THROUGH FRIENDSHIP

SAFEGUARDING & CHILD PROTECTION POLICY & PROCEDURES

All children (under the age of 18 years) and young people (children between the age of 16 – 18 years are often described as young people) have the right to be protected from harm, regardless of age, disability, gender, racial heritage, religious belief, sexual orientation or identity.

This policy sets out the Fun in Action for Children commitment to safeguarding. Our commitment to recognising children's rights as individuals and treating them with dignity and respect is underpinned by our values in that our practice is anti-discriminatory and recognises the additional needs of some children from minority ethnic groups and all disabled children and the barriers they may face, especially around communication.

We deliver our commitment to safeguarding through rigorous checking procedures, training, support and our Designated Safeguarding Person (DSP) who has the chief responsibility for listening to concerns, referring concerns to a higher level, monitoring adherence to our Safeguarding policy, and raising awareness of child protection procedures for all staff, volunteers, children and young people associated with Fun in Action for Children.

Relevant Guidance

The following guidance informs this policy, procedures and all our training and support:

- Children Act 1989
- Children Act 2004 (amendment)
- Every Child Matters 2004
- Working together to safeguard children Guidance 2015
- Views from current volunteer befrienders, staff, Trustees, parents, care givers and children involved with Fun in Action for Children.

Scope

This policy relates to all Fun in Action for Children staff and volunteers and parents or care givers. It relates to all activities undertaken with children, including transportation.

Review

This policy is reviewed annually by our Trustees.

Section A: The steps for our safeguarding procedures are:

1. All volunteers, those resident with volunteer befrienders or a person with whom the child may be left in the care of, Trustees and members of staff will undergo a DBS check and 2-year renewal;
2. Volunteer befrienders, in addition to DBS check, 1 professional and 2 personal references, will attend at least 2 in-depth interviews as well as a home visit. The home visit will include an interview with all other residents of this home address, DBS check of all other residents and an electoral roll check of all those living at the address;
3. All members of staff and Trustees will attend induction training that includes safeguarding training. Additionally, Trustees will complete online safeguarding training to level 1;
4. Volunteer befrienders will attend our Befriender Training Programme (this includes safeguarding and equality & diversity training) and sign a Befriender Agreement before being matched with a child;

5. Volunteer Befrienders will maintain regular contact, every 8 weeks, with their assigned Befriender and Training Manager as set out in the Befriender Agreement. Ongoing practice is that Befrienders, parents or care givers and children have regular monitoring reviews;
6. Staff, volunteers, parents and care givers will be responsible and accountable for raising any safeguarding concerns with either their assigned Family and child Support Worker or their assigned Befriender and Training Manager in the first instance and then our Designated Safeguarding Person (DSP);
7. Our Designated Safeguarding Person (DSP) is required to acknowledge, inform our Project Leader and Chair, and commence investigation (inform police, Brighton & Hove Children local safeguarding board, MASH and other relevant authorities as required) for all concerns raised within 24 hours.

Section B: Conduct and Responsibilities:

1. **All our staff and volunteers must abide by the following Safeguarding code of conduct:**

It is not permissible (and in some instances may be unlawful) for you to do any of the following. We reserve the right to terminate our contract/relationship if you:

- use your position to intimidate, bully, threaten, discriminate against, coerce or undermine children, young people, volunteers or staff;
- behave or communicate with children, young people or adults at risk in ways which seek to build inappropriate relationships in order to abuse or put them at risk;
- use a relationship with a service user or their family for personal gain;
- give special rewards or privileges in an attempt to build inappropriate relationships with children or young people,
- engage in, or attempt to engage in, sexual or inappropriate relationships with children or young people including the use of suggestive conversations, comments, emails and any form of social media;
- publish photos of FIA children on social media;
- possess indecent images of children. This will always be reported to the police regardless of the explanation provided;
- carry out your duties or volunteering whilst adversely affected by alcohol or drugs;
- encourage or assist others to break the law in any way.

You will conduct yourself in accordance with this Safeguarding Code of Conduct in all your work/volunteering roles.

2. Whether you are a member of staff or a volunteer, you are responsible and accountable for bringing to our attention, specifically to the attention of our Designated Safeguarding Person (DSP), any safeguarding issues you may be told about, observe, or have any concerns about. If you identify anything, no matter how small, that prompts you to feel worried, it is vital that you report your concerns. Trust your instincts and report your concerns. For further guidance please refer to Appendix 1, Indicators of Harm and Dealing with Disclosures. Also refer to the guidance provided in befriender training. We recommend the following steps:

a) **Is there actual harm or a potential harm situation?** Try to make some confidential notes about what you have been told, observed or have concerns about, to create as clear a picture as possible. It is likely the child may be frightened, so do not 'push' the child for more information or react in a shocked way that may upset the child further. Try to remain calm. Your role is to listen. Think about your safeguarding training.

b) **Immediately** contact your assigned Befriender and Training Manager to discuss the matter, then contact our Designated Safeguarding Person (DSP) Details on our website and given to you during induction training and Befriender Training Programme. If for any reason, you are unable to contact our DSP, then please contact our Project Leader, Russell Lerner on 07973 515164. Our DSP will discuss the situation with you and then raise this at a higher level, or with authorities, such as Brighton & Hove local safeguarding children board, police, etc., as appropriate and necessary. You will be supported throughout by Fun in Action.

APPENDIX 1 - INDICATORS OF HARM

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.

Indicators in the child

Bruising

It is often possible to differentiate between accidental and inflicted bruises. The following must be considered as non-accidental unless there is evidence or an adequate explanation provided:

- Bruising in or around the mouth
- Two simultaneous bruised eyes, without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive)
- Repeated or multiple bruising on the head or on sites unlikely to be injured accidentally, for example the back, mouth, cheek, ear, stomach, chest, under the arm, neck, genital and rectal areas
- Variation in colour, possibly indicating injuries caused at different times
- The outline of an object used e.g. belt marks, hand prints or a hair brush
- Linear bruising at any site, particularly on the buttocks, back or face
- Bruising or tears around, or behind, the earlobe/s indicating injury by pulling or twisting
- Bruising around the face
- Grasp marks to the upper arms, forearms or leg
- Petechae haemorrhages (pinpoint blood spots under the skin.) Commonly associated with slapping, smothering/suffocation, strangling and squeezing

Fractures

Fractures may cause pain, swelling and discolouration over a bone or joint. It is unlikely that a child will have had a fracture without the carers being aware of the child's distress.

If the child is not using a limb, has pain on movement and/or swelling of the limb, there may be a fracture.

There are grounds for concern if:

- The history provided is vague, non-existent or inconsistent
- There are associated old fractures
- Medical attention is sought after a period of delay when the fracture has caused symptoms such as swelling, pain or loss of movement

Rib fractures are only caused in major trauma such as in a road traffic accident, a severe shaking injury or a direct injury such as a kick.

Skull fractures are uncommon in ordinary falls, i.e. from three feet or less. The injury is usually witnessed, the child will cry and if there is a fracture, there is likely to be swelling on the skull developing over 2 to 3 hours. All fractures of the skull should be taken seriously.

Mouth Injuries

Tears to the frenulum (tissue attaching upper lip to gum) often indicates force feeding of a baby or a child with a disability. There is often finger bruising to the cheeks and around the mouth. Rarely, there may also be grazing on the palate.

Poisoning

Ingestion of tablets or domestic poisoning in children under 5 is usually due to the carelessness of a parent or carer, but it may be self-harm even in young children.

Fabricated or Induced Illness

Professionals may be concerned at the possibility of a child suffering significant harm as a result of having illness fabricated or induced by their carer. Possible concerns are:

- Discrepancies between reported and observed medical conditions, such as the incidence of fits
- Attendance at various hospitals, in different geographical areas
- Development of feeding / eating disorders, as a result of unpleasant feeding interactions
- The child developing abnormal attitudes to their own health
- Non organic failure to thrive - a child does not put on weight and grow and there is no underlying medical cause
- Speech, language or motor developmental delays
- Dislike of close physical contact
- Attachment disorders
- Low self esteem
- Poor quality or no relationships with peers because social interactions are restricted
- Poor attendance at school and under-achievement

Bite Marks

Bite marks can leave clear impressions of the teeth when seen shortly after the injury has been inflicted. The shape then becomes a more defused ring bruise or oval or crescent shaped. Those over 3cm in diameter are more likely to have been caused by an adult or older child.

A medical/dental opinion, preferably within the first 24 hours, should be sought where there is any doubt over the origin of the bite.

Burns and Scalds

It can be difficult to distinguish between accidental and non-accidental burns and scalds. Scalds are the most common intentional burn injury recorded.

Any burn with a clear outline may be suspicious e.g. circular burns from cigarettes, 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.

Old scars indicating previous burns/scalds which did not have appropriate treatment or adequate explanation.

Scalds to the buttocks of a child, particularly in the absence of burns to the feet, are indicative of dipping into a hot liquid or bath.

The following points are also worth remembering:

- A responsible adult checks the temperature of the bath before the child gets in.
- A child is unlikely to sit down voluntarily in a hot bath and cannot accidentally scald its bottom without also scalding his or her feet.
- A child getting into too hot water of his or her own accord will struggle to get but and there will be splash marks

Scars

A large number of scars or scars of different sizes or ages, or on different parts of the body, or unusually shaped, may suggest abuse.

Emotional / behavioural presentation

Refusal to discuss injuries
Admission of punishment which appears excessive
Fear of parents being contacted and fear of returning home
Withdrawal from physical contact
Arms and legs kept covered in hot weather
Fear of medical help
Aggression towards others
Frequently absent from school
An explanation which is inconsistent with an injury
Several different explanations provided for an injury

Indicators in the parent

May have injuries themselves that suggest domestic violence
Not seeking medical help/unexplained delay in seeking treatment
Reluctant to give information or mention previous injuries
Absent without good reason when their child is presented for treatment
Disinterested or undisturbed by accident or injury
Aggressive towards child or others
Unauthorised attempts to administer medication
Tries to draw the child into their own illness.
Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault
Parent / carer may be over involved in participating in medical tests, taking temperatures and measuring bodily fluids
Observed to be intensely involved with their children, never taking a much needed break nor allowing anyone else to undertake their child's care.
May appear unusually concerned about the results of investigations which may indicate physical illness in the child
Wider parenting difficulties may (or may not) be associated with this form of abuse.
Parent / carer has convictions for violent crimes.

Indicators in the family/environment

Marginalised or isolated by the community
History of mental health, alcohol or drug misuse or domestic violence
History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.

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 insofar 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 involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyberbullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.
Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Indicators in the child

Developmental delay
Abnormal attachment between a child and parent/carer e.g. anxious, indiscriminate or no attachment
Aggressive behaviour towards others
Child scapegoated within the family
Frozen watchfulness, particularly in pre-school children
Low self-esteem and lack of confidence
Withdrawn or seen as a 'loner' - difficulty relating to others
Over-reaction to mistakes
Fear of new situations
Inappropriate emotional responses to painful situations
Neurotic behaviour (e.g. rocking, hair twisting, thumb sucking)
Self-harm
Fear of parents being contacted
Extremes of passivity or aggression
Drug/solvent abuse
Chronic running away
Compulsive stealing

Low self-esteem
Air of detachment – 'don't care' attitude
Social isolation – does not join in and has few friends
Depression, withdrawal
Behavioural problems e.g. aggression, attention seeking, hyperactivity, poor attention
Low self-esteem, lack of confidence, fearful, distressed, anxious
Poor peer relationships including withdrawn or isolated behaviour

Indicators in the parent

Domestic abuse, adult mental health problems and parental substance misuse may be features in families where children are exposed to abuse.
Abnormal attachment to child e.g. overly anxious or disinterest in the child
Scapegoats one child in the family
Imposes inappropriate expectations on the child e.g. prevents the child's developmental exploration or learning, or normal social interaction through overprotection.
Wider parenting difficulties may (or may not) be associated with this form of abuse.

Indicators of in the family/environment

Lack of support from family or social network.
Marginalised or isolated by the community.
History of mental health, alcohol or drug misuse or domestic violence.
History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.

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 care-givers); or***
- ***ensure access to appropriate medical care or treatment.***

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

Indicators in the child

Physical presentation

Failure to thrive or, in older children, short stature
Underweight
Frequent hunger

Dirty, unkempt condition
Inadequately clothed, clothing in a poor state of repair
Red/purple mottled skin, particularly on the hands and feet, seen in the winter due to cold
Swollen limbs with sores that are slow to heal, usually associated with cold injury
Abnormal voracious appetite
Dry, sparse hair
Recurrent / untreated infections or skin conditions e.g. severe nappy rash, eczema or persistent head lice / scabies/ diarrhoea
Unmanaged / untreated health / medical conditions including poor dental health
Frequent accidents or injuries

Development
General delay, especially speech and language delay
Inadequate social skills and poor socialization

Emotional/behavioural presentation
Attachment disorders
Absence of normal social responsiveness
Indiscriminate behaviour in relationships with adults
Emotionally needy
Compulsive stealing
Constant tiredness
Frequently absent or late at school
Poor self esteem
Destructive tendencies
Thrives away from home environment
Aggressive and impulsive behaviour
Disturbed peer relationships
Self-harming behaviour

Indicators in the parent
Dirty, unkempt presentation
Inadequately clothed
Inadequate social skills and poor socialisation
Abnormal attachment to the child .e.g. anxious
Low self- esteem and lack of confidence
Failure to meet the basic essential needs e.g. adequate food, clothes, warmth, hygiene
Failure to meet the child's health and medical needs e.g. poor dental health; failure to attend or keep appointments with health visitor, GP or hospital; lack of GP registration; failure to seek or comply with appropriate medical treatment; failure to address parental substance misuse during pregnancy
Child left with adults who are intoxicated or violent
Child abandoned or left alone for excessive periods
Wider parenting difficulties, may (or may not) be associated with this form of abuse

Indicators in the family/environment

History of neglect in the family
Family marginalised or isolated by the community.
Family has history of mental health, alcohol or drug misuse or domestic violence.
History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
Family has a past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.
Dangerous or hazardous home environment including failure to use home safety equipment; risk from animals
Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements, inadequate ventilation (including passive smoking) and lack of adequate heating
Lack of opportunities for child to play and learn

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 or not the child is aware of what is happening.

The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).
Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.

Indicators in the child

Physical presentation

Urinary infections, bleeding or soreness in the genital or anal areas
Recurrent pain on passing urine or faeces
Blood on underclothes
Sexually transmitted infections
Vaginal soreness or bleeding
Pregnancy in a younger girl where the identity of the father is not disclosed and/or there is secrecy or vagueness about the identity of the father
Physical symptoms such as injuries to the genital or anal area, bruising to buttocks, abdomen and thighs, sexually transmitted disease, presence of semen on vagina, anus, external genitalia or clothing

Emotional / behavioural presentation

Makes a disclosure.
Demonstrates sexual knowledge or behaviour inappropriate to age/stage of development, or that is unusually explicit
Inexplicable changes in behaviour, such as becoming aggressive or withdrawn
Self-harm - eating disorders, self-mutilation and suicide attempts

Poor self-image, self-harm, self-hatred
Reluctant to undress for PE
Running away from home
Poor attention / concentration (world of their own)
Sudden changes in school work habits, become truant
Withdrawal, isolation or excessive worrying
Inappropriate sexualised conduct
Sexually exploited or indiscriminate choice of sexual partners
Wetting or other regressive behaviours e.g. thumb sucking
Draws sexually explicit pictures
Depression

Indicators in the parents

Comments made by the parent/carer about the child.
Lack of sexual boundaries
Wider parenting difficulties or vulnerabilities
Grooming behaviour
Parent is a sex offender

Indicators in the family/environment

Marginalised or isolated by the community.
History of mental health, alcohol or drug misuse or domestic violence.
History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.
Family member is a sex offender.

Specific Safeguarding Issues:

Please see page 9 of this policy for a list of specific issues relating to safeguarding and details of links to government web-sites with more information regarding these issues.

In addition the following information is from Keeping Children Safe in Education 2014 page 10:

Further information on Child Sexual Exploitation and Female Genital Mutilation

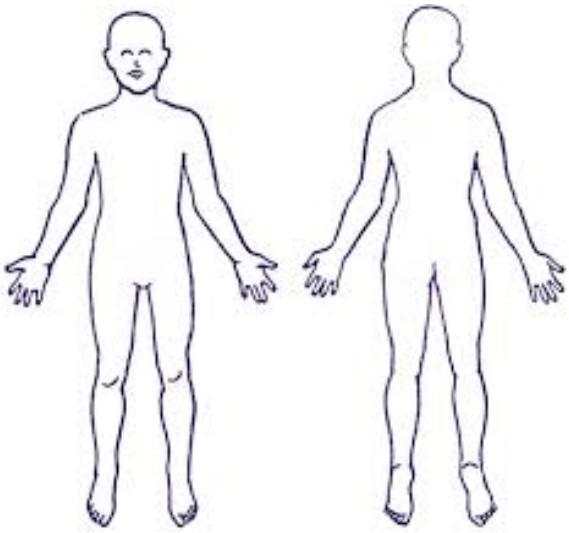
Child sexual exploitation (CSE) involves exploitative situations, contexts and relationships where young people receive something (for example food, accommodation, drugs, alcohol, gifts, money or in some cases simply affection) as a result of engaging in sexual activities. Sexual exploitation can take 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 is a range of potential indicators that a child or young person may be at risk of FGM, which individually 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 practise 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.

SAFEGUARDING DISCLOSURE

Child's name:	
Date:	
Befriender logging the disclosure:	
Signature of the Befriender:	

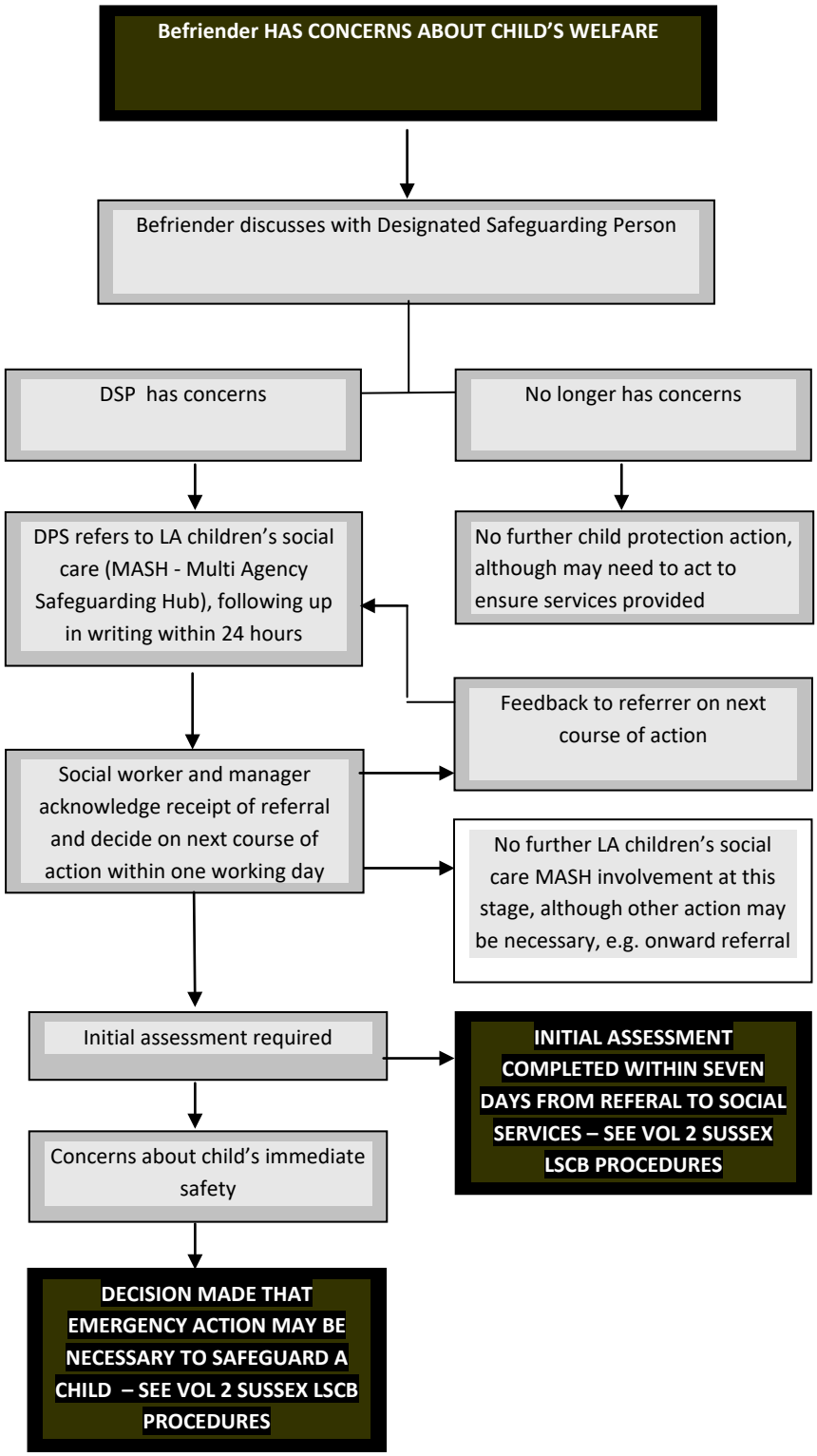
RECORDING A DISCLOSURE Please keep a copy of any original notes and attach originals to this.	
Date of disclosure	
Time of disclosure	
Place where the disclosure happened	
Who else was around?	
Any noticeable non verbal behaviour?	
Using the child's words – what did the child tell you? Avoid translating what you think they meant.	

Draw a diagram to indicate any physical marks	

Date and time concern received by (DPS):	
Any Follow up/Discussion	
Consideration/Evaluation Notes: Have there been any other concerns? What does this information suggest? What are the implications of doing nothing?	

Decision / Agreed action	
1. **Monitor** 2. **Further information to be gathered** 3. **CAF initiated with consultation from Help Desk** 4. **Referral (note who)** 5. **If referral – followed up in writing** 6. **Other** 7. **Contact social services helpline** 8. **Contact social services urgently**	
Signature : **Date :**	

PROCEDURE FOR REPORTING AND RECORDING CONCERNS.



CHILD PROTECTION REFERRAL FORM

Referral Form - CONFIDENTIAL

THIS FORM SHOULD ONLY BE COMPLETED FOLLOWING A CONVERSATION WITH A DUTY SOCIAL WORKER AND SHOULD BE RETURNED WITHIN 24 HOURS OF CONTACT

1

To:	**at Children's Social Care**
Initial date of contact:	**Today's date:**
Are you aware if a CAF form may have already been completed?	**Yes/No/Do not know**

2

FAMILY/CLIENT DETAILS

Are family aware of referral? **Yes** ☐ **No** ☐

Re-referral **Yes** ☐ **No** ☐

CHILD/YOUNG PERSON'S FULL NAME(S)

DATE OF BIRTH/Expected date of delivery **GENDER:** **M** ☐ **F** ☐

ADDRESS:

PHONE:

3

ETHNICITY

☐ African ☐ Bangladeshi ☐ Caribbean ☐ Chinese ☐ Indian ☐ Pakistani

☐ White British ☐ White & Asian ☐ Other Asian ☐ White & Black African ☐ White & Black Caribbean

☐ White Irish ☐ Other White ☐ Other Black ☐ Other Ethnic Group ☐ Other Ethnic Group ☐ Not given

4

OTHER HOUSEHOLD MEMBERS/CHILDREN

Name	D.O.B	Relationship	Parental Responsibility
_____	_____	_____	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐
_____	_____	_____	Y ☐ N ☐

5

OTHER SIGNIFICANT ADULTS/PEOPLE (LIVING ELSEWHERE)

Name:	Relationship:	Address:	Tel:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6

REFERRAL DETAILS

These should include information on:-
- The presenting issue, with evidence and facts
- Summary of previous involvement
- Expectations of referrer (what you feel needs to happen)
- Family's view of referral
- CAF/Framework of Assessment, where possible

Please continue on separate sheet if necessary, and attach any supporting documents.

7

OTHER KEY AGENCIES

Name/Role:	Address:	Tel:	email:

8

REFERRER DETAILS

Name: **Agency:**

Address:

Signature:

Tel: **Fax:** **email:**

Only to be sent electronically if you have a secure email and it is being sent to a secure email address