



# MCTC

Child  
Protection  
And  
Safeguarding  
Policy

April 2011

Part One

**INTER AGENCY POLICY**

# **MILITARY CORRECTIVE TRAINING CENTRE (MCTC) CHILD PROTECTION AND SAFEGUARDING - INTER AGENCY POLICY**

## **INTRODUCTION**

1. The MCTC Child Protection and Safeguarding Policy is in partnership with Essex Social Care Children's Services Department (SCCSD) who have a statutory responsibility for all children and young people in need or at risk in their area.
2. The responsibility for action will remain with Essex SCCSD until negotiations with home Local Authority have taken place and written agreement, where applicable, has been received.
3. All Child Protection enquiries will be conducted under the Children Act 1989, Children Act 2004, Child Protection Department of Health Guidelines "Working Together to Safeguard Children 2010" and the Southend, Essex and Thurrock (SET) Child Protection Procedures.
4. The MCTC Child Protection and Safeguarding Policy is to be reviewed annually or in the event of local/national developments and is contained in three parts:
  - Part One - Inter Agency Policy
  - Part Two - MCTC Child Protection Structure
  - Part Three - Child Protection - Action Guide.

## **PART ONE – INTER AGENCY POLICY**

### **Procedural process**

5. All referrals, which raise suspicion that a child or young person may be subject to significant harm should be directed to the local Children's Assessment and Family Support Team (CAFS) Team, Colchester via Essex Social Care Direct and using the inter-agency referral form.
6. All unborn children whose mothers are resident in the MCTC should be referred to Colchester CAFS Team and are the responsibility of Essex SCCSD, until assessment is completed and/or Essex SCCSD achieve written agreement of responsibility from another Local Authority.
7. All allegations of abuse of children or young people under 18 years of age, by a professional carer, including MCTC staff, should be referred to Colchester CAFS Team and Colchester Police Child Abuse Investigation Unit (CAIU).
8. All allegations of historical abuse where there are no indications that a child is at risk of significant harm should be referred to the Police Child Abuse Investigation Unit (CAIU) in the area where the alleged abuse occurred.
9. The MCTC will notify the custodian of the Child Protection Register (Essex Children's Services) of the presence of any young person or unborn child resident in the MCTC whose name is on the Child Protection Register of an authority other than Essex.
10. The MCTC will notify Essex SCCSD of any child under 16 years of age admitted to the Centre. A meeting of professionals will be held within 24 hours to make recommendations for appropriate future care of the child.

11. The MCTC will notify Essex SCCSD of any child under the age of 18 years being admitted into the Centre.

12. The MCTC will notify Essex SCCSD of any detainee being released into Essex who has been previously or is currently convicted of an offence which could impose a risk to children for whom they care or with whom they have contact.

### **Roles and responsibilities**

13. The Commandant will ensure that the internal child protection arrangements are robust and that all staff are appropriately aware of their reporting responsibilities.

14. The Commandant and the Essex Safeguarding Children Board (ESCB) will establish and maintain lines of communication which are clear and ensure that staff understand the need for multi-agency working together in order to assist the development of best practice.

15. The Commandant will be a member of the ESCB.

16. The ESCB will monitor and review aggregated data from MCTC in relation to Child Protection as part of the reporting process. This will be undertaken annually.

17. The ESCB will support and advise on staff training and initiatives to create a child safe environment within the MCTC establishment.

18. Essex SCCSD will provide a named lead Service Manager for representation, consultation and advice.

19. Essex SCCSD will be represented on the MCTC Safeguarding Children Board (SCB).

20. Essex SCCSD has responsibility for the transfer of its statutory responsibilities to other Local Authorities.

21. Essex SCCSD will inform "the establishment" of outcomes in any enquiry in order to achieve closure.

### **Criteria for referrals**

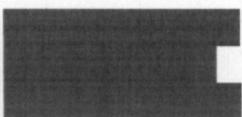
22. The management of all allegations of physical, sexual, neglect and emotional abuse, which indicate that a young person is suffering or may be at risk of suffering **significant harm**.

23. The management of all disclosure of historical abuse.

24. Dealing with the welfare of a young person where there are concerns of abuse occurring within a family or by another person.

25. Any abuse by a professional carer.

26. When a child is identified as being **'in need'** of services from Children's Social Care.





# MCTC

## Child Protection And Safeguarding Policy

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Part Two

**MCTC CHILD PROTECTION STRUCTURE**

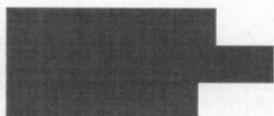
## CHILD PROTECTION POLICY STATEMENT

This Child Protection procedure is based upon well-established inter-agency arrangements for promoting the welfare of young people (**all persons under 18 years of age**) and safeguarding them from harm. It recognises the inherent vulnerability of young people held in secure establishments and that many of them will have previously been the victims of abuse and exploitation.

It is the duty of all staff at the Military Corrective Training Centre (MCTC) to know how to recognise and respond to potential indicators of abuse or neglect of young people in our care.

MCTC may be made aware that a young person has been abused whilst in our care or the young person may inform staff that they have been abused in the past. Similarly, they may inform staff that they have knowledge that a person(s) outside of the MCTC is/are at risk. Information about alleged abuse may also come to light via other routes – for example in reports contained on file.

Whatever the source of concern, appropriate action must be taken to safeguard the young person and to make appropriate enquiries according to this policy. Also, to ensure there is effective inter-agency working to safeguard and promote the welfare of young people through applying the “duty to co-operate” and sharing of information. Our duty is to develop practice in accord with JSP 834, Children Act 1989, Children Act 2004 and associated Regulations and Guidance; in particular, Southend, Essex and Thurrock (SET) Child Protection Procedures 2011 under which the MCTC Child Protection and Safeguarding Policy sits.



Date:

## INTRODUCTION

1. The MCTC recognises that it has a clear duty to protect children: children who come into the MCTC and children who come into contact with adults and young people that are in detention. This protocol, the related procedures and the training provided under the terms of this protocol, establish the roles and responsibilities of management and staff in discharging the MCTC responsibility towards the protection of children.

## CHILD PROTECTION RESPONSIBILITIES

2. **Overall responsibility.** The Commandant has overall responsibility within the MCTC for ensuring that the internal child protection policy is robust and that all staff are appropriately trained and aware of their individual responsibilities under it. The Commandant will ensure that all allegations or suspicions of sexual, physical or emotional abuse of any child detainee are referred to the Colchester Social Care Children's Services Department (SCCSD) Children's Assessment and Family Support Team (CAFS), in accordance with Essex SCCSD protocol, and that concerns regarding the abuse of children visiting the MCTC or through a disclosure of historical abuse are reported to the authorities.

3. **Delegated responsibility.** The day to day management of child protection matters within the MCTC will be undertaken by the Welfare Officer or the Assistant Welfare Officer in the absence of the Welfare Officer on behalf of the Commandant.

4. **Individual responsibility.** All staff employed within the MCTC are to ensure that they are conversant with the MCTC Child Protection and Safeguarding Policy (CPSP) and have received appropriate training. It is the duty of staff to refer cases where abuse is known to have occurred or is suspected. ***No member of staff has a right or responsibility to withhold information or to respect a child's/young person's wish for confidentiality when this may place a child/young person, or other children/young people at risk of further abuse.*** This relates equally to children or young people who are believed to be victims of abuse and to children or young people who are believed to have perpetrated abuse.

## MCTC SAFEGUARDING CHILDREN BOARD

5. The MCTC Safeguarding Children Board (SCB) will assist the Commandant with the implementation of the MCTC CPSP and shall meet quarterly. Composition of the SCB is:

- Commandant. - Chairperson
- Welfare Officer - MCTC Child Protection Co-ordinator.
- Medical Officer - MCTC Medical Officer
- SEO - MCTC Senior Education Officer
- ADJT - MCTC Vetting and Registration Officer
- Service Manager - Assessment and Family Support
- RQMS - MCTC
- A Coy CSM - MCTC
- D Coy/SCP CSM - MCTC (2ic Safer Custody Team)

- Training WO - MCTC
- QMSI Gym - MCTC
- Security WO - MCTC
- WOIC (V) - MCTC (CP Training Coordinator)
- SNCO IC DUS Rec - MCTC
- IT Systems Manager - MCTC

6. The objectives of the MCTC SCB are:

- a. To establish a common understanding between the MCTC and the Essex Safeguarding Children Board (ESCB) regarding the arrangements for safeguarding children and young people in the MCTC.
- b. To provide a liaison point for contact with appropriate other agencies, including SCCSD and Police CAIU on both a formal and informal basis.
- c. To agree the criteria for assessing circumstances which may lead to a formal referral and keep this criteria under constant review.
- d. To monitor procedures for dealing with incidents of significant harm which may have occurred prior to a detainee entering into the MCTC.
- e. To monitor the investigation of allegations or suspicions of abuse to children.
- f. To monitor the implementation of this policy and to act as a focus, advice or contact point for staff concerns about possible harm to children at or visiting the MCTC.
- h. To bring to the attention of the Commandant concerns regarding unsafe practice in respect of children at MCTC.
- i. To disseminate and support good practice through awareness raising and training for staff.

## STAFF TRAINING

7. The Commandant will ensure that all staff are properly trained and supervised to promote the protection of children through the operation of line management supervision, training and advice on safe working practices. This is to be achieved by:

a. **Training the trainer.** ESCB shall train and qualify a selected nucleus of MCTC personnel to enable them to conduct child protection and safeguarding training to MCTC staff.

b. **Individual training.** Individual training shall be conducted on a rolling basis by ESCB trained MCTC staff, to approved ESCB standards, through the inclusion of child protection and safeguarding as part of the syllabus on the following internal courses:

- AGC (MPS) Custodial NCO's Course
- MCTC Induction Course

c. **Annual refresher training.** All MCTC staff are to attend annual child protection and safeguarding refresher training in accordance with a syllabus agreed by ESCB.

d. **Training and records.** The Welfare Officer is responsible to the Commandant for all child protection and safeguarding training and, is to maintain a register of staff attendance at both initial training and annual refresher training.

## ACCESS TO CHILD PROTECTION POLICY

8. **Location and access.** It is the responsibility of Heads of Departments to ensure that staff are aware of the location of child protection literature within their area of responsibility. ***The SET Child Protection Procedures 2011 and MCTC Child Protection and Safeguarding Policy are available on-line at MCTC REC-01-02-10-01.*** Copies of the MCTC Child Protection Policy are available in hard copy at the following locations:

- A, D Coy and SCP Gate (24hr access)
- Main Gate (24hr access)
- Duty Field Officer (24hr access)
- Medical Centre
- Gymnasium Office
- Training Wing Office
- Welfare Office
- MCTC HQ (Adjt)
- Education (WO)
- MPS (V)

9. **Communication.** The focal point within the MCTC for child protection and safeguarding matters is the Welfare Officer (or the Assistant Welfare Officer in the absence of the Welfare Officer) who, through the medium of MCTC Part One Orders, Command Board Meetings, Line Managers and annual refresher training will keep staff updated about child protection.

#### **CHILD PROTECTION REGISTER**

10. The Welfare Officer is to maintain the MCTC Child Protection Register which is to be retained in the Welfare safe.

#### **CHILD PROTECTION – ACTION GUIDE**

11. In the event of a child protection and safeguarding matter coming to the attention of staff, detailed instructions of actions to be carried out are contained at Part Three of this instruction. Further guidance can also be obtained from the SET Child Protection Procedures 2011; copies of this publication can be located in accordance with paragraph 8.





# MCTC

## Child Protection And Safeguarding Policy

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Part Three

**CHILD PROTECTION – ACTION GUIDE**

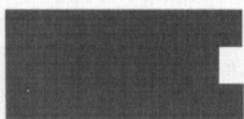
## **CHILD PROTECTION – ACTION GUIDE**

### **INTRODUCTION**

1. The supporting annexes contain a comprehensive guide regarding actions to be carried out in respect of child protection and safeguarding matters within the MCTC.

### **FURTHER GUIDANCE**

2. Further guidance can be found in Parts One and Two of the MCTC Child Protection and Safeguarding Policy as well as the SET Child Protection Procedures 2011.



#### Annexes:

- A. Recognition and Indicators of Child Abuse.
- B. Initial Disclosure Guidelines for Staff.
- C. Internal Referral Process.
- D. External Referral Process.
- E. Child Protection Concerns Within MCTC.
- F. Child Protection Referral - Flowchart.
- G. Essex Safeguarding Children Agencies – Contact Details.
- H. MCTC Child Protection Information Report.
- I. MCTC Child Protection Log.
- J. External Child Protection Referral Form.

## RECOGNITION AND INDICATORS OF CHILD ABUSE

### INTRODUCTION

1. The first indication that a child (*a child is any person under the age of 18 years, including Service personnel*) or young person is being abused is not necessarily the presence of a severe injury. Concerns that a child or young person is being abused may be aroused by the sight of bruises, burns/scalds, bites, scars or fractures and joint injuries on a child/young person's body or by remarks made by a child/young person, their parents, friends or colleagues. It may also be by observation of a child/young person's behaviour or reactions, from being aware that a family member is under stress and may need help with caring for the children or from a number of other factors.

2. *Although the MCTC is licensed to accept detainees from 16 years of age upwards, the detainee population is predominantly adult of which some may have been subjected to abuse as children. Appendix 1 to this Annex provides details of the most common symptoms/problems faced by adults who may have been abused as children.*

### KEY CONCEPTS

#### Significant Harm

3. *The Children Act 1989* introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children, and gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering or likely to suffer significant harm.

4. There are no absolute on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation and the presence or degree of threat, coercion, sadism and bizarre or unusual elements.

5. Sometimes, a single traumatic event may constitute significant harm (e.g. a violent assault, suffocation or poisoning). More often, significant harm is a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child's physical and psychological development.

6. Some children live in family and social circumstances where their health and development are neglected. For them, it is the impact of long-term neglect, physical or sexual abuse that causes impairment to the extent of constituting significant harm.

### LEGAL FRAMEWORK

7. *The Children Act 1989* provides the legal framework for defining the situations in which local authorities have a duty to make enquiries about what, if any, action they should take to safeguard or promote the welfare of a child.

8. Section 47 of the Act requires that if a local authority has 'reasonable cause to **suspect** that a child in their area of responsibility is suffering or likely to suffer significant harm' the authority shall make or cause to be made, such enquiries as they consider necessary.

9. Under section 31 (9) of the Children Act 1989 as amended by the Adoption and Children Act 2002:

- **'Harm'** means ill treatment, or impairment of health or development, including, for example, impairment suffered from seeing or hearing the ill-treatment of another.
- **'Development'** means physical, intellectual, emotional, social or behavioural development.
- **'Health'** includes physical and mental health.
- **'Ill treatment'** includes sexual abuse and forms of ill treatment which are not physical.

## **ABUSE AND NEGLECT**

10. Child abuse and neglect; are forms of maltreatment of a child. These terms include serious physical and sexual assaults as well as cases where the standard of care does not adequately support the child's health or development. Children and young people may be abused or neglected through the infliction of harm, or through the failure to act to prevent harm.

11. Abuse can occur within the family or in an institution or community setting. Abuse can occur within all social groups regardless of religion, culture, social class or financial position. Children and young people may be abused by those known to them or, more rarely, by a stranger. They may be abused by an adult/s, or another child/ren or fellow Service personnel.

12. The first indication that a child or young person is being abused is not necessarily the presence of a severe injury. Concerns that a child or young person is being abused may be aroused by the sight of bruises, burns/scalds, bites, scars or fractures and joint injuries on a child/young person's body or by remarks made by a child/young person, their parents or friends. It may also be by observation of a child/young person's behaviour or reactions, from being aware that a family member is under stress and may need help with caring for the children or from a number of other factors.

13. An abused child or young person frequently suffers more than a single type of abuse. The four broad categories of abuse as defined in *Working Together to Safeguard Children 2010* and which overlap are:

- Physical abuse:
- Emotional abuse
- Sexual abuse
- Neglect

## **CATEGORIES AND RECOGNITION OF ABUSE AND NEGLECT**

### **PHYSICAL ABUSE**

14. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. It may also be caused when a parent / carer fabricates symptoms of, or deliberately induces illness in a child.

15. **Concerns.** The following may be indicators of concern:

- An explanation which is inconsistent with an injury
- Several different explanations provided for an injury
- Unexplained delay in seeking treatment
- Repeated presentation of minor injuries which may represent a 'cry for help' and if ignored could lead to a more serious injury, or may represent fabricated or induced illness
- Reluctance to give information or mention previous injuries
- Domestic abuse within the family

### **Physical Indicators**

16. **Bruising.** Children can have accidental bruising, but the following must be considered as highly suspicious of a non accidental injury unless there is an adequate explanation provided:

- Bruising seen away from bony prominences
- Simultaneous bruising to both eyes without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive)
- Bruising on sites less commonly injured accidentally: the face, back, abdomen, buttocks, ears and hands
- Cluster of bruises may indicate defensive injuries on the upper arm, outside of thigh or the trunk and adjacent limb
- Multiple bruising of uniform shape
- Bruises that carry the imprint of an implement used e.g. belt marks, hand prints, grasp marks or a hair brush
- Linear pink marks, haemorrhages or pale scars may be caused by ligature, especially at wrists, ankles, neck, male genitalia
- Bruising or tears around, or behind, the earlobe/s indicating injury by pulling or twisting or slapping
- Broken teeth and mouth injuries

17. **Bite Marks.** Bite marks can leave clear impressions of the teeth. Human bite marks are oval or crescent shaped. Those over 3cm in diameter are more likely to have been caused by an adult or older child. A medical opinion should be sought where there is any doubt over the origin of the bite.

18. **Burns and Scalds.** It can be difficult to distinguish between accidental and non-accidental burns and scalds, and will always require experienced medical opinion. Any burn with a clear outline may be suspicious e.g.:

- Circular burns from cigarettes are characteristically punched out lesions 0.6 – 0.7 cm in diameter and healing usually leaves a scar
- Friction burns resulting from being dragged
- Linear burns from hot metal rods or electrical fire elements
- Burns of uniform depth over a large area
- Scalds that have a line indicating immersion or poured liquid (a child getting into hot water of its own accord will struggle to get out and cause splash marks)
- Old scars indicating previous burns/scalds which did not have appropriate treatment or adequate explanation

19. **Fractures.** Fractures may cause pain, swelling and discolouration over a bone or joint. There are grounds for concern if:

- History provided is vague, non-existent or inconsistent with the fracture type
- There are associated old and / or multiple fractures
- Medical attention is sought after a delay when the fracture has caused symptoms such as swelling, pain or loss of movement.

20. **Scars.** A large number of scars, or scars of different sizes or ages, or on different parts of the body, may suggest abuse.

### **Behavioural Indicators**

21. Changes in behaviour can indicate that an individual has been subject to physical abuse. The age of the child or young person would affect the level of presentation of the behaviour. These behaviours may include:

- Lying or stealing
- Fighting
- Aggressive behaviour or severe temper outbursts
- Depression
- Withdrawn behaviour
- Flinching when touched or approached
- Hyper vigilance
- Reluctance to change in public

- Abusing alcohol or drugs
- Emotional and social withdrawal
- Difficulty entering into and sustaining relationships.
- Lack of interest in activities
- Self Harm

## **SEXUAL ABUSE**

22. Sexual abuse involves forcing or enticing a child / 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 clothing.

23. Sexual activities may also include non-contact activities, e.g. involving children in looking at, or in production of abusive images, watching sexual activities, encouraging children to behave in sexually inappropriate ways. This may include use of photographs, pictures, cartoons, literature or sound recordings e.g. the internet, books, magazines, audio cassettes, tapes, CD's or DVD's.

24. It may also involve 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. Children under 16 years of age cannot provide lawful consent to any sexual activity, though in practice many are involved in sexual contact to which, as individuals, they may have agreed. ***For further information, refer to SET Child Protection Procedures 2011, section 9.34 Sexually Active Children.***

25. If a child makes an allegation of sexual abuse, it is very important that they are taken seriously. Allegations can often initially be indirect as the child tests the professional's response. There may be no physical signs and indications are likely to be emotional / behavioural.

### **Physical Indicators**

26. The physical signs of sexual abuse may include:

- Disclosure
- Pain or itching of genital area
- Vaginal discharge
- Bed wetting
- Sexually transmitted infections (STI) on genital area or throat
- Blood on underclothes
- Pregnancy
- Stomach pains
- Discomfort when sitting or walking

27. Physical injury may be part of the sexual abuse, e.g. bite marks, signs of strangulation, restraining marks or bruises.

### **Behavioural Indicators**

28. Many children who suffer sexual abuse experience pain, shame, fear and confusion. It is now well established that these children are at risk of a range of mental health and behavioural difficulties, particularly those who are not believed or supported. The child will present different behaviours depending on age, however it should be noted that those children in adolescence and early adulthood present in a similar manner to younger children. Behaviours include:

- Low self-esteem
- Dissociation – state of disconnect with their physical self
- Inappropriate sexualised conduct
- Sexually explicit behaviour, play or conversation, inappropriate to the child's age
- Continual and inappropriate or excessive masturbation
- Self-harm
- Self mutilation
- Suicide attempts
- Involvement in sexual exploitation or indiscriminate choice of sexual partners
- An anxious unwillingness to remove clothes for sports events
- Running away
- Substance or drug abuse
- Sexual knowledge beyond their age

29. Adult survivors of sexual abuse are at an increased risk of physical and mental problems. These problems are generally mediated by poor self-concepts, unsupported and dangerous social relationships, and unhealthy life styles.

### **Grooming**

30. Members of staff working with children, adults and families should be alert to the possibility that:

- A child may already have been / is being, abused and the images distributed on the internet or by mobile telephone
- An adult or older child may be grooming a child for sexual abuse, including for involvement in making abusive images. This process can involve the child being shown abusive images
- An adult or older child may be viewing and downloading child sexual abuse images

31. Children may also be shown images of their own abuse by their abuser, and they typically hold a personal responsibility for not stopping their own abuse and that of others involved. All these aspects reflect the impact of the grooming process of the abusers, who endeavour to make the child feel that it is their fault and that they could have stopped the abuse

## **EMOTIONAL ABUSE**

32. Emotional abuse is the persistent emotional ill treatment of a child such as to cause severe and persistent effects on the child's emotional development, and may involve:

- Spurning which includes hostile rejection and degrading put downs of children. Belittling, shaming, humiliation and ridicule are most likely to happen when the child needs affection or is in distress.
- Terrorising in which the carer threatens to abandon, hurt, maim or kill the child in an attempt to change the child's behaviour.
- Isolation of the child from everyday activities and from other children
- Exploiting or corruption of the child to develop anti-social, self-destructive or criminal behaviours
- Denying the child emotional responsiveness, when the child shows some success.
- Failing to meet the child's medical and health needs.

33. Some level of emotional abuse is involved in most types of ill treatment of children, though emotional abuse may occur alone.

## **Behavioural Indicators**

34. Emotional abuse may be difficult to recognise, as signs are usually behavioural rather than physical. The indicators of emotional abuse are often also associated with other forms of abuse. Recognition of emotional abuse is usually based on observations over time and the following offer some associated indicators:

- Delay in achieving developmental, cognitive and / or other educational milestones
- Failure to thrive / faltering growth
- Aggression
- Attention seeking
- Lack of confidence
- Anxiousness
- Difficult peer relationships
- Withdrawn

## **SELF HARM**

35. Self harm, self mutilation, eating disorders, suicide threats and gestures by a child must always be taken seriously and may be indicative of a serious mental or emotional disturbance. In the event of escalating self harm the Medical Officer must refer to mental health services.

36. In most cases of deliberate self harm the young person should be seen as a child in need. In the first instance, members of staff are to take action in accordance with *MCTC USO 313- Guide to Action on Self Harm* and then review the detainee's risk category in accordance with *USO 214 – Risk Assessment and Grading of Detainees*.

37. The possibility that self-harm, including a serious eating disorder, has been caused or triggered by any form of abuse or chronic neglect should not be overlooked. The above possibility may justify a referral to Children's Social Care for an assessment as a child in need and/or in need of protection. Members of staff are to make a referral in accordance with *MCTC Child Protection and Safeguarding Policy, Part 3 Annex C, Paragraph 3 without delay*.

38. Consideration must also be given to protect children who engage in high risk behaviour which may cause serious self injury such as drug or substance misuse, running away, partaking in daring behaviour i.e. running in front of cars etc, all of which may indicate underlying behavioural or emotional difficulties or abuse.

### **Further information**

39. Further information relating to the recognition of child abuse and neglect – not covered in this guidance can be found in Section 4 of the Southend Essex and Thurrock (SET) Child Protection procedures which are available at MCTC Common Information, or [www.escb.co.uk](http://www.escb.co.uk).

Appendix.

1. Advice In Relation To Adults Who May Have Been Abused As Children.

## **ADVICE IN RELATION TO ADULTS WHO MAY HAVE BEEN ABUSED AS CHILDREN**

### **INTRODUCTION**

1. Consideration must be given to the age range of those individuals detained within the Military Corrective Training Centre (MCTC). By far, the greater proportion of the detainee population will be older than 18 yrs, and some may be in their early 50's. The majority of adult survivors of childhood abuse may have developed coping mechanisms to allow them to lead 'normal' lives. It is only when additional stress factors impact on their 'normal' life that may result in them disclosing incidents of Historic Abuse. Such additional stress factors may include a family bereavement, a birth in the family or more pertinent to the MCTC, detention or the sentencing of imprisonment.

2. Outlined below are the most common symptoms/problems faced by adults who were abused during childhood.

### **COMMON SYMPTOMS**

#### **Lack of confidence**

3. This is the most common symptom and stems from mistaken beliefs, developed in childhood, of guilt and an innate sense of 'badness' or feeling defective. *(Mistaken beliefs may be: I'm not good enough. I'm ruined. I'm bad. It's my fault).*

#### **Low self esteem**

4. This feeling is often associated with the person's outward appearance, believing they are ugly and repulsive, regardless of what they actually look like or positive input they may receive, but is also associated with their inner feelings of not being 'enough'. *(Mistaken beliefs may be: I'm not good enough. I'm ruined. I'm contaminated. I'm bad. I'm ugly, repulsive).*

#### **Aversion to making noise**

5. This includes sex, crying, and laughing or body functions. This person is often soft spoken and may pause a lot while speaking as they monitor their words. *(Mistaken beliefs may be: I don't count. I'm not important. I am not safe. Feelings are unsafe).*

#### **Strong feelings of inadequacy**

6. A belief of innate 'badness', guilt and blame prohibits personal achievement that in turn is followed by self sabotage. This person's vocabulary will be full of 'I can't' statements. *(Mistaken beliefs may be: I'm bad. I ruin everything. I can't win. I don't deserve happiness. It's always my fault).*

## **Inability to trust**

7. When trust in a respected and trusted adult, particularly a parent, is broken at an early age, the child quickly learns to believe that no one can be trusted. As an adult they will be unconsciously responding to the belief that others will let them down. Often victims of abuse will sabotage friendships and intimate relationships by initiating a cut off from the person they care about. It seems easier to cut off and hurt yourself before others have a chance, particularly when you believe the hurt is inevitable. This cutting off is often done by setting unrealistic tests for the person cared for, when the test is failed, the person's belief that no one can be trusted is strengthened. That in turn strengthens the feeling/belief that it is safer to stay behind emotional walls. Others believe that they will not be accepted if others know about the abuse. Although most are crying out for love and acceptance, their fear and erroneous belief system keeps them trapped within themselves, feeling isolated and hopeless. *(Mistaken beliefs may be: No one can be trusted. I can't trust myself. People will hurt me. There is no safety. To feel is to be unsafe/vulnerable. I can never tell. I can never be known. I'll always be trapped with hurt? There is no way out).*

## **Problem relationships**

8. Many symptoms on this list (sexual dysfunction, inability to touch, inability to trust, etc.) cause serious relationship problems. Victims of abuse often choose an abusive or inadequate partner because damaged personalities feel more familiar and 'normal' to them. This is because the experience of growing up in a dysfunctional family causes dysfunctional people to seem familiar and it is natural to be drawn to what is familiar. Some people choose an inadequate partner as a result of believing that their own 'unworthiness' prohibits a partnership with a 'nice' person. *(Mistaken beliefs may be: I'm bad. I'm ruined. I don't deserve happiness. I should be punished. I don't count. I'm not good enough. No one can be trusted. I'm unlovable. I'm useless.)*

## **Sexual dysfunction**

9. Approximately two thirds of people who are sexually abused as children are sexually repressed, while the remainder are often promiscuous. Many lack accurate sexual knowledge and therefore do not have proper information of their body functions or sexual organs. Many have become frightened of their sexuality, believing that their bodies are dirty or shameful. Some have had many sexual experiences but have not shared love with those partners. Others may use sex as a way of gaining acceptance or as a manipulative tool (learned behaviour). Still others put up a mental block concerning their sexuality, sex no longer matters. *(Mistaken beliefs may be: I'm bad, dirty, ruined. I'm defective. I don't count. I'm contaminated. I'm not important. I don't deserve happiness).*

## **Inability to touch or be touched**

10. This problem can be triggered by feelings of dirtiness (a fear that the other person will somehow know of the abuse and be rejecting); fear of contaminating others (an irrational thought stemming from feeling dirty and bad); low self esteem (not worthy, self punishment) and the fear that in some way, by allowing physical contact one is at risk of further abuse (loss of control, being at another's mercy). Touch may bring back memories of unwanted touch from childhood or touch which produced some pleasurable feeling but now brings shame and self disgust. It can also reflect a fear of one's sexuality. *(Mistaken belief may be: I am bad, dirty, ruined, contaminated. I have no control. My feelings are bad. I don't count. I deserve to be punished).*

## **Food/drug/alcohol abuse**

11. Food abuse can be manifested by either anorexia or bulimia. Some people who have experienced abuse sometimes hold the erroneous belief that they will not have to face their sexuality if they are unattractive. It is also another form of self punishment. Those who are obese can also use food as a form of comfort and their excess weight as a defence against feeling small and vulnerable. Drug or alcohol abuse can be used as a form of self punishment, a dulling buffer, a comfort/crutch or a memory blocking device. *(Mistaken beliefs may be: I'm bad. I don't count. To be ugly (or fat) is to be safe. I deserve to be hurt or punished. I'm not important).*

## **Alienation from body**

12. This person is not at home in their own body, there is often a failure to heed body signals (pain, fatigue, hunger, thirst) and a lack of care for their body in either fitness or health areas. There is usually a poor body image and sometimes a manipulation of body size to avoid sexual attention, (Dovetailing with food/drug/alcohol abuse and low self esteem listed above.) Many times this person spends much of their time in a disassociated state, i.e. 'watching' their life happen rather than experiencing it. *(Mistaken beliefs may be: I don't count. I'm not important. I'm bad, dirty, ruined, contaminated. My body is bad, dirty, etc... I am not safe).*

## **Illness**

46. Emotional trauma that has never been resolved can produce physical illness. Migraines, stomach disorders, asthma, skin disorders, bowel disorders, back problems, gynaecological problems and general aches and pains are the most common. *(Mistaken beliefs may be: I'm bad, dirty, contaminated, ruined. I deserve punishment. I don't count. My body is bad).*

## **Low or over emotional control**

13. Some people will perceive ordinary stressful situations as a crisis, resulting in that person going into shock or emotional shutdown. They are often termed 'dramatic or hysterical types'. Others are in a fairly consistent state of emotional and physical numbness, not much really 'gets' to them. Those people who have low emotional control are generally seen to over react very quickly, easily bursting into tears, having outbursts of anger, pacing agitatedly, laughing loudly/inappropriately and generally appearing demanding and vulnerable. This behaviour may temporarily give a sense of comfort from the attention received, but comfort is short lived because the attention is usually negative. Surprisingly enough, a connection is seldom made by this person between their behaviour and the response people give them. Their inappropriate behaviour has become a second skin, and to them, it feels right. In their point of view, the other person is wrong.

14. Some people are extremely over controlled emotionally, almost robotic. They are often terrified of their anger, believing that to show any strong emotion could cause them to lose control and give into the violent rage they fear. At other times over control stems from the misguided childhood belief that the less emotion displayed, the less chance of being noticed; a hope that this control would lessen the risk of further abuse - it is an illusion of safety.

15. Some children learned that they had no rights to emotion, therefore finding it difficult to laugh, cry, complain or even express an opinion. Parents or carers may well have crushed any sign of emotion from these children from an early age. As adults they often build an invisible wall around their feelings, promising themselves that no one will ever see the pain they have suffered, no one will be allowed in to hurt them again. *(Mistaken beliefs may be: I don't count. It's not safe to have feelings. I can't be known. No one can be trusted. Hurt other people first. People will always hurt me. I'm bad. I'm not important).*

### **High/Low Risk Taking**

16. Some people find they almost have a compulsion for "daring the fates". Their work or social life can be a series of very high risk taking events. On the flip side of that, there will be other people who go the opposite direction and find it impossible to take even the smallest risk. *(Mistaken beliefs may be: I don't count. I'm not important. I can never be safe. There is no safety).*

### **Panic attacks**

17. Panic attacks can include the following physical symptoms: Difficulty breathing, throat closing up, heart racing, vision changes, sweating, shaking, nausea, desire to run, feeling out of control, feeling trapped, desire to scream, feeling like your going to pass out, feeling like your body will explode and a fear that you are going crazy or will die. A full blown panic attack is terribly frightening. Panic attacks are triggered by some thought, smell, taste, sound, feeling or action that somehow reflects the abuse suffered in childhood and most of the time the victim does not have a clue what that trigger might have been. Some people who have not yet remembered abuse suffer from panic attacks and are understandably very confused about the cause. Panic attacks seem like they come from nowhere, but there is always a trigger. *(Mistaken beliefs may be: I have no control. I will always be unsafe. There is no safety).*

### **Phobias**

18. Phobias can be a form of self sabotage; self punishment, an underlying feeling that; I am not worthy to enjoy life, therefore if I cannot function properly then I will not enjoy life. It can also take the form of a distraction. When a person has a serious phobia or illness to deal with then the fear of facing the deep emotional scarring of childhood abuse can be put off. *(Mistaken beliefs may be: I deserve punishment. I don't count. I'm bad, dirty, contaminated, ruined).*

### **Sleep disturbances**

19. Reoccurring nightmares is the most common sleep disturbance. Insomnia is also a frequent experience, but others may use excessive sleep as a form of escape, a method of coping. *(Mistaken beliefs may be: I'm bad, dirty, ruined, contaminated. It's my fault. I'll never have peace. It's unsafe to be still).*

### **Flashbacks**

20. Flashbacks can be in the form of quick visual pictures, like a slide compared to a film, or in the form of feelings (emotional or physical). These often accompany everyday activities or perhaps reading or hearing about other victim's abuse experience. They are triggered by some connection with the abuse through visual, auditory, touch, taste or smell sources. Flashbacks are usually fragmented views of the abuse and can offer a 'way in' to a more complete memory. On rare occasions a flashback can take a video form and go on for quite a while with the detainee associated in the event. *(Mistaken beliefs may be: I have no control. I will never be safe. There is no safety. I'm trapped with the pain).*

## **Depression**

21. People with abusive childhood backgrounds will experience depression because they believe they will never change, their environment or relatives will never change, they are so bad and dirty that they do not belong with 'nice' people, no one understands them, etc. If a person has no memory of abuse, depression will result because there is no logical reason for the symptoms s/he is experiencing. Having said that, many people do not associate the symptoms they have with the experience of abuse, even when they do remember it. *(Mistaken beliefs may be: I am bad, dirty, ruined, contaminated. I am trapped with the pain. There is no escape. I will never be safe).*

## **Self-harm**

22. Common examples are: biting or clawing limbs, cutting body with razor blades or knives, burning body with cigarettes, repeated bruising injuries or banging head on the wall or with an object, but self-harm can be as inventive as a person's imagination makes it. Self-harm is sometimes used by victims of abuse to control their experience of pain. It can also provide an intense feeling of relief and release that is often craved. It can be an attempt to control something in one's life; a type of self punishment; a means of expressing anger or a way to have feelings. It can be a futile attempt to call for help or needed attention. It can be manifested in both children and adults. Sometimes the physical pain can be a distraction from the more feared emotional pain or it can be an attempt to indicate to others just how strong the emotional pain is or a place to express anger - on the only one safe to vent it towards - self. *(Mistaken beliefs may be: I'm bad, dirty, contaminated, ruined. I can't be angry. I'm defective. It's my fault. I deserve to be punished. I can't let the pain out).*

## **Suicide attempts**

23. People who have suffered abuse may see suicide as their only way out of the pain. Some of those who have displayed acute symptoms of abuse have been judged mentally ill and sent for psychiatric treatment. Typical advice given (as reported by clients) was "Well, that is all in the past. Do you feel that you will abuse? No? Well then, go home and concentrate on your partner and family, find yourself something else to think about. Take your mind off it and stop dwelling on it." The inference taken was often, "I think you are wasting my time, it is a lot about nothing" With the person's last hope shattered of finding someone to help and understand, suicide may have seemed the only way left to stop the pain. This is particularly true for the person who has struggled with symptoms for a long time and feels they are in a losing battle. *(Mistaken beliefs may be: I can never escape. I am bad, dirty, ruined, contaminated. There is no way out).*

## **Security seeking**

24. In stressful situations this person may actually hide or cower in a corner. Nervousness is evident when this person feels they are being watched and often they report feeling watched when no one is actually around. They are usually hyper vigilant and have a strong startle response to surprise situations, which may be followed by anger or nervousness. Often there is a need to be invisible. *(Mistaken beliefs may be: I have no control. I cannot be safe. There is no safety. No one can be trusted. I cannot trust myself).*

## **Memory blanks**

25. People who have memory blanks of a year or several years during their childhood and have several of the above symptoms are typical examples of people who have repressed abuse memories. This usually happens when trauma experienced during childhood is so threatening the child shuts off all memory of it as a coping mechanism.

## **SUMMARY**

26. The fact that an adult detainee displays one or more of the symptoms listed above does not necessarily mean that the detainee suffered abuse as a child – there may well have been other life experiences which are the cause of this type of behaviour. It is, therefore, incumbent upon staff identifying in a detainee the behavioural patterns listed in the preceding text not to jump to conclusions, but to seek further advice from the Welfare and/or Medical Officer at the earliest opportunity.

## INITIAL DISCLOSURE GUIDELINES FOR STAFF

### INTRODUCTION

1. It is vital that when a child/detainee ***has chosen to disclose to you*** that they have been abused or are being abused at the MCTC that the moment is not lost through not knowing how to correctly respond. Listed below are guidelines to follow:

- a. **Location.** The location that you select to discuss matters with the child/detainee should be easily accessible, free from disruptions and allow confidentiality to be maintained throughout your discussions.
- b. **Communication.** Allow the child/detainee freedom to communicate in their words what has taken place. Do not rush matters or encourage through leading questions and avoid interrupting them, however, it is important to empathise events with the child/detainee. If possible, obtain details of what, when and where the incident occurred, who was involved and details of any witnesses. Talk calmly to the child/detainee about what can be done about the alleged abuse. There needs to be a balance between what must be done (duty of care) and what the child/detainee may want or not want to happen. Do not make promises and keep the child/detainee advised of what is happening at all times.
- c. **Evidence trail.** Record in the child/detainee's words the content of your discussions and ensure there is a clear "evidence trail" in all matters relating to the alleged incident.
- d. **Isolation/support.** If you leave the child/detainee at any time, outline to them what is going to happen immediately after you have left and how long you expect to be away. If they are very distressed, ensure that a colleague is able to be with them. In some cases it may be appropriate to locate them to Welfare or the Medical Centre.
- e. **Confidentiality.** Staff should not inform or discuss the allegation with any other person outside of the "incident reporting process" and in particular, with the alleged perpetrator as this may jeopardise a subsequent investigation.
- f. **Onward reporting.** The incident must be promptly brought to the attention of the Child Protection Co-ordinator (Welfare Officer) by completing a Child Protection Information Report (CPIR) (Annex H sections 1 – 3). In the event that he/she is unavailable, the CPIR is to be submitted to the Duty Field Officer (DFO).

### SUMMARY

2. In addition to the above guidelines further information can be found in the SET Child Protection Procedures 2011.

## INTERNAL REFERRAL PROCESS

### CRITERIA FOR REFERRALS

1. The agreed criteria for referrals with ESCB is:
  - The management of all allegations of physical, sexual, neglect and emotional abuse, which indicate that a young person is suffering **or may be at risk** of suffering **significant harm**.
  - The management of all disclosure of historical abuse.
  - Dealing with the welfare of a young person where there are concerns of abuse occurring within a family or by another person.
  - Any abuse by a professional carer.
  - When a child is identified as being **in need** of services from Children's Social Care.

### INTERNAL REFERRAL PROCESS

2. **Suspicion of abuse.** Where a member of staff suspects that some form of abuse has taken place or there is likely to be a case to answer but has insufficient evidence to warrant significant harm, the member of staff concerned must ensure that the referral process is **initiated immediately**. The referral process detailed below should be read in conjunction with the Child Protection Referral Flowchart at Annex F.
3. **Initial action.** **The referring member of staff** is to complete the Child Protection Information Report (CPIR) (Annex H sections 1-3) and submit it **without delay** to the Child Protection Co-ordinator (Welfare Officer) or in his/her absence the Duty Field Officer (DFO). Irrespective of whether the CPIR was submitted to the Child Protection Co-ordinator (CPC) or the DFO, the referring member of staff is to ensure that both the CPC/DFO are aware that a CPIR has been raised. If either one is unable to be contacted, the Duty Warrant Officer (DWO) is to be informed instead. The DWO is to record an entry in their duty report and advise the Commandant immediately. The referrer, where applicable, is to make an entry in their notebook.
4. **CPC/ DFO.** **The CPC/DFO** must, without delay, inform the **Commandant** about the referral. These parties will then make a preliminary assessment to agree if a referral to the Essex SCCSD/Police CAIU is appropriate. Also, without prejudice, what steps need to be taken to ensure the safety of the young person, and if necessary, the alleged perpetrator. The CPIR and Child Protection Log are to be completed and Coy Security informed that a referral has been made. If required, advice may be obtained from the local SCCSD or Police CAIU. SCCSD and Police CAIU contact details are contained at Annex G.
5. **Case leader.** There must be no confusion as to whom the responsibility for taking the referral forward lays with out of the CPC and DFO. **The first party informed by the referrer shall become the case leader** and shall be responsible for taking the referral forward in accordance with Annex F. Ultimately, the CPC should lead the referral. This must be achieved through a **formal handover/takeover** of responsibilities and is to be properly recorded in the Child Protection Log (Annex I).

## **RECORDING PROCESS**

6. The CPC/DFO is to ensure that all actions taken throughout the process are comprehensive and accurately recorded in the CPIR (Annex H) and the Child Protection Log (Annex I).

## **PARENTS**

7. The CPC/DFO must take all reasonable steps to inform the young persons parent(s) or guardian(s) or other carer where appropriate of the alleged incident. Whilst every effort should be made to involve parents and respect their rights, it should always be clear that in any conflict of interests, the protection of the child/young person must take priority over all other considerations. In essence – if informing the family places the young person at risk then this should not happen. A clear record of this decision and the family's response must be made in the Child Protection Log (Annex I).

## **SCENE OF CRIME**

8. The CPC/DFO must ascertain if the scene of crime is known. If it is, ensure that it has been isolated as a matter of priority in order to preserve evidence.

## **CONFIDENTIALITY**

9. Staff are not to inform or discuss their concerns with any other person outside of the "incident reporting process" and in particular, with the alleged perpetrator. Further detail regarding confidentiality is contained in the SET Child Protection Procedures 2011 (Section 3).

## **POST INVESTIGATION**

10. Following an investigation the Commandant is to initiate a review of the circumstances of the case in order to identify and implement any lessons learned.

## EXTERNAL REFERRAL PROCESS

### CRITERIA FOR REFERRAL

1. When the suspicion of **significant harm** to a young person is obvious or a young person discloses or a witness sees a young person being harmed then this becomes the threshold for a referral to be made to the Essex SCCSD/Police CAIU without delay. Further information pertaining to referrals, particularly the internal referral process, is contained at Annex C.

### EXTERNAL REFERRAL PROCESS

2. **Initial action.** The referring member of staff who suspects that a young person has been subjected to **significant harm** should make their referral **without delay** to the CPC/DFO/DWO in accordance with the procedure contained at Annex C.

3. **CPC/DFO.** The CPC/DFO must inform the Commandant without delay. These parties will then make a preliminary assessment regarding what needs to be done to ensure the safety of the young person and if necessary, without prejudice, the alleged perpetrator. The Case Leader (refer to Annex C, paragraph 5) must ensure that the CPIR and Child Protection Log are completed in detail at this and every subsequent stage throughout the process. Also, inform Coy Security that a referral has been made.

4. **Communication.** It is important that good lines of communication are established and maintained throughout the complete referral process. At this juncture, the Case Leader must take all practicable steps to inform:

- a. **Parents/Guardians.** Refer to Annex C paragraph 7 for guidance details.
- b. **Other parties.** There may be a requirement to inform the Youth Justice Board, Youth Offending Team, Independent Board of Visitors or previously appointed social workers at this stage.

5. **Referral to SCCSD.** If **significant harm** is believed or suspected to have occurred then a referral to the SCCSD must be made by the Case Leader, without delay, in accordance with the instructions contained at Annex G. CAFS should contact the MCTC to acknowledge receipt of the referral. At this stage the SCCSD may call for a strategy discussion that could involve the Commandant, CPC/DFO as well as representatives from CAFS, Police CAIU and other professional agencies.

### ADDITIONAL POINTS TO CONSIDER.

6. **Alleged victim.** In order to facilitate an enquiry, the alleged victim should not be moved from the MCTC unless it is absolutely necessary for their well-being and safety.

7. **Alleged perpetrator.** Consideration must also be given to the well being and safety of the alleged perpetrator and ensure that actions taken do not prejudice any subsequent investigation. However, the overriding factor as to what happens to the alleged perpetrator is to be driven by the concern/need to ensure that children are protected from any risk of harm.

8. **Scene of crime.** The Case Leader must ensure that if the scene of crime is known, it is isolated as a matter of priority to preserve evidence.

9. **Confidentiality.** Staff are not to discuss this referral with any person outside of the incident reporting process and in particular, with the alleged perpetrator.

## **VISITS**

10. **Concerns of abuse.** Any member of staff on visits may at any time have concerns that a child has been abused. Where the concern is that abuse has actually occurred on the visit the most senior member of staff must **contact the CPC/DFO immediately**. Where the abuse is ongoing, staff are to take appropriate steps to bring the abuse to a stop in a firm but discreet manner. In the first instance, the most senior member of staff present should consult the CPC/DFO to ascertain the most appropriate course of action.

11. **Information gathering.** The most senior member of staff present should discreetly ascertain the child's identity and/or a description of the child. Also, if possible, details of the child's address or home address. Staff are to make confidential notes of what has occurred and what caused the initial suspicion. **However, under no circumstances is the child to be questioned by a member of staff.**

12. **Referral process.** The most senior member of staff present must take referral action in accordance with Annex C, paragraph 3 and forward it **without delay** to the CPC/DFO. The CPC/DFO, having informed the Commandant may, if appropriate, make a referral to Essex SCCSD/Police CAIU.

## **OTHER REFERRALS**

13. **Historical abuse.** Where allegations of historical abuse is reported to staff but there are no indications that the child is at risk of significant harm, staff are to report this to the CPC without delay in accordance with the referral procedure contained at Annex C. The CPC is then to refer the case to the Police CAIU in the area where the alleged abuse occurred.

14. **Unborn children.** All unborn children whose mothers are detained in the MCTC are to be referred to Colchester CAFS Team by the CPC.

15. **Child Protection Register.** Staff are to inform the CPC **without delay**, of the presence of any young person or unborn child resident in the MCTC whose name is on the Child Protection Register of an authority other than Essex. The CPC is to notify the custodian of the Child Protection Register, Essex SCCSD.

16. **Risk to children.** Staff are to inform the CPC **without delay**, of any detainee being released into Essex who has been previously or is currently convicted of an offence which could impose a risk to children for whom they care or with whom they have contact. The CPC is to notify Essex SCCSD.

## **POST INVESTIGATION**

17. Following an investigation the Commandant is to initiate a review of the circumstances of the case in order to identify and implement any lessons learned.

## CHILD PROTECTION CONCERNS FROM WITHIN MCTC

### INTRODUCTION

1. The MCTC unequivocally recognises that it has a clear duty to protect children: children who come into the MCTC and children who come into contact with adults and young people in detention. It is, therefore, expected that all members of staff conduct themselves beyond reproach in their dealings with young people and children who are either visiting or detained in the MCTC. Staff who harm young people and children will be subject to disciplinary action.

### CHILD PROTECTION CONCERNS

2. **Referral process.** Should the alleged perpetrator be a member of staff, the referral process, time frame and recording procedures remain extant as documented in Annexes C and D and are to be adhered to. However, the exception to this process is if the alleged perpetrator is the victims line manager or has child protection responsibilities within the MCTC. In these instances the following exceptional procedures are to be adopted

3. **Exceptional referral procedures – line manager.** Where the alleged perpetrator is the victims line manager, the normal referral process should be adhered to ensuring that the victim and perpetrator do not come into contact and that knowledge of the referral is refined to those staff that need to know. The referring member of staff must inform, as a ***matter of urgency***, the CPC/DFO who in turn are to ***immediately*** inform the Commandant. The Commandant will then act within Service employment and disciplinary guidelines and take any decision to suspend or exclude the member of staff from the MCTC within established procedures. The member of staff is not to be allowed to go off duty until agreed by the police as this may allow for contamination of evidence.

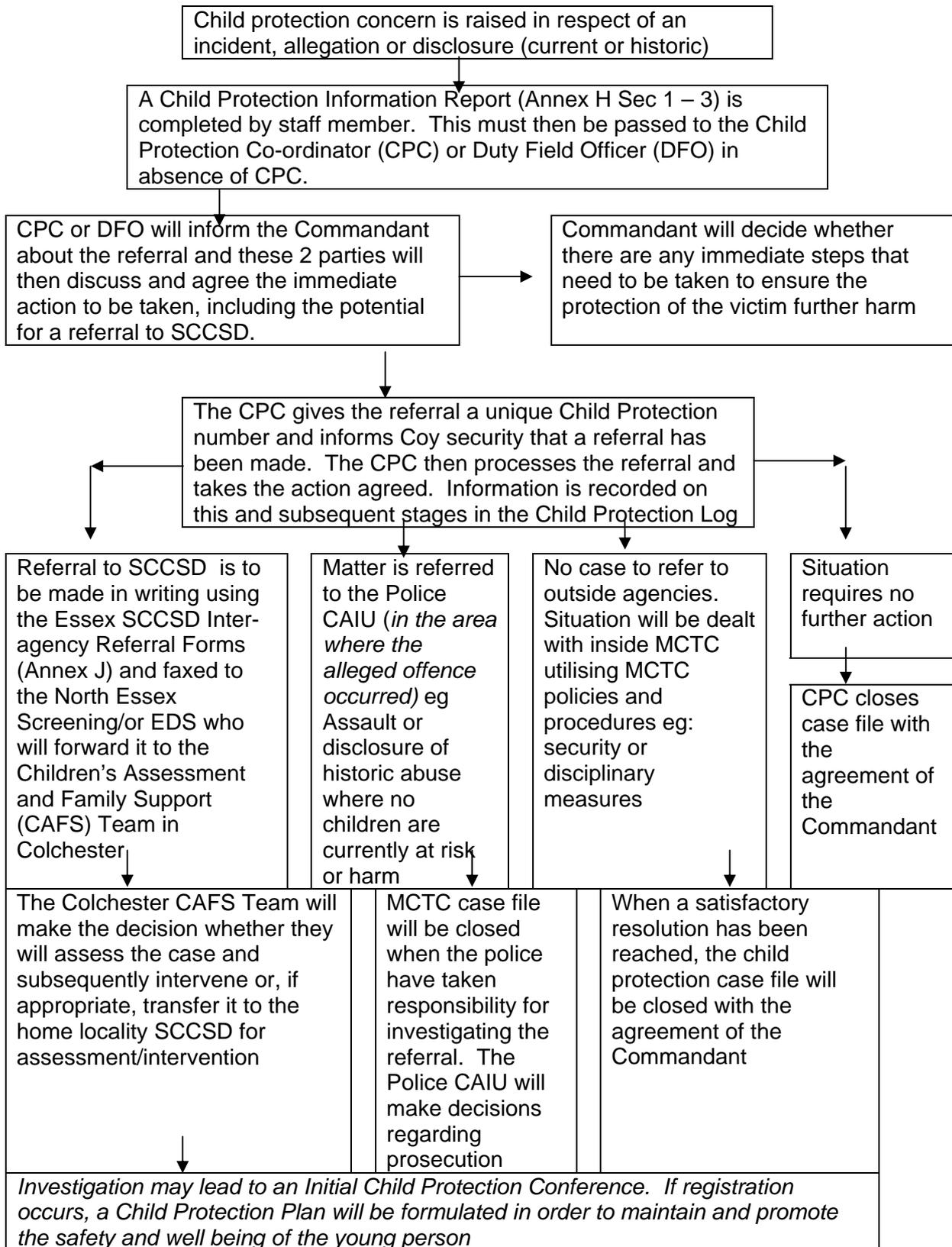
4. **Exceptional referral procedures – child protection responsibilities.** If the alleged perpetrator has child protection responsibilities within the MCTC the referring member of staff is to initially adhere to the referral process contained at Annexes C and D. Having completed sections 1-3 of the CPIR, if the alleged perpetrator is the person (CPC/DFO) to whom the CPIR would normally be passed or a person (DWO) who may be informed at this juncture, then this is not to happen. ***The referring member of staff must, without delay, inform the Commandant direct who will decide on the appropriate course of action. If the perpetrator is the Commandant, then the course of action is to inform the MCTC Deputy Commandant and Duty Officer HQ PM(A).***

5. **Local Authority Designated Officer (LADO).** When an allegation of abuse is made against a member of staff, LADO is to be informed in accordance with SET Child Protection Procedures 2011 (Section 11).

### CONFIDENTIALITY

6. The sensitivity surrounding the aforementioned scenarios cannot be over emphasised and the referring member of staff is to ensure the ***highest level of confidentiality*** is maintained at all times.

**CHILD PROTECTION REFERRAL – FLOWCHART**



## ESSEX SAFEGUARDING CHILDREN AGENCIES – CONTACT DETAILS

1. **First point of contact (POC).** The first POC in the referral process (*less urgent referrals*) is:
  - **Daytime Protection Line**  
Timings: Mon – Thur 0900 – 1730hrs & Fri 0900 – 1630hrs.  
Telephone: 0845 6037627
  - **Emergency Duty Service.**  
Timings: Mon – Thur 1730 – 0845hrs & Fri 1630 – Mon 0845 hrs  
Telephone: 0845 6061212
2. **Urgent referrals.** If you know a social worker is already involved with the child or family, contact them immediately (or their manager in their absence). If you are not aware of Social Services involvement, make an immediate telephone referral to the **Emergency Duty Service** (0845 6061212). Follow this up by completing the Inter Agency Referral Form at Annex J.
3. **Non urgent referrals.** You should normally make non-urgent referrals by using the Inter Agency Referral Form at Annex J. Non-urgent referrals may also be made by telephoning the **Daytime Protection Line** (0845 6037627) and then completing an Inter Agency Referral Form at Annex J.
4. **First POC out of hours.** The first POC outside of working hours for *all referrals is the Emergency Duty Service* – 0845 6061212.
5. **Other useful contacts are:**
  - **Children and Families Initial Response Team (CFIRT):**  
Telephone: 0845 6037634  
Fax: 0845 6016230  
Email: [REDACTED]
  - **Assessment and Family Support (Colchester).**  
Telephone: [REDACTED]  
Fax: [REDACTED]
  - **Essex Police Child Abuse Investigation Unit (CAIU) (Colchester).**  
Telephone: [REDACTED]  
Fax: [REDACTED]
6. Further details can be obtained from Appendix 1 (Contact Details) SET Child Protection Procedures 2011.

|   |  |
|---|--|
| <i>IF IMMEDIATE ACTION<br/>IS REQUIRED, ENDORSE<br/>HERE IN RED</i> |  |
|---|--|

## CHILD PROTECTION INFORMATION REPORT

|                    |
|--------------------|
| <b>CPIR NUMBER</b> |
|                    |

*To be completed by any member of staff who believes that a Detainee has been subjected to any form of harm (physical, sexual, emotional abuse or neglect) whilst in Detention or before they arrived at the MCTC*

| <b>DOSSIER CONTENTS</b>          | <b>INITIAL AND DATE RECEIVED</b> |
|----------------------------------|----------------------------------|
| <b>INFORMATION REPORT</b>        |                                  |
| <b>EVALUATION</b>                |                                  |
| <b>CP CO-ORDINATOR'S REPORT</b>  |                                  |
| <b>COMMANDANT'S COMMENTS</b>     |                                  |
| <b>FURTHER ACTION/CLOSED OFF</b> |                                  |

## YOUR INFORMATION

The member of staff making the referral should complete Sections 1 – 3 and submit the report to the Child Protection Co-ordinator (CPC) or the Duty Field Officer (DFO) without delay.

|                       |                 |       |
|-----------------------|-----------------|-------|
| <b>SECTION 1</b>      |                 |       |
| DETAINEE:<br>Initial: | Service Number: | Name: |
| COY:                  | DB Number:      | EPDR: |

|   |
|---|
| <b>SECTION 2 – Full details of your Child Protection concerns</b> (including details of to whom, how and where any disclosure was made) |
|   |

|                          |       |           |       |
|--------------------------|-------|-----------|-------|
| <b>SECTION 3</b>         |       |           |       |
| Signature:               | No:   | Rank:     | Name: |
| Date:                    | Time: | Location: |       |
| Passed to CPC/DFO (name) |       | On:       | Time: |

# CHILD PROTECTION INFORMATION REPORT

(To be completed by CPC or DFO)

|   |
|---|
| <b>SECTION 4 – Notification to the Commandant</b>   |
| <b>IF THE INFORMATION REQUIRES IMMEDIATE ACTION YOU SHOULD ENDORSE THE FRONT PAGE IN RED</b>                        |
| <b>DUTY FIELD OFFICER INFORMED: YES/NO</b> ( <i>Please delete as appropriate</i> )<br>The Commandant informed ..... |

|   |  |                   |  |
|---|--|-------------------|--|
| <b>SECTION 5 – Sources searched for related intelligence:</b> |  |                   |  |
| DUS Records   |  | Pre-Booked Visits |  |
| Coy Records   |  | Welfare File      |  |
| DAR   |  | Previous CPIRs    |  |
| Adjt  |  | Others (Specify)  |  |

|   |
|---|
| <b>SECTION 6 – Summary of Supporting/related intelligence</b> |
| <br><br><br><br><br>  |

|                                     |
|-------------------------------------|
| <b>SECTION 7 – CPC's assessment</b> |
| <br><br><br><br><br>                |

|   |
|---|
| Report completed by CPC on: .....at: .....(time)<br>Signature: ..... Print Name:<br>..... |
|---|

**NB:**

- 1. Initial and date the action completion box on front page of CPIR.
- 2. Acknowledge receipt of CPIR (Sections 1-3) from referring member of staff using Appendix One.

|   |
|---|
| <b>SECTION 8</b>                                      |
| Report passed to Commandant<br>on:.....at:.....(time) |
| Signature:.....No:.....Rank:.....Name:.....           |

|   |
|---|
| <b>SECTION 9 – Commandant’s Comments</b>    |
| <br><br><br><br><br><br><br><br><br><br>    |
| Signature:.....No:.....Rank:.....Name:..... |

|  |                 |  |  |
|--|-----------------|--|--|
| <b>SECTION 10 – CPC</b>  |                 |  |  |
| Adjt advised on:   | CPIR IT         |  |  |
| DUS Records advised on:  | DUS Records IT  |  |  |
| CPIR acknowledged on:  | Other (specify) |  |  |
| Further actions initiated:<br><br><br><br><br><br><br><br><br><br> |                 |  |  |

|                                  |  |                     |  |
|----------------------------------|--|---------------------|--|
| Further action completed:<br>YES |  | CPIR Closed:<br>YES |  |
|----------------------------------|--|---------------------|--|

Signature:.....Print Name:.....

**NB: Initial and date the action completion box on the front page**

Appendix.

1. Child Protection Information Report – Acknowledgement Proforma



**MCTC CHILD PROTECTION LOG**

**CPIR Number:** .....

**Original Referral Date:** .....

**Referring Member of Staff:**

Service Number: ..... Rank:.....

Full Name:.....

**Child Victim Details:**

Service Number:..... DOB:.....

MCTC DB No:..... EPDR:.....

Full Name: .....

Sentence:..... Offence:.....

Family History:

**Others Involved:**

Service Number:..... DOB:.....

MCTC DB No:..... EPDR:.....

Full Name:.....

Sentence:..... Offence:.....

Service Number:..... DOB:.....

MCTC DB No:..... EPDR:.....

Full Name:.....

Sentence:..... Offence:.....

**Date Set Up:**.....

**SCCSD Initial Response Team Members Name: .....**

**SCCSD Emergency Duty Service Members Name:.....**

**Child Protection Referral Fax Sent: Yes No Date:.....**

**Strategy Discussion Arranged: Yes No Date:.....**

**Other Key Workers Contacted:**

Name:..... Agency:.....

Name:..... Agency:.....

Name:..... Agency:.....

**Date SCCSD s.47 Enquiry Started:.....**



**To:** Essex Social Care Direct  
Essex House  
200 The Crescent  
Colchester  
CO4 9YQ

Telephone: 0845 603 7627      Fax: 0845 601 6230

**From:** Number:                      Rank:                      Name:  
Appointment:  
Military Corrective Training Centre  
Berechurch Hall Camp  
COLCHESTER  
CO2 9NU

Telephone:                                      Fax:

**Subject:**      **CHILD PROTECTION REFERRAL**

**Text:**      Please find attached for your attention Inter Agency Referral Form  
ESS999 (Rev 03/02) in respect of

**Authors Signature:**

**MCTC CPIR Number:**

**Number of Pages including Cover Sheet:**

**Acknowledgement:** Please acknowledge receipt of this Fax.

# Inter Agency Referral Form (Children & Young People)

This form is to assist agencies to either make a referral about a child or young person to children's social care services or confirm a referral in writing already made by telephone (*all professionals making telephone referrals to social services must confirm this in writing within 48 hours*). This form may be posted, transmitted by fax, or sent as an email attachment (see below). This form should be completed, with reference to the Guidance Notes (separately available).

Making a referral/inquiry by telephone

|   |
|---|
| <p><b>Normal telephone inquiries/referrals:</b> 0845 603 7627</p> <p><b>Out of hours:</b> (5.30pm - 9.00am Mon - Thurs, 4.30pm Fri - 9.00am Mon and Bank holidays): 0845 606 1212 and Fax 01245 434700</p> <p><b>Where there are concerns about the immediate welfare or safety of a child/young person: 0845 603 7634 (all callers) OR 0845 606 1212 (Office hours number for professionals only).</b></p> |
|---|

Sending this form to social services

|  |
|--|
| <p><b>By email to:</b> <a href="mailto:socialcaredirect@essexcc.gov.uk">socialcaredirect@essexcc.gov.uk</a> as an attachment (must be password protected – see guidance notes)</p> <p><b>By post to:</b> Essex Social Care Direct, Essex House, 200 The Crescent, Colchester, Essex CO4 9YQ</p> <p><b>By fax to:</b> 0845 601 6230</p> |
|--|

This is a new referral

**OR**

This is confirmation of a referral I made by telephone on \_\_\_\_\_ (date), Reference \_\_\_\_\_

**PART 1: CHILD/YOUNG PERSON'S DETAILS**

|  |                                    |  |  |  |
|--|------------------------------------|--|--|--|
| Family Name: Given names:  |                                    |  |  |  |
| Date of Birth or expected date of delivery: <input type="text"/>   |                                    |  |  |  |
| Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Unborn <input type="checkbox"/>                    |                                    |  |  |  |
| Usual or home address:   |                                    |  | Postcode:  | Tel No:  |
| Child or young person's first language or preferred means of communication:  |                                    |  |  |  |
| Is an interpreter required? Yes <input type="checkbox"/> No <input type="checkbox"/>                                     |                                    |  |  |  |
| Current address if different: (eg staying with relative or friend)   |                                    |  | Postcode:  | Tel No:  |
| Responsible local authority (if child/young person is known to be in the care of another authority but living in Essex): |                                    |  |  |  |
| <b>Child/young person's main carers:</b>   |                                    |  |  |  |
| Name   | Relationship to child/young person | Ethnicity  | First language   | Parental Responsibility                                  |
|  |                                    |  |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
|  |                                    |  |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Is an interpreter/signer required?   |                                    | Mother: Yes <input type="checkbox"/> No <input type="checkbox"/> | Father: Yes <input type="checkbox"/> No <input type="checkbox"/> |  |
| Other main carers (please specify name)  |                                    |  |  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Are any of the main carers disabled?   |                                    | Mother: Yes <input type="checkbox"/> No <input type="checkbox"/> | Father: Yes <input type="checkbox"/> No <input type="checkbox"/> |  |

The child/young person or the child's parents should be asked which ethnic group the child belongs to. This information on ethnicity will help us to assess fair access to services by all communities, better plan services and complete statistical returns required by Government (these categories are supplied by Government).

| Black or Black British                              | Asian or Asian British                              | White   | Mixed   | Other Ethnic Groups                             |
|---|---|---|---|---|
| Caribbean <input type="checkbox"/>                  | Indian <input type="checkbox"/>                     | White British <input type="checkbox"/>              | White & Black Caribbean <input type="checkbox"/>    | Chinese <input type="checkbox"/>                |
| African <input type="checkbox"/>                    | Pakistani <input type="checkbox"/>                  | White Irish <input type="checkbox"/>                | White & Black African <input type="checkbox"/>      | Any other <input type="checkbox"/> ethnic group |
| Any other Black background <input type="checkbox"/> | Bangladeshi <input type="checkbox"/>                | Any other White background <input type="checkbox"/> | White & Asian <input type="checkbox"/>              | Not given <input type="checkbox"/>              |
|   | Any other Asian background <input type="checkbox"/> |   | Any other Mixed background <input type="checkbox"/> | If other, please specify:                       |

Further details regarding child/young person's ethnicity:

Child/young person's religion:

Child/young person's nationality (if not British and if known):

Nationality:

Home Office registration number:

Immigration status: Asylum seeking  Refugee status  Exceptional leave to remain

Child/young person's Unique Pupil Number (if school age and if known):

Other Unique identifier (if used – please give identifier and describe what this is):

Parent's details if not main carers (and if known):

Mother's name Mother's address

Postcode Tel:

Mother's first language Mother's ethnicity

Father's name Father's address

Postcode Tel:

Father's first language Father's ethnicity

Does father have parental responsibility? Yes No

Is either parent disabled? Mother Yes  No  Father Yes  No

Is an interpreter/signer required? Mother Yes  No  Father Yes  No

**Other household members (including non-family members – if known):**

| Family name identifier (if known) | Given name unique identifier (if known) | DOB | UPN also referring to Social Services at same time as child | Other | Relationship to child | Tick if you are          |
|-----------------------------------|---|-----|---|-------|-----------------------|--------------------------|
|                                   |   |     |   |       |                       | <input type="checkbox"/> |
|                                   |   |     |   |       |                       | <input type="checkbox"/> |
|                                   |   |     |   |       |                       | <input type="checkbox"/> |
|                                   |   |     |   |       |                       | <input type="checkbox"/> |
|                                   |   |     |   |       |                       | <input type="checkbox"/> |
|                                   |   |     |   |       |                       | <input type="checkbox"/> |

As far as you know has the child/young person, or another child of the family been: (please give details)

|                                   |                          |                          |       |
|-----------------------------------|--------------------------|--------------------------|-------|
|                                   | Yes                      | No                       |       |
| on the disability record          | <input type="checkbox"/> | <input type="checkbox"/> | Name: |
|                                   | Date(s):                 |                          |       |
| on a child protection register    | <input type="checkbox"/> | <input type="checkbox"/> | Name: |
|                                   | Date on:                 | Date off:                |       |
|                                   | Category:                |                          |       |
| looked after by a local authority | <input type="checkbox"/> | <input type="checkbox"/> | Name: |
|                                   | Date(s):                 |                          |       |

Any other family members who are not living in the child/young person's household but who has significant involvement (eg sibling, relative):

| Surname | Forename | Relationship | Address | Phone No |
|---------|----------|--------------|---------|----------|
|         |          |              |         |          |

**Agencies involved with the child.** Please complete if currently involved with family. You do not need to contact other agencies, social services will do so if necessary.

| Agency   | Name  | Phone No | If a common assessment   |
|--|-------|----------|--------------------------|
| has been completed and permission has been shared please tick. | given |          | for it to be             |
| GP   |       |          | <input type="checkbox"/> |
| Health Visitor   |       |          | <input type="checkbox"/> |
| Nursery  |       |          | <input type="checkbox"/> |
| School   |       |          | <input type="checkbox"/> |
| Education Welfare Officer                                      |       |          | <input type="checkbox"/> |
| School Nurse   |       |          | <input type="checkbox"/> |
| Community Paediatrician  |       |          | <input type="checkbox"/> |
| Dentist  |       |          | <input type="checkbox"/> |
| Child and Family Consultation Service                          |       |          | <input type="checkbox"/> |
| Police   |       |          | <input type="checkbox"/> |
| Youth Offending Team   |       |          | <input type="checkbox"/> |
| Other  |       |          | <input type="checkbox"/> |

**PART 2: REASON FOR REFERRAL**

Please give your reasons for referral/request for services (please continue on separate sheet as necessary).

Awareness of referral (The child/young person and parents/carers should be made aware of your intention to make a referral to Social Services, unless there is a specific reason for this being inappropriate, eg risk of significant harm).

Is the parent/carer aware of the referral? Yes  No  Is child/young person aware? Yes  No

Has the parent, carer (or young person, if competent) given consent to the referral? Parent/carer Yes  No  If No consent please give reason for this being inappropriate. Young person Yes  No

**PART 3: REFERRER'S DETAILS**

|   |           |                |  |
|---|-----------|----------------|--|
| <b>Referred by</b>  |           |                |  |
| Agency:   |           | Name:          |  |
| Address:  |           |                |  |
| Postcode:   | Phone No: | Email address: |  |
| Date of any previous referral to Social Services if relevant.   |           |                |  |
| What services are you or your organisation already providing to the child/young person or family?   |           |                |  |
| <b>Have you completed a Common Assessment concerning this child/young person? Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes please attach)</b> |           |                |  |
| Any safety issues to be aware of? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>                                       |           |                |  |
| If yes, please specify.   |           |                |  |
| Completed by:   |           |                |  |
| Name ..... Signature ..... Date .....   |           |                |  |

**PART 4: TO BE COMPLETED BY ECC STAFF ONLY**

**Action by Social Care Direct**

Date Received by Social Care Direct:

SWIFT Record number:

Date sent to children's operational team:

**Action by Children's operational team**

Date Received by Children's operational team:

Decision by Team Manager on referral   NFA    Initial Assessment

Date referral acknowledged:

Date outcome of referral notified to referrer (if different):

**PART 6: TO BE COMPLETED BY ECC OPERATIONAL TEAM, DETACHED AND SENT TO THE REFERRER**

Date:

Referrer's Name:

Referrer's Address:

Dear Colleague

**Concerning:** (Child/young person's name)

**Address:** (Child/young person's address)

**Referred on:** (Referral date)

Thank you for your referral. I am writing to confirm the outcome of your referral.

**Decision on referral:**

NFA

OR

Initial Assessment

Date of decision

**Contacts for further inquiries about this referral:**

The social worker who should be contacted about this matter is:

OR

There is no allocated social worker in this case. Any further inquiries should be directed to: (name and contact details)

Signed:

Team Manager Name:

Team Manager Contact Details: