



Child Protection Policy Appendices

Date	19th January 2017
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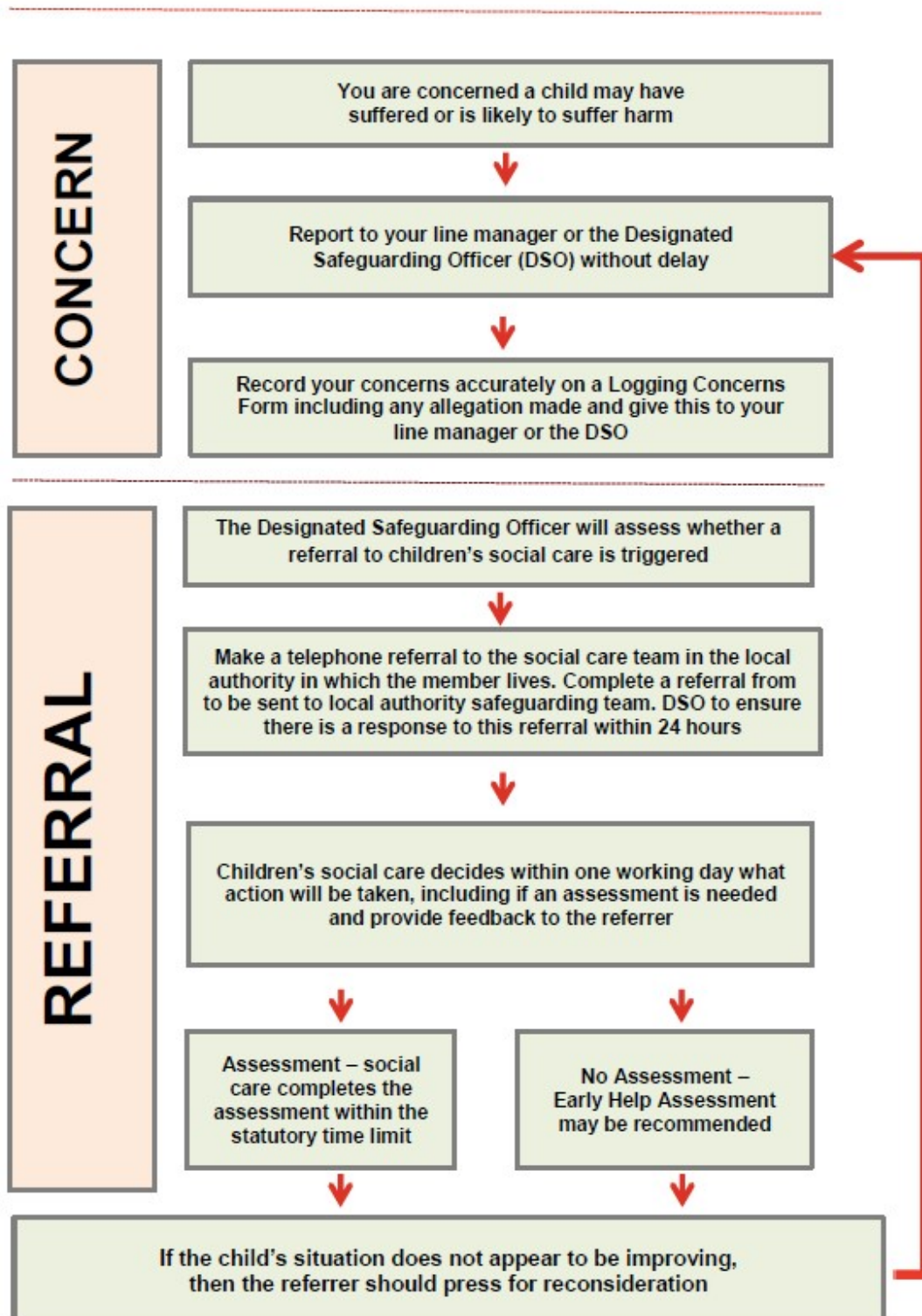
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Appendix 1 – Action when a child has suffered or is likely to suffer harm

Autism Bedfordshire - Child Protection and Safeguarding

Action when raising a concern



Appendix 2 – Logging concerns form

LOGGING CONCERNS ABOUT AN INDIVIDUAL'S SAFETY AND WELFARE (Within Children's Services)

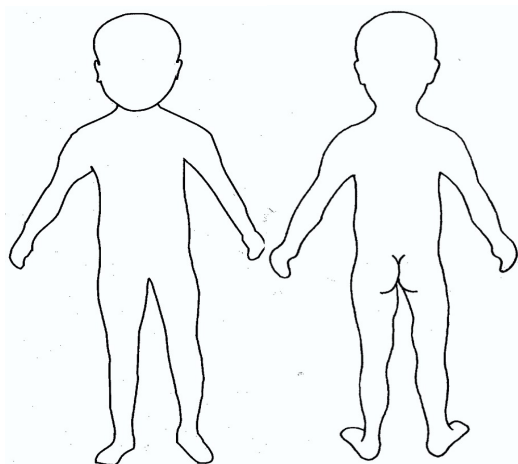
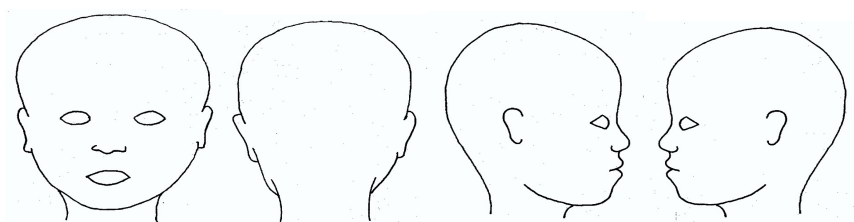
1. Information about the person reporting		
Full name:		
Signature:		
Position:		
Other people who saw the incident or have information relating to the concern:	Name	Position

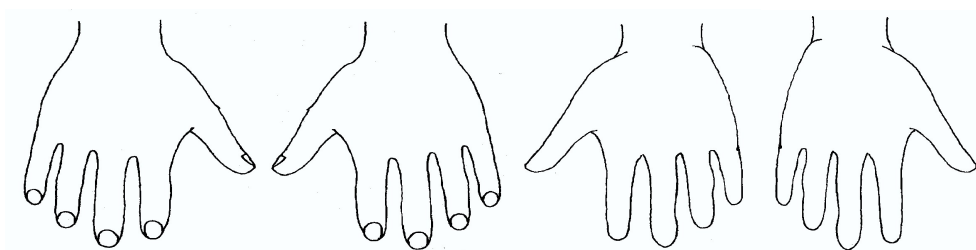
2. Information about the person that the concern is about	
This concern is about:	Child (0-9yrs) Young Person (10-17yrs) Adult (please specify parent, carer, or AB staff member)
Full name:	
DOB:	
Their address:	
Diagnosis/needs:	
Parent/ carer/ guardian name:	
Parent/ carer/ guardian address: <i>(If different from child/ young person)</i>	

4. Details of injury as observed (if applicable):

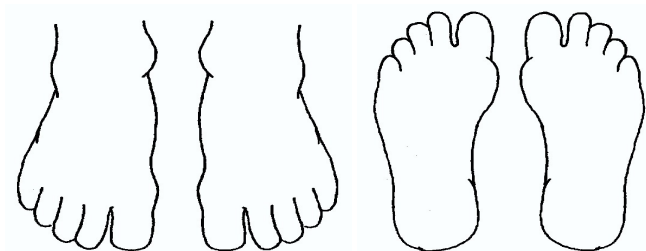
When you notice an injury to the individual, try to record the following information in respect of each mark identified.
e.g. red areas, swelling, bruising, cuts, lacerations and wounds, scalds, and burns

Exact site of injury on the body: e.g. upper outer arm/left cheek.					
Size of injury: (in appropriate cm or inches)					
Approximate shape of injury e.g. round/square or straight line					
Colour of injury: (If more than one colour, say so)					
Is there a scab/any blistering/any bleeding?					
	Yes	No	Not sure	Unknown	Further details
Is the skin broken?	☐	☐	☐	☐	
Is there any swelling at the site of the injury, or elsewhere?	☐	☐	☐	☐	
Is mobility restricted as a result of the injury?	☐	☐	☐	☐	
Does the site of the injury feel hot?	☐	☐	☐	☐	
Does the child feel hot?	☐	☐	☐	☐	
Does the child feel pain?	☐	☐	☐	☐	
Body map completed separately to this form?	☐	☐			

4b. Body Map: TORSO. This must be completed at the time of observation.**Body Map: HEAD. This must be completed at the time of observation.****Body Map: HANDS. This must be completed at the time of observation.**



Body Map: FEET. This must be completed at the time of observation.



5. Accident reporting

Who has the concern been reported to?	Name	Reported	Date reported
	Lauren Barry <i>Children's services Manager & Designated Safeguarding Lead</i>	☐	
	Gemma Malins <i>MK Children's Services Co-ordinator</i>	☐	
	Lewie Gentilella <i>Children's Services Co-ordinator</i>	☐	
	Emma Reade <i>Chief Executive Officer (CEO) & Designated Safeguarding Lead</i>	☐	
	Liz McTernan <i>Keyworker Manager & Designated Safeguarding Lead</i>	☐	
	Parent/ carer	☐	
	Other _____	☐	

6. FOR SAFEGUARDING LEAD'S PURPOSES ONLY

Timeline of events

(Include discussions such as MASH team calls, when any MASH forms were submitted, parent/ carer discussions, other professionals contacted, date of confirmation that concern is being dealt with and Autism Beds can close case on their end)

Date	Time	Details

Additional information: Action Taken/ Next steps

--

Name	Signed
Signature	Date

Form now on Salesforce?

Yes ☐ No ☐

Appendix 3 – Body Map Guidance

Body Maps should be used to document and illustrate visible signs of harm and physical injuries.

Always use a black pen (never a pencil) and do not use correction fluid or any other eraser.

Do not remove clothing for the purpose of the examination unless the injury site is freely available because of treatment.

Please only complete the relevant body map.

***At no time should a member of staff be asked to or consider taking photographic evidence of any injuries' or marks to a child's person, this type of behaviour could lead to the staff member being taken into managing allegations procedures, the body map below should be used in accordance with recording guidance. Any concerns should be reported and recorded without delay to the appropriate safeguarding services, e.g. Early Help Services or the child's social worker if already an open case to social care.**

When you notice an injury to a child, try to record the following information in respect of each mark identified e.g. red areas, swelling, bruising, cuts, lacerations and wounds, scalds, and burns:

- Exact site of injury on the body, e.g. upper outer arm/left cheek.
- Size of injury - in appropriate centimetres or inches.
- Approximate shape of injury, e.g. round/square or straight line.
- Colour of injury - if more than one colour, say so.
- Is the skin broken?
- Is there any swelling at the site of the injury, or elsewhere?
- Is there a scab/any blistering/any bleeding?
- Is the injury clean or is there grit/fluff etc?
- Is mobility restricted as a result of the injury?
- Does the site of the injury feel hot?
- Does the child feel hot?
- Does the child feel pain?
- Has the child's body shape changed/are they holding themselves differently?

Importantly the date and time of the recording must be stated as well as the name and designation of the person making the record. Add any further comments as required.

Ensure First Aid is provided where required and record

A copy of the body map should be kept on the child's concern/confidential file.

The body map used is now within the Logging Concerns Form (See Appendix 2)

APPENDIX 4, 5, 6, 7 – WAS BODY MAP SEGMENTS – THIS IS NOW PART OF THE SAFEGUARDING CONCERNS FORM – (SEE APPENDIX 2)

Appendix 8 – Definitions & Indicators of Abuse

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- Provide adequate food, clothing, and shelter (including exclusion from home or abandonment)
- Protect a child from physical and emotional harm or danger.
- Ensure adequate supervision (including the use of inadequate caregivers); or
- Ensure access to appropriate medical care or treatment.
- It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.
-

The following may be indicators of neglect (this is not designed to be used as a checklist):

- Constant hunger.
- Stealing, scavenging and/or hoarding food.
- Frequent tiredness or listlessness.
- Frequently dirty or unkempt.
- Often poorly or inappropriately clad for the weather.
- Poor school attendance or often late for school.
- Poor concentration.
- Affection or attention seeking behaviour.
- Illnesses or injuries that are left untreated.
- Failure to achieve developmental milestones, for example growth, weight.
- Failure to develop intellectually or socially.
- Responsibility for activity that is not age appropriate such as cooking, ironing, caring for siblings.
- The child is regularly not collected or received from school.
- The child is left at home alone or with inappropriate carers.

Physical Abuse

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

The following may be indicators of physical abuse (this is not designed to be used as a checklist):

- Multiple bruises in clusters, or of uniform shape.
- Bruises that carry an imprint, such as a hand or a belt.
- Bite marks.
- Round burn marks.
- Multiple burn marks and burns on unusual areas of the body such as the back, shoulders or buttocks.
- An injury that is not consistent with the account given.
- Changing or different accounts of how an injury occurred.
- Bald patches.
- Symptoms of drug or alcohol intoxication or poisoning.
- Unaccountable covering of limbs, even in hot weather.
- Fear of going home or parents being contacted.
- Fear of medical help.
- Fear of changing for PE.
- Inexplicable fear of adults or over-compliance.
- Violence or aggression towards others including bullying.
- Isolation from peers.

Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether 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.

The following may be indicators of sexual abuse (this is not designed to be used as a checklist):

- Sexually explicit play or behaviour or age-inappropriate knowledge.
- Anal or vaginal discharge, soreness, or scratching.
- Reluctance to go home.
- Inability to concentrate, tiredness.
- Refusal to communicate.
- Thrush, persistent complaints of stomach disorders or pains.
- Eating disorders, for example anorexia nervosa and bulimia.
- Attention seeking behaviour, self-mutilation, substance abuse.
- Aggressive behaviour including sexual harassment or molestation.
- Unusual compliance.
- Regressive behaviour, enuresis, soiling.
- Frequent or open masturbation, touching others inappropriately.
- Depression, withdrawal, isolation from peer group.
- Reluctance to undress for PE or swimming.
- Bruises or scratches in the genital area.

Sexual Exploitation

Child sexual exploitation occurs when a child or young person, or another person, receives “something” (for example food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of the child/young person performing sexual activities, or another person performing sexual activities on the child/young person.

The presence of any significant indicator for sexual exploitation should trigger a referral to children’s social care. The significant indicators are:

- Having a relationship of concern with a controlling adult or young person (this may involve physical and/or emotional abuse and/or gang activity).
- Entering and/or leaving vehicles driven by unknown adults.
- Possessing unexplained amounts of money, expensive clothes, or other items.
- Frequenting areas known for risky activities.
- Being groomed or abused via the Internet and mobile technology; and
- Having unexplained contact with hotels, taxi companies or fast-food outlets.
- The intelligence reporting form on the LSCB website will be used to share information with Police and children’s social care that raises a concern around CSE.

In addition to making referrals to children’s social care, referrals of children thought to be at risk of, or experiencing CSE will be referred to the Child Sexual Exploitation panel.

Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only as far as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may also involve seeing or hearing the ill-treatment of another person. 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.

The following may be indicators of emotional abuse (this is not designed to be used as a checklist):

- The child consistently describes him/herself in very negative ways – as stupid, naughty, hopeless, ugly.
- Over-reaction to mistakes.
- Delayed physical, mental or emotional development.
- Sudden speech or sensory disorders.
- Inappropriate emotional responses, fantasies.
- Behaviours such as rocking, banging head, regression, tics and twitches.
- Self-harming, drug or solvent abuse.
- Fear of parents being contacted.
- Running away.
- Compulsive stealing.
- Appetite disorders - anorexia nervosa, bulimia.
- Soiling, smearing faeces, enuresis.
- N.B.: Some situations where children stop communication suddenly (known as “traumatic mutism”) can indicate maltreatment.

Responses from Parents

Research and experience indicate that the following responses from parents may suggest a cause for concern across all four categories:

- Delay in seeking treatment that is obviously needed.
- Unawareness or denial of any injury, pain, or loss of function (for example, a fractured limb).
- Incompatible explanations offered, several different explanations or the child is said to have acted in a way that is inappropriate to her/his age and development.

Appendix 9 – Dealing with a Disclosure of Abuse

When a child tells me about abuse s/he has suffered, what must I remember?

- Stay calm.
- Do not communicate shock, anger, or embarrassment.
- Reassure the child. Tell her/him you are pleased that s/he is speaking to you.
- Never enter a pact of secrecy with the child. Assure her/him that you will try to help but let the child know that you will have to tell other people to do this. State who this will be and why.
- Tell her/him that you believe them. Children very rarely lie about abuse; but s/he may have tried to tell others and not been heard or believed.
- Tell the child that it is not her/his fault.
- Encourage the child to talk but do not ask "leading questions" or press for information.
- Listen and remember.
- Check that you have understood correctly what the child is trying to tell you.
- Praise the child for telling you. Communicate that s/he has a right to be safe and protected.
- Do not tell the child that what s/he experienced is dirty, naughty, or bad.
- It is inappropriate to make any comments about the alleged offender.
- Be aware that the child may retract what s/he has told you. It is essential to record all you have heard.
- At the end of the conversation, tell the child again who you are going to tell and why that person or those people need to know.
- As soon as you can afterwards, make a detailed record of the conversation using the child's own language. Include any questions you may have asked. Do not add any opinions or interpretations.

NB - It is not the role of staff or volunteers to seek disclosures. Their role is to observe that something may be wrong, ask about it, listen, be available and try to talk.

Immediately afterwards.

You must not deal with this yourself. Clear indications or disclosure of abuse must be reported to children's social care with-out delay, by the Designated Safeguarding Lead.

Children making a disclosure may do so with difficulty, having chosen carefully to whom they will speak. Listening to and supporting a child/young person who has been abused can be traumatic for the adults involved. Support for you will be available from your Designated Safeguarding Lead or relevant member of the Board of Trustees.

Appendix 10 – Indicators of Vulnerability to Radicalisation

Indicators of Vulnerability to Radicalisation

1. Radicalisation refers to the process by which a person comes to support terrorism and forms of extremism leading to terrorism.
2. Extremism is defined by the Government in the Prevent Strategy as:
Vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs. We also include in our definition of extremism calls for the death of members of our armed forces, whether in this country or overseas.
3. Extremism is defined by the Crown Prosecution Service as:
 - The demonstration of unacceptable behaviour by using any means or medium to express views which:
 - Encourage, justify, or glorify terrorist violence in furtherance of particular beliefs.
 - Seek to provoke others to terrorist acts.
 - Encourage other serious criminal activity or seek to provoke others to serious criminal acts; or
 - Foster hatred which might lead to inter-community violence in the UK.
4. There is no such thing as a “typical extremist”: those who become involved in extremist actions come from a range of backgrounds and experiences, and most individuals, even those who hold radical views, do not become involved in violent extremist activity.
5. Children may become susceptible to radicalisation through a range of social, personal, and environmental factors - it is known that violent extremists exploit vulnerabilities in individuals to drive a wedge between them and their families and communities. It is vital that school staff can recognise those vulnerabilities.
6. Indicators of vulnerability include:
 - Identity Crisis – the child is distanced from their cultural / religious heritage and experiences discomfort about their place in society.
 - Personal Crisis – the child may be experiencing family tensions; a sense of isolation; and low self-esteem; they may have dissociated from their existing friendship group and become involved with a new and different group of friends; they may be searching for answers to questions about identity, faith and belonging.
 - Personal Circumstances – migration; local community tensions; and events affecting the child’s country or region of origin may contribute to a sense of grievance that is triggered by personal experience of racism or discrimination or aspects of Government policy.
 - Unmet Aspirations – the child may have perceptions of injustice; a feeling of failure; rejection of civic life.
 - Experiences of Criminality – which may include involvement with criminal groups, imprisonment, and poor resettlement / reintegration.
 - Special Educational Need – children may experience difficulties with social interaction, empathy with others, understanding the consequences of their actions and awareness of the motivations of others.
7. However, this list is not exhaustive, nor does it mean that all young people experiencing the above are at risk of radicalisation for the purposes of violent extremism.
8. More critical risk factors could include:
 - Being in contact with extremist recruiters.
 - Accessing violent extremist websites, especially those with a social networking element.
 - Possessing or accessing violent extremist literature.
 - Using extremist narratives and a global ideology to explain personal disadvantage.
 - Justifying the use of violence to solve societal issues.
 - Joining or seeking to join extremist organisations; and
 - Significant changes to appearance and / or behaviour.
 - Experiencing a high level of social isolation resulting in issues of identity crisis and / or personal crisis.

Appendix 11 – Female Genital Mutilation

Female Genital Mutilation (FGM)

Female genital mutilation (FGM) is a procedure where the female genitals are deliberately cut, injured, or changed, but where there is no medical reason for this to be done. It is also known as "female circumcision" or "cutting", and by other terms such as sunna, gudniin, halalays, tahur, megrez and khitan, among others.

FGM is usually conducted on young girls between infancy and the age of 15, most commonly before puberty starts. It is illegal in the UK and is child abuse. It is very painful and can seriously harm the health of women and girls. It can also cause long-term problems with sex, childbirth, and mental health.

Effects of FGM

There are no health benefits to FGM, and it can cause serious harm, including:

- Constant pain.
- Pain and/or difficulty having sex.
- Repeated infections, which can lead to infertility.
- Bleeding, cysts and abscesses.
- Problems passing urine or incontinence.
- Depression, flashbacks, and self-harm; and
- Problems during labour and childbirth, which can be life-threatening for mother and baby.

Some girls die from blood loss or infection as a direct result of the procedure.

Why FGM is conducted?

FGM is conducted for various cultural, religious, and social reasons within families and communities in the mistaken belief that it will benefit the girl in some way (for example, as a preparation for marriage or to preserve her virginity).

However, there are no acceptable reasons that justify FGM. It is a harmful practice that is not required by any religion and there are no religious texts that say it should be done. There are no health benefits of FGM.

FGM usually happens to girls whose mothers, grandmothers or extended female family members have had FGM themselves or if their father comes from a community where it is conducted.

Where FGM is conducted

Girls are sometimes taken abroad for FGM, but they may not be aware that this is the reason for their travel. Girls are more at risk of FGM being conducted during the summer holidays, as this allows more time for them to "heal" before they return to school.

Communities that perform FGM are found in many parts of Africa, the Middle East and Asia. Girls who were born in the UK or are resident here but whose families originate from an FGM practising community are at greater risk of FGM happening to them.

Communities at particular risk of FGM in the UK originate from:

- Egypt Yemen Eritrea Sudan
- Ethiopia Somalia Gambia Sierra Leone
- Guinea Nigeria Indonesia Mali
- Ivory Coast Malaysia Kenya Liberia

The law and FGM

FGM is illegal in the UK.

It is an offence to:

- Perform FGM (including taking a child abroad for FGM).
- Help a girl perform FGM on herself in or outside the UK.
- Help anyone perform FGM in the UK.
- Help anyone perform FGM outside the UK on a UK national or resident.
- Fail to protect a girl for whom you are responsible from FGM.

Anyone who performs FGM can face up to 14 years in prison. Anyone found guilty of failing to protect a girl from FGM can face up to seven years in prison.

Female Genital Mutilation Act 2003 (section 74 of the Serious Crime Act 2015) places a statutory duty upon teachers (along with social workers and healthcare professionals) to report to the police where they discover (either through disclosure by the victim or visual evidence) that FGM appears to have been conducted on a girl under 18.

Possible signs and indicators of FGM

A girl or woman who's had FGM may:

- Have difficulty walking, sitting or standing.
- Spend longer than normal in the bathroom or toilet.
- Have unusual behaviour after an absence from school or college.
- Be particularly reluctant to undergo normal medical examinations.
- Ask for help but may not be explicit about the problem due to embarrassment or fear.

Below are some warning signs that MAY indicate a girl is at risk of FGM.

- Parents requesting additional periods of leave around school holiday times.
- If the girl comes from a country with a high prevalence of FGM
- Mother and siblings have undergone FGM.
- Child may indicate that they are going for a special event.

Further information can be obtained from:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/512906/Multi_Agency_Statutory_Guidance_on_FGM_-_FINAL.pdf

Appendix 12 – Youth Produced Sexual Imagery

If you have any doubts about whether to involve other agencies, you should make a referral to the police.

Assessing the risks

The circumstances of incidents can vary widely. If at the initial review stage, a decision has been made not to refer to police and/or children's social care, the DSL should conduct a further review (including an interview with the young people involved) to establish the facts and assess the risks.

When assessing the risks the following should be considered:

- Why was the imagery shared? Was the young person coerced or put under pressure to produce the imagery?
- Who has shared the imagery? Where has the imagery been shared? Was it shared and received with the knowledge of the pupil in the imagery?
- Are there any adults involved in the sharing of the imagery?
- What is the impact on the young people involved?
- Do the young people involved have additional vulnerabilities?
- Does the young person understand consent?
- Has the young person taken part in this kind of activity before?

Informing parents (or carers)

Parents (or carers) should be informed and involved in the process at an early stage unless informing the parent will put the young person at risk of harm. Any decision not to inform the parents would be made in conjunction with other services such as children's social care and/or the police, who would take the lead in deciding when the parents should be informed.

DSLs may work with the young people involved to decide on the best approach for informing parents. In some cases, DSLs may work to support the young people to inform their parents themselves.

Searching devices, viewing, and deleting imagery

Viewing the imagery:

Adults should not view youth produced sexual imagery unless there is good and clear reason to do so. Wherever responses to incidents should be based on what DSLs have been told about the content of the imagery.

If a decision is made to view imagery, the DSL would need to be satisfied that viewing:

- Is the only way to decide about whether to involve other agencies (i.e. it is not possible to establish the facts from the young people involved).
- Is necessary to report the image to a website, app, or suitable reporting agency to have it taken down, or to support the young person or parent in making a report.
- Is unavoidable because a young person has presented an image directly to a staff member or the imagery has been found on a device or network.

If it is necessary to view the imagery, then the DSL should:

- Never copy, print, or share the imagery; this is illegal.
- Discuss the decision with the relevant member of the Board of Trustees
- Ensure viewing is undertaken by the DSL or another member of the safeguarding team with delegated authority from the relevant member of the Board of Trustees
- Ensure viewing takes place with another member of staff present in the room, ideally the relevant member of the Board of Trustees. This staff member does not need to view the images.
- Wherever possible ensure viewing takes place on AB premises, ideally in a closed office.
- Ensure wherever possible that images are viewed by a staff member of the same sex as the young person in the imagery.
- Record the viewing of the imagery in Autism Bedfordshire's safeguarding records including who was present, why the image was viewed and any subsequent actions and ensure safeguarding recording procedures are followed.

Appendix 13 – Gang Involvement

There are particular risk factors and triggers that young people experience in their lives that can lead to them becoming involved in gangs. Many of these risk factors are similar to involvement in other harmful activities such as youth offending or violent extremism.

Risk indicators may include:

- Becoming withdrawn from family.
- Sudden loss of interest in school – decline in attendance or academic achievement.
- Starting to use new or unknown slang words.
- Holding unexplained money or possessions.
- Staying out unusually late without reason.
- Sudden change in appearance – dressing in a particular style or ‘uniform’.
- Dropping out of positive activities.
- New nickname.
- Unexplained physical injuries.
- Graffiti style tags on possessions, schoolbooks, walls.
- Constantly talking about another young person who seems to have a lot of influence over them.
- Broken off with old friends and hanging around with a new group.
- Increased use of social networking sites.
- Starting to adopt codes of group behaviour e.g. ways of talking and hand signs.
- Expressing aggressive or intimidating views towards other groups of young people some of whom may have been friends in the past.
- Being scared when entering certain areas.
- Being concerned by the presence of unknown youths in their neighbourhood.

This is not an exhaustive list and should be used as a guide, amended as appropriate in light of local knowledge of the risk factors in a particular area.

Appendix 14 – Child Sexual Exploitation (CSE)

Child sexual exploitation takes different forms - from a seemingly 'consensual' relationship where sex is exchanged for attention, affection, accommodation, or gifts, to serious organised crime and child trafficking. Child sexual exploitation involves differing degrees of abusive activities, including coercion, intimidation or enticement, unwanted pressure from peers to have sex, sexual bullying (including cyber bullying), and grooming for sexual activity.

There is increasing concern about the role of technology in Sexual Abuse, including via social networking and other internet sites and mobile phones. The key issue in relation to child sexual exploitation is the imbalance of power within the 'relationship.' The perpetrator always has power over the victim, increasing the dependence of the victim as the exploitative relationship develops.

Many children and young people are groomed into sexually exploitative relationships, but other forms of entry exist. Some young people are engaged in informal economies that incorporate the exchange of sex for rewards such as drugs, alcohol, money, or gifts. Others exchange sex for accommodation or money as a result of homelessness and experiences of poverty. Some young people have been bullied and threatened into sexual activities by peers or gangs which is then used against them as a form of extortion and to keep them compliant.

The key indicators of child sexual exploitation include:

Health

- Physical symptoms (bruising suggestive of either physical or sexual assault).
- Chronic fatigue.
- Recurring or multiple sexually transmitted infections.
- Pregnancy and/or seeking an abortion.
- Evidence of drug, alcohol or other substance misuse.
- Sexually risky behaviour.

Education

- Truancy/disengagement with education or considerable change in performance at school.

Emotional and Behavioural Issues

- Volatile behaviour exhibiting extreme array of mood swings or use of abusive language.
- Involvement in petty crime such as shoplifting, stealing.
- Secretive behaviour.
- Entering or leaving vehicles driven by unknown adults.
- Reports of being seen in places known to be used for sexual exploitation, including public toilets known for cottaging or adult venues (pubs and clubs).

Identity

- Low self-image, low self-esteem, self-harming behaviour, e.g. cutting, overdosing, eating disorder, promiscuity.

Relationships

- Hostility in relationships with staff, family members as appropriate and significant others.
- Physical aggression.
- Placement breakdown.
- Reports from reliable sources (e.g. family, friends, or other professionals) suggesting the likelihood of involvement in sexual exploitation.
- Detachment from age-appropriate activities.
- Associating with other young people who are known to be sexually exploited.
- Known to be sexually active.
- Sexual relationship with a significantly older person, or younger person who is suspected of being abusive.
- Unexplained relationships with older adults.
- Possible inappropriate use of the Internet and forming relationships, particularly with adults, via the Internet.
- Phone calls, text messages or letters from unknown adults.
- Adults or older youths loitering outside the home.
- Persistently missing, staying out overnight or returning late with no plausible explanation.
- Returning after having been missing, looking well cared for despite having no known home base.
- Missing for extended periods of time, with no known home base.
- Going missing and being found in areas where they have no known links.

Please note: Whilst the focus is often on older men as perpetrators, younger men and women may also be involved, and staff should be aware of this possibility.

Social Presentation

- Change in appearance.
- Going out dressed in clothing unusual for them (inappropriate for age, borrowing clothing from older young people).

Family and Environmental Factors

- History of physical, sexual, and/or emotional abuse; neglect; domestic violence; parental difficulties. Housing
- Pattern of previous street homelessness.
- Having keys to premises other than those known about.

Income

- Possession of substantial amounts of money with no plausible explanation.
- Acquisition of expensive clothes, mobile phones, or other possessions without plausible explanation.
- Accounts of social activities with no plausible explanation of the source of necessary funding.

This list is not exhaustive.

Staff and foster carers should be aware that many children and young people who are sexually exploited do not see themselves as victims.