**Safeguarding Procedure**

**1 Introduction**

1. The purpose of this procedure is to provide a framework for all staff and volunteers of Hope Support Services (Hope).
2. It should be used in conjunction with Safeguarding Policy to prevent and reduce the risk of abuse to all children who use Hope's services at our sites, at an event or outreach activity off site, online/digitally or come into contact with staff or volunteers.
3. The procedure details the steps the individuals and key persons are expected to take.

**2 Areas of responsibility**

1. Everyone's responsibility: safeguarding and protecting children from abuse and neglect is the responsibility of all staff including temporary and agency, freelance and contractors, hereafter referred to as staff, volunteers, and trustees who work for or represent Hope. This includes a responsibility to ensure they are informed and trained to an appropriate level.
2. All staff, volunteers, and trustees are expected to report and discuss any concerns to the Designated Safeguarding Lead (DSL) immediately. The seniority of the DSL should never be a block to anyone raising a concern.
3. The Designated Safeguarding Leads are listed here and together they form the Safeguarding Working Group:
    1. DSL, Lorna Russell, 07776663868
    2. Deputy DSL, Kate Croudace, 07776663853
    3. Safeguarding Trustee, Helen Bolt, helen.bolt@hopesupport.org.uk
4. The DSLs outlined above have responsibility for all matters relating to safeguarding within Hope.
5. The group meet regularly, with the expectation that they will be aware of any concerns and ensure these procedures are implemented.
6. They group works with colleagues to ensure safer recruitment processes are followed and provide support regarding safeguarding concerns relating to staff, trustees and volunteers.
7. Herefordshire is part of the West Midlands Safeguarding Children Procedures of agreed multi-agency child protection policies and procedures for ten Local Safeguarding Children Boards and Partnerships throughout the West Midlands Region.
    1. Our local LADO is Paul Rooney, 01432 261739
8. The DSL has overall responsibility for all safeguarding matters.
9. The DSL will also be required to offer consultation to the Safeguarding Trustee and Deputy DSLs on any matters which are seen as complex or challenging, and the Chair of Trustees will be briefed dependent on the level of seriousness of the concern.

10. The Safeguarding Trustee and DSL work closely and have responsibility for ensuring all appropriate actions have been taken and for providing staff, volunteers, the executive board and trustees with the guidance required.
    1. The only occasion when one of them should not be informed of a concern is if they are themselves implicated in abuse; in such circumstances staff will always go to the next named senior member of staff.

**3 Procedure details**

1. The procedures detailed here are mandatory and must be followed.
2. The flowcharts that accompany this procedure constitute the basic outline of the processes that need to be considered and followed.
3. Procedures cannot predict every set of circumstances and if any member of staff/volunteer is dealing with a safeguarding matter, they should raise concerns immediately to the DSL.

**4 Recognition of the signs and indicators of abuse**

1. Recognition of the signs and indicators of abuse poses considerable challenges for most professional staff who work with children and do not deal with protection and safeguarding issues on a day to day basis.
2. Identifying abuse of children with disabilities or special educational needs, who may also present with a range of challenging behaviours is not straightforward. It is crucial to effective safeguarding that all staff and volunteers are able to recognise signs and indicators of abuse and this requires recognition that disabled children are more likely to be abused than children without disabilities.
3. Even for those experienced in working with child abuse, it is not always easy to recognise a situation where abuse may occur or already be taking place. It is acknowledged that staff and volunteers are not experts in such recognition. Therefore any concerns should be discussed as detailed within this procedure.
4. The guidance on the recognition of signs and indicators of abuse given below is not an exhaustive list of concerns, and the presence of one or more of the indicators is not proof abuse has taken place. Staff must however be open to the possibility that something may have occurred and may require further action.
5. Staff should be aware of the potential risk to children when individuals previously known or suspected to have abused children are moving to, or have contact with, the household in which the child lives.
6. If the member of staff or volunteer believes that a child is at immediate risk of harm or abuse, they will take immediate and reasonable steps to protect the child; however such situations are very rare and in most circumstances staff will raise a concern following the process outlined in appendix 1 and section 12.

**5 Definitions and potential signs of abuse: physical abuse**

1. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child.

2. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.
3. The following may be indicators of concern:
    1. An explanation which is inconsistent with an injury;
    2. Unexplained and/or suspicious injury i.e. abuse, cut or burn particularly if situated in a part of the body not normally prone to such injuries;
    3. Different explanations provided to different professionals for an injury;
    4. Unexplained delay in seeking treatment;
    5. Parents/carers are uninterested or undisturbed by an accident or injury;
    6. Parents/carers are absent without good reason when a child is presented for treatment;
    7. Presentation of minor injuries which may represent a "cry for help" and if ignored could lead to more serious injuries or may represent fabricated or induced illness;
    8. Families using different doctors, hospitals, or any minor injury units 'walk in' centres, and other direct access health provisions;
    9. Reluctance to give information concerning previous injuries.
4. Children can have accidents or bruising, but the following must be considered as highly suspicious of a non-accidental injury unless there is an adequate explanation provided:
    1. Any bruising or other soft tissue injury to a pre crawling or pre-walking infant or non-mobile disabled child;
    2. Bruises seen away from bony prominences;
    3. Simultaneous bruises to both eyes without bruising to the forehead;
    4. Bruising on sites less commonly injured accidentally;
    5. Clusters of bruising may indicate defensive injuries on the upper arm, outside of a thigh or adjacent limbs;
    6. Multiple bruising of uniform shape;
    7. Bruises that carry the imprint of an implement i.e. belt mark, hand print, glass mark or hair brush handle;
    8. Linear pink marks - pale scars caused by gripping especially at wrists, ankles, necks or male genitals;
    9. Bruising or tears around or behind the earlobes indicating an injury by pulling, twisting or slapping;
    10. Broken teeth and mouth injuries;
    11. Bite marks showing clear impressions of the teeth;

    12. Bite marks of 3 centimetres in diameter are more likely to been caused by an adult or older child.

5. It can be difficult to establish accidental or non-accidental burns and scars and proof will always require experienced medical opinion. Any burns with a clear outline may be suspicious i.e:

    1. Circular burns from cigarettes are characteristically punched out lesions 0.6 to 0.7cm in diameter and healing usually leaves a scar;

    2. Friction burns result from being dragged;

    3. Linear burns from hot metal rods or related to coal fire elements;

    4. Burns of uniform depths over a large area;

    5. Scars which have a line indicating immersion or poured liquid - a child getting into water of their own accord would struggle to get out and cause splash marks instead.

6. Fractures may be causing pain and swelling, and discoloration over a burn or joint - the possibility of this should be considered carefully for all fractures in non-mobile children. Fractures are grounds for concern if:

    1. An unexplained fracture occurs in the first 18 month of life;

    2. The history provided is not very common, non-existent or inconsistent with the fracture type;

    3. They are associated with old or notable fractures;

    4. Medical attention is sought after delay when the fracture has caused symptoms of swelling, pain or loss of movement.

**6 Definitions and potential signs of abuse: emotional abuse**

1. 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.

    1. 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;

    2. 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;

    3. 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;

    4. It may involve seeing or hearing the ill-treatment of another;

    5. It may involve serious bullying (including cyber-bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children.

2. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.
3. Emotional abuse may be difficult to recognise as signs are usually behavioural rather than physical, and the indicators of emotional abuse are often associated with other forms of abuse.
4. Children with Autism are likely to exhibit some of these signs and indicators as a part of their condition, therefore the recognition of abuse is much more challenging.
5. Recognition of emotional abuse is usually based on observations over time:
6. Indicators related to the parent/carer and child relationship may include:
    1. Abnormal attachment between child/parent and carer e.g. anxious, indiscriminate or no attachment (although this can appear to be the case with children with Autism and therefore the attitudes and responses of the parent to this situation become more salient);
    2. Parent frequently complains about/to the child or fails to provide attention or praise (high criticism/low warmth environment);
    3. Conveying to a child that he/she is worthless or unloved, inadequate or only valued in so far as meeting the needs of another person e.g. persistent negative comments about the child or "scapegoating" within the family;
    4. Developing inappropriate or inconsistent expectation e.g. overprotection, limited exploration or learning interaction beyond child's developmental capability;
    5. Prevention of normal social interaction;
    6. Causing a child to feel frightened or in danger through witnessing domestic abuse, seeing or hearing ill-treatment of another.
7. Indicators related to the child's presenting concerns may include:
    1. Delay in achieving developmental cognitive and/or educational milestones;
    2. Failure to thrive or faltering growth;
    3. Behavioural problems e.g. aggression or attention seeking;
    4. Frozen watchfulness, particularly in preschool children;
    5. Low self-esteem, lack of confidence, fearful, distressed, anxious;
    6. Poor peer relationships including withdrawn or isolated behaviour (again with children with Autism this indicator should be treated with caution and related to how the child has previously presented).
8. Indicators related to possible parent/carer issues may include:
    1. Dysfunctional family relationships including domestic abuse
    2. Parental problems that may lead to lack of awareness of child's needs e.g. their mental health, substance misuse, learning difficulties;

3. Parental/Carer emotionally or psychologically distancing the child.

**7 Definitions and potential signs of abuse: sexual abuse**

1. Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening and whether or not violence is involved.
2. 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.
3. 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).
4. Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children.
5. Boys and girls of all ages may be sexually abused and are frequently too scared to say anything due to guilt and or fear. This abuse is particularly difficult for a child to talk about.
6. Recognition can be difficult unless the child discloses and is believed. There may be no physical signs and indicators are likely to be emotional/behavioural.
7. Behavioural indicators or sexual abuse can include:
    1. Inappropriate sexualised conduct;
    2. Sexually explicit behaviour, play or conversation inappropriate to the child's age;
    3. Continual and inappropriate or excessive masturbation;
    4. Self-harm (including eating disorder), self-mutilation and suicide attempts;
    5. Involvement in prostitution or indiscriminate choice of sexual partners;
    6. An anxiousness and unwillingness to remove clothing for sports events (but this may be related to cultural norms or physical difficulties);
    7. Running away.
8. Physical indicators or sexual abuse can include:
    1. Pain in the genital area, vaginal discharge;
    2. Sexually transmitted diseases;
    3. Blood on underclothes;
    4. Pregnancy;
    5. Injuries to genital or anal area;
    6. Bruising to buttocks, abdomen and thighs;

    7. Presence of semen on vagina, anus or external genitals.

**8 Definitions and potential signs of abuse: neglect**

1. 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.
2. Neglect may occur during pregnancy as a result of maternal substance abuse.
3. 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.
4. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.
5. Evidence of neglect builds up over a period of time and it is the one type of abuse where early intervention is most successful.
6. Child related indicators of neglect may include:
    1. A child who is unkempt, or inadequately clothed, or dirty, or smells;
    2. A child perceived to be frequently hungry;
    3. A child who seems to be listless, apathetic and unresponsive with no apparent medical cause or displaying anxious attachment, aggression or indiscriminate friendliness (with a child with Autism this should be considered as a factor when there is a detrimental change in a child's behaviour);
    4. Failure to grow or develop within normal expected patterns with accompanying weight loss or speech/language delay;
    5. Recurrent/untreated infection or skin conditions. e.g. severe nappy rash, eczema, or persistent head lice/scabies;
    6. Unmanaged/untreated health or medical conditions including poor dental health;
    7. Frequent accident or injuries;
    8. Child frequently absent or late at school;
    9. Poor self esteem;
    10. Child thrives away from the home environment.
7. Indicators of neglect in the care provided may include:
    1. Failure by parents or carers to meet the basic and essential needs such as food, clothing, warmth and hygiene;
    2. Failure by parents or carers to meet the child's health and medical needs i.e. poor dental health, failure to attend appointments with health visitors, GP or hospitals or lack of GP registration, failure to seek or comply with appropriate medical treatment;

3. A dangerous or hazardous home environment including failure to use home safety equipment or risk from animals;
4. Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements, inadequate ventilation including passive smoking, lack of adequate heating;
5. Lack of opportunities for a child to play and learn;
6. Child left with adults who are intoxicated, misuse substances or are violent;
7. Child abandoned or left alone for excessive periods.

**9 Increased vulnerability of disabled children and those with special educational needs**

1. Evidence suggests disabled children are at increased risk of abuse, and the presence of multiple disability increases the risk of both abuse and neglect.
2. A disabled child may be especially vulnerable because of:
    1. A need for practical assistance in daily living, including intimate care from what may be a number of carers;
    2. Carers/Staff lacking ability to communicate adequately with them;
    3. A lack of continuity in care leading to increased risk that behavioural changes may go unnoticed;
    4. Carers working with the disabled child in isolation;
    5. Physical dependency with consequent reduction in the ability to be able to resist abuse;
    6. Increased likelihood that they are socially isolated;
    7. Lack of access to "keep safe" structures available to others;
    8. Communication or learning difficulties preventing disclosure;
    9. Lack of advice e.g. due to hearing impairment;
    10. Parent/Carers own needs and ways of coping may conflict with the needs of the child;
    11. Bullying and intimidation, abuse by peers;
    12. A fear of complaining in case services are withdrawn;
3. Some sex offenders may target disabled children in the belief that they are less likely to be detected.
4. Some disabled children are highly adept in the use of social media and other online tools but lack the social awareness to be able to protect themselves from online grooming or abuse.
5. In addition to the universal indicators of abuse/neglect mentioned previously the following abuse behaviours must also be considered:

    1. Force-feeding;
    2. Unjustified or excessive physical restraint;
    3. Rough handling;
    4. Extreme behaviour modification 'techniques' including the deprivation of liquid, medication, food or clothing;
    5. Misuse of medication, sedation, heavy tranquillisation;
    6. Invasive procedures against the child's will;
    7. Deliberate failure to follow medically recommended regimes;
    8. Misapplication of programmes or regimes;
    9. Ill-fitting equipment, which may cause injury or pain or inappropriate splinting.

**10 Listening to children**

1. One of the key indicators of abuse and neglect is a direct allegation from a child that they are being abused.
2. The disclosure of abuse is often frightening and can awake painful memories, and the strong emotions felt can be very difficult to express.
3. If the child alleges that they are being abused or information is received which causes concern that they may be being abused or have some knowledge of an abusive situation, the person receiving this information from the child should:
    1. React calmly so as to not frighten the child.
    2. Listen to what the child is saying and recognise difficulties - avoid interpreting what is being said by the child, they may have a speech disability and or difficulties with language;
    3. Keep open to the fact that the child may not have the necessary vocabulary for describing what has happened to them - remember that disclosure does not have to be verbal;
    4. Avoid direct questions (unless the nature of the child's disability or preferred communication method means that this is the only way to ascertain whether the child is at risk), ensure a clear and accurate understanding of what is being said, use minimal prompts and where appropriate repeat back what is being said to clarify;
    5. Do not ask leading questions as these could jeopardise the investigation or the outcome of any criminal proceedings (unless the nature of the child's disability or preferred communication method means that this is the only way to ascertain whether the child is at risk);
    6. It is important to reassure the child but not make promises of confidentiality which might not be sustainable in the light of subsequent investigations - ensure the child knows you have to pass the disclosure to the safeguarding team;

7. It is imperative that a full record of what is being said, heard and seen is made as soon as possible in line with section 13.

**11 Essential safeguards for disabled children**

1. Safeguards for disabled children are essentially the same as for non-disabled children and should include enabling them to:
    1. Make their wishes and feelings known;
    2. Receive appropriate personal, social and health education;
    3. Raise concerns;
    4. Have an effective means of communication and range of adults with whom they can communicate.

**12 Raising a concern**

1. All staff, volunteers and trustees are issued a copy of this procedure with the contact details of the DSL and deputy DSL.
2. Staff will raise a concern by reporting it immediately to the Designated Safeguarding Lead (DSL). If the DSL is not immediately available then the deputy DSL should be contacted.
3. Immediately after raising a concern, staff will also make a detailed written account of what they have seen, observed or heard as detailed in section 13.

**13 Recording a concern**

1. The keeping of accurate and prompt recording is fundamental to effective child protection and safeguarding.
2. All staff and volunteers have a responsibility to ensure all concerns are recorded appropriately.
    1. If the child is known to Hope and has a CRM record, the concern should be logged on the risk assessment tab of this record.
    2. If the child is not known to Hope, the written record should be logged on the risk assessment tab of the “Safeguarding” CRM record.
3. For those without access to the CRM, the DSL will send an email copy of the form and provide support for the staff member or volunteer to complete it.
4. Records should be factual and clear and, where opinion is expressed, it should be recorded as such and distinguished from fact. E.g "In my personal opinion .....".
5. When reporting a concern to the local authority, the DSL will inform the local authority that a written record of the concern is available and will securely email details of the concerns to the local authority if required.
6. If at any stage Hope or the local authority decide that no further action is to be taken, then the reason for this and who made the decision will be recorded.

7. All subsequent actions/events following the reporting of a concern should be recorded and attached to the original concern in chronological order as should any documentation received from the local authority, police or other agencies.

**14 Confidentiality and storage**

1. The DSL has a responsibility to ensure all concerns are recorded, monitored and secured.
2. Electronic records including email will be saved to the relevant place in the CRM.
3. Paper records will be scanned and kept within the relevant place on the CRM.
4. Access to these records will be strictly limited on a need to know basis and controlled by the DSL and Safeguarding Trustee.
5. Client data required for safeguarding, such as address and postcode, mobile phone number and emergency contact details, will be stored securely in line with our data protection policy.

**15 Responding to concerns involving the public**

1. All staff and volunteers are responsible for raising concerns about the behaviour, actions or attitude of a member of the public towards a child.
2. The procedures for raising a concern, recording, storage and initial fact finding must be followed.
3. If the initial fact finding suggests that the concerns relate to a member of the public or a stranger, then the DSL, Deputy DSL or the Safeguarding Trustee (as appropriate) should report the matter to Children's Services and the Police immediately. Some local authorities indicate they will contact the Police in such circumstances. It is essential that the Police are informed so this needs to be clarified at the time of raising the concern and the agreed actions recorded. In such circumstances the Police lead investigations and may need to interview staff or volunteers as witnesses.
4. Refer to flow chart in Appendix 1.

**16 Responding to concerns of peer to peer abuse**

1. All staff and volunteers are responsible for raising concerns about the behaviour of children and young people towards other children and young people.
2. These concerns could be:
    1. about the behaviour, actions or attitude of a child/young person towards another child/young person participating in our activities;
    2. about the inappropriate actions or behaviour towards a child/young person outside of Hope activities.
3. The procedures for raising a concern, recording, storage and initial fact finding must be followed.
4. Refer to flow chart Appendix 1.

**17 Responding to concerns of self-harm**

1. All staff and volunteers are responsible for raising concerns about a young person who may be:
    1. self-harming (including but not limited to physical harm, misusing substances, or displaying unsafe coping mechanisms);
    2. having suicidal ideation (either passive or active).
2. The procedures for raising a concern, recording, storage and initial fact finding must be followed.
3. Refer to flow chart Appendix 1.

**18 Responding to concerns where a staff member or volunteer may have abused a child**

1. All staff and volunteers are responsible for raising concerns about colleagues.
2. These concerns could be about:
    1. the behaviour, actions or attitude of a member of staff towards a child;
    2. inappropriate use of restraint;
    3. actions or behaviour towards a child outside of Hope;
    4. accessing or making use of inappropriate online data including child pornography;
    5. anything that raises significant questions about their suitability to work with children.
3. The procedures outlined for raising a concern, recording, storage and initial fact finding should be followed, and concerns should be reported without delay directly to the DSL.
4. There are likely to be tensions and anxieties for any member of staff who notes signs and indicators that suggest a colleague poses a concern. Hope will support any member of staff or volunteer if they do so appropriately, in good faith and in a timely fashion.
5. If the concerns relate to the DSL, Safeguarding Trustee or Executive Board then the Chair of Trustees should be informed.
6. Refer to flow chart Appendix 1.

**19 Concerns related to a staff member: initial fact finding**

1. Initial fact finding when there are concerns about a member of staff requires a high level of confidentiality. It is still reasonable to check some basic facts prior to alerting other professionals. If there is any doubt about the most appropriate way to proceed then the DSL/deputy DSL will seek advice immediately.
2. The DSL or Safeguarding Trustee will lead on initial fact finding and, in these circumstances, they will not delegate to other staff.
3. In these circumstances initial fact finding should involve checking files and recent records and clarifying basic facts with key staff.

4. Initial fact finding should never involve asking a child to discuss the concerns or repeat a disclosure or allegation that has been made.
5. Initial fact finding can lead to the DSL or Safeguarding Trustee deciding that there are no protection concerns which warrant a referral to the Local Authority Designated Officer (LADO).
    1. In such circumstances, when no further action is being taken, then the decision needs to be recorded on the Safeguarding report form and conveyed to the Safeguarding Trustee.
6. If the concerns/initial fact finding conclude that a member of staff may have harmed a child, or has harmed a child, or has possibly committed an offence against or related to a child, the Local Authority Designated Officer (LADO) for the local authority in which the child is located must be informed without delay. See Appendix 5 for contact details of Children's Services, LADOS and Police.
7. The Safeguarding Trustee and Chair of Trustees must be informed of the referral to the LADO.
    1. Informing them will include agreement on next steps to be taken and how all risks are to be managed as appropriate to the circumstances.
    2. It is expected that they will be kept updated as the situation develops.
8. Discussions with the LADO should include taking advice on and ideally reaching agreement on a decision about suspension or not, as well as an agreement about informing parents or not (if known).
    1. It is essential that a shared understanding is established about next steps to be taken.
    2. The instructions of the LADO or the police should always be followed.
9. Following these discussions, it is essential that confirmation is made in writing to the LADO detailing the concern and the discussions with the LADO.
10. It is also essential that at all stages a full record is kept.

**20 Concerns related to a staff member: initiating allegation procedures**

1. The LADO will decide whether the incident fits the criteria of an allegation against staff.
    1. Local procedures will be set out by the LSCB (local safeguarding children board) on the relevant local authority website.
2. Senior managers from Hope will need to provide the LADO, and if necessary the police, with access to all available evidence and a full written account of the concerns and any responses to those concerns to date.

**21 Concerns related to a staff member: workplace arrangements**

1. The LADO will advise whether the member of staff should remain in the workplace or whether they should be suspended until the investigation is resolved.

    1. If the member of staff remains in the workplace, safeguards will be put in place to protect the member of staff and the child/children involved.
    2. The member of staff will be advised to seek legal advice, if relevant, and Hope will provide support as appropriate.
2. The senior member of staff will keep the member of staff up to date with regard to timescales of meetings and the procedures being put in place. If Hope decides that suspension is necessary, then this will be done without prejudice.
3. Suspension should be considered without delay if it is indicated that:
    1. A staff member, volunteer or trustee has behaved in a way that may have or has harmed a child;
    2. A staff member, volunteer or trustee has possibly committed an offence against or related to a child;
    3. A staff member, volunteer or trustee has behaved towards a child in a way which indicates she/he is now unsuitable to work with children;
    4. The Children Services, police or the LADO is advising suspension;
    5. It is likely to be impossible to undertake the necessary investigation properly if they remain in the workplace.
4. No formal internal inquiry can start until the LADO and the police have concluded their processes.
    1. Agreement should be obtained in writing from the LADO that an internal inquiry can commence.
5. At each stage the DSLs will need to take HR advice, keep the staff member updated (following agreement with the LADO) and keep the family of the child updated (following agreement with the LADO).

**22 Concerns related to a staff member: strategy meeting**

1. The LADO will schedule a strategy meeting with the representative from the organisation and from the Police.
2. A Police check will be conducted prior to the strategy meeting to determine whether any previous incidents involving that member of staff are known.
3. Unless the concerns relate to a senior member of staff, then senior managers should be invited to attend the strategy meeting.
4. It is essential that preparation for the strategy meeting includes checking the member of staff concerned's:
    1. personnel file;
    2. training record;
    3. supervision record;
    4. last annual appraisal.

**23 Concerns related to a staff member: decisions and next steps**

1. Professionals at the strategy meeting will decide what next steps to take: these may include criminal proceedings, child protection procedures, disciplinary procedures, training needs, or no further action.
2. 'No Further Action' by police and the local authority does not mean there is 'no case to answer' internally and HR advice should be considered.
3. The decision to take disciplinary procedures lies with Hope and may require an internal inquiry; this can only take place once the Police and LADO have concluded their processes. The LADO may inquire what actions were taken.
4. Once an internal inquiry is complete, then the disciplinary procedures can be invoked.
5. If there is a disciplinary that does not lead to a dismissal, then 'lessons learnt' should be incorporated into safeguarding training.

**24 Concerns related to a staff member: notifying the disclosure and barring service**

1. If a staff member is dismissed because of abuse concerns, then Hope has a legal duty to formally notify the Disclosure & Barring Service. This also applies if a member of staff resigns as a result of safeguarding concerns being raised.
2. The referral process is fully detailed on the DBS website.
3. If a staff member is dismissed or resigns because of abuse/neglect concerns, then Hope has a duty to formally notify relevant professional bodies the member of staff belonged to; for example the British Association for Counselling and Psychotherapy (BACP).

**25 Training and implementing safeguarding policy and procedure**

1. The DSL will ensure that the staff, volunteers and the public has access to the safeguarding policy and procedure and an understanding that the charity has a duty to inform Children's Services or the Police if there are concerns about abuse.
    1. This will be achieved by publishing the policy and procedure on Sharepoint and Hope's website.
2. Hope will ensure that all staff and volunteers sign a statement to agree that they understand and will follow the safeguarding policy and procedure.
3. Hope will also ensure that staff and volunteers will undertake training and/or awareness sessions as appropriate to their role and responsibilities. This will include training on the recognition of abuse and neglect and how to respond to such concerns.
4. Line managers will ensure that all new staff, as part of their induction, will be asked to read and understand the policy and procedure, highlighting the roles and responsibilities of the individual, the DSL and the Safeguarding Trustee.
5. Line managers will ensure all temporary members of staff and volunteers will be asked to read and understand the policy and procedure, highlighting the roles and responsibilities of the individual, the DSL and the Safeguarding Trustee.

**26 Standards of behaviour for staff and volunteers**

1. The following are expected behaviours of Hope staff, volunteers, and trustees.
2. Do:
    1. Approach any child or young person who appears to be in distress and ask if you can help;
    2. Seek assistance from colleagues where appropriate;
    3. Question situations that you find suspicious;
    4. Look out for unaccompanied children/young people and follow the Lost/Found Children procedure appropriate to the place you are working in;
    5. Unless you are delivering a one-to-one support session, avoid situations where you are likely to be in a one-to-one situation with a child/young person by remaining in a public area;
    6. Remember that the primary responsibility for care, safety and welfare rests you as the child/young person's supervising adult;
    7. Report any allegation (even if it is just a suspicion) of abuse or inappropriate conduct immediately in line with section 12 and the flowchart in appendix 1;
    8. Always act appropriately, professionally and consider, 'How would my behaviour look to anyone else and can I justify my actions?'
3. Do not:
    1. Physically restrain a child or young person except in exceptional circumstances, e.g. to prevent injury, damage to property or collections or to prevent theft. In these circumstances minimum restraint should be used;
    2. Commit or attempt to commit any act which may endanger persons or property or which breaches any safety rule, organisation policy or legislation;
    3. Engage in any form of physical or verbal abuse, threatening behaviour or harassment on the organisation's premises or when working on the organisation's business off site;
    4. Provide personal telephone numbers/contact details to any child/young person encountered through work;
    5. Communicate with any child encountered through work through social networking sites (with the exception of official or approved social network channels, e.g. Hope's Facebook page);
    6. Provide lifts in a personal vehicle to children who are not currently supported by Hope;
    7. Do things of a personal nature for children/young people that they can do for themselves, or their supervising adult can do for them, e.g. taking them to the toilet;

8. Allow or engage in inappropriate touching of any kind. The main principles of touch are:
    i. The desired touch should always be initiated by the child;
    ii. Touch should always be appropriate to the age and stage of development of the child.

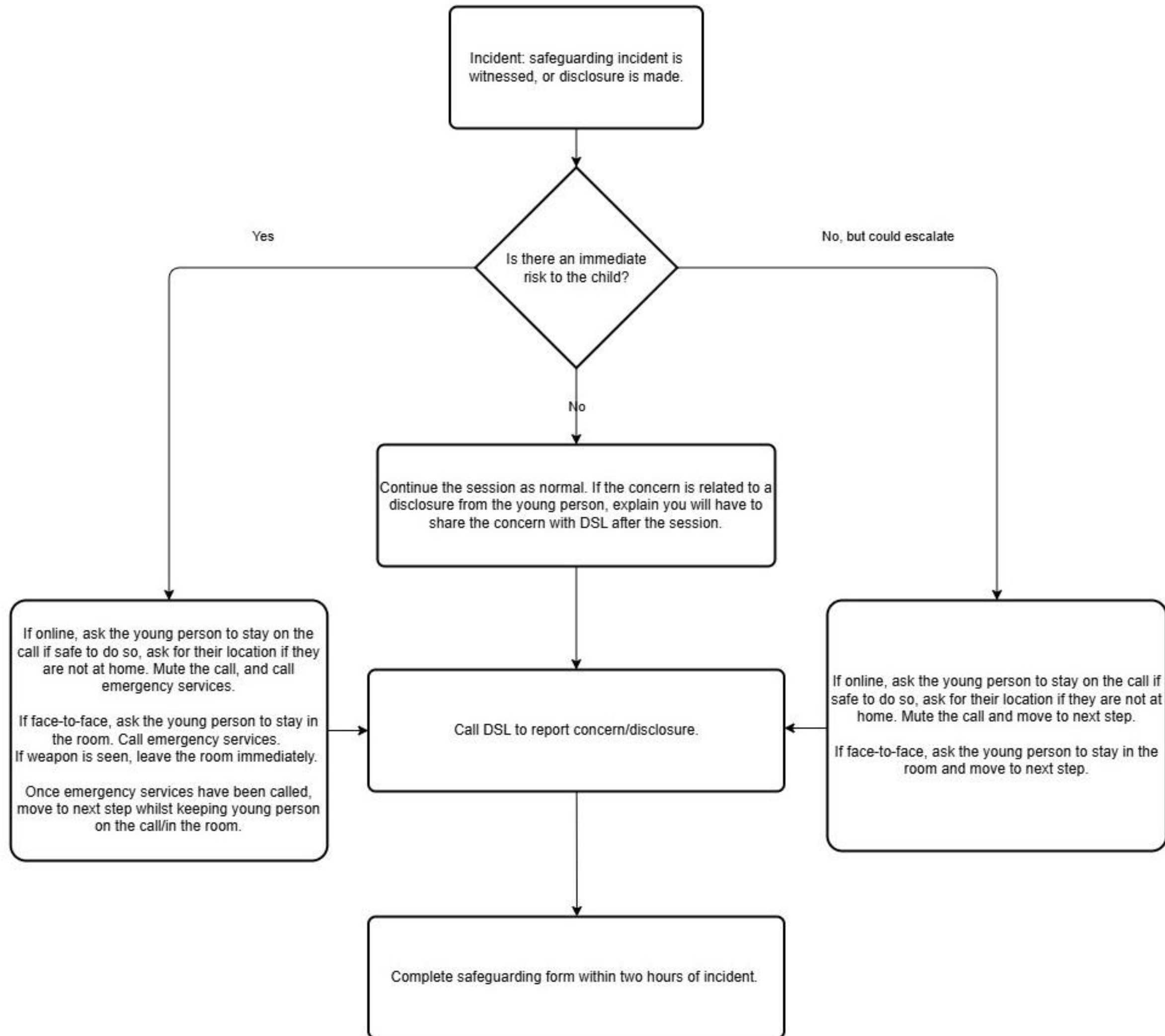
**27 Work experience**

1. Hope currently welcomes students on work experience placements, some of whom will be under the age of 18.
2. Enquiries regarding work experience should be referred to the Operations Manager.
3. Any concerns relating to the welfare and safety of a child participating in a work experience activity should be referred to the DSL.
4. Work experience students will be told who to report any concerns/direct any questions to as part of their induction.

**28 E Safety**

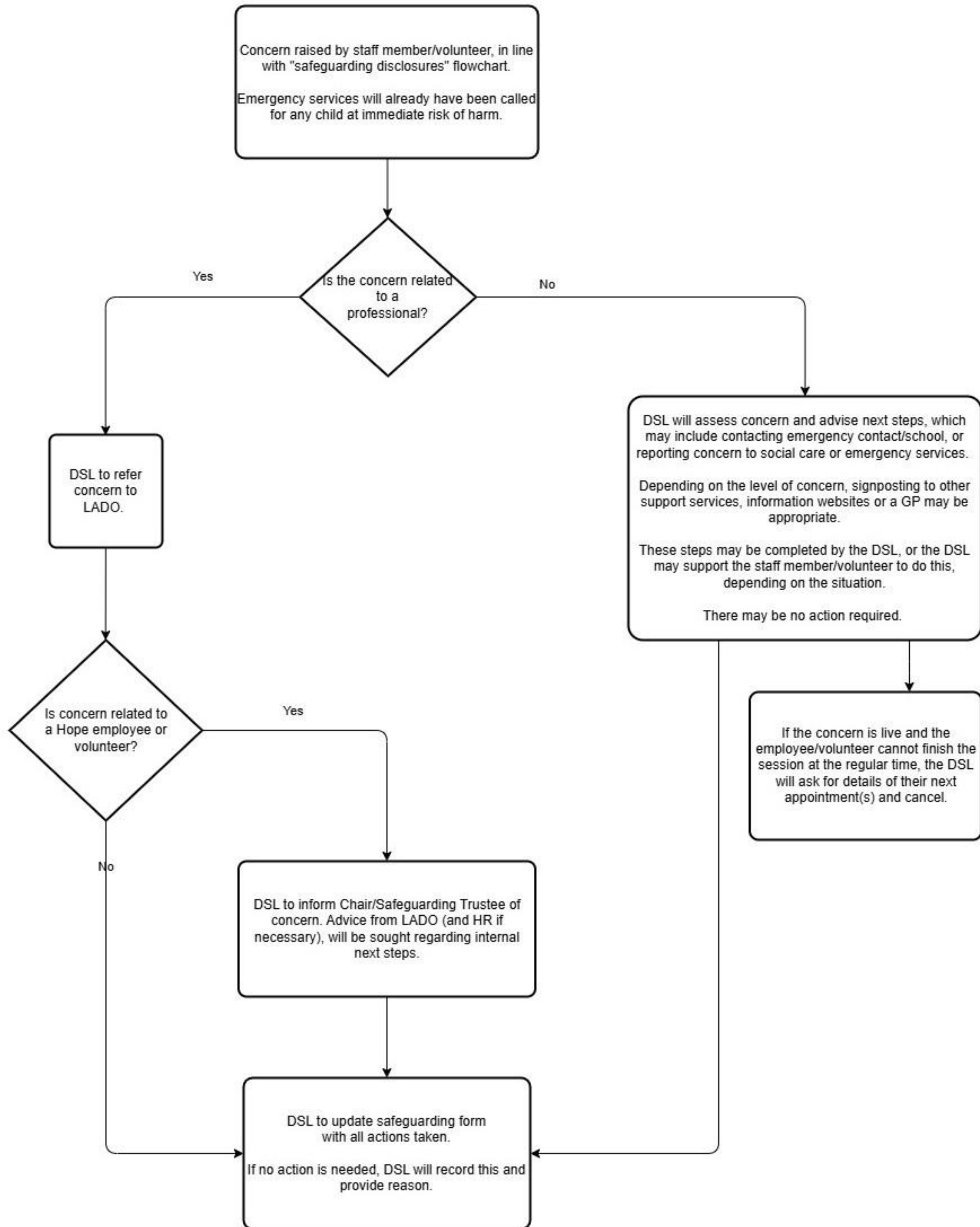
1. Hope is committed to the safety of children and young people engaging in online and digital activities with Hope and online activity.
2. Guidance appropriate to the digital activity will be available to children and their parents/carers and the CEOP internet safety link will be provided on a relevant webpage to enable members of the public to report concerns directly to CEOP (Child Exploitation and Online Protection Centre).
3. All digital and online activity will be developed in accordance with the following Hope policies:
    1. Use of IT and the Internet
    2. Social Media
    3. Data protection
    4. E-Safety

**Appendix 1:**



**Appendix 2:**

Safeguarding flowchart: procedure for DSL after concern has been raised




Date of last review: 20th April 2026

Date of next review: 20th April 2027