SAFEGUARDING AND CHILD PROTECTION POLICY

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APPLICABLE TO: ALL OXPIP STAFF, VOLUNTEERS AND TRUSTEES

Contents

Appendices

1. Introduction and Statement

OXPIP promotes secure attachments between parents and their babies under two. OXPIP is a small charitable organisation with a team of therapists and a board of trustees. Any staff working directly with children and/or vulnerable adults are DBS checked.

OXPIP aims to promote emotional wellbeing and to protect infants from harm. OXPIP aims to improve children's and parents' health and welfare, including their physical, emotional, social and intellectual development.

OXPIP is fully committed to safeguarding and protecting the welfare of all children and taking all reasonable steps to promote safe practice and protect children from harm, abuse and neglect.

OXPIP recognises its duty of care to safeguard children as detailed under the Children Acts' 1989 and 2004 and Working Together to Safeguard Children 2015.

OXPIP acknowledges its duty to act appropriately with regards to any allegations towards anyone working on its behalf, or towards any disclosures or suspicion of abuse.

OXPIP believes that:

- The welfare of all children and young people is paramount. We treat infants as individuals entitled to dignity and respect.
- All children, regardless of age, ability, gender, racial heritage, religious or spiritual beliefs, sexual orientation and /or identity, have the right to equal protection from harm or abuse.
- Some children are additionally vulnerable because of the impact of previous experiences, their level of dependency, communication needs or other issues.
- Working in partnership with children, their parents, carers, and other agencies is essential in promoting young people's welfare.
- We are all responsible for raising awareness of best practice.
- Safety is the responsibility of all members of OXPIP.
- We should adopt and apply safe recruitment practices for all staff.
- Parents/carers and therapists should be aware of procedures to be followed should abuse be suspected.

2. Legal Framework

This policy has been developed in accordance with the principles established by the following legislation and guidance:

- Children Act 1989
- United Nations Convention on the Rights of the Child 1991
- Children Act 2004
- Equality Act 2010
- Children and Families Act 2014
- Special educational needs and disability (SEND) code of practice: 0 to 25 years
- Working Together to Safeguard Children 2015
- What to do if you are worried a Child is being Abused 2015
- Keeping Children Safe in Education 2016
- Oxfordshire Safeguarding Children Board guidelines

This policy applies to all staff, including senior managers, committee members/board of trustees, paid staff, volunteers and sessional workers, agency staff, students or anyone in a position of trust.

A child is defined as a person under the age of 18 (The Children's Act 1989).

3. Organisational Policies and Procedures

This policy should be read alongside the following organisational policies and guidance:

- Recruitment, induction and training
- Safer recruitment
- Recording, storing and sharing information
- Confidentiality
- Code of conduct for staff and volunteers
- ICT, Social Media and E-safety
- Photography and use of images of children
- Health and safety
- Anti-bullying
- Whistleblowing
- Training, supervision and support

4. Purpose of Policy

The purpose of this policy is to:

- Protect children and young people who receive OXPIP services. This includes children of adults who use our services;
- Provide all those in a position of trust with the overarching principles that guide our approach to safeguarding and child protection.

5. OXPIP's Commitment to Safeguarding Children

To keep children safe OXPIP will:

- Provide a setting where children/infants feel listened to, safe, secure, valued and respected.
- Ensure a safe environment for infants, parents, therapists and staff at OXPIP main base, other locations where the OXPIP service is available, in therapists' own or hired consulting rooms and for home visiting.
- Ensure that there is proper and adequate supervision of therapist and staff in relationship to management of boundaries, clear communication channels and assessment skills. OXPIP requires therapists to continue their professional development.
- Appoint a Designated Safeguarding Lead for children/infants and ensure a clear line of accountability with regards to safeguarding concerns.
- Ensure all those in a position of trust have been provided with up to date and relevant information, training, support and supervision to enable them to fulfil their role and responsibilities in relation to safeguarding and child protection.
- Provide a clear procedure to follow when safeguarding and child protection concerns arise.
- Ensure effective and appropriate communication between all individuals in a position of trust.

- Build strong partnerships with other agencies to promote effective and appropriate multi-agency working, information sharing and good practice.

6. Roles and Responsibilities

All individuals in a position of trust must:

- Understand the different types of abuse and recognise the possible risks and Indicators
- Understand their responsibility to report any concerns that a child is being, or is at risk of being, abused or neglected. This includes reporting any concern they may have regarding another person's behaviour towards a child or children
- If appropriate; liaise with other agencies, contribute to safeguarding assessments and attend child protection meetings / core groups / conferences
- Record and store information legally, professionally and securely in line with organisational policies and procedures
- Undertake the required level of training for their role in line with Oxfordshire Safeguarding Children Board standards, every 3 years for Generalist and Advanced Safeguarding and every 2 years for Designated Leads.
- Understand the line of accountability for reporting safeguarding concerns and be fully aware of the organisation's safeguarding lead and their role within the organisation.

Name of Safeguarding Lead: Helen Callaghan 01865 778034 / 07934 517 400

Name of Deputy Safeguarding Leads:
Joanna Chapman: 01865 778034 / 07864 661 903
Catherine O'Keefe: 01865 778034 / 07925 094 848

All individuals working in a position of trust at OXPIP will follow the Oxfordshire Safeguarding Children Board Procedures/Local Authority guidance in all cases of abuse, or suspected abuse (these can be found at OSCB.org.uk).

The Management Committee is ultimately accountable for ensuring settings provided by OXPIP are safe, including the implementation of effective safeguarding procedures.

This policy is available to all and can be accessed by emailing info@oxpip.org.uk.

7. Safer Recruitment

Safe recruitment is central to the safeguarding of children and young people. All organisations which employ people to work with children in a position of trust have a duty to safeguard and promote their welfare. This includes ensuring that the organisation adopts safe recruitment and selection procedures which prevent unsuitable persons from gaining

access to children. Please see the Schools Safeguarding Safer Recruitment Toolkit for further guidance on safe recruitment, http://schools.oxfordshire.gov.uk/cms/node/358

Procedures in relation to selection, recruitment, vetting and police checking are undertaken in accordance with written procedures.

8. Monitoring and Review

The policy will be reviewed annually. All individuals in a position of trust should have access to this policy and sign to the effect that they have read and understood its contents.

OXPIP will complete an annual self-assessment to appraise their safeguarding practice against OSCB standards, please see www.oscb.org.uk/

9. Document Version History

Document version history				
Document Name:		Safeguarding and Child Protection Policy		
Owner:		Helen Callaghan, CEO, Clinical Director		
Author:		Catherine O'Keefe, Senior Parent-Infant Therapist		
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V2	March 2021	Updated Helen Callaghan's job title, Joanna Chapman's work mobile, Rob Kenny as Chair of Trustees and COVID-19 section	Lizi Potter, Operations Manager	Helen Callaghan, CEO, Clinical Director
V1	December 2019	New version prepared in line with OSCB template	Catherine O'Keefe, Senior Parent-Infant Therapist	Helen Callaghan, Clinical Director

Appendix A

Child Protection and Safeguarding Procedures

1. Introduction

All professionals have a responsibility to report concerns to Children's social care under section 11 of the Children Act 2004, if they believe or suspect that the child;

- Has suffered significant harm;
- Is likely to suffer significant harm;
- Has a disability, developmental and welfare needs which are likely only to be met through provision of family support services (with agreement of the child's parent) under the Children Act 1989;
- Is a Child in Need whose development would be likely to be impaired without provision of service.

2. What to do if you are concerned about a child

If an allegation is made or concerns are raised, they should always be brought to the attention of the Clinical Director (safeguarding lead). A record should be kept of the observations provoking concern, all conversations and interventions which took place, what action was taken and why. The therapist must always record whether the mother / parent has been kept fully informed of the action taken.

OXPIP staff should not investigate allegations but should listen and record what is said or seen and refer it to Social Services who are trained to make inquiries, which will indicate whether further investigations are necessary. (If a serious incident has occurred which leads to a criminal trial, it is essential that there is no suggestion that witnesses have been led to say what they did.)

Supporting children

If/when a child reports they are suffering or have suffered significant harm through abuse or neglect, or have caused or are causing physical or sexual harm to others, the initial response from all professionals should be to listen carefully to what the child says and to observe the child's behaviour and circumstances to:

- Clarify the concerns;
- Offer re-assurance about how the child will be kept safe;
- Explain what action will be taken and within what timeframe.

The child must not be pressed for information, led or cross-examined or given false assurances of absolute confidentiality, as this could prejudice police investigations, especially in cases of sexual abuse.

If the child can understand the significance and consequences of making a referral to children's social care, they should be asked for their views.

It should be explained to the child that whilst their view will be taken into account, the professional has a responsibility to take whatever action is required to ensure the child's safety and the safety of other children**.**

Confidentiality

Children have a right to confidentiality under Article 8 of the European Convention on Human Rights. It's important to respect the wishes of a child or any person who doesn't consent to share confidential information.

All personal information about parents and families is treated as confidential and is discussed only with the Clinical Director and supervisors.

If you're not given consent to share information, you may still lawfully go ahead if the child is experiencing, or is at risk of, significant harm.

Child protection concerns, disclosures from children or safeguarding allegations made against a person in a position of trust must not be discussed across the workforce as a whole. This information should be shared solely with Designated Safeguarding Leads, Children's Social Care and/or the Local Area Designated Officer (LADO) as appropriate.

Personal information which is shared by the child or young person on a 1:1 level, such as sexual orientation or gender identification, should not be disclosed to the workforce as a whole.

If staff and volunteers wish to discuss situations with colleagues to gain a wider perspective, this should be done on an anonymous basis with names and other identifying information relating to the child and their family remaining strictly confidential.

Seven golden rules for information sharing

1. Remember that the Data Protection Act 1998 and human rights law are not barriers to justified information sharing but provide a framework to ensure that personal information about living individuals is shared appropriate.
2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.
3. Seek advice from other practitioners if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.
4. Share with informed consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgement, there is good reason to do so, such as where safety may be at risk. You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be certain of the basis upon which you are doing so. Where you have consent, be mindful that an individual might not expect information to be shared.
5. Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.
6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up to date, is shared in a timely fashion, and is shared securely.
7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

Reporting concerns

The referrer should provide information about their concerns and any information they may have gathered prior to referral. The infant's non-verbal communication should be documented and form part of the referral. They will be asked for the following:

- Full names, dates of birth and gender of all child/ren in the household;
- Family address and (where relevant) school / nursery attended;
- Identity of those with parental responsibility and any other significant adults who may be involved in caring for the child such as grandparents;
- Names and date of birth of all household members, if available;
- Ethnicity, first language and religion of children and parents;
- Any special needs of children or parents;
- Any significant/important recent or historical events/incidents;
- Cause for concern including details of any allegations, their sources, timing and location;
- Child's current location and emotional and physical condition;
- Whether the child needs immediate protection;
- Details of alleged perpetrator, if relevant;
- Referrer's relationship and knowledge of child and parents;
- Known involvement of other agencies / professionals (e.g. GP);
- Information regarding parental knowledge of, and agreement to, the referral;
- The child's views and wishes, if known.

Other information may be relevant, and some information may not be available at the time of making the referral. However, the report should not be delayed, in order to collect information, if the delay may place the child at risk of significant harm.

Where a therapist has concerns about the mental health of a parent where this may impact on a parent's capacity to care for a child or may put a child at risk, the therapist should inform the Clinical Director and contact the client's GP to pass this information on. Further action may need to be taken in discussion with the Clinical Director or GP.

Parents/carers must be informed about any referral unless to do so would place the child at an increased risk of harm.

3. To report a new concern

Immediate concerns about a child

The Multi-Agency Safeguarding Hub (MASH) is the front door to Children's Social Care for all child protection and immediate safeguarding concerns. If there is an immediate safeguarding concern, for example:

* Allegations/concerns that the child has been sexually/physically abused

* Concerns that the child is suffering from severe neglect or other severe health risks

* Concern that a child is living in or will be returned to a situation that may place him/her at immediate risk

* The child is frightened to return home

* The child has been abandoned or parent is absent

You should call the MASH immediately Tel: 0333 014 3325 or 0345 050 7666 (The latter number will take you through to Customer Services who will ask a series of questions and triage into MASH where safeguarding concerns are raised).

The Oxfordshire MASH Referral Form (MASH Enquiry online referral form) may be used by professionals only to refer children to social services. Or you can email a report to MASH on the secure email on: mash-childrens@oxfordshire.gcsx.gov.uk

If you have a concern about a child/family but it is not an immediate safeguarding concern, you should refer to the Threshold of Needs matrix which can be found at, http://www.oscb.org.uk/wp-content/uploads/Oxfordshire-Threshold-of-Needs_Final.pdf

This tool is designed to support professionals to make decisions as to whether contact should be made with Children's Social Care.

If after consulting the Threshold of Need, you still have concerns that do not require an immediate safeguarding response, you should contact the Locality and Community Support Service (LCSS) and request a 'no names' consultation (meaning you don't give the child's name). You can then discuss the situation with them and they will advise you on what to do next. If a referral needs to be made they will advise you of this.

- LCSS Central : 0345 241 2705
- LCSS North (including Banbury, Witney, Bicester, Carterton and Woodstock): 0345 241 2703
- LCSS South (including Abingdon, Faringdon, Wantage, Thame, Didcot and Henley): 0345 241 2608

If you have a concern out of office hours call Emergency Duty Team on 0800 833 408

4. Referrals on open cases

If you want to speak to someone about an already open case contact the relevant Children's Social Care Team. If you do not have the name and contact details for the relevant Social Worker, contact MASH on 0345 050 7666.

5. Allegations against others working with children

All allegations of abuse by those who work with children must be taken seriously, whether they are in a paid or unpaid capacity. This procedure should be applied when there is an allegation or concern that a person who works with children, has:

- Behaved in a way that has harmed a child, or may have harmed a child;
- Possibly committed a criminal offence against or related to a child;
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

To report an allegation or concern about a person in a position of trust, please contact the LADO and Safeguarding Team on 01865 810603 or email: LADO.safeguardingchildren@oxfordshire.gov.uk

5. Whistleblowing

We recognise that children cannot be expected to raise concerns in an environment where those in a position of trust fail to do so. All those in a position of trust should be aware of their duty to raise concerns about dangerous or illegal activity, or any wrongdoing within their organisation.

(see OXPIP's Whistleblowing policy)

Appendix B

Definitions and Indicators of Abuse

The table below outlines the main categories of abuse as defined by the Department of Health 'Working Together to Safeguard Children' document 2015. (Full definitions can be found in this document). All staff should be aware that the possible indicators are not definitive and that some children may present these behaviours for reasons other than abuse.

Type of Abuse	**Possible Indicators**
Neglect The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: • provide adequate food, clothing and shelter (including exclusion from home or abandonment); • protect a child from physical and emotional harm or danger; • ensure adequate supervision (including the use of inadequate care-givers); or • ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs. It is also vital that therapist and staff are aware of the possibility of third-party abuse and report concerns appropriately. Therapists should also be alert to instances when there is a deterioration in the mental health of the parent and there is concern that this will impact on the parent's capacity to care for their children or that this may put the children at risk.	Signs that may indicate a child is living in a neglectful situation: • excessive hunger • poor personal hygiene • frequent tiredness • inadequate clothing • frequent lateness or non-attendance at school • untreated medical problems • not brought • poor relationships with peers • compulsive stealing and scavenging • rocking, hair twisting and thumb sucking • running away • loss of weight or being constantly underweight (the same applies to weight gain, or being excessively overweight • low self esteem • poor dental hygiene

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.	Signs that may indicate physical abuse: • Physical signs that do not tally with the given account of occurrence, • conflicting or unrealistic explanations of causes • repeated injuries • delay in reporting or seeking medical advice.
Sexual Abuse Involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not, the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.	Signs that may indicate sexual abuse: Changes in: • Behaviour • Language • Social interaction • Physical wellbeing It is almost important to recognise there may be **no signs**.
Emotional Abuse The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the	Signs that may indicate emotional abuse: • Lack of self-confidence/esteem • Sudden speech disorders • Self-harming (including eating disorders) • Drug, alcohol, solvent abuse • Lack of empathy (including cruelty to animals)

needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.	• Concerning interactions between parent/carer and the child (e.g. excessive criticism of the child or a lack of boundaries)
<u>Child Sexual Exploitation (CSE)</u> 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.	Signs that may indicate CSE: • Going missing from school/home/care placement • Associating with older people/adults • Isolation from family/friends/peer group • Physical symptoms including bruising/STI's • Substance misuse • Mental health • Unexplained possessions, goods and/or money The indicators can be spotted when speaking to the young person themselves or family/friends If a child or young person has made a disclosure regarding sexual exploitation, or if you think a child may be at risk of being

	sexually exploited please contact the Kingfisher Team on 01865 309196. Out of hours calls will divert to Thames Valley Police Referral Centre.

Other type of abuse you should be aware of

Child Exploitation

Child exploitation describes how gangs from large urban areas supply drugs to suburban and rural locations, using vulnerable children and young people to courier drugs and money.

Typically, gangs use mobile phone lines to facilitate drug orders and supply to users. They also use local property as a base; these often belong to a vulnerable adult and are obtained through force or coercion (this exploitation is sometimes referred to as 'cuckooing').

It also finds that the age of those involved is getting younger, with children as young as 12 being targeted. Gangs 'recruit' through deception, intimidation, violence, debt bondage and/or grooming into drug use and/or child sexual exploitation.

While there has been an increased awareness of the use of children and young people in county line markets, more needs to be done as it cuts across a number of issues such as drug dealing, violence, gangs, child sexual exploitation, safeguarding, modern slavery and missing persons.

Signs that may indicate drug/criminal exploitation are similar to CSE, as follows:

- Going missing from school/home/care placement
- Associating with older people/adults
- Isolation from family/friends/peer group
- Physical symptoms including bruising
- Substance misuse
- Mental health
- Unexplained possessions, goods and/or money

The NSPCC information on CSE can be found at Child Sexual Exploitation: at a glance/NSPCC

Domestic Abuse

Defined as, "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial or emotional".

Forced marriage

A forced marriage (FM) is a marriage conducted without the valid consent of one or both parties and where duress is a factor. Forced marriage is now a specific offence under s121 of the Anti-Social Behaviour, Crime and Policing Act 2014 that came into force on 16 June 2014.

FM is very different to an arranged marriage where both parties give consent.

Modern Slavery and Human Trafficking

Modern slavery can take many forms including the trafficking or people, forced labour, servitude and slavery. Victims can include adults and children and come from all walks of life and backgrounds. A quarter of all victims are children.

The Modern Slavery Act 2015 places a duty on specified public authorities to report details of suspected cases of modern slavery to the National Crime Agency.

Indicators of Modern Slavery can include:

- Lack of access to legal documents (e.g. passports)
- Appearance (malnourished, unkempt, etc)
- Untreated or unexplained injuries
- Attitude (withdrawn, frightened, unable to speak for themselves)
- Indebtedness or in a situation of dependence
- Frequent changes of location or restrictions on movement

Female Genital Mutilation

Female genital mutilation (FGM), sometimes referred to as female circumcision, refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The practice is illegal in the UK.

There are no health benefits to FGM, it is carried out for cultural and social reasons within families and communities. The procedure is traditionally carried out by an older woman with no medical training. Anaesthetics and antiseptic treatment are not generally used and

H. Callaghan.

the practice is usually carried out using basic tools such as knives, scissors, scalpels, pieces of glass and razor blades.

The Oxford Rose Clinic is a specialised clinic run at the John Radcliffe Hospital to address the health and safeguarding issues associated with FGM. Women should be referred to this clinic by emailing oxfordrose.clinic@nhs.net or calling 01865 222969.

Healthcare professionals have a duty to safeguard any children who may be at risk of FGM. Information about how to identify children at risk of FGM, including a screening tool and pathways are available on the Oxfordshire Safeguarding Children Board website

Historical sexual abuse

Where this is disclosed, and the perpetrator is still alive and still has access to children, please discuss with the safeguarding lead or carry out a no named social service consultation.

Self-Harm

Deliberate self-harm is intentional self-poisoning or injury, irrespective of the apparent purpose of the act, (www.nice.org.uk). Self-harm is an expression of personal distress, not an illness.

Self-harm can involve:

- Cutting, burning, biting
- Substance misuse
- Head banging and hitting
- Taking personal risk
- Picking and scratching
- Self-neglect
- Pulling out hair
- Disordered eating
- Overdosing and self-poisoning

Indicators of self-harm may include:

- Changing in eating/sleeping habits
- Lowering of academic grades
- Changes in activity and mood
- Abusing drugs or alcohol
- Increased isolation from friends and family

- Becoming socially withdrawn
- Talking about self-harming or suicide

  Giving away possessions
  Expressing feelings of failure, uselessness or loss of hope

Bullying

Bullying is not always easy to recognise as it can take a number of forms. A child may encounter bullying attacks that are:

- physical: pushing, kicking, hitting, pinching and other forms of violence or threats
- verbal: name-calling, sarcasm, spreading rumours, persistent teasing
- emotional: excluding (sending to Coventry), tormenting, ridiculing, humiliating.

Persistent bullying can result in depression, low self-esteem, shyness, poor academic achievement, isolation, threatened or attempted suicide

Indicators a child is being bullied can be:

- coming home with cuts and bruises
- torn clothes
- asking for stolen possessions to be replaced
- losing dinner money
- falling out with previously good friends
- being moody and bad tempered
- wanting to avoid leaving their home
- aggression with younger brothers and sisters
- doing less well at school
- sleep problems
- anxiety
- becoming quiet and withdrawn

Peer on Peer Abuse

Peer-on-peer abuse is any form of physical, sexual, emotional and financial abuse, and coercive control, exercised between children and within children's relationships (both intimate and non-intimate).

Peer-on-peer abuse can take various forms, including: serious bullying (including cyber-bullying), relationship abuse, domestic violence, child sexual exploitation, youth and serious youth violence, harmful sexual behaviour, and/or gender-based violence.

Prevent - Extremism

The Counter-Terrorism and Security Act 2015 places a safeguarding duty on settings to have "due regard to the need to prevent people from being drawn into terrorism".

Settings subject to the Prevent Duty will be expected to demonstrate activity in the following areas:

- Assessing the risk of children being drawn into terrorism
- Demonstrate that they are protecting children and young people from being drawn into terrorism by having robust safeguarding policies.
- Ensure that their safeguarding arrangements take into account the policies and procedures of the Local Safeguarding Children Board.
- 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
- Ensure children are safe from terrorist and extremist material when accessing the internet in the setting

Preventing vulnerable adults and children from being drawn into extremism is a safeguarding concern. It is essential that frontline staff are able to spot the signs and make a safeguarding referral.

Indicators may include:

- Withdrawing from usual activities
- Accessing extremist literature/websites
- Expressing 'us and them' thinking
- Expressing feelings of anger, grievance or injustice

To find out more about the national counter terrorism strategy look online:
homeoffice.gov.uk/counter-terrorism/review-of-prevent-strategy/

To report concerns about child radicalisation:

1. Make safe – If emergency services are required – call 999. Take reasonable steps to ensure that there is no immediate danger.
2. Refer concern identified by member of the public or professional
3. Call MASH on 0333 014 3325

Appendix C

Further Safeguarding Guidelines for Digital Working - March 2020

- Within one working day of a referral received, the client is contacted by an OXPIP Therapist and a client assessment takes place. At this initial contact, a suicide risk assessment is also undertaken and recorded in the client file. If appropriate, a plan is agreed with the client over the telephone about what they might do if suicidal thoughts arise.
- If the client agrees a plan, this is escalated to their GP or on-call OUH psychiatrist.
- Depending on the safeguarding issues highlighted in the call, further follow up support calls will be offered whilst the client waits for OXPIP clinical sessions to commence. The client is also able to call an OXPIP number during working hours to receive further support. We ask clients to contact their GP Out of Hours Service if help is needed outside OXPIP's working hours.
- The HADS (Hospital Anxiety and Depression Scale) form is completed during the first appointment, so that the client's response can be addressed straight away by their Therapist if there is any cause for concern. If it is not possible to complete the form in the session, and it needs to be sent in afterwards; it is uploaded to Oasis (CMS) and any causes for concern are flagged with the Therapist at this stage (or the member of staff covering Safeguarding on that day if the Therapist is not available).
- Once clinical sessions have started, in the first session Therapists will speak about confidentiality with the client and the importance of the parent and baby being in a room without others present and able to freely talk. If there this is not possible, then the Therapist will try to arrange a more convenient time. If there is a risk that other children may sometimes come into the sessions, there may need to be further safeguarding management for those children, as per the usual safeguarding procedures.
- All staff and freelancers are either provided with an OXPIP laptop or required to set up a separate password protected profile on their laptop specifically for OXPIP work in order to keep any OXPIP related work separate and secure. To enhance our security while working remotely, we are also set up with a Remote VPN which must be connected to each time any OXPIP work is carried out. Any confidential information to be sent remotely must be sent by Egress Switch, to ensure confidentiality of the email content and attachments. For further details please see OXPIP's Remote Working Policy.

Key Contacts for OXPIP

OXPIP Safeguarding Lead:	Helen Callaghan 01865 778034 / 07934 517 400
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OXPIP Clinical Trustee:	Anne Burns annerb21@gmail.com
OXPIP Chair of Trustees:	Rob Kenny robkenny1@gmail.com

Revised and approved March 2021 by Helen Callaghan, CEO, Clinical Director:
And Rob Kenny, Chair of Trustees

H. Callaghan.

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