saffron

Sheffield Women's Counselling and Therapy Service

Safeguarding Policy - Children

Date Reviewed	Reviewed by / scheduled for review by
16/12/2016	Miranda Atherton, Clinical Manager - completed
25/03/2019	Shabina Ishaq, Head of Clinical Services - completed
09/01/2020	Ingrid Harris, Head of Clinical Service - completed
12/01/2022	Ingrid Harris, Head of Clinical Service - completed

Contents

Safeguarding Policy - Children

Lead for Child Safeguarding: Ingrid Harris, Head of Clinical Service, ingrid.harris@saffronsheffield.org.uk, 07719 868089
Deputy Lead for Child Safeguarding: Sarah Smart, CEO, sarah.smart@saffronsheffield.org.uk, 0114 2752157
Trustee for Child Safeguarding: Ahmina Akhtar, ahmina.akhtar@saffronsheffield.org.uk, 07538 670950
Sheffield Safeguarding Hub: 0114 273 4855

Saffron Sheffield recognises that it has a duty and a responsibility to ensure the safety and well being of vulnerable children involved in its work and activities.

This policy applies to anyone employed by Saffron Sheffield in a full, part-time or casual capacity and any volunteer. All team members have a responsibility to be aware of this policy and to report any suspicions that they might have concerning child abuse. It will not prescribe actions for all staff in all eventualities that may occur but sets out principles within which actions may need to be taken. Professional judgement remains crucial when addressing which other organisations to involve or inform.

The Lead/Deputy for child safeguarding is responsible for:

- monitoring and recording concerns
- making referrals to the Police or Social Care without delay
- liaison with other agencies
- arranging training for all team members

1:0 Policy statement

- Saffron Sheffield recognises the importance of safeguarding the welfare of children and their right to protection from all forms of abuse.
- Saffron Sheffield will take all allegations of abusive behaviour and/or practice in all forms seriously and will respond to such allegations quickly.
- Saffron Sheffield considers that the well being of all children is of paramount importance.
- All team members will treat all children with dignity and respect in attitude, language and actions, listening and responding appropriately.
- All team members will abide by our Confidentiality Policy.

Where there are concerns about the welfare of any child at risk, all team members in our organisation are expected to share those concerns with the lead for child safeguarding (or the deputy, if the lead is unavailable).

1:1 What is safeguarding?

Saffron Sheffield uses the Department of Health and Social Care (DHSC) definition that Safeguarding is the action that is taken to promote the welfare of children and protect them from harm.

Safeguarding means:

- protecting children from abuse and maltreatment
- preventing harm to children's health or development
- ensuring children grow up with the provision of safe and effective care
- taking action to enable all children and young people to have the best outcomes.

Child protection is part of the safeguarding process. It focuses on protecting individual children identified as suffering or likely to suffer significant harm. This includes child protection procedures which detail how to respond to concerns about a child.

1:2 What is child abuse?
A child is defined as a person under the age of 18 (The Children Act 2004) and for this policy the term 'child' will be used to describe all children and young people under the age of 18.

The Sheffield Safeguarding Children's Board offer the following definition of abuse and neglect:

> "Abuse and neglect are forms of maltreatment of a child. An individual may abuse or neglect a child by inflicting harm or failing to act to prevent harm. A child may be abused in a family, institutional or community setting, by those known to them or, more rarely, by a stranger. They may be abused by an adult or adults, or by another child or children."

1:3 Types and indicators of abuse
The categories are not mutually exclusive and a child might be subjected to more than one type of abuse at the same time. This abuse might be historical or current. The indicators may suggest some form of abuse but caution is suggested as child abuse cannot be defined merely on their presence without further detailed investigation. The types and indicators listed are not exhaustive and only some may be present.

Physical Abuse
- Hitting, slapping, scratching
- Pushing and rough handling
- Assault
- Restraint without justifiable reasons
- Misuse of medication
- Inappropriate sanctions e.g. depriving food, clothing, warmth or health care

Indicators:
- History of unexplained falls or minor injuries especially at different stages of healing
- Unexplained bruising in well protected areas of the body e.g. inside of thighs
- Unexplained bruising or injuries of any sort
- Burn marks of unusual causation e.g.by cigarettes or ropes
- History of frequent changing of GPs or reluctance to attend GP visits
- Accumulation of medication prescribed to the child but not given
- Malnutrition, ulcers, bedsores and being left in wet clothing

Child Sexual Abuse
- Rape or attempted rape
- Sexual assault or harassment
- Inappropriate touching
- Non-contact abuse e.g. voyeurism, pornography

Indicators:
(A child's behaviour shows one or more of the following-)
- Unexplained changes in the behaviour/demeanour of the child
- Tendency to withdraw and spend time alone
- Expression of explicit sexual behaviour and/or language by the child
- Unwilling to be left alone with certain individuals

- Unwilling to go to bed or sleep disturbed, particularly with bed-wetting
- Bruising or bleeding in rectal or genital areas
- Torn or stained underclothes, particularly with blood or semen
- Sexually transmitted diseases or pregnancy where the child is below the age of consent or cannot give informed consent
- Self-harm

Emotional/Psychological Abuse

- Verbal abuse
- Humiliation or ridicule
- Threats of punishments, abandonment, intimidation or exclusion
- Isolation or withdrawal from education, services or support networks
- Deliberate denial of cultural or religious needs
- Failure to provide access to appropriate social skills and educational development

Indicators:

- Loss of previously achieved developmental milestones
- Inability to sleep or spending prolonged periods in bed
- Loss of appetite or overeating at inappropriate times
- Anxiety, confusion or general resignation
- Tendency to withdraw and isolate themselves
- Presentation of fear and loss of self-esteem
- Uncharacteristically manipulative, uncooperative or aggressive
- Self-harm

Neglect and acts of omission

- Ignoring medical or physical care needs
- Failure to access care or equipment to achieve functional independence
- Failure to administer prescribed medication
- Failure to facilitate access to appropriate health, Social Care or educational services
- Neglect of basic accommodation requirements e.g. heating, lighting
- Failure to support dignity and privacy
- Professional neglect

Indicators:

- Inadequate heating, lighting, food, fluids etc.
- Poor physical condition i.e. child appears unkempt
- Prescribed medication not administered or appropriate medical/dental treatment not accessed
- Apparent unexplained weight loss
- Carers reluctant to engage with professionals or refusal to facilitate visits
- Inappropriate or inadequate clothing, including for the time of day
- Sensory deprivation e.g. not accessing glasses or hearing aids when required
- Child has no way to call for assistance

1:4 Female Genital Mutilation (FGM)

FGM refers to the practice of intentionally altering or causing injury to a female's genital organs for non-medical reasons and is illegal in the UK. It is prevalent in Africa, the Middle East and Asia. In the UK it appears to be more prevalent in areas where there are larger populations of first-generation immigrants, refugees and asylum seekers from these regions, and this includes Sheffield. FGM is carried out for cultural, religious or social reasons and is often considered a necessary preparation for adulthood and marriage.

If you are concerned someone is at risk of FGM or has had FGM you need to share this information with Social Care or the Police.

1:5 Forced Marriage

Forcing someone to marry has been illegal in the UK since 2014. 'Forced marriage' refers to one or both spouses not giving consent or being unable to give consent to marriage and being under duress to do so. It can include physical, psychological, financial and emotional pressure. Sometimes this can include abuse from the wider family.

Indicators:

- Anxious
- Depressed or emotionally withdrawn
- Suddenly being met or picked up from work/school, finances being controlled and poor performance/attendance
- Sudden absence from education, extended leave or a failure to return from a visit to another country
- A sudden engagement to an apparent stranger

1:6 Prevent: Indoctrination to extreme Ideation

Under Section 26 of the Counter-Terrorism and Security Act (2015) certain bodies are required to have "due regard to the need to prevent people from being drawn into terrorism". As part of this 'duty' extremism is defined as "vocal or active opposition to fundamental British values, including democracy, the rule of law, individual liberty and mutual respect and tolerance of different faiths and beliefs." It also highlights extremists calling for the death of those serving in the British Armed Forces or exhibiting disrespectful attitudes towards individuals and groups with protected characteristics identified in the Equality Act (2010). Within the CONTEST strategy the 'Prevent' element aims to safeguard vulnerable individuals who may be at risk of becoming involved in terrorist activities. Terrorism is defined as an action that endangers or causes serious violence to a person or property, designed to influence government or intimidate the public and is made for the purpose of advancing a political, religious or ideological cause.

All health related services have a statutory duty to show "due regard to the need to prevent people from being drawn into terrorism" under the Counter-Terrrorism and Security Act (2015).

Motivators identifying children vulnerable to radicalisation:

- Feelings of anger, grievance or injustice
- Feelings of threat or insecurity
- Need for identity, meaning or to belong
- Need for status
- Need for excitement, comradeship or adventure
- Dominance and control
- Susceptibility to indoctrination or group thinking
- Political or moral motivation
- Family/friends support extremism

Indicators:

- Extreme behaviour change (particularly domination of others)
- Transitory period in life
- Changes in Faith or ideology
- Secrecy on the internet
- Narrow or limited religious or political views

- Known attendance at ideological meetings or rallies
- 'Them' and 'Us' language or rhetoric
- Isolation from family, friends or social groups
- Possession of propaganda
- Sudden unexplained foriegn travel

To report concerns or for advice call 101 and ask for the local area police team. In addition, follow the child protection procedures. If you are reporting concerns DO NOT SPEAK TO THE INDIVIDUAL CONCERNED ABOUT IT (this may increase risk).

1:7 Financial Abuse (Not specifically a Safeguarding issue but a crime might have been committed)

- Misuse or theft of money
- Fraud and extortion of assets
- Misuse or misappropriation of property, possessions or benefits
- Exploitation or pressure in connection with Wills, property or inheritance

Indicators:

- Unexplained inability to pay for things
- Withdrawal of large sums of money which cannot be explained
- Personal belongings going missing
- Substandard of living unsatisfactory in contrast to the child's family's apparent financial position
- Unusual or extraordinary interest and involvement by the carer, family or friend in assets

1:8 Human Trafficking

Human trafficking is the movement of a person from one place to another into conditions of exploitation, using deception, coercion, the abuse of power or the abuse of someone's vulnerability. It is possible to be a victim even if consent has been given. Movement often involves an international cross-border element but it is also possible to be trafficked within your own country. **Children cannot give consent to being moved** therefore the coercion or deception elements do not need to be present. Different countries interpret what constitutes human trafficking in different ways even within Europe where the Palermo Protocol is in place. Three main elements of human trafficking:

- Movement - recruiting, transporting, transferring, harbouring or receiving of people
- Control - threat, use of force, coercion, abduction, fraud, deception, abuse of power or vulnerability, or the giving of payments or benefits to a person in control
- Purpose - exploitation of a person, including prostitution and other sexual exploitation, forced labour, slavery or similar practices, and the removal of organs

The **UK Human Trafficking Centre** (UKHTC) plays a central role in the National Crime Agency's fight against serious and organised crime and more information can be found through them: NCA Human Trafficking

1:9 Discriminatory Abuse

- Discrimintion based on any grounds including sex, race, language, culture, religion, politics, sexual orientation, disability or age
- Harassment and slurs which are degrading
- Hate crimes

Indicators:

- Tendency to withdrawal or isolation
- Fearfulness or anxiety
- Refused access to education or services or excluded inappropriately

- Loss of self esteem
- Resistance or refusal to access education or services that are needed
- Expressions of anger or frustration

1:10 Online Abuse
Online abuse is any type of abuse that happens on the web, whether through social media and networks, playing online games or using mobile phones. It may include cyberbullying, grooming, sexual abuse or exploitation, or emotional abuse.

2:0 Who may be the Abuser:
Children may be abused by a wide range of people including relatives, professional or paid staff, volunteers, other Service Users, friends and neighbours and those who deliberately exploit vulnerable people or children. There is particular concern when the perpetrator is someone in a position of power or authority. Abuse can be carried out by one child towards another: this is still abuse and should not be ignored. In this situation the alleged abuser might also be at risk and this child will also undergo a safeguarding investigation.

2:1 Where abuse may occur:
Abuse can occur in any context. The child might live alone or with others. Abuse can happen within schools, nursing, residential or day care settings, in hospitals or custodial settings, public places, places of worship or other places previously assumed safe.

2:2 Patterns of abuse:
Patterns of abuse vary and may reflect very different dynamics including:

- Serial abuse in which the perpetrator seeks out and 'grooms' vulnerable individuals. Sexual abuse usually falls into this pattern as do some forms of financial abuse and ideological persuasion or radicalisation
- Long-term abuse in the context of an ongoing family relationship such as in domestic abuse between partners or generations
- Opportunistic abuse such as theft occurring because money has been left around
- Situational abuse which arises due to pressures building and or because of difficult or challenging situations or behaviours
- Neglect of a child's needs because those around them are not able to be responsible for their care, possibly due to debt, alcohol or their own mental health problems
- Institutional abuse featuring poor care standards or inadequate response to complex needs, inadequate staffing or insufficient knowledge of staff
- Unacceptable 'treatments' such as sanctions or punishments e.g. withholding food and drink, seclusion, unnecessary use of control or restraint
- Unacceptable teaching regarding ideology or radicalisation
- Failure of agencies to ensure appropriate guidance for staff regarding anti-racist and anti-discriminatory practices
- Failure to access key services e.g. health care
- Misappropriation of benefits or money
- Fraud or intimidation e.g. Wills or assets

3.0 Safeguarding concerns may arise due to:

- What you have seen

- What a child at risk has told you
- What your team members report to you
- Complaints or allegations from parents, carers or the child at risk herself.
- How a child at risk behaves
- How a responsible adult in your organisation behaves
- Allegations of historical abuse
- Anonymous information

4.0 Confidentiality

Saffron Sheffield undertakes to inform clients about any reasonably foreseeable limitations of privacy or confidentiality in advance. Clients are made aware of this via the Client Data Information Sheet, at assessment, and also in their first one-to-one session with their therapist.

Under normal circumstances, what a client tells a therapist in a session is confidential. An exception to this is when the client's disclosures express a danger to herself or to others. It is important that clients are aware of these limits to confidentiality from the outset. Gaining consent is not essential in order for information to be passed on if the disclosure poses a danger, and this is covered in our client 2contract and data policies.

5:0 Working with clients 16 to 18 years old

People aged 16 or over are entitled to consent to their own treatment, and this can only be overruled in exceptional circumstances. In UK law, Children Act (1989), a person's 18th birthday draws the line between childhood and adulthood but to a more limited extent 16 and 17 year olds can also take medical decisions independently of their parents.

Capacity and consent in 16 and 17 year olds

Once children reach the age of 16, they are presumed in law to be competent. Therefore, in many respects they should be treated as adults and give consent for their own treatment. Parents cannot override consent or refusal from a 16-17 year old.

However, the Department of Health and Social Care (DHSC) recommends that it is good practice to encourage children of this age to involve their families in decisions, unless it would not be in a child's interests to do so. If the 16-17 year old does not want their parent or guardian contacted when risk is present, this should be discussed with them and the Head of Clinical Service. Consideration should be given to referring to Social Care if in any doubt. In an emergency situation when the person with parental responsibility is not available to consent, the child's best interests must be considered and treatment limited to what is reasonably required to meet the emergency.

Full access to records of a client with competency under 18 is not an automatic right of parents or guardians. Therapists will need consent from the young person to disclose any information. **However, a 'best interests disclosure' could be possible if appropriate.**

If there is any doubt about a young person's capacity they should be referred to CAMHS for consideration of Mental Capacity Assessment under the Mental Capacity Act (2005).

5:1 Self-harm, suicide and risktaking behaviours

Where a 16-17 year old presents with self-harm, suicidal thoughts and/or risk taking behaviour, it is important to carry out a clear risk assessment. Due to the age of the young person a clinical judgement will need to be made as to whether urgent action needs to be taken and/or whether the risk needs to be shared with parents

and/or external agencies. **This decision should be made through a discussion with the Head of Clinical Service** and all decisions and rationale recorded in the young person's notes.

6:0 Reporting Procedures

If the allegation or suspicion of abuse is discovered by a team member then they should inform the Head of Clinical Service as soon as possible. If the Head of Clinical Service is not available, the report should be referred immediately to the CEO or the Trustee for Child Safeguarding. The team member should make a written record of the allegation or suspicion of abuse on the Safeguarding Incident Form and discuss the situation with the Head of Clinical Service, who will then carry out a risk assessment to determine if concerns need to be shared with Social Care. If a therapist has been told about the allegation of abuse in confidence, they should attempt to gain consent to refer the matter to the relevant authority. However, gaining consent is not essential in order for information to be passed on if the disclosure poses a danger, and this is communicated as outlined in 1:3. In assessing if the abuse justifies intervention consideration needs to be given to:

- Vulnerability of the child
- Nature and extent of the abuse
- Length of time it has been occuring
- Impact on the child
- Risk of repeated or increasingly serious acts involving this or other children

In cases of disclosure of abuse of a child at risk, we are obliged to share the information and will refer our concerns to Social Care or the Police in an emergency. If there is any doubt about whether or not to report an issue to Social Care then it should be reported. In emergency situations (e.g. where there is the risk or occurrence of severe physical injury), where immediate action is needed to safeguard the health and safety of the individual child or anyone else who may be at risk, the emergency services must be contacted. Where a crime is taking place, has just occurred or is suspected, the Police must be contacted immediately.

Team members at Saffron will seek to 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 a child or children. This can be done either when issues first arise or where a child is already known to local authorities, and we have additional information to share. All team members should be alert to sharing important information about any adults that the child or children have contact with which may impact their safety or welfare.

If the situation is not urgent and time allows, always discuss the situation with the Head of Clinical Service or CEO.

To discuss concerns or to report child abuse ring Sheffield Safeguarding Hub on: 0114 273 4855

7:0 Working with children

It is essential that care is taken to minimise the possibility for abuse and misunderstanding and misinterpretation. False allegations are rare but general good practice will help prevent them. In a counselling context it would not be expected that any of these behaviours would arise. The following list includes behaviour that team members working with children should never do:

- engage in physical activity with the child or children
- make inappropriate sexual comments or jokes
- invite or allow children into their home

- give a child a lift in their car except in emergencies
- let allegations made by anyone go unacknowledged, unresolved or not acted upon

Team members should be aware of the potential for misunderstanding when touching children. In a counselling and therapy setting, team members should not ordinarily touch children. However, consoling a child who is upset, administering first aid or supporting a child in an activity is acceptable behaviour.

Team members should, however, endeavour to minimise any possible misunderstanding of their actions.

7:1 Team member allegations
Concerns about the behaviour of team members in the organisation with regard to safeguarding, will be referred without delay to the Lead for Child Safeguarding who will contact Social Care, or the Police, if a crime may have been committed.

7:2 Whistleblowing
In the rare situations that the concerns are about the Lead for Child Safeguarding, it is important to refer to the Deputy Lead for Child Safeguarding. This may not be appropriate, in which case any team member may personally refer directly to the Local Area Designated Officer who can be contacted via Social Care, and will liaise with Social Care and the Police if a crime may have been committed.

7:3 Safer recruitment at Saffron Sheffield
Saffron Sheffield will endeavour to take all possible steps to prevent unsuitable people working with children.

When interviewing potential team members with direct access to children and young people Saffron Sheffield shall ensure:

- there is an open recruitment process
- there is a rigorous interview
- an appropriate level of DBS check has been performed and proved negative
- references are taken up by direct contact with referees
- evidence of the date of birth and address of the potential team member is sought
- evidence of qualifications and ID should be sought

7:4 Safeguarding Audit

Our safeguarding practice is reviewed annually. Any suggested improvements to our current safeguarding policy or any significant findings will then be documented and reported to the Board of Trustees.

7:5 Safeguarding training and updates
All team members at Saffron Sheffield have safeguarding training updates every three years in addition to safeguarding competencies being reviewed annually in staff appraisals. We keep a clinical log of any training that has been done elsewhere.

All team members are required to read and understand our policies. It is highlighted in line management if any further information is needed.

Related policies and procedures

This policy statement should be read alongside our organisational policies and procedures, including:

Client Data Information Sheet

Safeguarding Incident Form

Adult Safeguarding Policy

Whistleblowing Policy

This policy has been drawn up in accordance with the following:

BACP Good Practice in Action 046 - Working with children and young people within the counselling professions 2018

Children Act 1989

Children Act 2004

Health and Safety at Work Act 1974

The Children (Protection from Offenders) (Miscellaneous Amendments) Regulations 1997

The United Nations Convention on the Rights of the Child

Working Together to Safeguard Children (2018)

Rehabilitation of Offenders Act 1974

Sheffield Safeguarding Children Board Child Protection and Safeguarding Procedures Manual

Sheffield CCG Assurance Tool to Monitor Safeguarding Adult & Children Standards for Independent Providers 2019