O R G A N I S A T I O N A L

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**Executive Summary**

* This policy applies to all staff in all roles paid and unpaid working on behalf of FFT. The full policy must be read and understood.
* Action is taken when children or young people (anyone under the age of 18) are at risk of suspected abuse or neglect
* Safeguarding Children is broader than ‘child protection’ and relates to the action taken to promote the welfare of children and protect them from harm.
* The law states that the welfare of the child is paramount.
* When it comes to safeguarding, you are accountable both for the actions you take and the actions you do not take.

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**Flowchart to show procedure for raising safeguarding concerns**

### Introduction

When a staff member has a concern about child safeguarding:

* **The staff member confirms the next steps with the service user using the dos and don’ts section for reference.**
* **Any immediate safety issues are addressed (e.g. contacting the police if required). If it is thought a child has suffered sexual abuse or severe harm or is at risk of immediate harm, the police must be contacted immediately.**

**WITHIN THE SAME DAY the staff member reports the concern to line manager using the safeguarding children reports form (Appendix 3).**

**The reporter and manager meet to agree the next steps. If the manager is not clinical, please consult with a Head of Clinical Services or Safeguarding Children Lead for guidance.** If neither the line manager nor the Head of Clinical Services is available, then the Associate Director of Clinical Services (ADCS) or Director of Clinical Services (DCS) should be notified. In the event that there is no manager available from Clinical Services, then the CEO should be notified**.**

Where it is agreed that the concern meets the criteria for safeguarding children, the following action is required:

* **Complete a reporting form for the local authority where the abuse or neglect is suspected to have occurred. Send to local authority safeguarding children services.**
* **Add a note to Daylight to record this decision & upload the completed form.**
* **Consider whether there is a safeguarding adult concern and if yes, follow the safeguarding adult’s procedure**

**The Head of Clinical Services updates the safeguarding tracker and alerts the Designated Safeguarding Lead. If the person raising the concern is not part of the clinical services directorate, please liaise directly with the Service Manager for the centre, or the Safeguarding Children’s Lead.** If neither the line manager nor the Head of Clinical Services is available, then the Associate Director of Clinical Services (ADCS) or Director of Clinical Services (DCS) should be notified. In the event that there is no manager available from Clinical Services, then the CEO should be notified.

An outcome is proactively sought from the local authority children safeguarding board WITHIN ONE WEEK. The Tracker is updated with the outcome and safeguarding lead updated.

Please have the confidence to challenge any decisions you disagree with.

1.1 Protecting people from abuse, harm and neglect is a fundamental purpose of any human rights organisation and of safe clinical practice.

1.2 Freedom from Torture believes that a child or young person should never experience abuse of any kind. We have a responsibility to help promote the welfare and wellbeing of all children and young people and keep them safe. We are all committed to working in ways that protect them.

### Scope

* 1. In line with our “whole organisation” approach to safeguarding, this policy applies to all staff and volunteers including trustees, employees, self-employed staff, pro bono or unpaid staff, interpreters, agency staff or anyone working on behalf of Freedom from Torture (FfT) (hereafter “staff”).

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| *Safeguarding is “everybody’s business” at Freedom from Torture – it is not just for clinicians. Many colleagues – including reception staff, interpreters, the service user engagement and survivor activism teams, legal and welfare advisors, researchers, staff dealing with clinical records, quality assurance and recruitment processes – come into contact with survivors of torture and their families and/or play a role in ensuring that our organisation is a safe place and that we take all the necessary steps to ensure that vulnerable people we work with or are aware of are kept safe.* |

* 1. For the purposes of this policy, a child is anyone who has not yet attained the age of 18, regardless of their life circumstances, including their developmental age and whether they live independently.
  2. Although the Children and Young People (Scotland) Act 2014 includes all children up to the age of 18, in Scotland a child legally becomes an adult when they turn 16, and where concerns are raised about a 16- or 17-year-old, agencies will consider which legislation or guidance is appropriate to follow depending on the age and situation of the young person.
  3. Safeguarding is a term which is broader than ‘child protection’ and relates to the action taken to promote the welfare of children and protect them from harm. This includes protecting children from maltreatment, preventing impairment of children’s health and development, ensuring that children are growing up in circumstances consistent with the provision of safe and effective care, and taking action to ensure children have the best outcomes.
  4. This policy is triggered whenever we identify a risk to a child’s welfare or a risk of significant harm to a child from abuse or neglect, has occurred or could regardless of whether abuse or neglect has occurred yet. This also include if a disclosure is made of past abuse which requires it to shared for the benefit of public protection of others usually children.
  5. Some of the particular types of child abuse we need to be alert to include: bullying including cyber bullying, child sexual exploitation, child trafficking, domestic abuse, female genital mutilation (FGM), forced marriage, grooming, neglect, physical or emotional abuse, sexual abuse, spirit possession and witchcraft. See [Appendix 2](#_Appendix_2:_Types) for more information about indicators of these and other forms of abuse.
  6. These risks to a child may arise in the home, an institutional setting or elsewhere.

### Purpose

* 1. The purpose of this policy is to:
* Ensure Freedom from Torture is a safe place for children, and we all work together to protect children and young people who receive our services, the children of adults who use our services, and any other children we come across in the course of our work.
* Ensure our staff to comply with their responsibilities and demonstrate exemplary safeguarding practice by providing them with the (i) overarching principles that guide our approach; and (ii) procedures to follow to ensure we are promoting the welfare of children and protecting them from harm.
* Help us build a culture of sensitivity to the needs of children as a means of improving our services to them and their families.

### The importance of exemplary safeguarding practice

* 1. The law states that the welfare of the child is paramount.
  2. A failure to identify and appropriately respond to safeguarding concerns can have significant ramifications for a child, their family and others. Serious case reviews have shown the dangers of not acting on concerns, leading to the serious harm, abuse, or even death of a child or others.
  3. The local authority that covers the area where any abuse has occurred takes the lead in investigating safeguarding concerns, working with police and other authorities as necessary. However, we are under legal duties to report concerns and cooperate with any investigations.
  4. Individual staff members who do not identify or respond appropriately to safeguarding concerns may also put themselves at risk. When it comes to safeguarding, you are accountable both for the actions you take and the actions you do not take. Failure to act could result in disciplinary action or investigation by Freedom from Torture and/or any relevant governing body that regulates you professionally.
  5. There are also serious reputational risk concerns for Freedom from Torture if we fail to safeguard children against abuse or neglect. There is rightfully increased scrutiny on charities to fulfil their safeguarding obligations and failure to do this could result in negative press coverage, significant reduction in donors, and potentially even closure.

### Legal Framework

* 1. This policy has been drawn up based on law and guidance that seeks to protect children.
  2. The key legislation and guidance for England is:
* [Children Act 1989](https://www.legislation.gov.uk/ukpga/1989/41/contents) especially section 17 (requiring local authorities to safeguard and promote the welfare of children within their area who are in need) and section 47 (placing local authorities under a duty to investigate if they believe a child has suffered or is likely to suffer significant harm);
* [Children Act 2004](mailto:jgratton@freedomfromtorture.org) especially section 11 (requiring a wide range of public bodies to ensure their functions are discharged having regard to the need to safeguard and promote the welfare of children);
* [Working Together to Safeguard Children 2022](http://www.legislation.gov.uk/ukpga/1995/36/contents) (statutory guidance explaining the legislation above and key responsibilities under it).
  1. The key legislation and guidance for Scotland is:
* [Children (Scotland) Act 1995](http://www.legislation.gov.uk/ukpga/2018/12/contents/enacted) especially section 22 (requiring local authorities to safeguard and promote the welfare of children in their area who are in need)
* [Children’s Hearings (Scotland) Act 2011](http://www.legislation.gov.uk/asp/2011/1/contents) especially sections 60-69 (relating to compulsory measures of supervision for children in need)
* [Children and Young People (Scotland) Act 2014](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573782/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf) (including provisions relation to the operation of the Child’s Plan)
* [Getting it right for Every Child 2015](http://www.gov.scot/Topics/People/Young-People/gettingitright) (Scotland) (setting out a national approach for improving outcomes for children and young people)
* [National Guidance for Child Protection 2021](http://www.londonscb.gov.uk/wp-content/uploads/2016/04/competence_still_matters_-2014.pdf) Scotland) (providing a national framework for shaping practices and procedures at the local level)
  1. Other relevant legislation and guidance includes: [Data Protection Act 2018](http://www.nspcc.org.uk/inform/resourcesforprofessionals/minorityethnic/female-genital-mutilation_wda96841.html), [Sexual Offences Act 2003](http://www.legislation.gov.uk/ukpga/2003/42/introduction), [Protection of Freedoms Act 2012](http://www.scotland.gov.uk/Topics/Justice/crimes/forced-marriage), [Sexual Offences (Scotland) Act 2009](http://www.legislation.gov.uk/asp/2009/9/contents), [Competence Still Matters 2014](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445978/3799_Revised_Prevent_Duty_Guidance__Scotland_V2.pdf) (London), [guidance on safeguarding women and girls at risk of FGM](https://www.elearning.prevent.homeoffice.gov.uk/) and [guidance on forced marriage](https://www.gov.uk/guidance/forced-marriage).
  2. See also [Safeguarding children and young people](https://www.ohchr.org/Documents/Publications/FactSheet23en.pdf) on the gov.uk website.

### Principles

* The law states that the welfare of the child is paramount.
* All children regardless of age, disability, gender, racial heritage, religious belief, sexual orientation or identity, have a right to equal protection from all types of harm or abuse.
* Some children are additionally vulnerable because of the impact of previous experiences (whether their own or other family members), their level of dependency, communication needs or other issues.
* Working in partnership with children, young people, their parents, carers and other agencies is essential in promoting children’s welfare and safety.
* Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare, and protect the safety, of children – even where the child or carer has requested confidentiality (see section 10 below)
* If in doubt – ask!
* Safeguarding issues are not always clear-cut. We want regular conversation about safeguarding matters in teams and especially with our designated safeguarding leads (see below) as part of our commitment to building a strong safeguarding culture at Freedom from Torture.
* Staff should always be attentive to the behaviour of children and any signs of need or abuse. In the best interests of the child / young person, any concerns you have should be raised with management.
* We recognise that the vast majority of children will not disclose abuse, but they may provide indications, including through non-verbal cues which may be intentional or unintentional.
* Where relationships of trust have developed between a staff member and a child, disclosure is more likely.

### Procedure – what to do if you think that a child is in need or being abused (please also see chart in Appendix 3

7.1 Where a child is considered to be at immediate risk of harm or has been harmed, contact should be made at once with the Police by the person identifying the risk. All concerns should be discussed with and managed together with the Designated Children’s Safeguarding Lead, unless it is too difficult to do so and delay might be risky for the child. If neither the relevant line manager nor the HEAD OF CLINICAL SERVICES is available on the day of the report, then the NDCS or CEO should be notified.

7.2 In the event that a child makes a disclosure of abuse, the following actions are to be taken:

* React calmly so as not to frighten or deter the child / young person
* Listen carefully to what the child / young person tells you without interrupting and take it seriously
* Ask questions for clarification only. Avoid asking questions that suggest a particular answer and do not investigate the allegation
* Do not stop a child / young person who is freely recalling significant events. Allow them to continue at their own pace
* Acknowledge how difficult it might be for them to share this with you
* Reassure them that they have done the right thing in disclosing
* Tell the child / young person they are not to blame
* Never promise a child / young person that what they have told you can be kept a secret. Explain to the child/ young person that you have a responsibility for their safety and therefore have to tell someone in authority. Let them know there are others who can help them and that they are not alone
* Tell them what you will do next and with whom the information will be shared
* Ensure the safety of the child / young person
* If you think a child is in immediate danger call the police on 999 straight away

It is not your responsibility to investigate if a child has been abused, however it is your responsibility to report concerns to the appropriate authorities including named person, social work or police. The organisation’s Designated Children’s Safeguarding Lead must be informed of any disclosure or concerns.

A child may recall former abuse once in a safe situation. Although they may be under no current threat to their safety, any disclosure must be raised with the Designated Children’s Safeguarding Lead and followed through appropriately.

If you have any concerns at all that a child is in need, even in the absence of disclosure, you must speak to the Designated Safeguarding Children Lead or National Director of Clinical Services in the first instance.

If you are in any way concerned about a child you must follow this procedure:

Report concerns to your line manager using the Safeguarding Children Concerns Report form (see [Appendix 3](#_Appendix_3:_Procedure)).  Line manager and reporter to ensure that issues of child safety are addressed.If the line manager is not clinical, the support of a clinical manager should be sought. *TIME* *SCALE: SAME DAY* if neither the line manager nor the Heads of Clinical Services (HoCS) is available, then the Associate Director of Clinical Services (ADCS) or National Director of Clinical Services (NDCS) should be notified. In the event that there is no manager available from Clinical Services, then the CEO should be notified.

Line manager and reporter to decide together whether issue should be reported to local safeguarding authorities – if in any doubt, the incident should still be reported. The decision-making process should be recorded on Daylight including the specific consideration that has been given to whether the safeguarding children concerns lead to any further concerns regarding safeguarding adults or clinical risk.

If it is considered that there is a requirement to make a safeguarding children referral, the report form for the local authority should be completed and sent to the relevant safeguarding board. These can be obtained from the website of most local authority safeguarding boards, or by contacting the safeguarding board by telephone. The clinical manager should update the safeguarding children’s tracker and notify the Designated Safeguarding Children lead. If neither the line manager nor the HoCS is available, then the ADCS or NDCS should be notified. In the event that there is no manager available from Clinical Services, then the CEO should be notified.

Consent is required for a s.17 children in need (Children Act 1989) referral unless there is a concern that seeking consent will increase risk, in which case the referral should be discussed with the duty social worker at the local authority where the abuse or neglect took place, prior to referral.

See [Appendix 2](#_Appendix_2:_Types) for contact details/websites for local authority Safeguarding Children Teams, NSPCC helpline and Childline.

Please note, if a decision is made not to report under safeguarding procedures, then consideration should be given to other action that should be taken to address the perceived risk. For example:

* Referral into another multiagency system
* Safety planning
* Signposting to other services
* Consideration should also be given by the manager as to whether the incident is notifiable to the Care Quality Commission/Healthcare Improvement Scotland (in which case our Quality Assurance Manager should also be informed).

* Outcome to be obtained from the local safeguarding board. *TIME SCALE: WITHIN ONE WEEK OF INITIAL REPORT.* It is important that if you disagree with the action taken by the safeguarding board that you raise these concerns directly with the safeguarding board and make a record of this action. There is extensive learning from serious case reviews that highlights the importance of this.

An allegation may relate to a person who works with children who 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; or behaved towards a child or children in a way that indicates they may pose a risk of harm to children.

Any concerns regarding allegations against Freedom from Torture staff members will be reported to the Local Authority Designated Officer (LADO) or Police Scotland by the Head of Clinical Services (formally Clinical Services Manager) or the National Director of Clinical Services*.* If neither the line manager nor the Heads of Clinical Services (HoCS) is available, then the Associate Director of Clinical Services (ADCS) or National Director of Clinical Services (NDCS) should be notified. In the event that there is no manager available from Clinical Services, then the CEO should be notified.

Regarding incidents where the alleged abuser is a member of staff, the Whistleblowing, Disciplinary & Capability, Professional Boundaries and Behaviour at Work policies apply.*Concerns involving a person in a professional capacity would require involvement of the Local Authority Designated Officer (LADO)*

* The safeguarding lead will decide and advise on whether the relevant safeguarding team will investigate the allegation or if the organisation should conduct an internal investigation. In Scotland the case may be referred to the area social work team for assessment. *TIME SCALE SAME DAY.*

* After the report to the LADO has been made, the line manager of the member of staff, the National Director of Clinical Services and Human Resources should be informed immediately. *TIME SCALE SAME DAY*.

* Where the line manager is the National Director of Clinical Services, then the Chief Executive should be informed. Where the manager is the Chief Executive the Chair of the Trustees should be informed. Where there are concerns raised that implicate the Chair of Trustees a vice chair should be contacted. Contact details can be obtained via the Human Resources Team.

* Once a decision has been received from the LADO, SMT, in conjunction with Human Resources, may consider whether the relevant member of staff should be suspended pending an investigation.
  1. In some cases a safeguarding matter may also warrant an incident form to be completed. Copies of all incident forms related to Safeguarding must be sent to the Director of Clinical Services and to the Quality Assurance and Information Governance Team.
  2. The Home Office also has internal safeguarding protocols. Home Office safeguarding incorporates a broader range of concerns than local authority safeguarding definitions. For example, we would not need to meet the same definition of an adult at risk under The Care Act to raise a concern via Home Office safeguarding, and a concern could be raised based on a lower threshold of vulnerability. It can be particularly helpful to consider Home Office safeguarding where there is an identified vulnerability, particularly when this relates to a Home Office provision e.g. when there is an issue with abusive behaviour within Home Office accommodation. If you think there may be a role for Home Office safeguarding to support a client, liaise with your line manager and local welfare advisor.

### PREVENT

PREVENT is part of the Government’s broader CONTEST strategy. PREVENT focuses on safeguarding interventions to stop people (adults and children) from being drawn into extremism through radicalisation and places specific duties on ‘specified authorities’ to have ‘due regard to the need to prevent people from being drawn into terrorism’ (Section 26, Counter-Terrorism and Security Act 2015).

Freedom from Torture, as a charity, is not a ‘specified authority’ (Schedule 6, Counter-Terrorism and Security Act 2015).However, our staff are required to consider risks of radicalisation and extremism as a safeguarding issue in relation to our clients, staff and public safety.

Freedom from Torture will support staff through training and information in seeking to recognise when individuals are at risk of being exploited and/or radicalised as part of a broader safeguarding structure and will make safeguarding referrals to statutory services regarding these concerns in the usual way. Statutory services will then be obliged to decide whether to treat a referral as a PREVENT matter or not.

Where a member of staff has a concern about risks relating to radicalisation and/or extremism, they should raise it in the same way as other safeguarding concerns and according to this policy. PREVENT do share information with the Home Office and on this basis, when considering a safeguarding referral in relation to risk of radicalisation, please ensure our Legal Advice and Welfare Service (LAWS) are involved in the safeguarding discussion.

Prevent guidance

Scotland:

[https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/445978/3799\_Revised\_Prevent\_Duty\_Guidance\_\_Scotland\_V2.pdf](http://vcf-uk.org/)

England & Wales:

<https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf>

Gov e-learning training: [https://www.elearning.prevent.homeoffice.gov.uk/](http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Spirit%20Possession%20and%20Witchcraft/Action_Plan_2012.pdf)

### Key internal contacts

Your first port of call when you have a safeguarding concern is your line manager. Every Head of Clinical Services (formally Clinical Services Manager) is trained to level 3 to respond to safeguarding concerns. In addition to this, we also have a national Designated Children’s Safeguarding Lead who is available to provide consultation and guidance. Our Designated Children’s Safeguarding Lead is:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Office** | **Tel/ext** | **Mobile** | **Email @freedomfromtorture.org** |
| Zohreh Rahimi | London | 0207777849 | 07494991130 | zrahimi@freedomfromtorture.org |

In the event that the Designated Children’s Safeguarding Lead is not available, please contact:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Office** | **Tel/text** | **Mobile** | **Email @freedomfromtorture.org** |
| Laura Kemmis | London & SE | 020 7697 7416 | 07534 856 547 | [LKemmis@freedomfromtorture.org](mailto:LKemmis@freedomfromtorture.org) |
| Ann Salter | Manchester | 0161 236 5744 | 07590056321 | ASalter@ freedomfromtorture.org |
| Stephanie Lai | Newcastle | Teams Call | Mobile TBC, office number: 0191 261 5825 | slai@freedomfromtorture.org |
| Beth Lacy | Birmingham | 0121 314 6825 | 07538320050 | BLacy@ freedomfromtorture.org |

In the event that none of the above contacts are available and in the event for cases of high risk, or needing further discussion, please contact:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Office** | **Tel/text** | **Mobile** | **Email**  **@freedomfromtorture.org** |
| **Jacqui Gratton** | London | Teams Call | 07904447737 | [jgratton@freedomfromtorture.org](http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Spirit%20Possession%20and%20Witchcraft/Response_to_Working_Together_Safeguarding_Children_from_Abuse_linked_to_a_belief_in_Spirit_Possession_and_Witchcraft.pdf) |
| **Helen McColl** | Director of Clinical Services | Teams Call | 07904998868 | hmccoll@freedomfromtorture.org |
| **Sonya Sceats** | CEO |  |  | ssceats@freedomfromtorture.org |

### Information sharing

10.1 Effective sharing of information between our staff and external agencies is essential for early identification of need, assessment and service provision to keep children safe.

10.2 Staff should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children. Staff should be cautious about sharing important information with any adults with whom that child has contact, which may impact the child’s safety or welfare.

10.3 Staff should aim to gain consent to share information, but should be mindful of situations where to do so would place a child at increased risk of harm. Information may be shared without consent if a staff member has reason to believe that there is good reason to do so and this will enhance the safeguarding of a child in a timely manner and giving consideration to past, present and future risk (this is expressly provided for in the Data Protection Act 2018).

10.4 When decisions are made to share or withhold information, staff must record who has been given the information and why.

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| **Myth-busting guide to information sharing**  Sharing information enables practitioners and agencies to identify and provide appropriate services that safeguard and promote the welfare of children. Below are common myths that may hinder effective information sharing.  **Myth 1: Data protection legislation is a barrier to sharing information**  No – the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) do not prohibit the collection and sharing of personal information, but rather provide a framework to ensure that personal information is shared appropriately. In particular, the Data Protection Act 2018 balances the rights of the information subject (the individual whom the information is about) and the possible need to share information about them.  **Myth 2: Consent is always needed to share personal information**  No – you do not necessarily need consent to share personal information. Wherever possible, you should seek consent and be open and honest with the individual from the outset as to why, what, how and with whom their information will be shared. You should seek consent where an individual may not expect their information to be passed on. When you gain consent to share information, it must be explicit, and freely given. There may be some circumstances where it is not appropriate to seek consent, because the individual cannot give consent, or it is not reasonable to obtain consent, or because to gain consent would put a child’s or young person’s safety at risk.  **Myth 3: Personal information collected by one organisation/agency cannot be disclosed to another**  No – this is not the case, unless the information is to be used for a purpose incompatible with the purpose for which it was originally collected. In the case of children in need, or children at risk of significant harm, it is difficult to foresee circumstances where information law would be a barrier to sharing personal information with other practitioners.  **Myth 4: The common law duty of confidence and the Human Rights Act 1998 prevent the sharing of personal information**  No – this is not the case. In addition to the Data Protection Act 2018 and GDPR, practitioners need to balance the common law duty of confidence and the Human Rights Act 1998 against the effect on individuals or others of not sharing the information.  Myth 5: IT Systems are often a barrier to effective information sharing  No – IT systems, such as the Child Protection Information Sharing project (CP-IS), can be useful for information sharing. IT systems are most valuable when practitioners use the shared data to make more informed decisions about how to support and safeguard a child. |

### 11. Management of Lone Children

11.1 This falls under the broader safeguarding children infrastructure.

The law does not say at what age a child can be left on their own. However, it is against the law to leave a child alone if it puts them at risk.

The purpose of this section of the policy is to ensure that children attending or visiting Freedom from Torture are not put at risk.

This guidance aims to keep children safe by establishing a clear understanding between:

* Freedom from Torture
* Those with parental responsibility[[1]](#footnote-2) for children attending/visiting FfT
* Children attending/visiting FfT about each party’s responsibilities for children whilst at FfT premises.
  1. All staff must ensure that the following principles are adhered to:
* The safety of the child is paramount.
* Everyone has a responsibility for safeguarding children
* Freedom from Torture has a responsibility for providing a safe environment for children through the implementation of relevant policies and procedures and the actions of its staff.
* Those with parental responsibility have overall responsibility for decisions about a child’s care.
* Children should be involved in decisions and information about attendance at FfT according to the age, maturity and understanding of the individual child.
* Children under 16 should not be left unaccompanied in FfT premises.
* In cases of age disputes, FfT will apply this policy according to the age given by the client.

Children attending family therapy appointments:

* Children attending family therapy will be under the care of their parent/carer whilst at FfT. If the child is being seen for Individual work, they need to have their own Day Light record and MFID. Each session should be recorded following the Record Keeping Policy.
* Family therapy may involve appointments or parts of appointments in which children are seen separately from their parent/carer. This will be with the consent of the parent/carer and, if appropriate, the child ([see Appendix 1](#_Appendix_1–_Children’s) children’s consent); and will involve the child being with either their parent/carer or a suitably qualified clinician[[2]](#footnote-3) at all times.
* Currently, we do not see or offer individual therapy to children under the age of 5 years old unless it is part of a family group context / family therapy session. If a therapist believes that a child under the age of 5 years requires an individual therapeutic intervention as part of a wider piece of family work this can be negotiated within the organisation. This requires FfT to update our insurers and so would need to be agreed as being required in the Multi Disciplinary Team (MDT) and with the Clinical Service Manager’s input. It would then need to be signed off by Associate Director or above and the insurers updated.

11.3 **Children attending other clinical appointments:**

Children may attend appointments for other FfT services (e.g. health assessments, psychotherapy, MLRs, LAWS).

Children attending these appointments will be accompanied to the FfT premises by an adult, who is either the parent/carer or someone chosen by the parent/carer and who will be responsible for the child whilst at FfT.

11.4 **Children without appointments but brought to FfT by their**  **parents/carers**

Appointments should be scheduled so as to assist parents/carers to attend at times when their children are being looked after (e.g. during nursery, school or when family/friends are able to look after them.

Where this is not possible, FfT is able to reimburse childcare costs if an invoice from a Ofsted/Care Commission registered child carer provider. This will be agreed and reviewed by the relevant Clinical Service Manager.

Despite this it is possible that parents/carers will bring children with them when attending their own appointments.

In these circumstances, the following arrangements should be followed:

* The child is brought into the appointment room and the practitioner and the parent/carer agree on the suitability of the child’s presence in the appointment and go through a consenting process (see [Appendix 1](#_Appendix_1–_Children’s)). This would usually only be suitable in some circumstances dependant on the age of the child, subject to the practitioner and the parent/carer agreeing to monitor and prevent distress to the child throughout the appointment); where the appointment is for advice and is unlikely to be distressing; for planning future appointments and for alternative childcare arrangements to be made.
* If the child is a 16-17 year old young person and can sit in the waiting area

The following arrangements cannot be made:

* Proceeding with an appointment that would be inappropriate in the child’s presence (e.g. a therapy appointment (unless with a baby).
* Leaving the child in the waiting area (unless aged 16-17).
* Asking a colleague to look after the child during the appointment (unless there is a situation relating to clinical risk or safeguarding situation that required immediate attention including an assessment of clinical and safeguarding risks and consideration should be give to seeking a Local Authority Referral at this point to support the child.)

11.5 **Young People aged 16-17**

Young people aged 16-17 may attend FfT and use the waiting area unaccompanied. For initial assessment appointments; this will be with the agreement of the referrer and for further appointments, this will be subject to capacity and risk assessments by the clinician.

In practice, it would be usual for a young person aged 16-17 who is accessing FfT services to be accompanied to appointments for the initial assessment stage and until they are comfortable to travel and attend unaccompanied. This may also be true for vulnerable young people aged 18- 25.

There may be exceptional circumstances in which FfT arranges to carry out an appointment with a separated young person below the age of 16, who is not accompanied at FfT premises. This would be through arrangement with his/her carer and would require the FfT practitioner (risk assess and ensure they have capacity (see [Appendix 1](#_Appendix_1–_Children’s)- children’s consent) and how feedback is given to those with parental responsibility and under what circumstances to ensure the child receives the appropriate care or support from staff in the event of a concern or distress to ensure their needs are properly met by the appropriate adult responsible for their care.

### 12. Responsibilities

**12.1 Trustees** have overall responsibility for ensuring that:

* Freedom from Torture has adequate safeguarding policies and procedures in place and that these are well understood and complied with across the charity
* Safeguarding policies are reviewed and updated annually to ensure continuing effectiveness and compliance with legislation and guidance
* We have a strong safeguarding culture at Freedom from Torture including collective reflection on learning from incidents
* There are clear whistleblowing and complaints procedures in place, to protect staff/volunteers and service users in line with the principles in Sir Robert Francis’s [Freedom to Speak Up review](https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm), that are referenced in staff training and codes of conduct
* Any serious incidents involving harm to our beneficiaries are reported to the Charity Commission or Office of the Scottish Charity Regulator

12.2 The **Senior Management Team** must ensure that:

* Freedom from Torture has effective safeguarding policies and procedures in place
* All managers and staff, including volunteers and interpreters are aware of these policies and procedures and discharge their safeguarding responsibilities – including by ensuring we have in place: (i) a framework to ensure staff are effectively/suitably/appropriately skilled and supported to discharge these responsibilities (ii) delegation to managers of operational management responsibility for safeguarding
* Freedom from Torture is abreast of the most up-to-date relevant legal, policy, best practice and other developments relating to safeguarding
* Safeguarding risks are identified and managed at a corporate level including via our risk register and collective reflection on incidents
* Reporting procedures are in place and complied with – including in relation to our regulators and “safeguarding partners” (local authorities, clinical commissioning group and police) and the Children’s Reporter in Scotland
* Should have an awareness of the role of the chaperone and inform them of how to raise a concern (see [Appendix 4](#_Appendix_4:_Safeguarding))
  1. The **National Director of Clinical Services** must ensure that:
* Services are delivered in accordance with this policy
* A Designated Children’s Safeguarding Lead is in place at all times, with clear deputising arrangements in the event of absence, so that staff have an expert to refer child safeguarding matters to at any time
* Should have an awareness of the role of the chaperone and inform them of how to raise a concern (see [Appendix 4](#_Appendix_4:_Safeguarding) & [Appendix 5](#_Appendix_5:_Use))
  1. **People managers** must ensure that:
* All staff in their team are familiar with this policy and their safeguarding responsibilities and are implementing and complying with the policy
* All staff in their team know what to do if they are worried about a child or adult at risk and have the necessary management support to act accordingly
* Safeguarding incidents are monitored and reported appropriately – internally and externally
* Team members are supervised in relation to compliance with this policy
* Team members have the relevant training (in line with the national guidance set out in section 5 above) and refresher training and that this is recorded on People HR
* Team members contribute to the audit programme / clinical incident review process which will inform the continual process to improve practice
* Act as the first port of call for any safeguarding concerns
* Should have an awareness of the role of the chaperone and inform them of how to raise a concern (see [Appendix 3](#_Appendix_3:_Procedure) & [Appendix 5](#_Appendix_5:_Use))
  1. **All staff who work with children and adults at risk** must be able to evidence that they:
* Understand their responsibilities in relation to safeguarding. (For LAWS responsibilities, see appendix 6.)
* Understand risk factors and recognise children and adults in need of support and/or safeguarding
* Pay attention to any verbal or non-verbal indicators of abuse
* Respond quickly and appropriately to all suspicions or allegations of abuse
* Provide parents / carers, children / young people with the opportunity to voice any concerns they have
* Liaise closely with other agencies and share information as appropriate
* Generally safeguard children and young people, including through preventative and proactive work
* All staff should have an awareness of the role of the chaperone and inform them of how to raise a concern (see [Appendix 3](#_Appendix_3:_Procedure) and [Appendix 5](#_Appendix_5:_Use))
  1. **All members of staff who are regulated health and social care professionals are now under a mandatory duty to report to the police any case of FGM in girls under 18 which they identify in the course of their professional work** (a helpful flowchart on this legal duty is available [here](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/525405/FGM_mandatory_reporting_map_A.pdf); see also Appendix 1 below). This includes all doctors, social workers and physiotherapists. Whilst this is legally mandatory only for certain roles, we require all Freedom from Torture staff to report in this way.
  2. **All staff** at Freedom from Torture must be able to demonstrate that they:
* Understand their responsibilities in relation to safeguarding
* Identify development and training needs in relation to safeguarding through mid- and end of year review processes
* Know how to report and document all concerns and subsequent actions in accordance with the procedures in this policy and any related policies.
* All staff should have an awareness of the role of the chaperone and inform them of how to raise a concern (see [Appendix 3](#_Appendix_3:_Procedure) & [Appendix 5)](#_Appendix_5:_Use)
  1. **Designated Children’s Safeguarding Lead**

Every organisation working with children has to have a person who takes a lead on safeguarding and child protection. We call this this role our Designated Children’s Safeguarding Lead (or “Children’s Safeguarding Lead”). (Previously this role was often referred to as the Child Protection Officer.)

Key Aspects of the Designated Children’s Safeguarding Lead role include:

* Keeping up to date with developments in children’s safeguarding legislation, guidance, reports and learning from major safeguarding incidents in the sector and beyond and ensure these are shared with the Senior Management Team
* Updating policies and procedures
* Making sure all staff are aware of how to raise safeguarding concerns
* Ensuring all staff understand the symptoms of child abuse, neglect and other forms of abuse
* Implementing any appropriate procedures and sharing concerns and information with relevant agencies, and involving parents and children appropriately when advice has been sought from other agencies.
* Monitoring children who are the subject of child protection plans
* Gathering and collating all information relating to child safeguarding incidents, concerns and referrals in all cases across the organisation – updating this at least once a month or more often as a case progresses
* Preparing and submitting a quarterly report to the Clinical Secretariat and Clinical and Legal Governance Committee
* Reporting to the Board on all matters pertaining to child safeguarding as required
* Maintaining accurate and secure child protection records. Storage of these records will be in line with GDPR requirements.
* Have an understanding and awareness of the role of the chaperone and inform them of how to raise a concern (see [Appendix 3](#_Appendix_3:_Procedure) & [Appendix 5](#_Appendix_5:_Use))
  1. **The** **Head of Human Resources** must ensure that:
* Safe recruitment practices are in place including for ensuring that all our staff and volunteers, including interpreters, temporary, locum and agency staff (and contractors where appropriate), are carefully selected and vetted through DBS (England) and PVG (Scotland) and have the relevant qualifications, accreditation and experience, and accept responsibility for helping to prevent the abuse of children in their care
* Compliance with our DBS (PVG) Check Policy, including in relation to renewals of these checks
* All interview letters inviting applicants to interview request specific identification documents (ID) to enable the DBS and PVG checks to be undertaken at the right level
* All relevant staff receive a mandatory induction, which includes familiarisation with their safeguarding responsibilities and the policies and procedures to be followed if they have concerns about a child’s safety or welfare.

### 13. Equality and Diversity

* 1. Freedom from Torture is committed to equality in both employment and the provision of services. No job applicant, employee, service referrer or service user shall be subjected to any discrimination, as defined in UK law. Any practice which may result in the provision of sub-standard service due to unfair or unlawful discrimination will not be tolerated.
  2. An equality & diversity Impact assessment has not been completed in the development and review of this policy. Following the issuing of an organisational procedure on Impact Assessments, an impact assessment will be completed at the next review.

### 14. Policies/procedures that strongly impact

* Safeguarding Adults at Risk
* Professional Boundaries
* Managing Incidents
* Clinical Risk Management
* Clinical Supervision Policy
* Working with Perpetrators
* Whistleblowing
* Health & Safety
* Process for Investigating Fitness to Practice of Doctors
* Recruitment and Selection Policy
* Disciplinary and Capability Policy
* DBS (PVG) Check Policy
* Grievance Policy
* Behaviour at Work
* Comments, Suggestions & Complaints
* Confidentiality
* Data Protection
* Diversity, Equality & Inclusion

### 15. Supporting documents

A1 – Types of Abuse

A2 – Basic Procedure

A3 – Safeguarding Children Concerns Form

A4 – Referrals to Local Authorities, NSPCC, Child Line

### 16. Policy Review

This policy is subject to revision at any time where considered necessary by Freedom from Torture. It also forms part of the regular review cycle and will be reviewed every 6 months.

# Appendices contents

Appendix 1: Children’s consent

Appendix 2: Types of abuse

Appendix 3: Procedure for raising safeguarding concerns

Appendix 4: Safeguarding Children Report form

Appendix 5: Use of Chaperones

Appendix 6: Legal and Welfare Service (LAWS) Safeguarding Process

## **Appendix 1– Children’s consent**

**16-17 year olds**

All people aged 16 and over are presumed in law to be competent to give their consent to treatment and to the release of information in England, Scotland, Wales and Northern Ireland.

**Under 16s**

Children under the age of 16 may be competent to give their consent but this needs to be assessed in each case on a continual basis. Practitioners should aim to involve all children and young people in decisions relating to their treatment. It is important to recognise when a young person is able to make a valid choice and is therefore competent to make a personal decision. Practitioners should not judge the ability of a particular child or young person solely on the basis of his or her age.

For a young person under the age of 16 to be competent, s/he should have:

* the ability to understand that there is a choice and that choices have consequences
* the ability to weigh the information and arrive at a decision
* a willingness to make a choice (including the choice that someone else should make the decision)
* an understanding of the nature and purpose of the proposed intervention
* an understanding of the proposed intervention’s risks and side effects
* an understanding of the alternatives to the proposed intervention, and the risks attached to them
* freedom from undue pressure.
* Competent under 16 year olds are sometimes referred to as being Gillick competent. In England, Wales and Northern Ireland children who are aged 12 or over are generally expected to have competence to give or withhold their consent to the release of information.
* In Scotland, anyone aged 12 or over is legally presumed to have such competence.

**How can competence be promoted?**

When assessing a child’s competence it is important to explain the issues in a way that is suitable for their age. A young person may be competent to make some, but not all decisions, and clinical staff should promote an environment in which young patients are enabled to engage in decisions as much as they are able. The child or young person’s ability to play a full part in decision-making can be enhanced by allowing time for discussion.

*(Taken from British Medical Association Children and young people’s toolkit)*

## **Appendix 2: Types of abuse**

**Types of Abuse**

Freedom from Torture acknowledges the evidence that child abuse in all its forms and violence against women is prevalent in all populations and communities from all faith and ethnic groups. The perpetration of physical and emotional abuse and neglect is not gender specific. The perpetrators of sexual abuse and exploitation and domestic violence are overwhelmingly male and the victims overwhelmingly children (both female and male) and women. Both perpetrators and victims come from all faith and ethnic groups.

Within this context, we recognise that many of our clients come from areas/countries with specific cultural and traditional practices that the World Health Organisation has declared as harmful to children and a violation of their rights. These include:

* Female Genital Mutilation
* Early and forced child marriage
* So-called ‘honour based’ violence
* Belief in spirit possession
* Use of extreme physical and psychological abuse to drive out spirits including administering of poison, immersion in water leading to drowning, physical chastisement using implements, exorcisms
* Breast ironing

The above practices while illegal in many countries in which they have historically been prevalent, are still practiced widely. All of them are illegal in the UK. It is also illegal to remove a child from the UK for the purposes of carrying out these practices. It is therefore incumbent on all staff to be alert to and aware of these practices and to know what to do if they consider a child to be at risk of, or be subject to, any of them.

**If you are a member of a regulated profession eg doctor, physiotherapist or social worker, you are legally mandated to report if you consider a child to have been a victim of Female Genital Mutilation, however we require all our staff to do so.**

Section 5B of the 2003 Female Genital Mutilation Act introduced a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report to the police ‘known’ cases of FGM in under 18s which they identify in the course of their professional work. The duty came into force on 31 October 2015. ‘Known’ cases are those where either a girl informs the person that an act of FGM – however described – has been carried out on her, or where the person observes physical signs on a girl appearing to show that an act of FGM has been carried out and the person has no reason to believe that the act was, or was part of, a surgical operation within section 1(2)(a) or (b) of the FGM Act 20032.

Failure to report may result in ‘fitness to practice’ investigations by the relevant professional body. For details see:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/573782/FGM\_Mandatory\_Reporting\_-\_procedural\_information\_nov16\_FINAL.pdf](https://www.gov.uk/government/publications/working-together-to-safeguard-children--2)

This link, which covers broader issues, is also useful.

[https://www.ohchr.org/Documents/Publications/FactSheet23en.pdf](http://freedomtospeakup.org.uk/the-report/)

**Domestic Abuse**

The current definition of domestic violence and abuse now states:  
Any incident or pattern of incidents of controlling, coercive or threatening behaviour,  violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

psychological

physical

sexual

financial

emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

This definition, which is not a legal definition,  includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

It can happen in any relationship, and even after the relationship has ended. Both men and women can be abused or abusers.

Domestic abuse can seriously harm children and young people. Witnessing domestic abuse is child abuse, and teenagers can suffer domestic abuse in their relationships.

Domestic abuse can include:

* sexual abuse and rape
* punching, kicking, cutting, hitting with an object
* withholding money or preventing someone from earning money
* taking control over aspects of someone's everyday life, which can include where they go and what they wear
* not letting someone leave the house
* reading emails, text messages or letters
* threatening to kill or harm them, a partner, another family member or pet.

**Children and young people witnessing domestic abuse**

Witnessing domestic abuse is highly distressing and scary for a child, and causes serious harm.

Children living in a home where domestic abuse is happening are at risk of other types of abuse too. Children can experience domestic abuse or violence in lots of different ways. They might:

* see the abuse
* hear the abuse from another room
* see a parent's injuries or distress afterwards
* be hurt by being nearby or trying to stop the abuse

**Teenagers experiencing domestic abuse**

Domestic abuse can happen in any relationship, and it affects young people too. They may not realise that what is happening is abuse. Even if they do, they might not tell anyone about it because they are scared of what will happen, or ashamed about what people will think.

https://www.gov.uk/government/news/new-definition-of-domestic-violence

**Sexual Abuse**

A child is sexually abused when they are forced or persuaded to take part in sexual activities.

This does not have to be physical contact and it can happen online.

Sometimes the child will not understand that what is happening to them is abuse. They may not even understand that it is wrong.

There are two different types of child sexual abuse: **contact abuse** and **non-contact abuse**.

**Contact abuse** involves touching activities where an abuser makes physical contact with a child, including penetration. It includes:

* sexual touching of any part of the body whether the child is wearing clothes or not
* rape or penetration by putting an object or body part inside a child's mouth, vagina or anus
* forcing or encouraging a child to take part in sexual activity
* making a child take their clothes off, touch someone else's genitals or masturbate.

**Non-contact abuse** involves non-touching activities, such as grooming, exploitation, persuading children to perform sexual acts over the internet and flashing. It includes:

* encouraging a child to watch or hear sexual acts
* not taking proper measures to prevent a child being exposed to sexual activities by others
* meeting a child following sexual grooming with the intent of abusing them
* online abuse including making, viewing or distributing child abuse images
* allowing someone else to make, view or distribute child abuse images
* showing pornography to a child
* sexually exploiting a child for money, power or status (child exploitation).

See the Brook [Sexual Behaviours Traffic Light Tool](https://www.brook.org.uk/our-work/the-sexual-behaviours-traffic-light-tool) for help to identify and respond appropriately to sexual behaviours.

**Neglect**

Neglect is the ongoing failure to meet a child's basic needs and is the most common form of child abuse.

A child may be left hungry or dirty, without adequate clothing, shelter, supervision, medical or health care. A child may be put in danger or not protected from physical or emotional harm. They may not get the love, care and attention they need from their parents. A child who is neglected will often suffer from other abuse as well. Neglect is dangerous and can cause serious, long-term damage - even death.

**Types of neglect:**

**Physical neglect**  
Failing to provide for a child’s basic needs such as food, clothing or shelter and/or failing to adequately supervise a child, or provide for their safety.  
  
**Educational neglect**  
Failing to ensure a child receives an education.

**Emotional neglect**  
Failing to meet a child’s needs for nurture and stimulation, perhaps by ignoring, humiliating, intimidating or isolating them. This is often the most difficult to prove.  
  
**Medical neglect**Failing to provide appropriate health care, including dental care and refusal of care or ignoring medical recommendations.

**Physical Abuse**

Physical abuse is deliberately hurting a child, causing injuries such as bruises, broken bones, burns or cuts. It is not accidental - children who are physically abused suffer violence such as being hit, kicked, poisoned, burned, slapped or having objects thrown at them. Shaking or hitting babies can cause non-accidental head injuries (NAHI). Sometimes parents or carers will make up or cause the symptoms of illness in their child, perhaps giving them medicine they do not need and making the child unwell – this is known as fabricated or induced illness (FII).

There is no excuse for physically abusing a child. It causes serious, and often long-lasting, harm – and in severe cases, death.

Official definitions of physical abuse:

**England**

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.

**Scotland**

Physical abuse is the causing of physical harm to a child or young person. Scotland has banned physical chastisement and a formal law is expected to come into force in late 2020.

Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating. Physical harm may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child they are looking after.

**Emotional Abuse**

Emotional abuse is the ongoing emotional maltreatment or emotional neglect of a child. It is sometimes called psychological abuse and can seriously damage a child’s emotional health and development.

Emotional abuse can involve deliberately trying to scare or humiliate a child or isolating or ignoring them.

Children who are emotionally abused are usually suffering another type of abuse or neglect at the same time – but this is not always the case.

What does emotional abuse include?

Because there is an element of emotional abuse in all other types of child abuse and neglect, it can be difficult to spot the signs and to separate emotional abuse from other types of abuse.

Emotional abuse includes:

* humiliating or constantly criticising a child
* threatening, shouting at a child or calling them names
* making the child the subject of jokes, or using sarcasm to hurt a child
* blaming, scapegoating
* making a child perform degrading acts
* not recognising a child's own individuality, trying to control their lives
* pushing a child too hard or not recognising their limitations
* exposing a child to distressing events or interactions such as domestic abuse or drug taking
* failing to promote a child's social development
* not allowing them to have friends
* persistently ignoring them
* being absent
* manipulating a child
* never saying anything kind, expressing positive feelings or congratulating a child on successes
* never showing any emotions in interactions with a child, also known as emotional neglect.

**Online Abuse and grooming**

Online abuse is any type of abuse that happens on the web, whether through social networks, playing online games or using mobile phones. Children and young people may experience cyberbullying, grooming, sexual abuse, sexual exploitation or emotional abuse.

Children can be at risk of online abuse from people they know, as well as from strangers. Online abuse may be part of abuse that is taking place in the real world (for example bullying or grooming), or it may be that the abuse only happens online (for example persuading children to take part in sexual activity online).

Children can feel like there is no escape from online abuse – abusers can contact them at any time of the day or night, the abuse can come into safe places like their bedrooms, and images and videos can be stored and shared with other people.

Cyberbullying is an increasingly common form of bullying behaviour which happens on social networks, games and mobile phones. Cyberbullying can include spreading rumours about someone, or posting nasty or embarrassing messages, images or videos.

Children may know who is bullying them online – it may be an extension of offline peer bullying - or they may be targeted by someone using a fake or anonymous account. It is easy to be anonymous online and this may increase the likelihood of engaging in bullying behaviour.

Cyberbullying includes:

* sending threatening or abusive text messages
* creating and sharing embarrassing images or videos
* 'trolling' - the sending of menacing or upsetting messages on social networks, chat rooms or online games
* excluding children from online games, activities or friendship groups
* setting up hate sites or groups about a particular child
* encouraging young people to self-harm
* voting for or against someone in an abusive poll
* creating fake accounts, hijacking or stealing online identities to embarrass a young person or cause trouble using their name
* sending explicit messages, also known as sexting
* pressuring children into sending sexual images or engaging in sexual conversations.

Grooming is when someone builds an emotional connection with a child to gain their trust for the purposes of sexual abuse, sexual exploitation or trafficking.

Children and young people can be groomed online or face-to-face, by a stranger or by someone they know - for example a family member, friend or professional.

Groomers may be male or female. They could be any age.

Many children and young people don't understand that they have been groomed or that what has happened is abuse.

Groomers can use social media sites, instant messaging apps including teen dating apps, or online gaming platforms to connect with a young person or child.

They can spend time learning about a young person’s interests from their online profiles and then use this knowledge to help them build up a relationship.

It is easy for groomers to hide their identity online - they may pretend to be a child and then chat and become ‘friends’ with children they are targeting.

Groomers may look for:

* usernames or comments that are flirtatious or have a sexual meaning
* public comments that suggest a child has low self-esteem or is vulnerable.

Groomers do not always target a particular child. Sometimes they will send messages to hundreds of young people and wait to see who responds.

Groomers no longer need to meet children in real life to abuse them. Increasingly, groomers are sexually exploiting their victims by persuading them to take part in online sexual activity

When sexual exploitation happens online, young people may be persuaded, or forced, to:

* send or post sexually explicit images of themselves
* take part in sexual activities via a webcam or smartphone
* have sexual conversations by text or online.

Abusers may threaten to send images, video or copies of conversations to the young person's friends and family unless they take part in other sexual activity.

Images or videos may continue to be shared long after the sexual abuse has stopped.

**Child trafficking**

Child trafficking is child abuse. Children are recruited, moved or transported and then exploited, forced to work or sold. They are often subject to multiple forms of exploitation.

Children are trafficked for:

* child sexual exploitation
* benefit fraud
* forced marriage
* domestic servitude such as cleaning, childcare, cooking
* forced labour in factories or agriculture
* criminal activity such as pickpocketing, begging, transporting drugs, working on cannabis farms, selling pirated DVDs, bag theft.

Many children are trafficked into the UK from abroad, but children can also be trafficked from one part of the UK to another. Any movement of a child without consent is classed as trafficking not only in / out of the country.

**Official definition of child trafficking:**

Council of Europe, ratified by the UK government in 2008: ‘The recruitment, transportation, transfer, harbouring or receipt of a child for the purpose of exploitation shall be considered 'trafficking in human beings'.

**Forced Marriage**

A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. It is an appalling and indefensible practice and is recognised in the UK as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights.

The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they’re bringing shame on their family). Financial abuse (taking your wages or not giving you any money) can also be a factor.

[The Anti-social Behaviour, Crime and Policing Act 2014](https://www.legislation.gov.uk/ukpga/2004/31/contents) makes it a criminal offence to force someone to marry. This includes:

* Taking someone overseas to force them to marry (whether or not the forced marriage takes place)
* Marrying someone who lacks the mental capacity to consent to the marriage (whether they are pressured to or not)
* Breaching a Forced Marriage Protection Order is also a criminal offence
* The civil remedy of obtaining a Forced Marriage Protection Order through the family courts will continue to exist alongside the new criminal offence, so victims can choose how they wish to be assisted
* Details of the new law can be found on the [Legislation website](http://www.legislation.gov.uk/ukpga/2014/12/part/10/enacted)

**Forced marriage Scotland**

Forced marriage is not condoned in Scotland and is considered to be an abuse of human rights. Children who are forced or subjected to emotional, physical or sexual abuse as a result, are protected by the **Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act 2011. Further information can be found by calling the f**orced marriage Helpline on **0800 027 1234 which is open 24 hours or by visiting:**

[http://www.scotland.gov.uk/Topics/Justice/crimes/forced-marriage](https://www.gov.scot/publications/national-guidance-child-protection-scotland-2021)

**Guidance for professionals**

#### [**Multi-Agency Statutory Guidance for dealing with forced marriage**](http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Spirit%20Possession%20and%20Witchcraft/Child_Abuse_Linked_to_Accusations_of_Possession_and_Witchcraft_government_response.pdf) **2014 - Guidance for all persons and bodies who exercise public function in relation to safeguarding and promoting the welfare of children and vulnerable adults.**

#### [**Multi-Agency practice guidelines: Handling cases of forced marriage**](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322307/HMG_MULTI_AGENCY_PRACTICE_GUIDELINES_v1_180614_FINAL.pdf) **2014 - Step-by-step advice for frontline workers. Essential reading for health professionals, educational staff, police, children’s social care, adult social services and local authority housing.**

**Female Genital Mutilation**

Female genital mutilation (FGM) is the partial or total removal of external female genitalia for non-medical reasons. It is also known as female circumcision or cutting.

Religious, social or cultural reasons are sometimes given for FGM. However, FGM is child abuse. It is dangerous and a criminal offence.

There are no medical reasons to carry out FGM. It does not enhance fertility and it does not make childbirth safer. It is used to control female sexuality and can cause severe and long-lasting damage to physical and emotional health.

FGM has been a criminal offence in the UK since 1985. In 2003 it also became a criminal offence for UK nationals or permanent UK residents to take their child abroad to have female genital mutilation. Anyone found guilty of the offence faces a maximum penalty of 14 years in prison.

From July 2015 anyone can apply to the court for an FGM Protection Order if they are concerned that someone is at risk of FGM. Breaching an FGM Protection Order is a criminal offence with a maximum sentence of 5 years imprisonment.

From October 2015, the FGM Act 2003 (as amended by section 74 of the Serious Crime Act 2015) introduced **a mandatory reporting duty for all regulated health and social care professionals and teachers in England and Wales** (see further information about above in the “Responsibilities” section about how Freedom from Torture approaches this duty). Professionals must make a report to the police by calling 101, if, in the course of their duties:

* they are informed by a girl under the age of 18 that she has undergone an act of FGM; or
* they observe physical signs that an act of FGM may have been carried out on a girl under the age of 18.

**Female Genital Mutilation (FGM) Scotland –**

It is an offence in Scotland to carry out this procedure or carry it out (or arrange to carry it out) abroad, even in countries where it is legal. Further information on FGM can be found at:

[http://www.nspcc.org.uk/inform/resourcesforprofessionals/minorityethnic/female-genital-mutilation\_wda96841.html](http://www.legislation.gov.uk/asp/2014/8/contents/enacted)

A 24 hour FGM advice line is available through the NSPCC by calling: **0800 028 355**

**Honour Based Violence**

There is no specific offence of "honour based crime". It is an umbrella term to encompass various offences covered by existing legislation. Honour based violence (HBV) can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.

It is a violation of human rights and may be a form of domestic and/or sexual violence. There is no, and cannot be, honour or justification for abusing the human rights of others.

The CPS, National Police Chiefs Council and support groups have a common definition of HBV:

"'Honour based violence' is a crime or incident which has or may have been committed to protect or defend the honour of the family and/or community."

Women and girls may lose honour through expressions of autonomy, particularly if this autonomy occurs within the area of sexuality. Men may be targeted either by the family of a woman who they are believed to have ‘dishonoured’, in which case both parties may be at risk, or by their own family if they are believed to be homosexual.

Common triggers for HBV include:

* Refusing an arranged marriage
* Having a relationship outside the approved group
* Loss of virginity
* Pregnancy
* Spending time without the supervision of a family member
* Reporting domestic violence
* Attempting to divorce
* Pushing for custody of children after divorce
* Refusing to divorce when ordered to do so by family members

**Spirit possession and witchcraft**

Child Abuse linked to a Belief in Spirit Possession and Witchcraft

**A Parents’ Belief**

In such cases of child abuse, a parent / carer has come to view a child as ‘different’. They have attributed this difference to the child being possessed and as such, will attempt to exorcise the child.

Reasons for the child being identified as ‘different’ may be a disobedient or independent nature, bedwetting, nightmares or illness. Attempts to exorcise the child may include:

* Beating
* Burning
* Starvation
* Cutting / Stabbing
* Isolation within the Household

Children with disabilities may also be viewed as different, and various degrees of disability have previously been interpreted as ‘possession’, from a stammer to epilepsy, autism or a life limiting illness.

**What is witchcraft?**

Witchcraft is known by many terms; black magic, kindoki, ndoki, the evil eye, djinns, voodoo, obeah or child sorcerers. All link to a genuine belief held by the family or carers (and in some cases, even the children themselves) that a child is able to use an evil force to harm others.

While these beliefs are not confined to any particular countries, cultures or religions, one message is clear: child abuse is never acceptable in any community or culture, under any circumstances.

**Procedures, Policies, Guidance and Good Practice documents:**

**BSCB Procedures**

[Child Abuse Linked to a Belief in Spirit Possession and Witchcraft](http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Spirit%20Possession%20and%20Witchcraft/Child_Abuse_Linked_to_a_Belief_in_Spirit_Possession_and_Witchcraft.pdf)

**Department of Education**

[Child Abuse Linked to Accusations of ‘Possession’ and ‘Witchcraft’ – Eleanor Stobart Report](http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Spirit%20Possession%20and%20Witchcraft/Child_Abuse_Linked_to_Accusations_of_Possession_and_Witchcraft.pdf)

[Child Abuse Linked to Accusations of ‘Possession’ and ‘Witchcraft’ – Government Response](http://www.legislation.gov.uk/ukpga/2014/12/contents/enacted)

**HM Government**

[Safeguarding Children from Abuse Linked to a Belief in Spirit Possession](http://www.bucks-lscb.org.uk/wp-content/uploads/BSCB-Procedures/Spirit%20Possession%20and%20Witchcraft/Safeguarding_Children_from_Abuse_Linked_to_a_Belief_in_Spirit_Possession.pdf)

**National Working Group on Abuse Linked to Faith or Belief**

[Action Plan 2012](https://www.gov.uk/government/publications/safeguarding-children-and-young-people/safeguarding-children-and-young-people)

**NSPCC**

[Response to Working Together: Safeguarding Children from Abuse linked to a belief in Spirit Possession and Witchcraft](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322310/HMG_Statutory_Guidance_publication_180614_Final.pdf)

**Useful websites or links:**

[Victoria Climbe Foundation](http://vcf-uk.org/)

[Victoria Climbe Foundation National Action Plan on Child Abuse Linked to Faith or Belief and Why It Matters](http://www.legislation.gov.uk/ukpga/2012/9/introduction/enacted?p=3517)

## **Appendix 3: Procedure for raising safeguarding concerns**

**WITHIN THE SAME DAY the staff member reports the concern to line manager using the safeguarding children reports form (Appendix 4).**

**The reporter and manager meet to agree the next steps. If the manager is not clinical, please consult with a Head of Clinical Services or Safeguarding Children Lead for guidance** If neither the line manager nor the Head of Clinical Services is available, then the Associate Director of Clinical Services (ADCS) or Director of Clinical Services (DCS) should be notified. In the event that there is no manager available from Clinical Services, then the CEO should be notified.

See section 7 above for more detailed guidance

When a staff member has a concern about child safeguarding:

1. **The staff member confirms the next steps with the service user using the dos and don’ts section for reference.**
2. **Any immediate safety issues are addressed (e.g. contacting the police if required). If it is thought a child has suffered sexual abuse or severe harm or is at risk of immediate harm, the police must be contacted immediately.**

Where it is agreed that the concern meets the criteria for safeguarding children, the following action is required:

1. **Complete a reporting form for the local authority where the abuse or neglect is suspected to have occurred. Send to local authority safeguarding children services.**
2. **Add a to Daylight to record this decision & upload the completed form.**
3. **Consider whether there is a safeguarding adult concern and if yes, follow the safeguarding adult’s procedure**
4. **The clinical manager updates the safeguarding tracker and alerts the Designated Safeguarding Lead. If the person raising the concern is not part of the clinical services directorate, please liaise directly with the Service Manager for the centre, or the Safeguarding Children’s Lead.** If neither the line manager nor the Head of Clinical Services is available, then the Associate Director of Clinical Services (ADCS) or Director of Clinical Services (DCS) should be notified. In the event that there is no manager available from Clinical Services, then the CEO should be notified.

An outcome is proactively sought from the local authority children safeguarding board WITHIN ONE WEEK. The Tracker is updated with the outcome and safeguarding lead updated.

Please have the confidence to challenge any decisions you disagree with.

**Where it is considered that the concern does not meet the criteria for safeguarding children:**

**Make a Daylight entry that confirms the rationale and decision making progress. An Early Help Assessment may be required**

**Consider any other actions required under other procedures, including risk planning with the service user. Update the service user and continue to review regularly.**

**The Designated Safeguarding Children Lead is available in a consultative role to discuss any**

**The Safeguarding Children Lead is available in a consultative role to discuss any safeguarding adult concerns.**

**Please note, even if the decision is that there is no safeguarding concern, this does not mean that there are not risks (clinical and otherwise) that need to be mitigated. Always consider what risk planning is required with the service user and consider whether there are any other needs that need to be addressed.**

*NB If the incident is not treated as a safeguarding issue and the reporter remains concerned, they MUST report these concerns both to their Head of Department (ie. their Line Manager’s Line Manager) and to the CEO, who then have a duty to reconsider. Where the Line Manager is the CEO, the report must go to the Chair of the Board of Trustees.*

*In case of any uncertainty, the Designated Safeguarding Adult/Child Leads for the organisation can be contacted, or the National Director of Clinical Services in the safeguarding leads absence.*

## **Appendix 4: Safeguarding Children Concerns Form**

|  |  |
| --- | --- |
| **Date** | **MF ID of child or** ID(s) of client(s) that the child is linked to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Name of reporter** | **Centre** |

Full Name of the Child:

Male / Female

Date of Birth

Address:

Contact Number

Who has the responsibility for this child?

Parent Carer Local authority

Name and contact details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Has a formal disclosure been made? If yes, please detail what the child said below using their words:**

**If no, go to “Details of your concern” below**

**Details of your concern**

**What immediate action has been taken if any?**

**Please give this form to your line manager on the same day as you have the concern.**

For manager’s use:

Record action taken and outcome (if not a safeguarding issue, please record how this decision was reached)

|  |  |  |  |
| --- | --- | --- | --- |
| **Action to be taken/authorities informed** | **By whom** | **By when** | **Date completed** |
|  |  |  |  |
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|  |  |  |  |
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|  |  |  |  |

Name ....................................... Form received on(date):................................

## **Appendix 5: Use of Chaperones**

There is no common definition of a chaperone, and their role varies considerably depending on the support or examination a service user requires. Broadly speaking their role can be considered in any of the following areas:

Providing emotional support or comfort or reassurance to service user. If the service user has capacity this is only likely to be for medical examinations and not routine therapy appointments.

To provide protection to health care professionals/ clinician from unfounded allegation of in proper behaviour.

An experienced chaperone will identify unusual or unacceptable behaviour on the part of the clinician /health care professional.

A chaperone is present as a safeguard for all parties (service user and practitioner) and is witness to continuing consent of the procedure. An advocate whose role is to support a client should not be considered a chaperone. Consent should always be proportionate to the examination or intervention being carried out. It is unlikely that a Chaperone would be required to support routine therapy appointments for a capacitated adult.

An interpreter may be present but is not a chaperone. However, they can bear witness to consent and can hear what is being said during interactions and have a duty to report any concerns to the centre manager.  Where any intimate examinations are conducted by doctors, this would be out of sight of the interpreter but within hearing, for instance, behind a screen.

All chaperones will have successfully completed a suitable training programme identified by the HoCS of the centre concerned. The name of the chaperone should be recorded in the clinical note on Daylight.

In the case of a child the chaperone would normally be a parent or guardian or someone they know, and trust and they should understand the procedure/intervention being carried out. If they have capacity to consent, then this can be given if Gillick competent and choose not to have one and the clinician agrees with this decision.

All staff should have an awareness of the role of the chaperone and inform them of how to raise a concern. All details of the examination and for the chaperone should be document in Daylight.

**Appendix 6: Legal And Welfare Service (LAWS) Safeguarding Process**

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The LAWS Team work directly with therapy clients and may identify client safeguarding concerns through this work.

The LAWS Team works on a referral basis; the advisors do not undertake end-to-end casework, so will only be intermittently involved with a client during their time in treatment. However, all of the clients that LAWS works with will have an allocated key-worker, either a clinician or a care coordinator, who is responsible for the client during their treatment.

Generally, if a LAWS Team member identifies a safeguarding concern about a client, they will alert the client’s key-worker to their concerns immediately. Where they do so by email, they will copy in the appropriate Head of Clinical Services, or key-worker’s line manager if different, and their own line manager. Where they do so by speaking to the key-worker, they will email their line-manager details of the concerns and outcome of the conversation with the key-worker.

In all cases, once notified, the client’s key-worker (or their line-manager if they are not available) will be responsible for progressing the matter in line with FfT’s Safeguarding Adults/Children Policies.

Where an emergency situation of immediate risk to a child or adult’s life, health or welfare arises and a LAWS Team member is the only staff member in a position to take any immediately necessary action, such as notifying the emergency services, they can do this, as long as it is in keeping with their professional duties.

In such situations, the LAWS Team member will follow the procedures set out in FfT’s Safeguarding Adults/Children Policies, as appropriate. This includes, where possible, obtaining the client’s consent to provide confidential information to third parties.

Where it is not possible to obtain the client’s consent, the LAWS Team member will provide the third party with the minimum information necessary to address the risk to the client or other individual. It must be understood that doing so would be a breach of the solicitors’ duty of confidentiality. Breaching confidentiality in such circumstances is likely to be justifiable, at least for those solicitors practicing in England and Wales and OISC accredited advisors, in line with the SRA’s guidance on the solicitor’s duty of confidentiality.1 However, each case will be considered on its facts, and the LAWS Team member must be able to justify the breach.

If a LAWS Team member has to take immediately necessary action as above, with or without the client’s consent, they must inform the client’s key worker, HEAD OF CLINICAL SERVICES and their own line manager as soon as possible and on the same day as the incident. The line manager (if anyone other than the Head of LAWS) must notify the Head of LAWS immediately.

Where a LAWS Team member has had to disclose confidential client information without consent, it is possible that LAWS will no longer be able to offer their services to the client. This will need to be considered on a case-by-case basis by the Head of LAWS.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Current document** | | | | | |
| **SU Consultation:** (Method and date) |  | | | | |
| **Staff Consultation:** (Method and date) | CS | | | | |
| **Reviewed by HR** (date)**:** | - | **Training in place** (where required)**:** | **Yes** | No | n/a |
| **E&D impact assessment** (date): | See section 13 | **Action plan in place to address –ve impact(s)** | Yes | no | **n/a** |
| **Reviewed by Finance** (date)**:** | N/A | **Financial resources in place** (where required) | **Yes** | No | n/a |
| **Reviewed by Facilities Manager (H&S)** (date)**:** | N/A | **H&S requirements in place** (where required)**:** | **Yes** | No | n/a |
| **Reviewed by QA Manager** (date)**:** | 2022-2-9 | **Monitoring requirements in place:** | **Yes** |  |  |
| **Date Intranet updated:** |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Review process** | | | |
| **Date review to commence:** |  | Responsible person(s): | DNCS / Child Safeguarding lead |
| Date draft to go out for consultation (date): |  | | |
| Date draft to go to SMT: |  | | |

1. Parents and Parental responsibility guidance - <http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_appendix_2.asp> [↑](#footnote-ref-2)
2. A professional whose training qualifies them to practice their profession with children. [↑](#footnote-ref-3)