SAFEGUARDING POLICY

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SAFEGUARDING: KEY INFORMATION

SAFEGUARDING TEAM

	NAME	CONTACT	DATE OF TRAINING	TRAINING DUE
Designated Safeguarding Lead (DSL):	Sarah Thomas	07967 060021	July 2019	July 2021
Designated Safeguarding Officer (DSO) & Deputy DSL:	Nora Bajaki-Sipos	07701 347557	July 2019	July 2021
Board Lead:	Tim Fenton	07808 361566		

REPORTING CONCERNS

To seek advice about whether to make a referral, or to make a referral, contact the Multi Agency Safeguarding Hub (MASH) formerly the Advice, Contact and Assessment Service (ACAS) at:

Email: mash@brighton-hove.gov.uk
Phone: **01273 290400**

OTHER USEFUL CONTACTS

Sussex Police	0845 60 70 or 999
Brighton & Hove Early Help Hub	01273 292632
Childline	0800 1111
Parent Plus	0808 800 2222
NSPCC 24-Hour Helpline	0800 800 5000

1. INTRODUCTION

1.1 STATEMENT OF INTENT

All children, young people and vulnerable adults have the right to protection from abuse, neglect, exploitation and harm.

Whoopsadaisy provides services to support the welfare of children with disabilities and young people. Research indicates that children with disabilities face an increased risk of abuse or neglect and can be abused and neglected in ways that others cannot. In order to ensure that the welfare of children with disabilities is safeguarded and promoted, we recognise that additional action is required.

This policy outlines our key principles, policies, procedures and people to ensure our commitment to safeguarding the wellbeing of children and young people is paramount.

1.2 SCOPE

Within the framework of the law, staff and volunteers have an important role in the protection of children from abuse. This policy applies to all staff, including trustees, employees, volunteers, sessional workers, contractors or anyone working on behalf of Whoopsadaisy.

This policy applies to all children (under 18 years) regardless of gender, ethnicity, disability, sexuality or religion. Children will be made aware of the policy in ways that are appropriate to their age, situation or ability.

2. LEGAL FRAMEWORK

2.1 LEGAL GUIDANCE

This policy has been written with reference to the following law and guidance:

- *Children's Act 1989, 2004*
- *Keeping Children Safe in Education – September 2018 (HM Government - Department for Education)*
- *Safeguarding Disabled Children: Practice Guidance (HM Government – Department for Children, Schools and Families, 2009)*
- *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children – 2018 (HM Government)*
- *Pan-Sussex Child Protection & Safeguarding Procedures*
- *United Nations Convention on the Rights of the Child 1991*

2.2 Legal Definitions

2.2.1 A Child in Need

Under Section 17 (10) of the Children Act 1989, a child is a Child in Need if:

1. He/she is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him/her of services by a local authority;
2. His/her health or development is likely to be significantly impaired, or further impaired, without the provision for him/her of such services; or
3. **He/she has a disability.**

2.2.2 Safeguarding

Safeguarding children is the action we take to promote the welfare of children and protect them from harm. Safeguarding and promoting the welfare of children is defined in *Working Together to Safeguard Children, 2018* as:

1. protect from maltreatment
2. prevent impairment of child's health or development
3. ensure that the child grows up in circumstances consistent with the provision of safe and effective care
4. take action to enable all children to have the best outcomes

2.2.3 Child abuse

> *"Abuse is a form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others (e.g. via the internet). They may be abused by an adult or adults, or another child or children." Working Together to Safeguard Children, 2018.*

Types of Child Abuse *(Keeping Children Safe in Education, 2018)*:

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

Emotional abuse: is the persistent emotional maltreatment of a child such that it causes severe and persistent adverse effects on the child's emotional development. It may involve:

- making a child feel worthless, unloved or inadequate
- only there to meet another's needs
- inappropriate age or developmental expectations
- overprotection and limitation of exploration, learning and social interaction

- seeing or hearing the ill treatment of another, e.g. domestic abuse
- making the child feel worthless and unloved - high criticism and low warmth
- serious bullying (including cyberbullying)
- exploitation or corruption

Some level of emotional abuse is involved in all types of maltreatment of a child, although it may occur alone.

Sexual abuse: involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. Activities may involve physical contact, including penetration of any part of the body, or non-penetrative acts. They may include non-contact activities, such as involving children looking at or in the production of sexual images, including on the internet, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Child sexual exploitation is also sexual abuse; it involves children and young people receiving something, for example accommodation, drugs, gifts or affection, as a result of them performing sexual activities, or having others perform sexual activities on them. It could take the form of grooming of children, e.g. to take part in sexual activities or to post sexual images of themselves on the internet.

Sexual abuse is not solely perpetrated by adult males. Women can also collude with and commit acts of sexual abuse, as can other children.

Neglect: is the persistent failure to meet a child's basic physical 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 misuse. Once a child is born, it may involve a parent failing to:

- provide adequate food, clothing and shelter, including exclusion from home or abandonment
- protect a child from physical and emotional harm or danger
- ensure adequate supervision, including the use of inadequate care givers
- ensure access to appropriate medical care or treatment

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

3. RECOGNISING ABUSE

There are a number of ways in which concerns regarding a child or young person's welfare might come to light. These might include:

- The child or young person discloses that he or she is being abused or neglected.
- A third party reports that the child or young person has disclosed that he or she is being abused or neglected.
- You may strongly suspect that a child or young person is being abused or neglected.
- An allegation is made against a member of staff, volunteer or trustee.
- A concern is raised without any specific disclosure of abuse or neglect.
- One child or young person is seen to be abusing another.

This list is not exhaustive and if staff or volunteers have any concerns, these must be discussed with your supervisor or the Designated Safeguarding Lead.

3.1 Signs and Behaviours That May be Indicators of Abuse

The NSPCC lists some of the signs and behaviours which may indicate that a child is being abused:

- *repeated minor injuries*
- *children who are dirty, smelly, poorly clothed or who appear underfed*
- *children who have lingering illnesses which are not attended to, or significant changes in behaviour, aggressive behaviour, severe tantrums*
- *an air of 'detachment' or 'don't care' attitude*
- *overly compliant behaviour*
- *a 'watchful attitude'*
- *sexually explicit behaviour (e.g. playing games and showing awareness which is inappropriate for the child's age)*
- *a child who is reluctant to go home, or is kept away from school for no apparent reason*
- *does not trust adults, particularly those who are close*
- *tummy pains with no medical reason*
- *eating problems, including over-eating or loss of appetite*
- *disturbed sleep, nightmares, bed wetting*
- *running away from home, suicide attempts*
- *self-inflicted wounds*
- *reverting to younger behaviour*
- *depression, withdrawal*
- *relationships between child and adults which are secretive and exclude others*
- *pregnancy*

These signs are not evidence themselves but may be a warning, particularly if a child exhibits several of them or a pattern emerges.

In an abusive relationship, the child may

- appear frightened of their parent(s)
- act in a way that is inappropriate to their age and development (taking full account of different patterns of development and different ethnic groups)

In an abusive relationship, the parent/ carer may:

- persistently avoid child health services and treatment of the child's illnesses
- have unrealistic expectations of the child
- frequently complain about or to the child and fail to provide attention or praise
- be absent
- be misusing substances
- persistently refuse to allow access on home visits by professionals
- be involved in domestic violence and abuse
- be socially isolated

Serious case reviews have found that parental substance misuse, domestic abuse and mental health problems, sometimes referred to as the 'toxic trio', if they coexist in a family could mean significant risks to children. Problems can be compounded by poverty, frequent house moves or eviction.

3.3 Specific Safeguarding Risks

Staff members need to be aware of specific safeguarding issues and be alert to any risks.

The government website GOV.UK has broad guidance on a variety of issues including:

- *Child sexual exploitation (CSE)*
- *Child criminal exploitation including County Lines*
- *Bullying including cyberbullying*
- *Exposure to domestic violence and/or abuse*
- *Drugs*
- *Fabricated or induced illness*
- *Faith abuse*
- *So-called 'honour-based violence (HBV) including forced marriage and practices such as breast ironing*
- *Female Genital Mutilation (FGM)*
- *Gangs and youth violence*
- *Gender-based violence/violence against women and girls (VAWG)*
- *Mental health*
- *Private fostering*
- *Preventing radicalisation and the Prevent duty*
- *Sexting*
- *Teenage relationship abuse*
- *Trafficking*
- *Self-harm*

- *Child missing from education*
- *Child missing from home or care*
- *E-Safety*

Child sexual exploitation (CSE): involves exploitative situations, contexts and relationships where young people receive something (for example food, accommodation, drugs, alcohol, gifts, money or in some cases simply affection) as a result of engaging in sexual activities. Sexual exploitation can take many forms, ranging from the seemingly 'consensual' relationship where sex is exchanged for affection or gifts, to serious organised crime by gangs and groups. What marks out exploitation is an imbalance of power in the relationship. The perpetrator always holds some kind of power over the victim, which increases as the exploitative relationship develops. Sexual exploitation involves varying degrees of coercion, intimidation or enticement, including unwanted pressure from peers to have sex, sexual bullying including cyberbullying and grooming.

However, it also important to recognise that some young people who are being sexually exploited do not exhibit any external signs of this abuse.

Female Genital Mutilation (FGM): professionals in all agencies, and individuals and groups in relevant communities, need to be alert to the possibility of a girl being at risk of FGM, or already having suffered FGM. There are a range of potential indicators that a child or young person may be at risk of FGM; individually these may not indicate risk, but if there are two or more indicators present this could signal a risk to the child or young person. Victims of FGM are likely to come from a community that is known to practice FGM. Professionals should note that girls at risk of FGM may not yet be aware of the practice or that it may be conducted on them, so sensitivity should always be shown when approaching the subject. Warning signs that FGM may be about to take place, or may have already taken place, can be found on pages 11-12 of the Multi-Agency Practice Guidelines referred to above. Staff should activate local safeguarding procedures, using existing national and local protocols for multi-agency liaison with police and children's social care.

Radicalisation: this refers to the process by which a person comes to support terrorism and forms of extremism leading to terrorism. During that process it is possible to intervene to prevent vulnerable people being drawn into terrorist-related activity.

Prevent is part of the Government's counter-terrorism strategy (CONTEST), which aims to stop people becoming terrorists or supporting terrorism. The Prevent strategy addresses all forms of terrorism and prioritises according to the threat posed to national security.

Protecting children from the risk of radicalisation is seen as part of our wider safeguarding duties and is similar in nature to protecting children from other harms. Possible indicators of radicalisation may include:

- Expressed opinions – such as support for violence and terrorism or the values of extremist organisations, airing of political or religious based grievances, unaccepting of other nationalities, religions or cultures.
- Material – possession of extremist literature; attempts to access extremist websites and associated password protected chat rooms; possession of material regarding weapons, explosives or military training.

- Behaviour and behavioural changes – such as withdrawal from family and peers; hostility towards former associates and family; association with proscribed organisations and those that hold extremist views.
- Personal history – Claims or evidence of involvement in organisations voicing violent extremist ideology and identifying with their cause.

4. SAFEGUARDING CHILDREN WITH DISABILITIES

Children with disabilities should be seen as children first. Having a disability should not and must not mask or deter an appropriate enquiry where there are child protection concerns.

4.1 Vulnerability to Abuse

Children with disabilities can face an increased risk of abuse and neglect and can be abused in ways that non-disabled children cannot. Reasons for this include:

- Many children with disabilities are at an increased likelihood of being socially isolated with fewer outside contacts than non-disabled children
- Their dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour
- They have an impaired capacity to resist or avoid abuse
  They may have speech, language and communication needs which may make it difficult to tell others what is happening
- They often do not have access to someone they can trust to disclose that they have been abused
- They are especially vulnerable to bullying and intimidation, and may not outwardly show signs
- Children with disabilities are more likely to suffer family break-up and/ or poverty, which can impact on parents' mental health
- They are also are significantly over-represented in populations of looked after children and are particularly susceptible to possible abuse due to their additional dependency on residential and hospital staff for day to day physical care needs

4.2 Indicators of Possible Abuse of a Child With Disabilities

The following are indicators of possible abuse or neglect that may be specific to children with disabilities:

- A bruise in a site that might not be of concern on an ambulant child, such as the shin, might be of concern on a non-mobile child
- Not getting enough help with feeding, leading to malnourishment
- Poor toileting arrangements
- Lack of stimulation
- Unjustified and/or excessive use of restraint
- Rough handling, extreme behaviour modification e.g. deprivation of food or liquid, misuse of medication, tampering with equipment or clothing to restrict movement
- Unwillingness to try to learn a child's means of communication
- Ill-fitting equipment e.g. callipers, sleep boards, inappropriate splinting
- Misappropriation of a child's finances
- Invasive procedures which are unnecessary or are carried out against the child's will

4.2 Implications for Practice

Staff should be aware that the belief that children with disabilities are not abused or beliefs that minimise the impact of abuse on children with disabilities can lead to the denial of, or failure to report, abuse or neglect.

A child's disability or impairment should not prevent us from considering possible causes for concern. Assumptions that e.g. behaviour, mood or injury relate to the child's disability may lead to signs of abuse or neglect being missed.

Over identifying with the child's parents/carers and being reluctant to accept that abuse or neglect is taking or has taken place or seeing it as being attributable to the stress and difficulties of caring for a child with disabilities, is a factor in under-reporting abuse.

Communication can be a barrier to effective safeguarding. It is essential that adults are given the skills and time to learn to listen to the specific ways that children with disabilities communicate their needs and preferences.

Consideration should be given to respecting and promoting children with disabilities' rights when making decisions regarding intimate care, handling difficult behaviour or consenting to treatment.

Additional resources and time may need to be allocated if an investigation of potential or alleged abuse is to be meaningful. This is a basic premise and should not be ignored at any stage of the safeguarding process.

See Appendices for detailed guidance to staff on topics including providing intimate care and bruising in children that are not independently mobile.

5. ROLES AND RESPONSIBILITIES

5.1 The Board of Trustees:

Trustees are collectively responsible for ensuring that safeguarding arrangements are fully embedded within Whoopsadaisy's ethos and reflected in the organisation's day-to-day practice. Specific tasks include:

1. Ensure safeguarding policies and procedures are in place and effectively implemented.
2. Conducting an annual audit of safeguarding policy and practice.
3. Monitor safeguarding incidents on a quarterly basis.
4. Seek specialist advice when required.
5. Appoint a named trustee who is available and appropriately trained to liaise with staff on safeguarding matters, receive relevant information, monitor the implementation of policies and procedures, and safeguarding issues to trustees

5.2 Manager:

The Manager will ensure that policies and procedures adopted by the Board are fully implemented and that sufficient resources and time are allocated to enable staff members to discharge their safeguarding responsibilities.

The Manager is usually the Designated Safeguarding Lead.

5.3 Designated Safeguarding Lead (DSL) and Designated Safeguarding Officer (DSO):

The DSL is usually the Manager or another employee with sufficient authority to carry out the role effectively.

The DSO is usually a Conductor or other employee with day-to-day direct contact with children, families and volunteers. The DSO fulfils the role of Deputy DSL in the absence of the DSL and supports the DSL in the tasks outlined below.

The roles of DSL and DSO are made explicit in their job descriptions and they are given the time, funding, training, resources and support to provide advice and support to other staff on welfare and safeguarding matters, to take part in strategy discussions and inter-agency meetings – and/or to support other staff to do so. Specific tasks include:

1. Managing referrals
2. Record keeping
3. Providing information to trustees to enable effective monitoring
4. Inter-agency working and information sharing
5. Ensuring staff training is up to date
6. Keeping up to date with legislative changes and updating policy and procedures
7. Awareness raising (including annual bulletin/ update for staff of changes to policy and procedures)

The DSL and DSO are supported in their role by the Board Safeguarding Lead.

5.5 All staff (including volunteers):

All staff (including volunteers working directly with children) are required to know how to recognise signs & symptoms of abuse, how to respond to individuals who disclose abuse and what to do if they are concerned about a child, young person or vulnerable adult. Employees are also responsible for supervising all visitors to the site and requesting ID if a visitor is unknown.

6. WHAT TO DO IF YOU HAVE A SAFEGUARDING CONCERN

If you have a concern about a child, or if you think s/he may be suffering or at risk of suffering harm, you have a duty to act immediately. Follow the **'5Rs Procedure'**:

Recognise

Abuse may be physical, emotional or sexual, or it may involve neglect. Be aware of the signs and symptoms of abuse and don't ignore your concerns.
The following is not an exhaustive list but cause for concern may include:
A physical injury which you believe to be non-accidental.
Something in the appearance of a child that leads you to think his/her needs are being neglected.
Behaviour which gives rise to concern.
A child telling you that s/he has been subjected to some form of abuse.

Respond

Act quickly if you are concerned about a child's safety. If a child talks to you about (discloses) abuse:

DO listen carefully without interruption, particularly if s/he is recalling significant events	**DON'T** ask them to repeat the disclosure or write a statement
DO ask 'open' questions to clarify what he/she said	**DON'T** ask leading questions or attempt to investigate the situation
DO remain calm and try not to show your emotions or shock at what they say	**DON'T** confront the person you think is responsible
DO tell the child you will need to tell someone what they have said	**DON'T** destroy any evidence

Report

Speak to the DSL as soon as possible (and definitely the same day). If the DSL is not available speak to another member of the Safeguarding Team.

Record

Note down what you saw/heard as soon as possible (and definitely the same day) on a Welfare Concern Form. Include the following:
When and **where** the incident happened
Who was involved (names and relationships)
What was the nature of the incident
If you think there is any **immediate or future risk**
Sign and **date** the form

Refer

The DSL will refer to the relevant agencies. It is not your role, or the role of Whoopsadaisy staff, to make a judgement about whether the child is telling the truth.

Anyone can make a referral if a child is in immediate danger or risk of harm. If a member of the Safeguarding Team is not available contact children's social care and/ or the police immediately using the number on the Safeguarding Poster and on the front page of this policy. Inform the DSL as soon as possible that a referral has been made.

7. RECORD KEEPING AND INFORMATION SHARING

7.1 Record Keeping

All child protection and welfare concerns, discussions and decisions will be recorded in writing and kept in a locked cabinet or drawer, accessible by the DSL. The DSL will ensure that records are maintained appropriately for all children and that stand-alone files are created and maintained regarding all safeguarding concerns.

We continue to support any child about whom there have been concerns when they no longer use our services by ensuring that all appropriate information, including child protection and safeguarding concerns, is forwarded under confidential cover to relevant agencies.

7.2 Confidentiality

All matters relating to child protection are confidential. Incidents should not be discussed with anyone other than the DSL and your supervisor. The DSL will disclose any information about safeguarding concerns to other members of staff on a need-to-know basis only.

7.3 Information Sharing & Consent

Staff members cannot promise to keep secrets which might compromise an individual's safety or wellbeing.

It is essential that people working with children can confidently share information as part of their day-to-day work. This is necessary not only to safeguard and protect individuals from harm but also to work together to improve outcomes for all.

Whoopsadaisy may have to share information about children, young people, or their parents or carers (such as their medical history, disability or substance misuse issues), for investigations of abuse carried out by social care agencies. All staff members have a professional responsibility to share information with other agencies in order to safeguard children.

We will actively seek out information as well as sharing it. This means checking with other professionals whether they have information that helps us to be well informed when working to support children.

We share any concerns we have with parents and carers at an early stage, unless this would put a child at greater risk or compromise an investigation. We recognise that parents and carers need to know what our responsibilities are for safeguarding children and that this involves sharing information about them with other professionals.

We are clear about the purpose of sharing confidential information and only share as much as is needed to achieve our purpose. If a member of staff or volunteer is in any doubt about the need for seeking consent, they should seek advice from the DSL.

We ensure staff understand the need to keep a record of their decision to share information, with or without consent, and the reasons for it. We recognise that it is just as important to keep a record of why it was decided not to share information.

7.4 Inter-agency working

We develop and promote effective working relationships with other agencies, including e.g. the police and Social Care agencies and ensure that relevant staff members participate in multi-agency meetings and forums.

We will participate in serious case reviews, other reviews and file audits as and when required to do so. We will ensure that we have a clear process for gathering the evidence required for reviews and audits, embedding recommendations into practice and completing required actions within agreed timescales.

8. SAFER WORKFORCE

8.1 Safer Recruitment

All individuals working in any capacity for Whoopsadaisy are subject to recruitment procedures in line with statutory guidance. We will:

1. Ensure all roles have a clear job description and person specification that includes a definition of the role and the skills and attributes required, and a clear statement about the safeguarding responsibilities of the post holder.
2. Ensure at least two members of staff are involved in all recruitment processes and one member of every appointment panel has received Safer Recruitment training.
3. Request all applicants complete a standard Application Form that accounts for any gaps in employment/ education history and includes a self-declaration of any previous convictions.
4. Ensure two satisfactory references are provided (including one from the most recent employer or tutor) that clearly state the referee's relationship to the applicant and whether they have any cause for concern about the applicant's suitability for the post.
5. Verify the applicant's identity.
6. Request an appropriate DBS Disclosure for all staff and volunteers engaged in regulated activity.
7. Ensure copies of Disclosure numbers and recruitment documentation are kept in a locked cabinet with staff records.

No unsupervised access to children will be permitted until all pre-recruitment checks are complete.

The Manager is responsible for ensuring that our records of employment checks, induction records and statutory training are accurate and up to date.

8.2 Staff Induction

All new staff (including volunteers) are provided with the Staff Code of Practice and all relevant policies. They also undertake an induction that includes an introduction to safeguarding by a member of the Safeguarding Team prior to starting work. This includes recognising signs of abuse and responding to concerns (including whistleblowing).

Whoopsadaisy maintains accurate records of staff induction.

8.3 Staff Training & Development

The **Designated Safeguarding Lead and Officer** will:

1. Undergo a minimum of 2-yearly inter-agency Safeguarding Lead training
2. Ensure they receive regular updates from appropriate agencies

All **employees** will:

1. Be offered live 'whole-staff' safeguarding training every three years, or more frequently if statutory requirements are subject to significant change
2. Be required to attend this training if they are involved in providing frontline services (or recruiting staff to provide front line services) for children; and required to undertake other relevant training where this is missed e.g. by joining inter-agency training
3. Read annual safeguarding bulletins and/or attend annual refresher briefings in staff meetings, provided by the DSL or DSO, on any changes to safeguarding legislation and our policy and procedures

Trustees will:

- Be offered live 'whole-staff' safeguarding training every three years, or more frequently if statutory requirements are subject to significant change
- Nominate a Trustee to undergo 2 yearly Safeguarding Lead training and receive regular updates from appropriate agencies.

We ensure that staff members provided by other agencies and third parties have received appropriate safeguarding training commensurate with their roles before starting work.

Whoopsadaisy maintains accurate records of staff training.

8.4 Whistle Blowing, Professional Challenge & Complaints

Working with children and can be complex and can involve uncertainty and strong feelings. To ensure that the best decisions are made for children in our care, we need to be able to challenge one another's practice.

We promote a culture that enables all staff members to raise, without fear of repercussions, any concerns they may have about the management of safeguarding in the organisation. This may include raising concerns about decisions, action and inaction by colleagues. If necessary, staff members will speak with the Designated Safeguarding Lead, the Chair of Trustees or directly with the Local Authority Designated Officer (LADO).

We ensure that all staff members are aware of their duty to raise concerns about the management of safeguarding concerns, which may include the attitude or actions of colleagues.

Whistleblowing Procedure

In the event of a concern about another member of staff (including volunteers), staff should do the following:

1. Report your concerns immediately to the DSL (or DSO in their absence);
2. In the event that the concern is about the DSL (or DSO), or if you feel your concern has not been acted on appropriately, inform the Chair of Trustees. You do not need to inform the DSL.

3. If you remain concerned, contact the LADO (contact details on the Safeguarding Poster and the front page of this policy).
4. If a child is in immediate danger or is at risk of harm a referral should be made to children's social care and/or the police immediately (using the number on the Safeguarding Poster and on the front page of this policy).

Professional Challenge

Cooperation across agencies is crucial; professionals need to work together, using their skills and experience, to make a robust contribution to safeguarding children, promoting their welfare within the framework of discussions, meetings, conferences and case management. If there are any professional disagreements with practitioners from other agencies, the DSL will raise concerns with the LADO.

Complaints

The Complaints Procedure is available on our website and staff ensure service users and parents/ carers are signposted to it where appropriate.

8.5 Allegations of Abuse made against Staff

The Pan Sussex Child Protection and Safeguarding Procedures provides guidance on managing cases of allegations that may indicate that a staff member may not be suitable to work with children in their current position or in any other capacity.

A 'staff member' is a person over the age of 16 years whose work brings them into contact with children in their setting. It applies to all adults, whether paid or working in a voluntary capacity (including agency workers), on or off site.

The procedures should be used in ALL cases in which it is alleged that a staff member has:

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

All staff and volunteers working with Whoopsadaisy are in a position of trust. Therefore, any allegation made against a member of staff could highlight a breach of that trust. Under the Sexual Offences Act 2003, it is an offence for a person over the age of eighteen to have a sexual relationship with a child under the age of eighteen where the person is in a position of trust in respect of that child, even if the relationship is consensual.

Information may also come to light about a staff member's conduct outside of the workplace which may indicate a breach of professional conduct or may raise concerns about their suitability to work within the children's workforce.

It is important that all allegations of abuse and breaches of professional conduct are taken seriously.

Whoopsadaisy will contact the Local Authority Designated Officer (LADO) within one day of the incident happening or the allegation being made. We will not commence an internal investigation before consulting with the LADO but should gather basic details (e.g. was the employee working that day, did they potentially come into contact with the child(ren) and have any other potential witnesses come forward to corroborate or discount the alleged incident?)

The LADO will consider the information and whether it meets the threshold for further consultation with Children's Services and the Police.

If an employee tenders his or her resignation or, in the case of a volunteer, ceases to make their services available to the organisation, Whoopsadaisy will still continue the investigation to completion in accordance with these procedures. This process will continue even in a case where the alleged perpetrator refuses to co-operate with the investigation. Any investigation that takes place internally will be recorded in detail as appropriate to everyone involved. Any internal investigation that takes place must not compromise any police investigation.

In cases of allegation of harm or potential harm to children and young people, there can be no 'compromise agreement' between Whoopsadaisy and the employee or volunteer. Whoopsadaisy will inform the LADO of all allegations made against staff or volunteers of the organisation.

The LADO will work with our Designated Safeguarding Lead to establish measures that should take place and the timescales for implementation. The investigation will, wherever possible, be completed by Whoopsadaisy. However, should the allegation be made against the Designated Safeguarding Lead, the trustees will commission an independent investigation.

The LADO will regularly monitor and review the progress of any case, either via review strategy discussions or by liaising with the police and/or children's social care colleagues or the employer as appropriate. Reviews should be at fortnightly or monthly intervals, depending on the complexity of the case.

If there is a police investigation, Sussex Police should set a target date for reviewing the progress of the investigation and contact the Crown Prosecution Service (CPS). Wherever possible, that review should take place no later than four weeks after the initial action meeting following the allegation.

The police or the CPS should inform the employer and LADO immediately when a criminal investigation and any subsequent trial is complete, or if it is decided to close an investigation without charge, or not to prosecute after the person has been charged. In those circumstances the LADO will discuss with Whoopsadaisy if any further action is appropriate and, if so, how to proceed.

If the allegation is substantiated, Whoopsadaisy will discuss with the LADO if it is appropriate to make a referral to the Protection of Children Act List or DfE List 99.

If the allegation is not substantiated, Whoopsadaisy will support the employee in his/her return to work. This may include the provision of additional support and discussions on how contact with the child/children who made the allegation might be managed.

If an allegation is determined to be unfounded, Whoopsadaisy will refer the matter to the LADO to determine if the child concerned is in need of services or may have been abused by someone else.

At the conclusion of a case, Whoopsadaisy will review the circumstances and determine whether there are any improvements to be made to the organisations procedures or practices to help prevent similar events in the future.

9. INFORMATION ABOUT THIS POLICY

9.1 MONITORING

Systems are in place to monitor the implementation of this policy and accompanying procedures. This includes termly audits of safeguarding files and records by the DSL and reports to Trustees.

Trustees complete an annual audit of Whoopsadaisy's safeguarding arrangements as part of a review of policy and practice.

The Manager and Trustees will ensure that action is taken to remedy any deficiencies and weaknesses identified in safeguarding arrangements without delay.

9.2 POLICY REVIEW

This policy and related procedures will be reviewed **annually** by the Board of Trustees. The Manager will work with the Safeguarding Team to ensure staff members are aware of any amendments to policies and procedures.

All other linked policies will be reviewed in line with the policy review cycle.

9.3 INFORMATION SHARING

This policy will be published on our website and made available to all staff alongside the Staff Handbook.

The names and contact details of the Safeguarding Team and procedures for reporting concerns will be clearly displayed on the premises, with a statement explaining Whoopsadaisy's role in referring and monitoring cases of suspected abuse.

9.4 LINKED POLICIES

- Health & Safety
- Equalities
- Complaints
- Staff Handbook (including e.g. Code of Conduct and Acceptable use of ICT)

APPENDICES: GUIDANCE AND INFORMATION FOR STAFF

APPENDIX 1: PHYSICAL CONTACT WITH CHILDREN

At Whoopsadaisy it is entirely appropriate and proper for staff (including volunteers) to have physical contact with children. Children with disabilities require more physical contact to assist their everyday learning and Conductive Education requires hands-on guidance and support.

However, we recognise that physical contact is a subjective issue and will be experienced by each child differently according to their experiences. This is an area that can lead to misinterpretation and allegations of inappropriate behaviour.

Any physical contact should be appropriate to the circumstances at the time, of limited duration and appropriate to the child's age, stage of development, gender, ethnicity and background. Adults should use their professional judgement at all times. Staff should listen, observe and take note of the child's reaction or feelings and, so far as is possible, use a level of contact and/or form of communication which is acceptable to the child.

Physical contact should never be secretive, or for the gratification of the adult, or represent a misuse of authority. If a member of staff believes that an action by them or a colleague could be misinterpreted, or if an action is observed which is possibly abusive, the incident and circumstances should be immediately reported to the DSL and recorded. Where appropriate, the DSL should consult with the LADO.

Extra caution may be required where it is known that a child has suffered previous abuse or neglect. Staff need to be aware that the child may associate physical contact with such experiences or that they may seek out inappropriate physical contact. In such circumstances staff should deter the child sensitively and help them to understand the importance of personal boundaries.

A general culture of 'safe touch' should be adopted, where appropriate, to the individual requirements of each child. This means that staff should:

- be aware that even well -intentioned physical contact may be misconstrued by the child, or an observer
- never touch a child in a way which may be considered indecent
- always be prepared to explain actions and accept that physical contact can be open to scrutiny
- never indulge in 'horseplay' or fun fights
- always allow/encourage children, where able, to undertake self-care tasks independently
- ensure the way they offer comfort to a distressed child is age appropriate and acceptable to the child, and always tell their supervisor when and how they offered comfort
- report and record situations which may give rise to concern
- be aware of cultural or religious views about touching and be sensitive to issues of gender
- be aware of children who have a plan relating to their physical contact needs

Thanks to ESCC.

Appendix 2: Providing Intimate Care

Intimate care can be defined as care tasks which demand direct or indirect contact with, or exposure of, the sexual parts of the body. Intimate care tasks carried out by staff at Whoopsadaisy include:

- Dressing and undressing including underwear
- Helping someone use the toilet
- Changing continence pads and nappies
- Washing intimate parts of the body

We recognise that children who experience intimate care may be more vulnerable to abuse and seek to balance this risk with the child's need for dignity and respect appropriate to their age and situation. An adult's attitude to intimate care is important. Confident, assertive children who feel their body belongs to them are less vulnerable to abuse. The approach taken to a child's intimate care can convey lots of messages to support or undermine a positive body image.

Guidelines for Providing Intimate Care

Involve children and parents/ carers in devising intimate care plans: Intimate care should, where possible, reflect home routines and respect the wishes and feelings of both the child and the parents/carers (including e.g. cultural and religious beliefs). Intimate care plans are included on children's information sheets. Copies should be given to the parents as well as being held within the child's records and reviewed at least annually.

Ensure privacy appropriate to the child's age and the situation: Whoopsadaisy supports intimate care being carried out by one employee alone with a child, unless the task requires two people (for example lifting or moving), or the need for a chaperone is identified. Having people working alone does increase the opportunity for possible abuse but this is balanced by the loss of privacy and lack of trust implied if two people are required to be present. However, if for any reason, there is concern about providing 1:1 intimate care, it may be possible to have a second member of staff in an adjoining room or nearby so that they are close to hand but do not compromise the child's sense of privacy.

Where possible, the member of staff carrying out intimate care should be someone chosen by the child or young person: E.g. for older children, it may be preferable if the member of staff is the same gender if this is possible. Whoopsadaisy will not allocate a single staff member but will encourage shared responsibility among employees, in order to reduce the risk of abuse.

Involve the child as far as possible in his/ her own intimate care: Try to avoid doing things for a child that s/he can do alone, and if a child is able to help (including removing underwear, washing etc) ensure that s/he is given the chance to do so. If a child is fully dependent on you, talk about what you are doing and give choices where possible.

Be responsive to a child's reactions: "Check" your practice by asking the child (particularly a child you have not previously cared for) "Is it OK to do it this way?"; "Can you wash there?"; "How does

mummy do that?". If a child expresses dislike of a certain person carrying out her or his intimate care, try and find out why and record this on the child's information sheet.

Make sure practice in intimate care is as "care planned" as possible: This means ensuring dialogue between staff to ensure a planned approach that is flexible enough to meet individual needs. E.g. do you use a flannel for washing or bare hands? Do you pull back a child's foreskin as part of washing? Is care during menstruation consistent across staff?

Never do something unless you know how to do it: Medical procedures, such as giving rectal medication, must **not** be carried out by staff.

Reporting and Recording Concerns

If a member of staff is concerned that during the intimate care of a child:

- You accidentally hurt the child
- The child seems sore or unusually tender in the genital area
- The child appears to be sexually aroused by your actions
- The child misunderstands or misinterprets something
- The child has a very emotional reaction without apparent cause (sudden crying or
- shouting)
- You suspect FGM has taken place

report as soon as possible to your supervisor or the Designated Safeguarding Lead, inform parents/carers (unless doing so may put the child at risk) and record your concern.

If a member of staff notices that a child's demeanour has changed following intimate care (e.g. sudden distress or withdrawal), or if child discloses abuse or harm as a result of intimate care, this should be recorded in writing and discussed with the DSL.

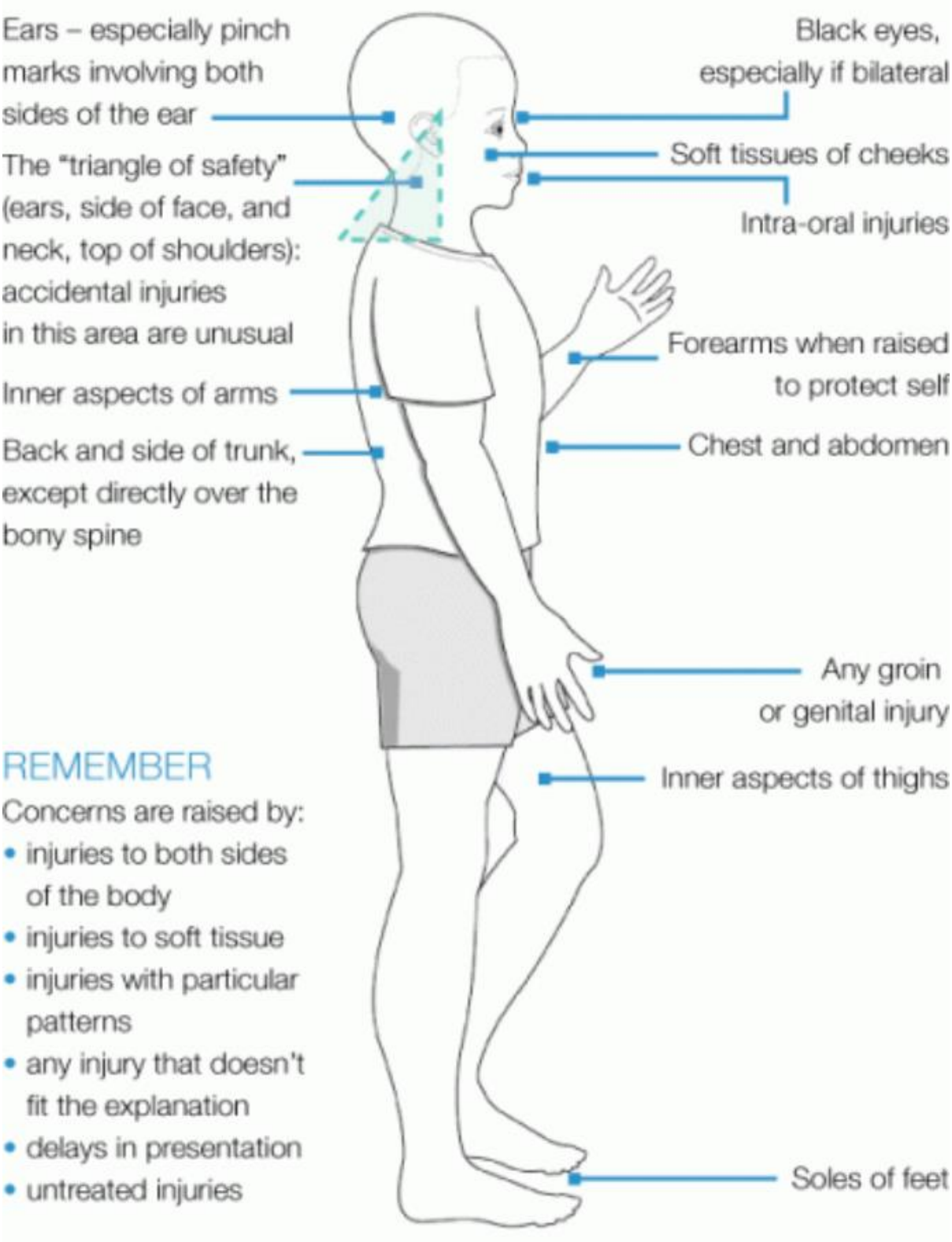
If a member of staff feels a child has a "grudge" against you or dislikes you providing intimate care, inform your supervisor and ensure your concern is recorded and shared with the DSL. In such circumstances every effort should be made to find an alternative person to undertake the care.

If a member of staff has concerns about the way in which another practitioner is undertaking intimate care these should be discussed with your supervisor or the DSL immediately. Where there is a serious cause for concern it may be necessary to report an allegation to the LADO for further investigation.

If staff are not comfortable with any aspect of these guidelines, they should speak to the Manager.

Thanks to Chailey Heritage Foundation and Leeds Safeguarding Children Partnership.

Appendix 3: Non-Accidental Injuries Guidance



Thanks to TES.

Appendix 4: Bruising In Children And Young People Who Are Not Independently Mobile

Children and young people who are not independently mobile (NIM) (i.e. not able to traverse the floor without assistance) will sometimes suffer bruising that has an innocent explanation. This will often be due to the equipment and aids that are required to support them, and their inability to take control of their limbs.

However, bruising is the commonest presenting feature of physical abuse in children. Serious case reviews have shown that professionals have sometimes underestimated the significance of the presence of bruising. As a result, NICE guidelines When to Suspect Child Maltreatment (Clinical Guideline 89, 2009) states bruising in a chid or young person who is not independently mobile should prompt suspicion of maltreatment.

If a staff member observes bruising or any skin mark, the following process must be followed in line with Pan Sussex Bruising in Children who are Not Independently Mobile (NIM) Guidance for Professionals.

Whenever a bruise of blemish is discovered, **a body map form must be completed.** The site of the bruise/blemish must be indicated on the body map, and relevant boxes on the form completed. Whoopsadaisy staff must not take photographs of bruising or skin marks.

Staff are authorised to ask the child and/or their parent/ carer for an explanation of the cause of the injury and record the response on the form.

In all cases, report the finding to the DSL, who will retain the completed body map in a safeguarding file.

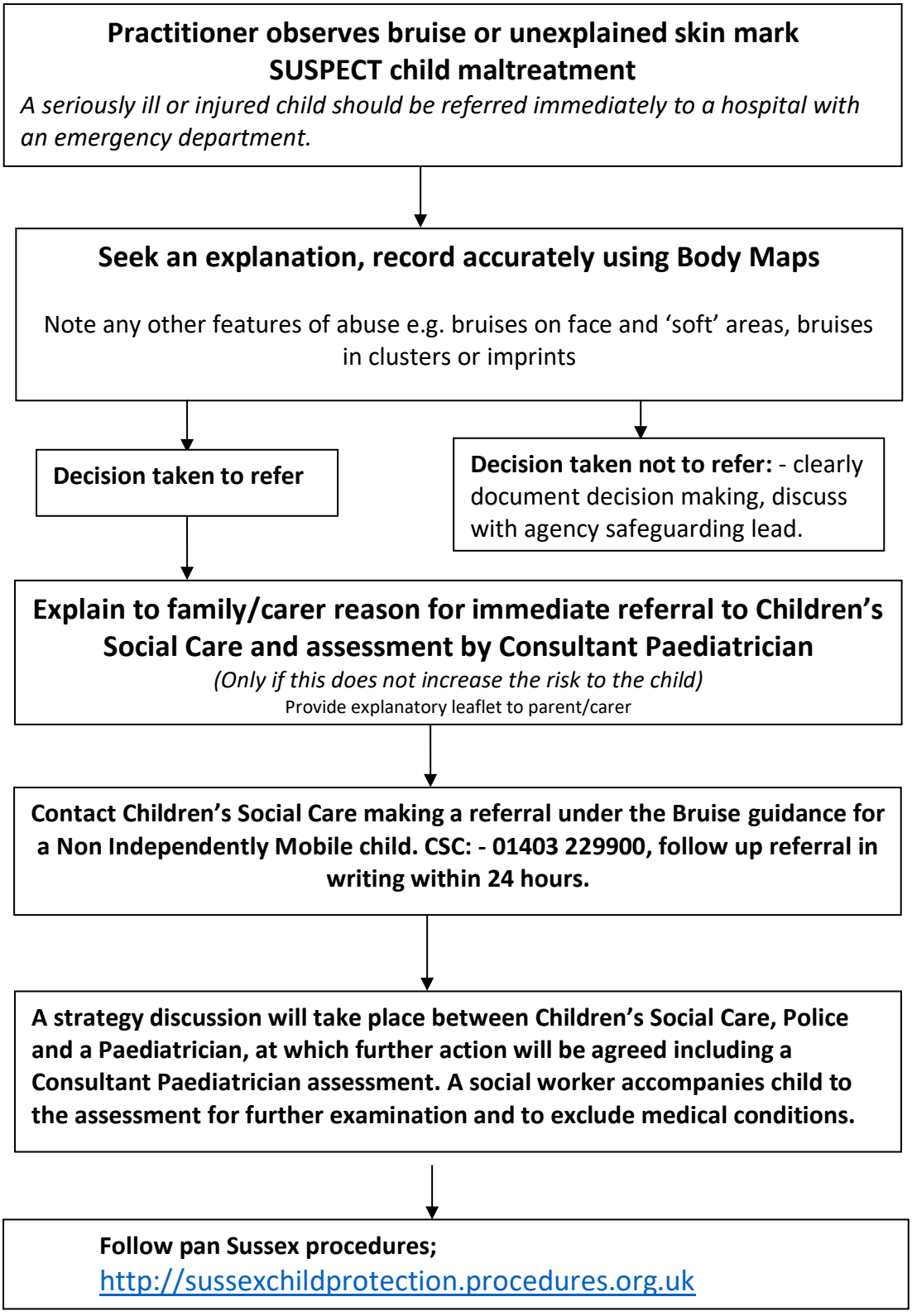
The DSL will consider the possible cause and assess whether there is an acceptable explanation. A bruise should not be interpreted in isolation and must always be assessed in the context of medical and social history including repeat presentations with similar concerns, developmental stage and appropriate explanation given.

If the DSL is not satisfied, or if there is a history of repeated presentations, the DSL will make a referral to **Children's Social Care (CSC) on 01403 229900** who will arrange an assessment with a Consultant Paediatrician.

If the decision is taken to refer to CSC, this should be explained to the parent/ carer. The family can be provided with this policy to help them understand our obligation to follow safeguarding protocol.

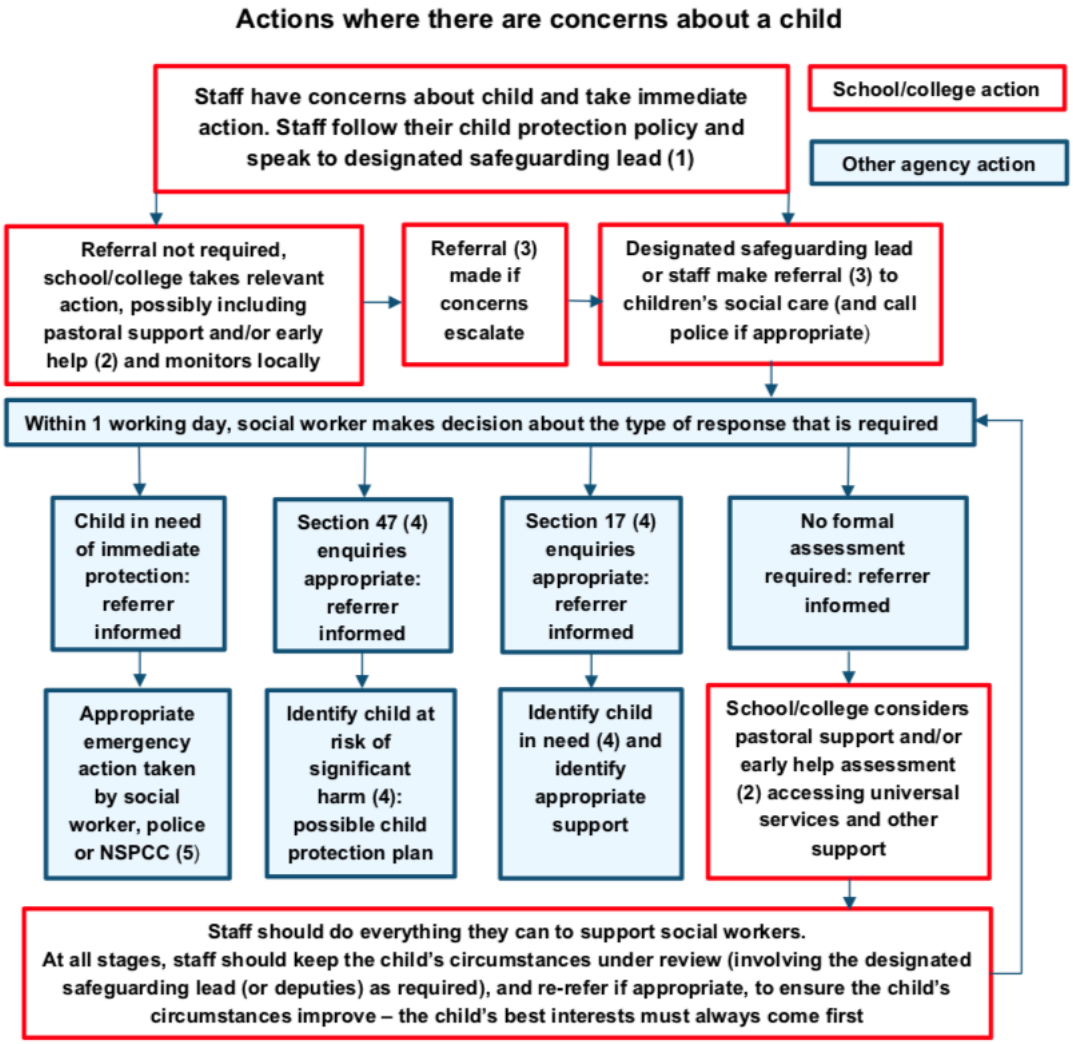
See Flowchart overleaf for Pan-Sussex Procedure.

Flowchart: Pan-Sussex Multi Agency Guidance: Bruising in Children who are Not Independently Mobile (NIM)



Appendix 5: Flowchart of Actions Where There are Concerns About a Child

Keeping Children Safe in Education 2018



Appendix 6: Making Referrals to MASH (Multi-Agency Safeguarding Hub)

What makes a good referral?

- Timely and using appropriate means (By phone if it is urgent. By email if not urgent)
- By email if following up an urgent referral in writing. Sending referrals by email ensures it will be legible and makes it easier to cut and paste the information into our (computer) records.
- If you have to write by hand use very, very clear handwriting
- Provides full details of the child, their sibling group, household and, if possible, any extended family members who provide regular support.
- Includes clear, concise description of current cause of concern, including timescales.
- Includes brief family history detailing known social issues.
- Clarifies "known unknowns" (what you know that you don't know) so that we don't waste everyone's time trying to get it off you later
- Includes relevant positive aspects – this helps us make balanced decisions.

What makes a bad referral?

- Vaguely refers to the concern, with insufficient detail.
- Uses high levels of jargon without translation.
- Leaves out crucial details, like the child's name, DoB, gender, or that there even is a child.
- Doesn't differentiate known facts, suspected concerns and unknowns.
- Is unnecessarily late – if you become aware of a concern on the first day of it coming to your attention, make the referral then. NOT a week later when the child is getting ready to break up for holidays.
- Is illegible

Poor/Good examples

Poor: "Mother has a history of drug use"
Good: "Mother reports a history of drug use (cannabis and occasional cocaine) until 6 months ago. Self-reports to be clean since she found she was pregnant. Unknown if drug services involved."

Poor: "Father has mental health problems"
Good: "Father stated that he had "difficulties" but refused to say further. Hospital records show one admission in 2007 reporting suicidal ideation. Known to CMHT, but not currently involved."

Poor: "Staff concerned about possible DV"
Good: "Suspect possible DV as father appeared very controlling of mother, wouldn't let her talk to staff and insisted he follow her, even when he left for a cigarette. Mother observed to flinch when he made sudden movements. No visible signs of physical injury."

Poor: "Mother had a rough childhood"
Good: "Mother reported sexual abuse from her uncle (not known if he's still around) – alluded to having spent time in care. Not able to get further details as inappropriate with others present."

Use everyday language and avoid jargon (here is a medical example)

Poor: "This 6/12 male presented after a history of pain on nappy changing, but no witnessed episode of trauma with a tense swollen left upper leg. Active movement was limited. Pain was elicited on attempted flexion, extension, abduction, adduction and internal & external rotation. Plain radiographs showed a spiral fracture of the proximal left femur with no involvement of the epiphysis. This fracture pattern is very concerning in a non-ambulant infant. The radiographic appearances are most consistent with some form of torsional injury pattern and the question of an intentional or non-accidental injury must be considered"

Good: "The 6 month old male wasn't moving his left leg and when we tried to move it, the baby cried. X-rays showed a spiral break. This is very unusual for babies who can't walk and is normally caused by a twisting injury, possibly deliberate."

Main Points to Remember

- 2 Practice Managers screen / process approximately 700-800 referrals a month – if yours isn't clear about what the issues are, they may need to wait until they have a moment to chase you up for more information, or they will make a decision based on what is on the form.
- If you're missing important information let us know that it's missing so we don't assume you've just forgotten to include it.
- Referrals should be made in writing and emailed to mash@brighton-hove.gov.uk
- If it's urgent, make the referral by phone: 01273 290400 (and then follow it up in writing).
- Poor communication between agencies is the thing most commonly highlighted in inquests following child deaths – the information you provide in your referral is the main tool of communication to alert Children's Social Care of concerns. Take the time you need to ensure it says what you need it to. Do not be afraid to say and write down what your concerns are. Do not assume that someone else will do it.

Thanks to Safety Net.

RECORD OF CONCERN FORM (1 of 2)

Date:	Name of Worker
Name of child and parent/carer if known	How has the concern come to your attention? ☐ Direct contact/ observation ☐ Disclosure ☐ Third party
Details about the child if known: D.O.B Gender Address Siblings/other family members	Do you think this issue is: ☐ Child Protection ☐ Safeguarding ☐ Bullying ☐ Equalities
Phone numbers for parent/carer(s) and child if known:	
What is your concern about this child or young person (Be specific: include when and where incident occurred, any evidence of what you saw or was reported, timelines if known)	

RECORD OF CONCERN FORM (2 of 2)

Who else, if anyone, was involved and how?	
Child or Young Person – were there any obvious signs in the child e.g., bruising, bleeding, changed behaviour? Did the child say anything?	
What action have you taken? (who have you spoken to and when?)	
Is there a follow up or support plan?	
Do the parents know? (delete as appropriate) YES / NO	
Has a referral been made to Children's Social Care?	YES/NO
Has a referral or follow up been made to another agency?	Who?
Name & Signature of person filling in this record of concern:	
Date and signature of Designated Safeguarding Lead (or Deputy):	

APPENDIX 8: FLOWCHART OF DBS CHECK REQUIREMENTS

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