensure that Channel is supported by the appropriate organisation and expertise. Guidance on the Channel programme can be found here:

https://www.gov.uk/government/publications/channel-guidance

Use of local authority resources

45. In complying with the duty we expect local authorities to ensure that publicly-owned venues and resources do not provide a platform for extremists and are not used to disseminate extremist views. This includes considering whether IT equipment available to the general public should use filtering solutions that limit access to terrorist and extremist material.

46. We expect local authorities to ensure that organisations who work with the local authority on Prevent are not engaged in any extremist activity or espouse extremist views.

47. Where appropriate, we also expect local authorities to take the opportunity when new contracts for the delivery of their services are being made to ensure that the principles of the duty are written in to those contracts in a suitable form.

Collaboration between areas

48. In two-tier areas, county and district councils will need to agree proportionate arrangements for sharing the assessment of risk and for agreeing local *Prevent* action plans. It is expected that neighbouring areas will also agree proportionate arrangements for sharing the assessment of risk and for agreeing local *Prevent* action plans as appropriate.

Prevent priority areas

49. The Home Office will continue to identify priority areas for *Prevent*-related activity. Priority areas will, as now, be funded to employ a local *Prevent* co-ordinator to give additional support and expertise and additional Home Office grant funding is available for Prevent projects and activities. The Home Office will continue to have oversight of local *Prevent* co-ordinators and the funding, evaluation and monitoring of these projects.

Other agencies and organisations supporting children

50. A range of private and voluntary agencies and organisations provide services or, in some cases, exercise functions in relation to children. The duty applies to those bodies, which include, for example, children's homes and independent fostering agencies and bodies exercising local authority functions whether under voluntary delegation arrangements or via the use of statutory intervention powers. These bodies should ensure they are part of their local authorities' safeguarding arrangements and that staff are aware of and know how to contribute to *Prevent*-related activity in their area where appropriate.

Out-of-school settings supporting children

51. Many children attend a range of out-of-school settings other than childcare including supplementary schools, and tuition centres to support home education. These settings are not regulated under education law. Local authorities should take steps to understand the range of activity and settings in their areas and take appropriate and proportionate steps to ensure that children attending such settings are properly safeguarded (which should include considering whether children attending such settings are at risk of being drawn into extremism or terrorism). In assessing the risks associated with such settings, local authorities should have regard to whether the settings subscribe to voluntary accreditation schemes and any other evidence about the extent to which the providers are taking steps to safeguard the children in their care. Where safeguarding concerns arise, local authorities should actively consider how to make use of the full range of powers available to them to reduce the risks to children, including relevant planning and health and safety powers.

Monitoring and enforcement

52. In fulfilling its central monitoring role (section D above) the Home Office can (and already does) scrutinise local *Prevent* action plans, project impact and overall performance. It will also consider work with local authority 'peers' to provide targeted assistance and help authorities develop good practice.

53. The Government anticipates that local authorities will comply with this duty and work effectively with local partners to prevent people from being drawn into terrorism. Where there are concerns about compliance, the Government may need to consider the appropriateness of using existing mechanisms such as section 10 of the Local Government Act 1999. This allows the Secretary of State to appoint an inspector to assess an authority's compliance with its statutory "best value" duty in relation to one or more of the specified functions.

54. If the Secretary of State is satisfied that a council in England has failed to discharge its "best value" duty in relation to the new *Prevent* duty, it would be open to him to use his powers under Section 15 of the Local Government Act 1999 to intervene. This could include requiring the council to undertake specific actions, appointing Commissioners and transferring some of the council's functions to them. The Secretary of State must consult the council before issuing a direction. The Secretary of State may also direct a local inquiry to be held into the exercise by the authority of specified functions. Welsh Ministers' powers of intervention in relation to a Welsh council that has failed to discharge its "improvement" duties are set out in the Local Government (Wales) Measure 2009.

55. If the Secretary of State is satisfied that a local authority is failing to perform any function relating to education, childcare or children's social care to an adequate standard he may use his powers under section 497A or the Education Act 1996 (applied to childcare under section 15(3) of the Children's Act, and children's social care under section 50(1) of the Children Act 2004) to take whatever action is deemed expedient to achieve necessary improvement. In Wales, Welsh Ministers have the power to intervene under the School Standards and Organisation (Wales) Act 2013. These intervention measures are considered in cases where Ofsted inspections (or Estyn in Wales) identify inadequate practice and serious concerns about practice in relation to safeguarding, adoption and looked-after children. The Care and Social Services Inspectorate Wales (CSSIW) has a role here in terms of care settings and standards.

56. In addition to the powers above, the Act provides the Secretary of State with the power to issue a direction where a local authority has failed to discharge the duty (see paragraph 26, above).

Schools and registered childcare providers (excluding higher and further education).

57. In England about eight million children are educated in some 23,000 publicly-funded and around 2,400 independent schools. The publicly-funded English school system comprises maintained schools (funded by local authorities), and academies (directly funded by central government. In Wales, over 450,000 children attend Local Authority maintained schools, and there are 70 independent schools.[1]

58. All publicly-funded schools in England are required by law to teach a broad and balanced curriculum which promotes the spiritual, moral, cultural, mental and physical development of pupils and prepares them for the opportunities, responsibilities and experiences of life. They must also promote community cohesion. Independent schools set their own curriculum but must comply with the Independent School Standards, which include an explicit requirement to promote fundamental British values as part of broader requirements relating to the quality of education and to promoting the spiritual, moral, social and cultural development of pupils. These standards also apply to academies (other than 16-19 academies), including free schools, as they are independent schools. 16-19 academies may have these standards imposed on them by the provisions of their funding agreement with the Secretary of State.

59. In Wales, independent schools set their own curriculum, but must comply with Independent Schools Standards made by the Welsh Ministers. These Standards also include a requirement to promote the spiritual, moral, social and cultural development of pupils.

60. Early years providers serve arguably the most vulnerable and impressionable members of society. The Early Years Foundation Stage (EYFS) accordingly places clear duties on providers to keep children safe and promote their welfare. It makes clear that to protect children in their care, providers must be alert to any safeguarding and child protection issues in the child's life at home or elsewhere (paragraph 3.4 EYFS). Early years providers must take action to protect children from harm and should be alert to harmful behaviour by other adults in the child's life.

61. Early years providers already focus on children's personal, social and emotional development The Early Years Foundation Stage framework supports early years providers to do this in an age appropriate way, through ensuring children learn right from wrong, mix and share with other children and value other's views, know about similarities and differences between themselves and others, and challenge negative attitudes and stereotypes.

62. This guidance should be read in conjunction with other relevant guidance. In England, this includes Working Together to Safeguard Children, Keeping Children Safe in Education and Information Sharing: Her Majesty's Government advice for professionals providing safeguarding services to children, young people, parents and carers.

https://www.gov.uk/government/publications/working-together-to-safeguard-children

https://www.gov.uk/government/publications/keeping-children-safe-in-education

63. In Wales it should be read alongside Keeping learners safe[2]:

http://wales.gov.uk/docs/dcells/publications/150114-keeping-learners-safe.pdf.

64. The authorities specified in paragraph 65 below are subject to the duty to have due regard to the need to prevent people from being drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit. Schools should be safe spaces in which children and young people can understand and discuss sensitive topics, including terrorism and the extremist ideas that are part of terrorist ideology, and learn how to challenge these ideas. The Prevent duty is not intended to limit discussion of these issues. Schools should, however, be mindful of their existing duties to forbid political indoctrination and secure a balanced presentation of political issues. These duties are imposed on maintained schools by sections 406 and 407 of the Education Act 1996. Similar duties are placed on the proprietors of independent schools, including academies (but not 16-19 academies) by the Independent School Standards.

[1] Schools Census results on Wales.gov.uk

[2] Keeping Learners Safe includes advice on radicalisation on page 51

Education and childcare specified authorities

65. The education and childcare specified authorities in Schedule 6 to the Act are as follows:

- the proprietors[3] of maintained schools, non-maintained special schools, maintained nursery schools, independent schools (including academies and free schools) and alternative provision academies[4]
- pupil referral units
- registered early years childcare providers[5]
- registered later years childcare providers[6]
- providers of holiday schemes for disabled children
- persons exercising local authority functions under a direction of the Secretary of State when the local authority is performing inadequately; and
- persons authorised by virtue of an order made under section 70 of the Deregulation and Contracting Out Act 1994 to exercise a function specified in Schedule 36A to the Education Act 1996.

66. In fulfilling the new duty, we would expect the specified authorities listed above to demonstrate activity in the following areas.

Risk assessment

67. Specified authorities are expected to assess the risk of children being drawn into terrorism, including support for extremist ideas that are part of terrorist ideology. This should be based on an understanding, shared with partners, of the potential risk in the local area.

68. Specified authorities will need to demonstrate that they are protecting children and young people from being drawn into terrorism by having robust safeguarding policies in place to identify children at risk, and intervening as appropriate. Institutions will need to consider the level of risk to identify the most appropriate referral, which could include Channel or Children's Social Care, for example. These policies should set out clear protocols for ensuring that any visiting speakers – whether invited by staff or by children themselves – are suitable and appropriately supervised.

Working in partnership

69. In England, governing bodies and proprietors of all schools and registered childcare providers should ensure that their safeguarding arrangements take into account the policies and procedures of the Local Safeguarding Children Board (LSCB). In Wales, Local Service Boards provide strategic oversight.

[3] Reference in this guidance to the 'proprietor' in the case of a maintained school, maintained nursery school and non-maintained special school is a reference to the governing body of the school.

[4] Including early years and later years childcare provision in schools that is exempt from registration under the Childcare Act 2006

[5] Those registered under Chapter 2or 2a of Part 3 of the Childcare Act 2006, including childminders

[6] Those registered under Chapter 3 or 2a of Part 3 of the Childcare Act 2006, including childminders

Staff training

70. Specified authorities should make sure that staff have training that gives them the knowledge and confidence to identify children at risk of being drawn into terrorism, and to challenge extremist ideas which can be used to legitimise terrorism and are shared by terrorist groups. They should know where and how to refer children and young people for further help. *Prevent* awareness training will be a key part of this.

IT policies

71. Specified authorities will be expected to ensure children are safe from terrorist and extremist material when accessing the internet in school, including by establishing appropriate levels of filtering.

Monitoring and enforcement

72. The Office for Standards in Education, Children's Services and Skills (Ofsted) inspects the specified authorities in England listed above, with the exception of some privately funded independent schools. When assessing the effectiveness of schools, Ofsted inspectors already have regard to the school's approach to keeping pupils safe from the dangers of radicalisation and extremism, and what is done when it is suspected that pupils are vulnerable to these. Maintained schools are subject to intervention, and academies and free schools may be subject to termination of their funding agreement, if they are judged by Ofsted to require significant improvement or special measures, or if they fail to take the steps required by their local authority, or for academies or free schools by the Secretary of State pursuant to their funding agreement, as applicable, to address unacceptably low standards, serious breakdowns of management or governance or if the safety of pupils or staff is threatened. In Wales, all publicly funded schools are inspected by Estyn.

73. Ofsted inspects 16-19 academies under the Common Inspection Framework for further education and skills.

74. Privately funded independent schools in England are inspected by Ofsted or one of three independent inspectorates. In Wales, Estyn inspects independent schools.If they fail to meet the Independent School Standards, they must remedy the problem or be subject to regulatory action by the Department for Education or the Welsh Government, which could include de-registration (which would make their continued operation unlawful).

75. Early education funding regulations in England have been amended to ensure that providers who fail to promote the fundamental British values of democracy, the rule of law, individual liberty and mutual respect and tolerance for those with different faiths and beliefs do not receive funding from local authorities for the free early years entitlement.

76. Ofsted's current inspection framework for early years provision reflects the requirements in the Statutory Framework for the Early Years Foundation Stage.

The health sector

77. Healthcare professionals will meet and treat people who may be vulnerable to being drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit.

78. The key challenge for the healthcare sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the healthcare worker is trained to recognise those signs correctly and is aware of and can locate available support, including the Channel programme where necessary. Preventing someone from being drawn into terrorism is substantially comparable to safeguarding in other areas, including child abuse or domestic violence.

79. There are already established arrangements in place, which we would expect to be built on in response to the statutory duty.

Health specified authorities

80. The health specified authorities in Schedule 6 to the Act are as follows:

- NHS Trusts
- NHS Foundation Trusts

81. NHS England has incorporated *Prevent* into its safeguarding arrangements, so that *Prevent* awareness and other relevant training is delivered to all staff who provide services to NHS patients. These arrangements have been effective and should continue.

82. The Chief Nursing Officer in NHS England has responsibility for all safeguarding, and a safeguarding lead, working to the Director of Nursing, is responsible for the overview and management of embedding the *Prevent* programme into safeguarding procedures across the NHS.

83. Each regional team in the NHS has a Head of Patient Experience who leads on safeguarding in their region. They are responsible for delivery of the *Prevent* strategy within their region and the health regional *Prevent* co-ordinators (RPCs).

84. These RPCs are expected to have regular contact with *Prevent* leads in NHS organisations to offer advice and guidance.

85. In Wales, NHS Trusts and Health Boards have CONTEST Prevent leads and part of multi-agency structures where these are in place. This guidance should be read in conjunction with *Building Partnerships-Staying Safe* issued by the Department of Health and Social Services, which provides advice to healthcare organisations on their role in preventing radicalisation of vulnerable people as part of their safeguarding responsibilities.

86. In fulfilling the duty, we would expect health bodies to demonstrate effective action in the following areas.

Partnership

87. All Sub Regions within the NHS should, under the NHS England Accountability and Assurance Framework, have in place local Safeguarding Forums, including local commissioners and providers of NHS Services. These forums have oversight of compliance with the duty, and ensure effective delivery. Within each area, the RPCs are responsible for promoting *Prevent* to providers and commissioners of NHS services, supporting organisations to embed *Prevent* into their policies and procedures, and delivering training.

88. We would expect there to be mechanisms for reporting issues to the National Prevent sub board.

89. We would also expect the *Prevent* lead to have networks in place for their own advice and support to make referrals to the Channel programme.

90. Since April 2013 commissioners have used the NHS Standard Contract for all commissioned services excluding Primary Care, including private and voluntary organisations. Since that time, the Safeguarding section of the contract

has required providers to embed *Prevent* into their delivery of services, policies and training. This should now be bolstered by the statutory duty.

Risk Assessment

91. All NHS Trusts in England have a *Prevent* lead who acts as a single point of contact for the health regional *Prevent* co-ordinators, and is responsible for implementing *Prevent* within their organisation. To comply with the duty, staff are expected, as a result of their training, to recognise and refer those at risk of being drawn into terrorism to the *Prevent* lead who may make a referral to the Channel programme. Regional health Prevent co-ordinators are able to provide advice and support to staff as required. In Wales, Health is a member of the Wales Contest Board and similar arrangements are in place.

Staff Training

92. The intercollegiate guidance, *Safeguarding Children and Young people: roles and competences for health care staff* includes *Prevent* information and identifies competencies for all healthcare staff against six levels.

93. The training should allow all relevant staff to recognise vulnerability to being drawn into terrorism, (which includes someone with extremist ideas that are used to legitimise terrorism and are shared by terrorist groups), including extremist ideas which can be used to legitimise terrorism and are shared by terrorist groups, and be aware of what action to take in response, including local processes and policies that will enable them to make referrals to the Channel programme and how to receive additional advice and support.

94. It is important that staff understand how to balance patient confidentiality with the duty. They should also be made aware of the information sharing agreements in place for sharing information with other sectors, and get advice and support on confidentiality issues when responding to potential evidence that someone is being drawn into terrorism, either during informal contact or consultation and treatment.

95. We would therefore expect providers to have in place:

- Policies that include the principles of the *Prevent* NHS guidance and toolkit, which are set out in *Building Partnerships, Staying Safe: guidance for healthcare organisations*, which can be found here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216534/dh_131912.pdf

- A programme to deliver Prevent training, resourced with accredited facilitators;
- Processes in place to ensure that using the intercollegiate guidance, staff receive Prevent awareness training appropriate to their role; and
- Procedures to comply with the Prevent Training and Competencies Framework.

Monitoring and enforcement

96. Within the NHS, we expect local safeguarding forums, including local commissioners and providers of NHS Services to have oversight of fulfilling the duty and ensuring effective delivery.

97. Externally, Monitor is the sector regulator for health services in England ensuring that independent NHS Foundation Trusts are well led so that they can provide quality care on a sustainable basis. The Trust Development Authority is responsible for overseeing the performance of NHS Trusts and the Care Quality Commission is the independent health and adult social care regulator that ensures these services provide people with safe, effective and high quality care. In Wales, the Healthcare Inspectorate Wales, and the Care and Social Services Inspectorate Wales could be considered to provide monitoring arrangements. We will work with the Welsh Government to consider the arrangements in Wales.

98. We are considering whether these internal arrangements are robust enough to effectively monitor compliance with the duty or whether the duty should be incorporated into the remit and inspection regimes of one of the existing health regulatory bodies, or another body.

Prisons and probation

99. As an executive agency of the Ministry of Justice, the National Offender Management Service (NOMS) is responsible for protecting the public and reducing re-offending through delivery of prison and probation services.

100. There are 122 prisons in England and Wales including 14 prisons operated under contract by private sector organisations. There are around 85,000 prisoners in custody at any one time
and 150,000 individuals in custody during a 12 month period.

101. Probation services are delivered by the National Probation Service (NPS), which supervises high-risk and other serious offenders, and 21 Community Rehabilitation Companies (CRCs), which supervise low and medium-risk offenders. NOMS is currently responsible for around 220,000 offenders under probation supervision, subject either to community sentences or to licence conditions after release from custody.

102. This responsibility for public protection and reducing re-offending gives both prisons and probation services a clear and important role both in working with offenders convicted of terrorism or terrorism-related offences and in preventing other offenders from being drawn into terrorism and the extremist ideas that are used to legitimise terrorism and are shared by terrorist groups.

Criminal justice specified authorities

103. The criminal justice specified authorities listed in Schedule 6 to the Act are as follows:

- prisons and Young Offender Institutions (YOI), including those that are contracted out;
- the under-18 secure estate (under-18 YOI, Secure training centres and Secure care homes;
- secure training centres;
- the National Probation Service; and
- Community Rehabilitation Companies.

Prisons

104. NOMS manages the risk of offenders being drawn into, or reverting to, any form of offending as part of its core business (identifying and managing the risks presented by offenders).

105. To comply with the duty we would expect public and contracted out prisons to carry out activity in the following areas.

Preliminary risk assessment

106. Prisons should perform initial risk assessments on reception, including cell-sharing risk assessments, and initial reception and induction interviews to establish concerns in relation to any form of extremism, be that faith based, animal rights, environmental, far right, far left extremism or any new emerging trends.

107. Contact with prisons chaplaincy should take place, as an integral part of the induction process. Any concerns raised as a result of chaplaincy contact with prisoners, including any concerns about extremism, should be reported throughout the sentence.

108. Prisoners should have regular contact with trained staff who will report on behaviours of concern.

109. Appropriate information and intelligence sharing should take place, for example with law enforcement partners, to understand whether extremism is an issue and to identify and manage any behaviours of concern.

Assessing ongoing risk and interventions

110. For offenders convicted of terrorist or terrorist-related offences, mainstream offender management processes will be used to determine whether interventions are necessary. These are intended to challenge the index offence and can include, where appropriate, intervention disruption and relocation.

111. Where concerns around someone being drawn into terrorism (which includes someone with extremist ideas that are used to legitimise terrorism and are shared by terrorist groups) are identified, either during the early days in custody or later, prison staff should report accordingly, through the intelligence reporting system. All such reporting should be regularly assessed by specialist staff in conjunction with the police.

112. Where such concerns are identified an establishment should look to support that individual. This could take the form of moving them away from a negative influence or providing them with mentoring from the relevant chaplain providing religious classes or guidance.

113. Management actions could also include a reduction in privilege level, anti-bullying intervention, adjudication or segregation. Alternatively, it may be appropriate to provide theological, motivational and behavioural interventions.

114. Intelligence and briefing packages targeted at staff working with terrorist and extremist prisoners and those at risk of being drawn into terrorism should continue to be made available and delivered. These should continue to be jointly delivered by appropriately trained prison staff and police, and will be updated as required. In complying with this duty, extremism awareness training provided to new staff should be increased.

Transition from custody to supervision in the community

115. Pre-release planning should take place for all prisoners, including those subject to sentences less than 12 months, who will now receive some level of post-release supervision. Prisons, probation providers and the police should consider what risks need to be managed in the community including those that have arisen whilst in custody and indicate a vulnerability to being drawn into terrorism. Where this is the case, a Channel referral will be considered as part of the risk management plans and a referral to Channel made at the earliest opportunity where appropriate.

116. For offenders already convicted of terrorism or terrorism-related offences, prisons will complete appropriate pre-release processes such as Multi-Agency Public Protection Arrangements (MAPPA) with relevant agencies including the police and the NPS. These processes ensure that the requirements of the duty are met in the management of terrorist offenders in the community with the NPS the lead agency in MAPPA for such cases.

117. For all prisoners, where sufficient remaining sentence time permits, a formal multi-agency meeting which includes the police and the probation counter terrorism lead, should take place to inform decisions after release. This will ensure that partner agencies work together to share relevant information and put provision in place to manage the risk or any outstanding concerns This can apply to periods of Release on Temporary Licence, Home Detention Curfew as well as eventual release on licence.

118. Where insufficient time remains, police and probation staff should be given fast time briefing by prison counter-terrorism staff as above and the National Probation Service CT lead will ensure the probation provider in the community is aware of the information, the risks and relevant personnel within partner agencies.

Staff training

119. In complying with the duty, we would expect all new prison staff to receive Prevent awareness training (tailored specifically to the prison environment). For staff already in post, this should be provided through specialist training and briefing packages that cover working with extremist behaviour. This training can be delivered in partnership with the police and be available to those members of staff who work most closely with terrorist and identified extremist prisoners. All staff should have an understanding of general intelligence systems, reporting and procedures to enable them to report on extremist prisoners and those vulnerable to extremist messaging.

Under-18 secure estate

120. The under-18 secure estate differs in terms of governance and service provision to that of the prisons and probation services for adults.

121. The Youth Justice Board (YJB) has a statutory responsibility to commission secure services for children and young people under the age of 18 and has a statutory duty to place children and young people sentenced or remanded by the courts into secure establishments.

The under-18 secure estates consists of:

- **Secure Children's Homes (SCHs)**
  Secure children's homes are run by local authority children's services, overseen by the Department of Health and the Department for Education. They have a high ratio of staff to young people and are generally small facilities, ranging in size from six to forty beds.
- **Secure Training Centres (STC)**
  Secure training centres are purpose-built centres for young offenders up to and including the age of 17. They are run by private operators under contracts, which set out detailed operational requirements. There are currently three STCs in England.
- **Young Offender Institutions (YOI)**
  Young offender institutions are facilities run by both the Prison Service and the private sector and can accommodate 15 to 21-year-old male offenders.

122. We would expect that staff at each secure estate and Youth Offending Teams (YOT) overseeing the care of the child or young person would receive appropriate training in identifying and managing those at risk of being drawn into terrorism.

123. As part of the ongoing care and monitoring of each child or young person, any indication of risk should be identified and a referral made to Channel if appropriate

Probation

124. To comply with the duty we would expect all providers of probation services, particularly the National Probation Service (NPS) and Community Rehabilitation Companies (CRCs) to demonstrate that they are delivering activities under all of the following categories.

Leadership

125. We would expect every NPS division to have a designated probation counter-terrorism lead (PCTL) to provide the leadership necessary at a regional level to ensure processes for identifying, assessing and managing high-risk terrorist offenders are followed. We would expect PCTLs to provide a consultative role to CRCs.

Partnerships

126. In all partnership working we would expect that all providers of probation services will comply with the duty; for example both the NPS and CRCs are partners in local Community Safety Partnerships (CSPs). Active participation in CSPs will enable all probation providers to work together with other partners to share information and develop joint referrals and interventions.

Risk assessment

127. We would expect probation staff to adopt an investigative stance in undertaking risk assessments as they should in all cases. Where there are concerns, albeit these may be intelligence led, about someone being at risk of being drawn into terrorism this should initially be recorded in the core risk assessment.

128. Additionally, we would expect existing risk assessment processes to be supplemented by specialist assessments, for example, extremism risk screening. We would expect PCTLs to provide a consultative role to CRCs in doing this, where appropriate.

129. For offenders already convicted of terrorist or terrorist-related offences we would expect the NPS to work in partnership with other agencies, including prisons and the police, to manage any risks identified via MAPPA and to provide bespoke interventions where relevant. For offenders who have not been convicted

of a terrorism-related offence and may not be MAPPA eligible, but who are subsequently at risk of being drawn into terrorism, we would expect probation providers to have processes in place to escalate these cases to other agencies or otherwise refer the offender for appropriate interventions – for example to the Channel programme.

Staff training

130. We would expect probation providers to ensure that all staff receive appropriate training in identifying and managing those at risk of being drawn into terrorism including those with extremist ideas that can be used to legitimise terrorism and are shared by terrorist groups. *Prevent* awareness training has already been given to probation staff in recent years. In complying with the duty, we expect this and other relevant *Prevent* training to continue.

131. In the future, we expect *Prevent* awareness training to be included within the Probation Qualification Framework, which is completed by all newly qualified probation staff in both the NPS and CRCs. In addition PCTLs should lead the development of, for example, faith awareness or Extremism Risk Screening training of local training and staff development to supplement the Prevent awareness training. This should focus on emerging issues and any new support and interventions that become available.

Monitoring and enforcement for prisons and probation

132. Within prisons, we would expect compliance with the duty to be monitored and enforced internally by:

- mandatory compliance with Prison Service Instructions and Orders which define policy and best practice; and
- regular assessment of levels and risk of extremism and radicalisation internally via regional counter-terrorism co-ordinators.

133. Externally, our preference is to use existing inspection regimes where appropriate to do so. We consider that a thematic inspection by HM Inspector of Prisons could be a useful addition to the monitoring arrangements outlined above.

134. For probation providers, internally, we would expect compliance with the duty to be reinforced by detailed operational guidance set out in Probation Instructions. CRCs are contractually required to comply with the mandatory actions in relevant Probation Instructions and a similar requirement exists for the NPS in Service Level Agreements. Compliance with Probation Instructions is monitored and assured internally by contract management and audit functions within NOMS and the Ministry of Justice

135. Externally, we consider that a thematic inspection by HM Inspector of Probation could be a useful addition to the monitoring arrangement outlined above.

136. The YJB monitors the flow of young people through the Youth Justice system identifying the needs and behaviours of young offenders working closely with local partners to improve the support available.

The police

137. The police play an essential role in most aspects of *Prevent* work alongside other agencies and partners. They hold information which can help assess the risk of radicalisation and disrupt people engaged in drawing others into terrorism (which includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit). The Police work alongside other sectors in this document to play a galvanising role in developing local *Prevent* partnerships and bring together a wide range of other organisations to support local delivery of *Prevent*.

138. The police are uniquely placed to tackle terrorism and whilst it is acknowledged that the Police Service will designate dedicated *Prevent* roles within Policing, a key objective for the police is to ensure that *Prevent* is embedded into all aspects of policing including patrol, neighbourhood and safeguarding functions. In fulfilment of their duties consideration must be given to the use of all suitable police resources, not just those specifically designed as *Prevent*.

Police specified authorities

139. The police specified authorities listed in Schedule 6 to the Act are as follows:

- police forces in England and Wales;
- Police and Crime Commissioners;
- the British Transport Police;
- port police forces; and
- the Civil Nuclear Police Authority

140. In fulfilling the new duty we would expect the police to take action in the following areas.

Prosecute, disrupt and deter extremists

141. In complying with the duty, police should engage and where appropriate disrupt extremist activity, in partnership with other agencies. We expect the police to prioritise projects to disrupt terrorist and extremist material on the internet and extremists working in this country. Officers should consider the full range of investigative and prosecution options when it comes to disrupting extremist behaviour, including the use of public order powers where appropriate. This may include:

- Enforcing terrorist proscription and public order legislation;
- Working with local authorities to consider municipal powers, including local highways and leafleting by-laws, using safeguarding of young people legislation;
- Advising other specified authorities, for example local authorities or universities, to develop venue booking processes and good practice;
- Lawfully disrupting or attending events involving extremist speakers in both private and municipal establishments;
- Providing high visibility police presence at relevant events in public places.

Supporting vulnerable individuals

142. Prevent requires a multi-agency approach to protect people at risk from radicalisation. When vulnerable individuals are identified the police will undertake the following:

- In partnership with other agencies including the local authority, consider appropriate interventions, including the Channel programme, to support vulnerable individuals;
- Work in partnership with and support Channel Panels chaired by local authorities to co-ordinate Channel partners and Channel actions;
- Support existing, and identify potential new Intervention Providers.

Partnership and risk assessment

143. The police should:

- Engage fully with the local multi-agency groups that will assess the risk of people being drawn into terrorism, providing (where appropriate) details of the police counter-terrorism local profile (CTLP);
- Support the development and implementation by the multi agency group of a Prevent action plan to address that risk;
- Support local authority Prevent co-ordinators, regional further and higher education co-ordinators, regional health Prevent leads and regional NOMS Prevent co-ordinators in carrying out their work;
- Co-ordinate the delivery of the Channel programme by accepting referrals, including acting as a conduit for Channel referrals with partners; and
- Ensure Prevent considerations are fully embedded into counter-terrorism investigations.

144. The success of Prevent work relies on communities supporting efforts to prevent people being drawn into terrorism and challenging the extremist ideas that are also part of terrorist ideology. The police have a critical role in helping communities do this. To comply with the duty, we would expect the police, to support others including local authorities, to build community resilience by:

- Supporting local authority Prevent Coordinators in developing Prevent-related projects and action plans;
- Supporting the Charity Commission in providing guidance to avoid money being inadvertently given to organisations which may endorse extremism or terrorism and enforcing legislation where fraud offences are identified.
- Supporting opportunities to develop community challenges to extremists; and
- Collate and analyse community tension reporting across the UK that enables police and partners to identify and respond to emerging concerns.

Monitoring and enforcement

145. The Strategic Policing Requirement makes clear that Police and Crime Commissioners (PCCs) and Chief Constables must demonstrate that they have contributed to the government's counter terrorism strategy (CONTEST). This includes the Prevent programme, where they are required to take into account the need to identify and divert those involved in or vulnerable to radicalisation. The Home Secretary can direct a PCC to take specific action to address a specific failure.

146. HM Inspectorate of Constabulary (HMIC) is the statutory body for inspecting the police. They can carry out thematic inspections and can be asked to inspect a particular force or theme by the Home Secretary.

F. Glossary of terms

'Having due regard' means that the authorities should place an appropriate amount of weight on the need to prevent people being drawn into terrorism when they consider all the other factors relevant to how they carry out their usual functions.

'Extremism' is defined in the 2011 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.

'Interventions' are projects intended to divert people who are being drawn into terrorist activity. Interventions can include mentoring, counselling, theological support, encouraging civic engagement, developing support networks (family and peer structures) or providing mainstream services (education, employment, health, finance or housing).

'Non-violent extremism' is extremism, as defined above, which is not accompanied by violence.

'Prevention' in the context of this document means reducing or eliminating the risk of individuals becoming involved in terrorism. Prevent includes but is not confined to the identification and referral of those at risk of being drawn into terrorism into appropriate interventions. These interventions aim to divert vulnerable people from radicalisation.

'Radicalisation' refers to the process by which a person comes to support terrorism and extremist ideologies associated with terrorist groups.

'Safeguarding' is the process of protecting vulnerable people, whether from crime, other forms of abuse or (in the context of this document) from being drawn into terrorist-related activity.

The current UK definition of **'terrorism'** is given in the Terrorism Act 2000 (TACT 2000). In summary this defines terrorism as an action that endangers or causes serious violence to a person/people; causes serious damage to property; or seriously interferes or disrupts an electronic system. The use or threat must be designed to influence the government or to intimidate the public and is made for the purpose of advancing a political, religious or ideological cause.

'Terrorist-related offences' are those (such as murder) which are not offences in terrorist legislation, but which are judged to be committed in relation to terrorism.

'Vulnerability' describes the condition of being capable of being injured; difficult to defend; open to moral or ideological attack. Within Prevent, the word describes factors and characteristics associated with being susceptible to radicalisation.

Buckinghamshire
BSCB
Safeguarding
Children Board

Buckinghamshire Safeguarding Children Board
BSCB Guidance: Self-Harm
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These guidelines are primarily intended for use by Professional carers/workers within Buckinghamshire and should be read in conjunction with the Buckinghamshire Safeguarding Children's Board (BSCB) procedures.

These guidelines are based on the Self Harm Guidelines for Staff within School and Residential Settings developed by the Oxfordshire Adolescent Self Harm Forum Steering Group (with representatives from OBMH, Oxfordshire PCT, Oxfordshire County Council, Oxfordshire PCAMHS, Oxfordshire Samaritans and Oxford University Centre for Suicide Research).

Self harm guidelines

These guidelines are intended to help carers and workers to support young people up to the age of 18 who harm themselves, and to access appropriate services where needed.

What is self harm and how common is it?

Self harm is any behaviour such as self-cutting, swallowing objects, taking an overdose, hanging or running in front of cars etc., where the intent is to deliberately cause self harm.

- Some people who self harm have a strong desire to kill themselves. However, there are other factors which motivate people to self harm including a desire to escape an unbearable situation or intolerable emotional pain, to reduce tension, to express hostility, to induce guilt or to increase caring from others. Even if the intent to die is not high, self harming behaviour may express a powerful sense of despair and needs to be taken seriously. Moreover, some people who do not intend to kill themselves may do so, because they do not realise the seriousness of the method they have chosen or because they do not get help in time.

- Over the last forty years there has been a large increase in the number of young people who deliberately harm themselves. A recent large community study in the UK found that in 15-16 year olds, approximately 6.9% of young people (3.2% males and 11.2% females) had self harmed in the last year. See Hawton et al. (2002) Deliberate self harm in adolescents: self report survey in schools in England. BMJ, 325, 1297-1211.

What causes self harm?

The following **risk factors,** particularly in combination, may make a young person vulnerable to self harm:

Individual Factors
- depression/anxiety
- poor communication skills
- low self esteem
- poor problem solving skills
- hopelessness
- impulsivity
- drug or alcohol abuse

Family factors
- unreasonable expectations
- abuse (physical, sexual, emotional or neglect)
- poor parental relationships and arguments
- depression, deliberate self harm, suicide or other mental health difficulties in the family
- drug/alcohol misuse in the family
- domestic violence

Social factors
- difficulty in making relationships/ loneliness
- persistent bullying or peer rejection
- easy availability of drugs, medication or other methods of self harm

The pressures for some groups of young people and in some specific settings may increase the risk of self harm:

- young people in residential settings (e.g. inpatient units, prison, sheltered housing or hostels or boarding schools)
- young people with mental health difficulties

A number of factors may **trigger** the self harm incident:

- family relationship difficulties **(the most common trigger for younger adolescents)**
- difficulties with peer relationships e.g. break up of relationship **(the most common trigger for older adolescents)**
- bullying
- significant trauma e.g. bereavement, abuse
- self harm behaviour in other students (contagion effect)
- identification with a peer group which promotes self harm
- self harm portrayed or reported in the media
- difficult times of the year (e.g. anniversaries)
- trouble in school or with the police
- feeling under pressure from families, school and peers to conform/achieve
- exam pressure
- times of change (e.g. parental separation/divorce)

Warning signs

There may be changes in the **behaviour** of the young person which are associated with self harm or other serious emotional difficulties:

- changes in eating/sleeping habits
- increased isolation from friends/family
- changes in activity and mood e.g. more aggressive than usual
- lowering of academic grades
- talking about self-harming or suicide
- abusing drugs or alcohol
- becoming socially withdrawn
- expressing feelings of failure, uselessness or loss of hope
- giving away possessions

N.B. Some young people get caught up in mild repetitive self harm such as scratching, which is often done in a peer group. In this case it may be helpful to take a low key approach, avoiding escalation, although at the same time being vigilant for signs of more serious self harm.

Examples of self harming behaviour

- cutting
- taking an overdose of tablets
- swallowing hazardous materials or substances
- burning – either physically or chemically
- over/under medicating e.g. misuse of insulin
- punching/hitting/bruising
- hair pulling/skin picking/head banging
- episodes of alcohol/drug/substance misuse or over/under eating can at times be acts of deliberate self harm

Self harm can be a transient behaviour in young people that is triggered by particular stresses and resolves fairly quickly, or it may be part of a longer term pattern of behaviour that is associated with more serious emotional/psychiatric difficulty. Where there are a number of underlying risk factors present, the risk of further self harm is greater.

What keeps self harm going?

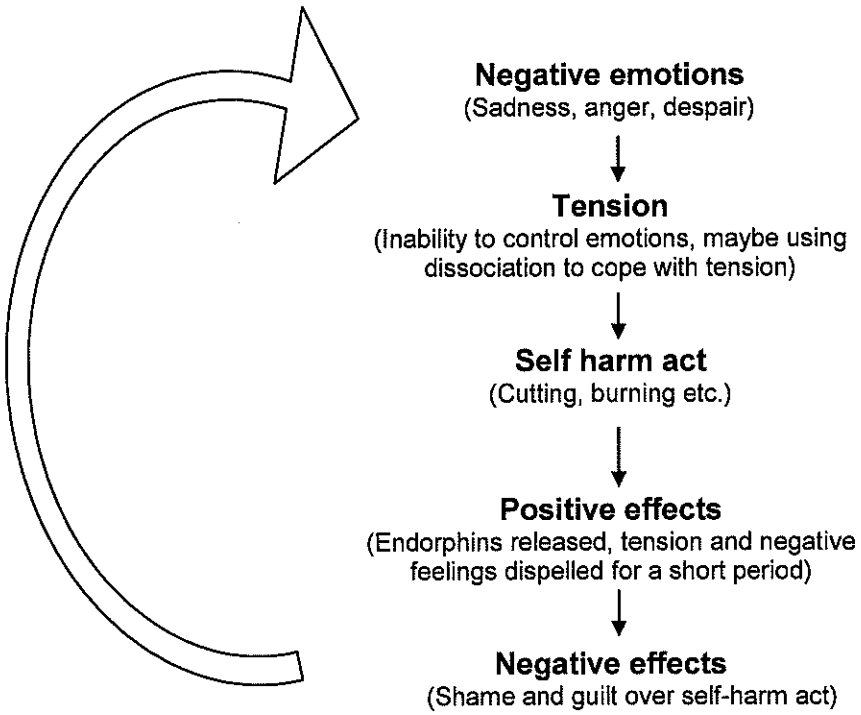
Once self harm (particularly cutting) is established, it may be difficult to stop. Self harm can have a number of functions for the student and it becomes a way of coping.

Examples of functions include

- Reduction in tension (safety valve)
- Distraction from problems
- Form of escape
- Outlet for anger and rage
- Opportunity to feel
- Way of punishing self or others
- Way of taking control
- Care-eliciting behaviour
- A means of getting identity with a peer group
- Non-verbal communication (e.g. of abusive situation)
- It can also be a suicidal act

The cycle of self harm/cutting

When a person inflicts pain upon himself or herself the body responds by producing endorphins, a natural pain reliever that gives temporary relief or a feeling of peace. The addictive nature of this feeling can make self harm difficult to stop.
Young people who self harm still feel pain, but some say the physical pain is easier to stand than the emotional/mental pain that led to the self harm initially.



Coping strategies

1. Using support networks

It is helpful to identify the support people in a young person's life and how to get in touch with them. Examples are friends, family, school teacher, counsellor. Knowing how to access a crisis line is also important.

2. Distraction activities

Replacing the cutting or other self harm with other safer activities can be a positive way of coping with the tension. What works depends on the reasons behind the self harm. Activities that involve the emotions intensely can be helpful.

Examples of distraction methods:

- Contacting a friend or family member
- Going for a walk/run or other forms of physical exercise
- Getting out of the house and going to a public place e.g. a cinema
- Reading a book
- Keeping a diary
- Looking after an animal
- Watching TV
- Listening to music

3. Coping with distress using self soothing

- Using stress management techniques such as relaxation
- Having a bubble bath
- Stroking a cat or other animal
- Going to the park and looking at the things around you (birds, flowers, trees)
- Listening to the sounds as you walk
- Listening to soothing music

4. Discharging unpleasant emotions in other ways

Sometimes it can be helpful to find other ways of discharging emotion which is less harmful than self harm:

- Clenching ice cubes in the hand until they melt – this can relieve some tension
- Writing, drawing and talking about feelings
- Writing a letter expressing feelings, which need not be sent
- Going into a field and screaming
- Hitting a pillow /soft object
- Listening to loud music
- Physical exercise can be a good way to discharge emotion

In the longer term a young person may need to develop ways of understanding and dealing with the underlying emotions and beliefs. Regular counselling/therapy may be helpful. Support from family members or carers is likely to be an important part of this. It may also help if the young person joins a group activity such as a youth club, a keep fit class or a school based club that will provide opportunities for them to develop friendships and feel better about themselves. Learning stress management techniques, ways to keep safe and how to relax may also be useful.

Reactions of staff

Staff may experience a range of feelings in response to self harm in a young person (e.g. anger, sadness, shock, disbelief, guilt, helplessness, disgust or rejection). It is important for all work colleagues to have an opportunity to discuss the impact that self harm has on them personally. The type and nature of the forums where these issues are discussed may vary between settings.

In *schools* young people may present with injuries to first aid or reception staff. It is important that these frontline staff are aware that an injury may be self inflicted, and that they pass on any concerns.
Within *residential settings*, young people may present to a range of staff, including key workers, domestic staff, admin staff or cooks.

The urge to escape difficulties

For some young people, self harm may express the strong desire to escape from a conflict or unhappiness at home and to live elsewhere. Injuring oneself can achieve a temporary respite if it entails a hospital admission or a short break at the home of a friend or relative. The young person may request admission to foster care or a residential home and parents may doubt their ability to cope at this stage. Entering care often carries with it many long-term disadvantages and increased vulnerability for the young person. It is acknowledged that for some young people being looked after is the best way forward but in most cases it is preferable to try to support the young person and family members in finding a resolution to their difficulties than to separate them further.

For those who are already in care, self harm may still be an expression of a desire to escape from their situation, for example, leaving the home. As before, it is important to support the young person, understand the nature of their difficulties and help them to find a way of resolving them.

If you believe that a young person would be at serious risk of abuse in returning home or in remaining in their residential setting, you should consult a Social Worker for advice.

If a child or young person goes missing from home or from a residential setting then the BSCB procedures should be initiated.

Thames Valley Missing Children Procedure: http://www.bucks-lscb.org.uk/bscb-procedures (Section 11)

How to help

If you are concerned that an episode of Self Harm was a serious attempt by the Young Person to end their life, please contact your local CAMHs Tier 3 team Duty Line (see appendix F) immediately.

1. First line help

When you recognise signs of distress try to talk with the young person about how they are feeling.

- Record and share with senior member of staff.
- When a young person has self harmed keep calm, give reassurance and follow the agreed first aid guidelines.
- In the case of an overdose of tablets advice must be obtained from a medical practitioner (GP or Accident and Emergency Department).
- If the young person is in a serious medical condition then an ambulance must be called.
- Try to work out together who you need to inform (see paragraph on confidentiality).
- Discuss the importance of letting parents know and address any concerns they have about this. For Children in Care discussion should include notifying the Social Worker (depending on the legal status of the Child).
- Contact parents to discuss concerns unless there are particular reasons why they should not be contacted. In these cases consult with designated safeguarding lead. Give the parents' fact sheet (Appendix D) when appropriate.
- For Children in Care contact their Social Worker in the first instance.
- Suggest to the parents and/or Social Worker a referral to CAMHS, or an appointment with the GP if there are serious medical issues. If young person is known to CAMHS contact Lead Professional / Care Co-ordinator or local teams duty line (Mon-Fri, 9-5).
- Ask for feedback from other agencies to support work with the young person.
- Work within Buckinghamshire Safeguarding Children Board policy/guidelines as appropriate (Child Protection Policies).
- Follow up contact with parents with a letter indicating your concern (Sample Appendix B).
- Have crisis telephone numbers available and easily accessible to young people.
- Follow agreed policy with regard to informing the senior management of your concerns.
- Record any incident (Sample Appendix C).
- Seek support for yourself if necessary.
- Advice can be obtained from the CAMHS telephone consultation service (see Appendix F).

2. Longer term support of a young person who self harms

It is important to understand the reasons behind the self harm and support the young person in keeping safe. Key workers/staff should work with the young person to build up self esteem, develop problem solving skills, and encourage strategies to cope with difficult feelings. If the young person is involved with CAMHS they should be supported to attend appointments and be encouraged to make use of the support offered.

Understanding and prevention of self harm

It may be helpful to explore with the young person what led to the self harm - the feelings, thoughts and behaviour involved. This can help the young person make sense of the self harm and develop alternative ways of coping.

An important part of prevention of self harm is having a supportive environment in the school or residential setting which is focused on building self esteem and encouraging healthy peer relationships. An effective anti-bullying policy and a means of identifying and supporting young people with emotional difficulties is an important aspect of this.

A check list of procedures and practices that can help schools manage and prevent self harm can be found in Appendix A.

Confidentiality

Confidentiality is a key concern for young people and they need to know that it may not be possible for their support member of staff or residential worker to offer complete confidentiality. If you consider that a young person is at serious risk of harming him/her self or others then confidentiality cannot be kept. It is important not to make promises of confidentiality that you cannot keep, even though the young person may put pressure on you to do so. If this is explained at the outset of any meeting the young person can make an informed decision as to how much information they wish to divulge.

Strategies to help in school or residential settings

- Arrange a mutually convenient time and place to meet.
- At the start of the meeting set a time limit.
- Make sure the young person understands the limits of your confidentiality.
- Encourage them to talk about what has led them to self harm.
- Remember that listening is a vital part of this process.
- Support the young person in beginning to take steps to keep him/herself safe and reduce the self-injury (if they wish to).e.g.
    - Washing implements used to cut.
    - Avoid alcohol if they feel they are likely to self-injure.
    - Take better care of injuries (the school health nurse or first aider may be helpful here).
- Help them to learn how to express their feelings in other ways e.g. talking, writing, drawing or using safer alternatives (as described earlier).
- Help them to build up self esteem
- Help them to find their own way of managing their problems. e.g.
    - If they say they dislike themselves, begin working on what they say they do like.
    - If life at home is impossible, begin working on how to talk to parents/carers.
- Help them identify their own support network.
- Offer information about support agencies; remember some internet sites may contain inappropriate information.

Further considerations

- Record any meeting with a young person; include an agreed action plan including dates, times and any concerns you have. Document who else has been informed of any information.
- It is important to encourage young people to let you know if one of their group is in trouble, upset or shows signs of harming. Friends can worry about betraying confidence, so they need to know self harm can be dangerous to life, and by seeking help and advice for their friend they are taking a responsible action.
- It can happen that two or more young people may self harm simultaneously. It is important that each case is looked at individually in terms of levels of risk and need

in the first instance. It is of course important at a later stage to consider what it was within the group dynamic that led to this situation and how best it could be managed in the future. (see Issues regarding contagion).

- The peer group of a young person who self harms may value the opportunity to talk to an adult, either individually or in a small group.

Response of supportive members of staff

For those who are supporting young people who self harm, it is important to be clear with each individual how often and for how long you are going to see them (i.e. the boundaries need to be clear). It can be easy to get caught up into providing too much, because of one's own anxiety. However, the young person needs to learn to take responsibility for their self harm.

If you find the self harm upsets you, it may be helpful to be honest with the young person. You need to be clear that you can deal with your own feelings and try to avoid the young person feeling blamed. They probably already feel low in mood and have a poor self-image; your anger/upset may add to their negative feelings. However, your feelings matter too. You will need the support of your colleagues and management, if you are to listen effectively to young peoples' difficulties.

Issues regarding contagion, multiple and copycat behaviours

When a young person is self harming it is important to be vigilant in case close contacts of this individual are also self harming.

Occasionally schools or residential settings may discover that a number of students in the same peer group are harming themselves. Self harm can become an acceptable way of dealing with stress within a peer group and may increase peer identity. This can cause considerable anxiety in school staff, parents and carers, as well as in other young people.

Each individual may have different reasons for self harming and should be given the opportunity for one to one support; however, it may also be helpful to discuss the matter openly with the group of young people involved. In general it is not advisable to offer regular group support for young people who self harm.

Where there appears to be linked behaviour or a local pattern emerging, a multi-agency strategy meeting should be convened.

Support/training aspects for staff

Staff giving support to young people who self harm may experience all sorts of reactions to this behaviour in young people (e.g. anger, helplessness, rejection); it is helpful for staff to have an opportunity to talk this through with work colleagues or senior management.

Staff taking this role should take the opportunity to attend training days on self harm or obtain relevant literature. Liaison with the local Child and Adolescent Mental Health Service may be helpful.

Consideration needs to be given to the impact the young person's self harming may have on their peer group.

Helping young people who self harm: Flow chart for young people. (universal)

If you are concerned that an episode of Self Harm was a serious attempt by the Young Person to end their life, please contact your local CAMHs Tier 3 team Duty Line (see appendix F) immediately.

Young person is self harming / is at risk of self harming

↓

Worker/carer informed/discovers a young person with problem.
Worker/carer to talk to young person
In an emergency, worker/carer to follow First Aid Guidelines

↓

Worker/carer to follow the organisation's policy regarding informing the senior management /leadership team (this allows the worker/carer to gain support of colleagues). Parents should be informed unless there are specific reasons not to.

↓

Discussion with relevant professionals involved with young person

↓

Ring CAMHS Consultation Line for advice **or** Social Care Contact Centre if there are safeguarding concerns

↓

IF APPROPRIATE:

- Meeting with parent(s) to inform and discuss concerns
- Follow up the meeting with a letter (Appendix B)
- Give crisis/help line details to parent and young person
- Give fact sheet for parents & carers (Appendix E)
- Refer to your organisations Safeguarding Lead / Guidelines and act accordingly (note confidentiality guidelines)

↓

Refer on to other agencies as appropriate

Appendix A

Self Harm Guidelines - Checklist for schools: Supporting the development of effective practice

The school has a policy or protocol approved by the governing body concerning self-harming	☐
ALL new members of staff receive an induction on self harm procedures and confidentiality	☐
ALL members of staff (teaching and non-teaching) receive regular training on child protection procedures	☐
The school has clear channels of communication that apply to this issue	☐
All members of staff know who to go to if they know a young person is self-harming	☐
Staff are supported throughout all processes concerned with this issue	☐
Staff know how to access support for themselves and students	☐
Students know who to go to for help	☐
The school has a culture that encourages young people to talk, adults to listen and believe	☐
Students are consulted on any curriculum provision (eg in PSHE) and pastoral support provided.	☐

Appendix B

Sample letter to parents following meeting about self harm

Date

Dear (Parent/Carer)

Thank you for coming to discuss.....

After our recent meeting I am writing to express concern about .....'s safety and welfare. The recent incident of self harm (or threat to self harm) by ..... suggests that he/she may need professional help.

I recommend that you visit your local GP for advice and help and /or as agreed, we have sent a referral to the Children and Adolescent Mental Health Service (CAMHS).

We will continue to provide support to ....., but would appreciate any information that you feel would help us to do this as effectively as possible.

If there is anything else we can do to help ..... please contact me.

Yours sincerely,

Title

Copies to:

Appendix C
Sample of an incident form to be used when a young person self harms

Young person's name		Date of report
Date of Birth		Gender
Professional's name		Job title
Agency		
School /College attended	Year	Special Needs

Incident

Date and time of occurrence

Action taken by professional

Decision made with respect to contacting parents
(and reasons for decision)

Recommendations

Follow up

Copies to:

Appendix D Fact sheet for parents/carers on self harm

It can be difficult to find out that someone you care about is harming him or her self. As a parent / carer you may feel angry, shocked, guilty and upset. These reactions are normal, but what the person you care about really needs, is support from you. They need you to stay calm and to listen to them. The reason someone self harms is to help them cope with very difficult feelings that build up and which they cannot express. They need to find a less harmful way of coping.

What is self harm?
Self harm is any behaviour such as self-cutting, swallowing objects, taking an overdose, hanging or running in front of cars etc. where the intent is to deliberately cause harm to self.

How common is self harm?
Over the last forty years there has been a large increase in the number of young people who harm themselves. A recent large community study found that in 15-16 year olds, approximately 6.9% of young people had self harmed in the previous year.

Is it just attention seeking?
Some people who self harm have a desire to kill themselves. However, there are many other factors which lead people to self harm, including a desire to escape, to reduce tension, to express hostility, to make someone feel guilty or to increase caring from others. Even if the young person does not intend to commit suicide, self harming behaviour may express a strong sense of despair and needs to be taken seriously. It is not just attention seeking behaviour.

Why do young people harm themselves?
All sorts of upsetting events can trigger self harm. Examples are: arguments with family, break up of a relationship, failure in exams or bullying at school. Sometimes several stresses occur over a short period of time and one more incident can be the final straw.

Young people who have emotional or behavioural problems or low self-esteem can be particularly at risk from self harm. Suffering a bereavement or serious rejection can also increase the risk. Sometimes young people try to escape their problems by taking drugs or alcohol. This only makes the situation worse. For some people self harm is a desperate attempt to show others that something is wrong in their lives.

What can you do to help?
Try to:

- Keep an open mind
- Make the time to listen
- Help them find different ways of coping
- Go with them to get the right kind of help as quickly as possible
- Some people you can contact for help, advice and support are:
- Your family doctor
- Young Minds Parents Information Service Tel: 0808 802 5544
- The Samaritans. Tel: 08457 90 90 90
- MIND Infoline. Tel: 0845 766 0163
- Youth Access. Tel: 0208 772 9900
- School Health Nurse/ Health Visitor

Appendix E Information sheet for young people on self harm

What is self harm?
Self harm is where someone does something to deliberately hurt him or herself. This may include: cutting parts of their body, burning, hitting or taking an overdose.

How many young people self harm?
A recent large study in the UK found that about 7% (i.e. 7 people out of every 100) of 15-16 year olds had self harmed in the last year.

Why do young people self harm?
Self harm is often a way of trying to cope with painful and confusing feelings. Difficult things that people who self harm talk about include:

- Feeling sad or feeling worried
- Not feeling very good or confident about themselves
- Being hurt by others: physically, sexually or emotionally
- Feeling under a lot of pressure at school or at home
- Losing someone close; this could include someone dying or leaving

When difficult or stressful things happen in someone's life, it can trigger self harm. Upsetting events that might lead to self harm include:

- Arguments with family or friends
- Break-up of a relationship
- Failing (or thinking you are going to fail) exams
- Being bullied

Often these things build up until the young person feels they cannot cope anymore. Self harm can be a way of trying to deal with or escaping from these difficult feelings. It can also be a way of showing other people that something is wrong in their lives.

How can you cope with self harm?
Replacing the self harm with other safer coping strategies can be a positive and more helpful way of dealing with difficult things in your life.

Helpful strategies can include:

- Finding someone to talk to about your feelings (this could be a friend or family member)
- Talking to someone on the phone (you might want to ring a help line)
- Sometimes it can be hard to talk about feelings; writing and drawing about your feelings may help.
- Scribbling on and/or ripping up paper
- Listening to music
- Going for a walk, run or other kinds of exercise
- Getting out of the house and going somewhere where there are other people
- Keeping a diary
- Having a bath/using relaxing oils e.g. lavender
- Hitting a pillow or other soft object
- Watching a favourite film

Getting help

In the longer term it is important that the young person can learn to understand and deal with the causes of the stress that they feel. The support of someone who understands and will listen to you can be very helpful in facing difficult feelings.

- **At home** - parents, brother/sister or another trusted family member
- **In school** - school counsellor, school nurse, teacher, teaching assistant or other member of staff
- **GP** – you can talk to your GP about your difficulties and he/she can make a referral for counselling
- **Help lines**:-

Young Minds	Tel: 0808 802 5544	youngminds@org.uk
The Samaritans	Tel: 08457 90 90 90	jo@samaritans.org.uk
MIND Infoline.	Tel: 0845 766 0163	
Youth Access.	Tel: 0208 772 9900	

National Self Harm Network
PO Box 16190
London NW1 3WW www.nshn.co.uk

My friend has a problem - How can I help?

- You can really help by just being there, listening and giving support.
- Be open and honest. If you are worried about your friend's safety, you should tell an adult. Let your friend know that you are going to do this and you are doing it because you care about him/her.
- Encourage your friend to get help. You can go with them or tell someone they want to know.
- Get information from telephone help lines, website, library etc. This can help you understand what your friend is experiencing.
- Your friendship may be changed by the problem. You may feel bad that you can't help your friend enough or guilty if you have had to tell other people. These feelings are common and don't mean that you have done something wrong/not done enough.
- Your friend may get angry with you or say you don't understand. It is important to try not to take this personally. Often when people are feeling bad about themselves they get angry with the people they are closest to.
- It can be difficult to look after someone who is having difficulties. It is important for you to find an adult to talk to, who can support you. You may not always be able to be there for your friend and that's OK.

Appendix F: Guidance for asking clients about internet and social media use (2017)

This document has been produced by Oxford Health NHS Foundation Trust and approved by the Oxfordshire Local Safeguarding Children Board. It is shared here as a resource that may also be helpful for professionals working in Buckinghamshire.

Guidance for asking clients about internet and social media us

- 91% of 16-24 year olds use the internet for social media[1]
- Social media use in relation to suicide and self-harm is an area of concern, particularly with young people [2]
- It is increasingly common for people to search the internet in the context of suicidality
- Social media and the internet generally can be protective as well as harmful[3]
- Assessments should incorporate internet and social media use in relation to self-harm/suicidality and clinicians/staff should engage clients in open dialogue around usage to try and reduce/minimise harmful use and promote helpful and protective resources[4]

The **internet** is predominantly used to search about methods of suicide, to purchase means e.g. prescription only medication and to look for support. Internet searching can also lead to social media platforms.

Social media includes:

- Suicide related chat rooms (pro suicide and preventative)
- Blogs
- Virtual bulletin boards and forums
- YouTube
- Social networking sites: Facebook, Twitter, MySpace, Google +
- Instant messaging (visual and text): Snapchat, Instagram, Tumblr
- Texting, email

In recent research[1] young people ranked **Instagram** and **Snapchat** as the social media networking sites that are most detrimental to mental wellbeing.

The same research identified potential negative and positive effects of social media on health:

	Potential positive effects of social media on health[1]
Anxiety & depression	Access to other people's health experiences and expert health information
Sleep	Emotional support and community building
Body image	Self-expression and self-identity
Cyberbullying	Making, maintaining and building upon relationships
Fear of missing out (FoMO)	

NB: both victims and perpetrators of cyberbullying have a higher risk of suicidality than the general population[2]

The risks associated with cyberbullying are the amplification of feelings of isolation, instability and hopelessness for those with pre-existing emotional, psychological or environmental stresses[2].

Additional concerns in relation to social media use:

- Cybersuicide pacts - these are generally made between strangers who have met through pro-suicide fora
- Introduction to new methods
- Influencing of decisions in relation to suicide e.g. peer pressure, idolisation
- Competition/challenges in relation to self-harm or suicide
- Contagion of self-harming or suicidal behaviour
- Suicide notes – increasing exposure of those reading them

Research has indicated that some clinicians/staff are unaware of clients' internet use and lack knowledge about chatrooms and social media[4]. It was noted that clinicians/staff can find themselves avoiding asking direct questions about internet and social media during suicide risk assessments for fear that it might 'put ideas into a patient's head'[3]. The same authors note that "*clinicians may be in a unique position to guide internet use, and knowing about internet activity could help to identify high risk clients and contribute to clinical decision making so that clients receive better support*".

Direct and curious questions are advised to elicit the extent of client's internet and social media use and to identify possible risks in relation to self-harm or suicide. By asking for names of sites/apps, potentially harmful platforms can be identified and passed on to managers and public health for consideration of preventative or safeguarding action.

Where suicidal ideation is disclosed and subsequent probing has identified that your client has thought about method, questions should seek to ascertain how research was carried out. For example:

- How did you decide on this method?
- Have you researched the method? How? Did you use the internet?
- Can you tell me what you looked at on the internet?
- What actions have you taken as a result of internet searching?
- Do you think you have seen anything online recently that may have influenced your decision around method?

Questions around social media use specific to self-harm might include:

- What social media sites are you using at the moment?
- Do you feel troubled by anything that takes place on your social media sites?
- Have you been involved in any discussions about self-harm (or suicide)
- Do you deliberately access social media that promotes self-harm or suicide?
- Do you deliberately seek out social media that promotes self-care and help seeking?

If potentially harmful self-harm /suicide related internet or social media use is elicited it is important for clinicians/staff to engage the patient in a dialogue to explore their motives for accessing such material and to try and support them in changing this behaviour. Possible questions might include:

- Why do you think you look at these internet sites/access this social media?
- How does it make you feel?
- Do you derive any benefit?
- What do you think the potential harms for you are?

Be curious as to why your client would choose to be exposed to potentially harmful internet/social media when there are supportive options easily accessible.

Focus on your client's ambivalence and encourage them to think of reasons for choosing more positive sites.

Sit with your patient and identify positive social media, apps and internet sites such as:

- Stay alive suicide prevention app
- Young Minds https://youngminds.org.uk/ https://www.facebook.com/youngmindsuk
- Student Minds http://www.studentminds.org.uk/ http://studentmindsorg.blogspot.co.uk/
- Mind https://www.mind.org.uk/ https://www.facebook.com/mindforbettermentalhealth
- Get Self Help https://www.getselfhelp.co.uk/
- Healthtalk http://www.healthtalk.org/young-peoples-experiences/depression-and-low-mood/depression-self-harm-suicidal-feelings

Incorporate positive internet and social media sites into safety planning.

AyeMind (ayemind.com) is a 'digital for youth wellbeing' site and has toolkits and resources for young people and professionals. If you are uncertain about navigating the internet or want to increase your knowledge this site is worth a visit.

References

1. Royal Society for Public Health (2017) Status of Mind: Social media and young people's mental health. London: Royal Society for Public health
2. Luxton, D. et al (2012). Social media and suicide: a public health perspective. American Journal of public health. 102(S2) S195-S200
3. Daine, K., Hawton, K., Singaravelu, V., Stewart, A., Simkin, S. and Montgomery, P., 2013. The power of the web: a systematic review of studies of the influence of the internet on self-harm and suicide in young people. *PloS one*, *8*(10), p.e77555.
4. Biddle, L. et al (2016). Priorities for suicide prevention: balancing the risks ad opportunities of internet use. Policy Report 7/2016, Bristol University.

Appendix G

Useful addresses and telephone help lines

CAMHS Consultation 9am – 5pm Mon – Fri:	01296 565365
Aylesbury CAMHs (duty line):	08442252414
High Wycombe CAMHs (duty line):	01296 564130
Amersham CAMHs (duty line):	01296 565250
Addaction	01296 331933
Young MINDS 102 – 108 Clerkenwell Road London ECIM 5SA E-mail youngminds@Ukonline.co.uk Mon and Fri. 10am – 1pm Tues, Weds, Thurs. 1pm – 4pm	020 7336 8445
Young MINDS Parents Information Service	0808 802 5544
Bristol Crisis Service for Women PO BOX 654 Bristol Avon BS99 IXH Fri. and Sat. 9pm– 2.30am Sun. 6pm-9pm	0117 925 1119
R-U-Safe? Young Women's Service The Centre Castlefield High Wycombe Buckinghamshire HP12 3LL	01494 534381
Samaritans 24 hour helpline	08457 90 90 90
Childline 24 hr helpline	0800 1111
CALM (Campaign Against Living Miserably) Helpline for 15 –24 year old males 7 days a week 5pm –3am	0800 58 58 58

Web sites

The Young People and Self-Harm Information Resource Website
www.ncb.org.uk/selfharm

Self-Injury and Related Issues (SIARI)
www.siari.co.uk

National Self-Harm Network
PO BOX 16190
London NW1 3WW
www.nshn.co.uk

Useful references

Hawton, K. (2006) By their own young hand. Deliberate self harm and suicidal ideas in adolescents. Jessica Kingsley Press

Schmidt, U and Davidson, K. (2000) Life after self harm: A guide to the future. Hove: Brunner-Routledge

Breast Ironing

BSCB Guidance http://www.bucks-lscb.org.uk/professionals/breast-ironing/

What is breast ironing?

Breast ironing is practiced in all ten regions of Cameroon and has been reported in Benin, Ivory Coast, Chad, Guinea-Bissau, Kenya, Togo, Zimbabwe and Guinea-Conakry. The charity CAWODIGO – CAME Women and Girls (http://www.cawogido.co.uk/index.php) is concerned that African immigrants have brought breast ironing practice with them to the UK. In their efforts to reduce the number of affected girls and women, CAME provides training for Cameroonian organisations working to protect girls from being abused through breast ironing and supporting families and communities. Girls aged between 9 and 15 have hot pestles, stones or other implements rubbed on their developing breast to stop them growing further. In the vast majority of cases breast ironing is carried out by mothers or grandmothers and the men in the family are unaware. Estimates range between 25% and 50% of girls in Cameroon are affected by breast ironing, affecting up to 3.8 million women across Africa.

Why does breast ironing happen?

The practice of breast ironing is seen as a protection to girls by making them seem 'child-like' for longer and reduce the likelihood of pregnancy. Once girls' breasts have developed, they are at risk of sexual harassment, rape, forced marriage and kidnapping; consequently, breast ironing is more prevalent in cities. Cameroon has one of the highest rates of literacy in Africa and ensuring that girls remain in education is seen as an important outcome of breast ironing.

Breast ironing is physical abuse

Breast ironing is a form of physical abuse that has been condemned by the United Nations and identified as Gender-based Violence. Although, countries where breast ironing is prevalent have ratified the African Charter on Human Rights to prevent harmful traditional practices, it is not against the law.

Breast ironing does not stop the breasts from growing, but development can be slowed down. Damage caused by the 'ironing' can leave women with malformed breasts, difficulty breastfeeding or producing milk, severe chest pains, infections and abscesses. In some cases, it may be related to the onset of breast cancer.

Breast Ironing in the UK

Concerns have been raised that breast ironing is also to be found amongst African communities in the UK, with as many as a 1,000 girls at risk. Keeping Children Safe in Education (2016) mentions breast ironing on page 54, as part of the section on so-called 'Honour Violence'. Staff worried about the risk of breast ironing in their school should speak to the Designated Safeguarding Lead as soon as possible. Schools need to know the risk level within their communities and tackle the risk as appropriate.

Video https://youtu.be/lOqXWTwnEEE

Tri.x have issued a paper with further information and links regarding this practice
http://www.trixonline.co.uk/website/news/pdf/policy_briefing_No-164.pdf