Version 13

Name of Policy	Safeguarding Children & Young People Policy
Date Document Released	October 2024
Document Approved By	Management Committee
Document Controlled By	Chief Executive Officer
Version	13
Review Due	September 2026
Document Amendments	Team contact details amended, references to Breathe HR added. Specific levels of training and links added. Location of SIS updated. Addition of anonymous reporting. Delegation of follow ups. Sharing information in a wider safeguarding context.
RCEW NSS Ref:	3.1

Safeguarding Children and Young People Policy

1. Introduction

This document sets out the Rape & Sexual Abuse Counselling Centre's (RSACC) policies and procedures for safeguarding children and young people (CYP) RSACC has specific responsibilities for safeguarding CYP and it also has a responsibility to conform to the government's Prevent agenda. Prevent applies to all CYP. We have chosen to incorporate our responsibilities for Prevent and our responsibilities to CYP into a Safeguarding CYP policy.

2. Aims

The aims of this policy are to:

- Promote good practice by providing children and young people with appropriate safety and protection whilst visiting/in the care of RSACC.
- Ensure RSACC meets the requirements of the Prevent agenda. The aim of the Prevent strategy is to stop people becoming extremists or supporting extremism (HM Government, 2011, Prevent Strategy).
- Ensure those employed by, or volunteering with, RSACC consider the safety and protection of children/young people to be of paramount importance.
- Ensure if a safeguarding issue arises, staff and volunteers are able to take appropriate action to protect children and young people and to allow all

staff/volunteers to make informed and confident responses to specific safeguarding issues.

- Meet safeguarding legislative requirements and those of funders and standards bodies such as Rape Crisis England and Wales National Service Standards and British Association for Counselling and Psychotherapy (BACP) Ethical Framework for the Counselling Professions.

3. Definitions and Terminology

This policy applies to safeguarding concerns relating to children and young people. RSACC has a separate policy for concerns relating to Vulnerable Adults.

RSACC defines a child/young person as any person under the age of 18. There is no single law that defines the age of a child across the UK. The UN Convention on the Rights of the Child, ratified by the UK government in 1991, states that a child

"means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier" (Article 1, Convention on the Rights of the Child, 1989).

The fact that a child has reached 16 years of age, is living independently or is in further education, does not change their entitlement to services or protection under the Children Act 1989 (page 103, Working Together, HM Government, 2018).

Safeguarding is defined as:

- protecting children from maltreatment;
- preventing impairment of children's health or development;
- ensuring that children are growing up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best life chances. (HM Government, 2018, Working together to safeguard children- A guide to inter-agency working to safeguard and promote the welfare of children).

RSACC's definition of safeguarding also includes protecting children from becoming radicalised, becoming terrorists or supporting terrorism. Our safeguarding policy is therefore intended to also cover matters that come under the Prevent agenda.

Safeguarding concerns regarding a child/young person may be raised by:

- the child/young person who is a client of ours, regardless of whether the safeguarding concern relates to them personally or to another child/young person
- an adult who is a client of ours, regardless of whether the child/young person is a client of ours
- Any member of staff or volunteer and any professional in contact with the centre.
- an individual with whom we have no client relationship, regarding a child/young person who may, or may not, be a client of ours.
- Anyone who has a serious concern regarding a child/young person becoming radicalised.

This policy applies to all members of staff and to volunteers. Within this policy, unless specified otherwise, the term 'volunteers' includes the trustees.

For a definition of the types of abuse covered by this document, please refer to Appendix 1: Definitions of Abuse.

4. Policy Statements

RSACC will ensure the safety and protection of all children and young people through adherence to the safeguarding guidelines it has adopted. All staff and volunteers have a duty to take steps to ensure that children and young people are safe from harm.

Given the nature of the service we provide, all children and young people accessing our service will have experienced some form of sexual violence or abuse. RSACC does not expect members of staff or volunteers to raise safeguarding concerns for child/young people who are currently safe from sexual violence, abuse or exploitation except where the child/young person expressly wishes this.

Where we consider a child/young person to be at risk of significant harm, RSACC will raise a safeguarding concern with the appropriate local authority safeguarding team. Where we suspect that a child/young person is at immediate risk, or actually engaged in the planning or implementation, of an act of terrorism, RSACC will report this to the Police.

If a member of staff or volunteer is operating outside of their RSACC role and receives information which leads to safeguarding concerns in a context which is not

governed by another organisation's safeguarding policy, they are encouraged to follow RSACC's policy.

Where a member of staff is operating within their role but in an environment controlled by another agency, then the policy of the other agency may well apply. In these circumstances the policies of that lead organisation should be followed and immediate responsibility would be that of the other organisation. However, if any member of staff has any concerns that safeguarding issues remain following this (that would be covered in the RSACC policy) they should raise this with the Designated Safeguarding Lead/ Line Manager/ CEO for consideration.

4.1. Where the child/young person is a client of ours

Where the child/young person is a client of ours, we will (with the exception of point 4 below) work with the child/young person to encourage them to refer directly to the Police or the local authority safeguarding team with our support.

RSACC will only make a safeguarding referral against the child/young person's wishes when:

1. We have attempted to convince the child/young person to act first.
2. We have attempted to seek consent from the child/young person to act on their behalf.
3. A child/young person is at risk of imminent harm.
4. We suspect that the child/young person is actually engaged in the planning or implementation of an act of terrorism.

4.2. Where the child/young person is not a client of ours

Where the child/young person is not a client of ours, we will work with the individual raising the safeguarding concern about the child to encourage them to refer directly to the Police or the local authority safeguarding team.

RSACC will only make a safeguarding referral against the individual's wishes when:

1. We have attempted to convince them to act first.
2. We have attempted to seek consent from them to act on their behalf. (It is also good practice to inform an adult with parental responsibility that the referral is being made, UNLESS doing so would place the child at further risk of significant

harm or may lead to the loss or destruction of evidence of a crime or influencing a child about the disclosure made).

3. A child/young person is at risk of imminent harm.

4. We suspect that the child/young person is actually engaged in the planning or implementation of an act of terrorism.

4.3. Confidentiality, consent and information sharing

RSACC aims for transparency around confidentiality for everyone who uses its services. RSACC believes that individuals should be given the opportunity to understand the implications of sharing information to enable them to maintain autonomy and control over their choices.

When we are requested to share information with other agencies, such as Children's Social Care, we will only share relevant information on a need-to-know basis and with a clear rationale for doing so: we will never freely give information about a service user when asked. We will take steps to ensure whoever asks for information is who they say they are and working for the relevant organisation and have authorisation to be requesting information.

Our policy on managing confidentiality, consent and information sharing in relation to safeguarding depends on whether we have an existing client relationship with the person disclosing the safeguarding concern or not. RSACC's policy is to discuss confidentiality and its limitations, how we manage consent and how we share information with our clients as part of the initial session/assessment. Where we do not have an existing client relationship, a person may disclose a safeguarding concern without us having been able to discuss these matters with them.

Where possible, RSACC seeks the consent of the person disclosing the safeguarding concern before we will share information. (It is also good practice to inform an adult with parental responsibility that the referral is being made, UNLESS doing so would place the child at further risk of significant harm or may lead to the loss or destruction of evidence of a crime or influencing a child about the disclosure made). We make a judgment as to whether the child has the capacity to consent based on Gillick Competencies/Fraser Guidelines. See Appendix 3: A Child/Young Person's Rights for more information. The person disclosing the safeguarding concern will be informed what type of information we may have to share and with whom this information may be shared.

Regardless of whether we have an existing client relationship or not, any person who discloses a safeguarding concern regarding a child/young person with us must be informed and helped to understand - in ways the individual relates to - that complete confidentiality is not possible in instances of risk of significant, imminent harm to a child/young person or another person. See Appendix 2: Recognising Abuse for a definition of imminent harm.

Confidentiality will not be maintained if any individual (adult or child, client or otherwise) discloses that they have perpetrated abuse. Referrals would be made to local authority child or adult's safeguarding teams, or Police, as relevant.

In the event of a concern being disclosed which needs to be reported and the client wishes to remain anonymous we can do this on their behalf. However, it is important to be clear that although we will not disclose any identifying information of the client, we would have to share that the concern is raised through RSACC and cannot guarantee that any third party will keep that information confidential.

In the event that there may be wider safeguarding concerns, it might be necessary to share information or raise a formal safeguarding concern with another agency. For example a client living in a shelter or in care may disclose having taken an overdose. With the consent of the client it may be prudent to inform those who are in control of the client's medication and ensure that it is recorded accurately on the DPMS client file to include details of who the information was shared and details of any actions they may take.

Practitioners must have due regard to the relevant data protection principles which allow them to share personal information, as provided for in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). To share information effectively:

- all practitioners should be confident of the processing conditions under the Data Protection Act 2018 and the GDPR which allow them to store and share information for safeguarding purposes, including information which is sensitive and personal, and should be treated as 'special category personal data'

- where practitioners need to share special category personal data, they should be aware that the Data Protection Act 2018 contains 'safeguarding of children and individuals at risk' as a processing condition that allows practitioners to share information. This includes allowing practitioners to share information without consent, if it is not possible to gain consent, it cannot be reasonably expected that a practitioner gains consent, or if to gain consent would place a child at risk.

(See page 19, Working Together to Safeguard Children, HM Government, 2018).

4.4. Reporting

Any member of staff or volunteer may raise and report a safeguarding concern.

Concerns that are significant enough to require a report, will be reported either to the police or to the relevant local authority safeguarding team depending on the urgency of the referral.

As far as possible any client who raises a concern (whether they are a child/young person or adult) will be supported to pass the information to the appropriate agency themselves, i.e. the relevant local authority children's safeguarding team. If this person is unwilling to, or does not, make the referral, we will take appropriate action to protect that child/young person in line with policy and legislation. Where the concern is related to the Prevent agenda and our concern is with the actions of a client, we may be required to report the concern without informing the client.

We will take action regardless of whether or not the child/young person is a RSACC client, related to an RSACC client or is a friend or colleague.

If we receive information from a third party (i.e. not from a client) that gives rise to an imminent safeguarding concern for a child/young person, we will report the safeguarding concern. If the child/young person who is subject to the concern is a client we will attempt to update them on the information we have shared at the earliest opportunity, where it is safe to do so, unless we have been advised not to by the local authority safeguarding team.

If we receive information from a third party (i.e. not from a client) that gives rise to a non-imminent safeguarding concern for a child/young person we will advise the third-party to raise a safeguarding concern themselves. If they are unwilling or unable to do so, we will raise the concern.

If someone tells us that they have a concern about a child or young person and they state they have made the referral to the relevant agency themselves, then they tell us again about the same incident or another incident stating again they are going to report, we will follow up that they have done so as standard procedure by making our own referral to the relevant Local Authority Children's safeguarding team raising our own concerns in light of what we have been told.

4.4.1. Managing concerns that are not classed as significant or imminent

Where a member of staff or volunteer identifies a concern that they do not class as significant or imminent, they will discuss it fully with a member of the safeguarding team). They will also be required to keep an internal record of decisions taken in their client notes on the DPMS. The situation will then be monitored and decisions reviewed. The member of staff or volunteer will be responsible for informing their line manager of any changes relating to the concern so appropriate action can be taken where necessary. If the concern becomes significant or imminent then this must be recorded on the **Safeguarding Information Sheet (SIS).**

4.4.2. Prevent

If we have a 'Prevent' concern and we suspect that any child or young person is at immediate risk, or actually engaged in the planning or implementation, of an act of extremism we will report this immediately to the Police.

If we suspect that a child or young person may be under the influence of radicalisation or extremism, but not in immediate danger we will raise a safeguarding concern.

If we suspect a child or young person may be under the influence of radicalisation or extremism, but not in immediate danger we will contact the anti-terrorist hotline on 0800 789 321.

4.5. Record Keeping

RSACC keeps a record of all safeguarding referrals and outcomes, regardless of whether the report was made directly to the Police or to a local authority safeguarding team. Records are electronically filed securely and destroyed in line with RSACC policies. As a minimum, on a weekly basis the RSACC Designated Safeguarding Lead (DSL) reviews the Safeguarding file to ensure that cases are being progressed. In cases where the removal of records is deemed necessary, the RSACC DSL must be informed.

The DSL also keeps an electronic Safeguarding spreadsheet which is updated as often as required. This spreadsheet is also checked on a weekly basis by the safeguarding team to ensure consistency with the Safeguarding file (where all SIS are stored).

4.6. Follow-up

In the case of an immediate referral to the Police, we will clarify with the Police if any further action is required by RSACC.

In the case of a referral to the local authority children's safeguarding team, we will obtain feedback from them on the outcome of the concern raised.

Details of any feedback will be included on the SIS and supplied to the DSL so that she may determine whether any organisational learning is required. The DSL will debrief those involved in making a referral to establish any organisational learning. Where necessary she will implement changes to this policy and relevant procedures to reflect that learning.

If you have made a referral, it is your responsibility to provide information to the DSL so that the log can be updated.

Additional measures should be taken if you are unable to make the follow up within the 48 hrs due to annual leave, working pattern, conflicting work commitments, sickness etc. In these situations the DSL or member of the safeguarding team must be informed to carry out any follow up actions required.

4.7. Recruitment

RSACC operates policies to ensure that we recruit and select members of staff and volunteers who are safe and competent to undertake the roles advertised. This includes undertaking an Enhanced Disclosure and Barring Service (DBS) check on any member of staff or volunteer who will be in contact with clients. Details can be found in the RSACC DBS Policy.

In relation to safeguarding, it is important to note that all candidates for any post being recruited must:

- Complete an appropriate application form
- Undertake an interview process to assess their suitability for the role
- Provide a minimum of 2 referees
- Undergo an Enhanced Disclosure and Barring Service check (organised by RSACC) before taking up the post.
- Staff or volunteers appointed will not engage with clients directly, or unsupervised, until a satisfactory disclosure has been received and all necessary referee checks complete.

4.8. Training & Induction

RSACC operates a training and induction process to ensure that all members of staff and volunteers understand their responsibilities related to safeguarding and Prevent concerns prior to the commencement of work.

All RSACC staff and volunteers engaging directly with service users undergo the RSACC internal training which involved the following steps (non-direct volunteer work e.g. trustees, undergo induction process only - see RSACC Volunteer Policy):

- An extensive/specialist training program delivered over 45 hours plus self directed study/further reading.
- Safeguarding training delivered by the local authority – with a requirement to be repeated every 2 years
- A Minimum of two telephone assessments of 30 and 45 minutes
- Final interview
- Induction process

The 'RSACC Induction Procedure' and 'Induction Checklist' details the requirements within the organisation in relation to the induction of staff and volunteers. In relation to safeguarding requirements, the Induction Procedure includes the following elements:

- Organisation overview (purpose, values, overview, structure)
- A requirement to have completed safeguarding training (minimum Adults Level 1, Children Level 1 & Prevent)
- A requirement to have completed a minimum of 80% of the internal training
- A requirement to have completed all skills assessments
- A requirement to have read all RSACC policies and procedures
- If counselling, a requirement to be a member of the British Association of Counselling and Psychotherapy (BACP) and have appropriate individual professional insurance. Minimum qualification for counsellors is final year foundation degree.

(RSACC as an organisational member of the BACP & has appropriate Professional Liability Insurance)

4.9. Supervision/Support

It is RSACC's policy to allocate a Designated Safeguarding Lead (DSL) who can provide advice and guidance on making a safeguarding referral. A Safeguarding team is also available in the absence of the DSL.

In addition to the support provided by the DSL and Safeguarding team, all members of staff and volunteers should discuss any safeguarding concerns with their clinical supervisor either at the first opportunity for more urgent concerns, or in the regular clinical supervision session. This is to provide the staff member/volunteer with support in relation to staff/volunteer welfare and also for reassurance regarding compliance to policy and best practice.

4.10. Ongoing Support and Training

All members of staff and volunteers are required to undertake regular safeguarding and Prevent training. (Every 2 years) to a minimum of Level 1. Members of the Safeguarding team must also comply to a minimum of Level 2.

There are level 1 & level 2 courses available to do digitally for Safeguarding Children & Young People on the Local Authority MeLearning Portal.

(https://app.melearning.co.uk/auth/validate-key?registerKey=CWGNJMFX)

Prevent can be found on the government website;

https://www.gov.uk/guidance/prevent-duty-training

Once complete, staff and volunteers will be emailed certificates. Staff must record their training on Breathe and be responsible for ensuring that training is up to date.All training must be recorded on Breathe,and the DSL must be notified.

Details of the training undertaken will be recorded in the Safeguarding Training spreadsheet. On a monthly basis the DSL monitors that the training for staff, volunteers and trustees is up-to-date.

RSACC volunteers must update their safeguard training in line with the policy requirements. RSACC will take into account any individual's safeguarding training completed outside of RSACC if this is deemed appropriate and relevant to the role and function performed in RSACC. For example, if they are working in an environment where they need to do safeguarding training and it is up to date, RSACC would not expect the individual to repeat the training. However, a certificate or confirmation of

attendance and successful completion must be provided as evidence of relevant training.

Where changes are made to the safeguarding policies, all members of staff and volunteers will be required to read the updated policy.

Where a debrief, or a follow-up, of a safeguarding report identifies that any individual requires additional training or support, this will be executed as quickly as possible with the support of the DSL and added to the Safeguarding Training spreadsheet.

Where an individual self-identifies that they require additional safeguarding training, they are expected to discuss this with their line manager. The line manager who will approve the need/support the sourcing and undertaking of appropriate and suitable training. The DSL should be advised of this training to include this in the Safeguarding Training spreadsheet if appropriate.

4.11. Miscellaneous Issues

RSACC also adheres to safe practice by implementing Rape Crisis England and Wales National Service Standards and the British Association for Counselling and Psychotherapy (BACP) Ethical Framework for the Counselling Professions.

RSACC also maintains clear guidelines relating to lone working which are detailed in the RSACC Lone Working Policy.

5. Responsibilities

The Board of Trustees has overall responsibility for safeguarding, however, it has delegated authority to the CEO, who has in turn delegated the authority to the Designated Safeguarding Lead (DSL). The current DSL is Alexandra Carruthers. The Board of Trustees is responsible for authorising RSACC's Safeguarding Policies.

The CEO will report any safeguarding concerns to the Board of Trustees at Board meetings every 6 weeks. The Trustees have a named safeguarding nominee who will conduct an annual audit of safeguarding activities, including checking the Safeguarding File at suitable intervals to ensure compliance with RSACC policy.

The DSL is responsible for taking the lead role in providing advice and managing processes operationally in order to ensure compliance with the safeguarding policies. For a detailed list of DSL responsibilities see Appendix 8.

RSACC has a Safeguarding Team in place to ensure that there is always someone with authority to act on safeguarding matters in the event of the absence of the DSL. The members of this team can provide support to other staff members and volunteers. These individuals can act on their own or as a team, depending on the issue raised. The Safeguarding Team should be consulted in the following order:

1. Alexandra Carruthers (Designated Safeguarding Lead)

Tel: 07497779069 Email: alex@rsacc-thecentre.org.uk

2. Hannah Brayson Tel: 07946 703786 Email: hannah@rsacc-thecentre.org.uk

3. Kate Larkin (Volunteer Manager)

Tel: 07508 170406 Email: kate@rsacc-thecentre.org.uk

4. Isabel Owens (CEO)

Tel: 07399794670 Email: isabel@rsacc-thecentre.org.uk

In the absence of any of the above, your Supervisor should be contacted or the nominated safeguarding trustee, Deborah Lewis-Bynoe (Email: deborah@rsacc-thecentre.org.uk).

It is the responsibility of the line managers & CEO to ensure that those they manage are inducted into RSACC's safeguarding policies, know the procedures and their level of accountability. Line managers are also responsible for updating staff/volunteers when the policy changes.

All staff and volunteers have an individual responsibility for the protection and safeguarding of children and young people and must know what to do if they are concerned that a child/young person is being abused, neglected or radicalised. The person who takes the disclosure should be the person who passes the concern to the relevant third party and who completes all relevant paperwork.

All staff and volunteers are responsible for recording all safeguarding referrals that are made to the local authorities or police, for following up the outcomes of the referral, and for advising the DSL. All staff and volunteers are also responsible for recording safeguarding concerns that are not reported and the justification for this including a record of who the matter has been discussed with (e.g. line manager, DSL, CEO etc.). A SIS must be completed in these circumstances and sent to the DSL for filing in the Safeguarding File.

All staff and volunteers must comply with this Policy, failure to do so may result in disciplinary action being taken under the RSACC's Disciplinary Procedure or RSACC's Volunteer Agreement.

6. Safeguarding Children and Young People Procedures

6.1. What constitutes a safeguarding referral/report?

If you think that a child or young person is experiencing, or could experience, significant harm from abuse or from radicalisation you have a duty to make a safeguarding referral.

If you think that:

- a child/young person is in imminent risk of harm or abuse, or
- a child/young person is at imminent risk from radicalisation or is engaged in or planning an act of terrorism

You must ensure that the Police are called on 999.

If you think the significant harm of abuse is not imminent, you must ensure that a safeguarding concern is raised with the local authority children's safeguarding board.

Details of exactly how to do this can be found in section 6.4 below.

Details of how to establish whether an issue constitutes significant harm or imminent harm can be found in Appendix 2: Recognising Abuse & the Continuum of Need.

If you are unsure whether the issue fits into one of the above criteria, please discuss the issue with your a member of the safeguarding team or the DSL

6.2. Managing concerns that are not classed as significant or imminent

If you do not think the harm is significant, you should discuss this with the DSL or a member of the safeguarding team and record in your DPMS client notes the factors behind your decision and monitor the situation; making your line manager aware of any changes in the situation. If the concern becomes significant or imminent then this must be recorded on a SIS.

Details of how to establish whether an issue constitutes significant harm or imminent harm can be found in Appendix 2: Recognising Abuse & Darlington Borough Council 'Continuum of Need'.

6.3. Discussing confidentiality and gaining consent for information sharing

6.3.1. At the start of the working relationship.

At the first opportunity, you must make clear to clients the limitations to confidentiality. For clients, you must openly discuss this during the initial session/assessment. For helpline and email support clients or callers to the general office, you should ideally discuss this before the client shares any personal contact details.

Counsellors and ISVA's should ensure that clients receive a copy of the contract ('Service user agreement' for counselling; 'Independent ISVA support agreement' for ISVA support) unless the client declines to take it. These documents give RSACC permission to contact any relevant third party when disclosures have been made and concerns are significant to warrant information sharing. This also enables RSACC to request information from a third party when it is needed. Clients are asked to sign the contract to confirm that they understand our policies. Staff / volunteers working with children & young people should establish whether the child/young person is capable of this understanding. Please refer to Appendix 3: A Child/Young Person's Legal Rights to establish this. Where they consider a child/young person incapable of this level of understanding, it is highly unlikely that we would consider it suitable to work with the client.

6.3.2. During a safeguarding disclosure

1. Listen carefully.
2. Remain calm and try to be reassuring.
3. DO NOT promise the person that you can keep the abuse confidential.
4. If you need to clarify the concern, ask non-leading questions and only gather the information you need in order to make the referral. DO NOT attempt to investigate the matter yourself.
5. Explain as sensitively as possible, and as soon as possible, that you will/may have to share the information which has been given with a third party in another agency which has primary responsibility for the protection of children/young people i.e. police and social services. It is fairer to the person concerned to be informed as soon as possible that the information being disclosed cannot necessarily be kept confidential. This enables an informed decision to be made about how much information to disclose.

6. You should, as far as practical and possible, encourage the person to pass on the information themselves or with support. This can be facilitated by either providing the person with access to a telephone to call the local authority children's safeguarding team or the Police, or it can mean providing signposting information or support completing Local Authority referral forms.. If the safeguarding concern is imminent, the referral must be made there and then. If the safeguarding concern is not imminent and the client offers to make the referral outside of the session, agree with the client when that referral will be made and explain that you will contact the local authority safeguarding team after this point to check that they have received the referral. The referral must be made within 48 hours.

7. If the person making the disclosure does not feel able to make contact, you will do it on their behalf.

8. Seek verbal consent from that person to pass on the information to a third party or to obtain information from a third party. (It is also good practice to inform an adult with parental responsibility that the referral is being made, UNLESS doing so would place the child at further risk of significant harm or may lead to the loss or destruction of evidence of a crime or influencing a child about the disclosure made).

9. Any individual, including a child or young person at risk, may refuse their consent for their information to be shared, but there are times when their wishes can and should, be over-ridden. In determining whether to override an individual's consent, you should give consideration to:

    - the seriousness and pervasiveness of the risk (and how imminent the risk is)
    - the ability of the individual to make decisions; please refer to Appendix 3: A Child and Young Person's Legal Rights to establish this in relation to children/young people.
    - the effect of the abuse on the individual in question and on others;
    - whether there is a need for others to know (e.g. to protect others who may not be involved in the immediate situation).

10. If the person refuses verbal consent, explain that our safeguarding commitments mean that we must share the information whether consent is given or not.

Explain to the person, as far as possible, what is happening, the steps you are taking and the reasons why you are doing this, in ways the person understands.

11. If the disclosure relates to a child/young person who is a client, discuss safety planning with them during your face-to-face sessions.

The breaking of confidentiality is assessed in terms of levels of risk and consideration of multiple, interacting factors. The RSACC Safeguarding Team is in place to help, support and guide anyone who needs help to understand these risks.

When considering sharing information, you must give priority to the best interest and safety of the child/young person. Any information shared with any third party must be on a need to know basis. You should consider when dealing with a disclosure from a child/young person, that it is not easy for a child/ young person to make a disclosure and the consequences are likely to have profound effects.

Where information about a safeguarding concern comes to light outside of a face-to-face meeting, you must attempt to contact the person to obtain consent to share, except if by doing so they will increase the risk of harm to the child/young person.

If a decision is made to make a safeguarding referral without a person's consent the person should be informed at the earliest opportunity, unless you are advised not to do this by the local authority safeguarding team. The reasons for making the referral should be explained clearly, respectfully and sensitively (and recorded accurately in the client notes and SIS.

6.4. Anonymous Clients

Through its helpline and email support services RSACC's works with callers who often choose to remain anonymous. This presents particular challenges when dealing with safeguarding concerns. In such cases it remains RSACC's policy to address safeguarding concerns immediately and support the caller to either access help directly or give relevant information to enable RSACC to progress with the safeguarding referral. Clear guidance is set out on how to address safeguarding concerns with anonymous clients in the RSACC Emotional Support Line Policy.

6.5. Making a Safeguarding or Police Referral

It is not your responsibility to decide whether abuse/radicalisation is occurring, or whether or not someone poses a real risk to the child/young person's welfare. It is, however, your responsibility to take action when information is obtained that abuse/radicalisation has occurred or is occurring.

Please refer to Appendix 4 - RSACC's Safeguarding Referral Flowchart for an overview of the process for recording and reporting disclosures and to Appendix 5 Staff and Volunteer Conduct for how to behave towards clients.

6.5.1. Consultation about the need to refer

If you have a concern about a child or young person but are unclear whether a safeguarding/Prevent referral is appropriate, you should discuss the concerns with the DSL or a member of the RSACC Safeguarding Team. You should only consult about the need to refer if there are no concerns about imminent danger. **If there is the possibility of imminent harm you must make an immediate safeguarding or Police referral..** If there are no concerns about imminent danger, you must consult within a time period that allows you to complete the safeguarding referral within 48 hours.

6.5.2. Child/young person is in immediate/imminent danger

1. Contact emergency services (999).
2. If the child/young person is with you whilst you make the report, discuss safety planning with them.
3. Advise the DSL or a member of the Safeguarding team (page 13) or the staff on-call if the issue is raised out of hours).(Details can be located on in the Emotional Support Services Rota)
4. Complete a SIS (located within the templates area in google drive) making a clear note of your actions. The DSL or member of the safeguarding team will advise you of the SIS reference number.
5. The completed SIS should be forwarded to the DSL and attached to the client DPMS file.
6. The activity in which the concern was raised should be highlighted by the relevant flag in the DPMS client file. (an orange flag for those under assessment and a red flag for those that have been reported). The reference number of the SIS should be recorded in the client note for this activity.

Appendix 7 contains for details of the information you will need to gather in order to complete the form.

If circumstances were to arise where the person is not a client or linked to a client then a SIS should still be completed and a client profile created on DPMS.

7. Keep the DSL informed of any follow up or additional information as and when it occurs.

6.5.3. Child/young person is not in immediate danger

1. Go on to the relevant local authority Safeguarding website and download the up-to-date referral form. (See Appendix 6 – Local Authority Contact Details.)

2. Complete the form with the person present (where appropriate) so that they are part of the process. This also enables you to gather the information needed by the relevant local authority. See Appendix 7 – Safeguard Checklist for the type of information you need to obtain.

3. If the person making the disclosure is with you whilst you are completing the form, explain what actions will be taken in a way the person understands.

4. If the disclosure relates to the child/young person who is assisting you to complete the form, discuss safety planning with them.

5. DO NOT confront anyone who has been identified as being responsible for what has happened, and do not tell them that a safeguarding concern has been raised.

6. Report to the appropriate local authority children's safeguarding team within 24 hours.

7. Complete the referral form from the relevant local authority safeguarding website and return it within 48 hours.

8. If the DSL has not been party to the decision to submit the referral form, inform the DSL or a member of the Safeguarding Team at the earliest opportunity.

9. Complete a SIS (located within the templates area in google drive) making a clear note of your actions. The DSL or member of the safeguarding team will advise you of the SIS reference number.
10. The completed SIS should be forwarded to the DSL and attached to the client DPMS file.
11. The activity in which the concern was raised should be highlighted by the relevant flag in the DPMS client file. (red flag for those that have been reported). The reference number of the SIS should be recorded in the client note for this activity.
12. Copies of all Local Authority Referrals and Decisions should be forwarded to the DSL and attached to the client DPMS file.

Appendix 7 contains for details of the information you will need to gather in order to complete the form.

If circumstances were to arise where the person is not a client or linked to a client then a SIS should still be completed and a client profile created on DPMS.

Multiple Reports

If someone tells us that they have a concern about a child or young person and they state they have made the referral to the relevant agency themselves, then they tell us again about the same incident or another incident stating again they are going to report, we will follow up that they have done so as standard procedure by making our own referral to the relevant Local Authority Children's safeguarding team raising our own concerns in light of what we have been told.

6.4.5 Prevent Concern - imminent or immediate

If you suspect that a person is at immediate risk, or actually engaged in the planning or implementation of an act of extremism call the police immediately on 999.

If the DSL has not been party to the decision to raise a Prevent report, inform the DSL or a member of the Safeguarding Team at the earliest opportunity.

6.4.6 Prevent Concern – not imminent or immediate

If you suspect that a person may be under the influence of radicalisation or extremism, but not in immediate danger, call the anti-terrorist hotline on 0800 789 321.

If the DSL has not been party to the decision to raise a Prevent report, inform the DSL or a member of the Safeguarding Team at the earliest opportunity.

Follow the same recording procedure:

1 Advise the DSL or a member of the Safeguarding team (page 13) or the staff on-call if the issue is raised out of hours. (Details can be located on in the 'Emotional Support Services Rota)

2 Complete a SIS (located within the templates area in google drive) making a clear note of your actions. The DSL or member of the safeguarding team will advise you of the SIS reference number.

3. The completed SIS should be forwarded to the DSL and attached to the client DPMS file.

4. The activity in which the concern was raised should be highlighted by the relevant flag in your DPMS client notes. (a red flag for those that have been reported).The reference number of the SIS should be recorded in the client note for this activity.

5.1. Record Keeping

1. When using a local authority safeguarding referral form you MUST go to the relevant local authority safeguarding website and download the latest version of their referral form.
2. Record factual, non-judgemental and relevant information. Avoid jargon and interpretation. Record clearly if doing by hand.
3. Phone and talk the referral through with the relevant agency (within 24 hours) and then agree how to send the information (within 48 hours). Usually this is by email. If you need to email a third party, use a secure CJSM or your work email address.
4. IIf you have made a report to the local authority Safeguarding team, inform the DSL or a member of the Safeguarding Team at the earliest opportunity.
5. Complete a SIS (located within the templates area in google drive) making a clear note of your actions. The DSL or member of the safeguarding team will advise you of the SIS reference number.
6. The completed SIS should be forwarded to the DSL and attached to the client DPMS file.
7. The activity in which the concern was raised should be highlighted by the relevant flag in the DPMS client file. (red flag for those that have been reported). The reference number of the SIS should be recorded in the client note for this activity.
8. Copies of all Local Authority Referrals and Decisions should be forwarded to the DSL and attached to the client DPMS file.

   Appendix 7 contains for details of the information you will need to gather in order to complete the form.

   If circumstances were to arise where the person is not a client or linked to a client then a SIS should still be completed and a client profile created on DPMS.
9. The DSL will also update the electronic Safeguarding spreadsheet with the information.

5.2. Follow-up

1. You should receive feedback from the appropriate local authority safeguarding team within one working day of referral unless stated otherwise by the local authority. If no feedback is received after three days, you must contact the local authority safeguarding team to seek feedback. Record the feedback on the SIS. and inform the DSL.
2. In the case of a call to the Police, clarify with the police if any further action is required by RSACC.
3. The DSL will de-brief the member of staff or volunteer who raised the safeguarding concern to establish whether any changes should be made to RSACC's safeguarding policies or procedures.
4. The DSL will participate as RSACC's representative on any Serious Case Reviews or Child Death Reviews and will amend RSACC's safeguarding policies and procedures based on any learning from these Reviews. In her absence one of the other Safeguard Team Members will attend on her behalf.

6.7 Completed Safeguarding Information Sheets (SIS)

Once the SIS form is complete (ensuring that **all fields** include a response even if there is no information or it is not applicable (N/A) It is the responsibility of the worker who instigated the SIS form to ensure that it is complete. The SIS needs to be sent to the DSL, attached to the DPMS client file. The action needs to have the relevant flag (orange or red) and the SIS reference number needs to be recorded in the notes for that activity

6. Monitoring

The Management Committee nominated Safeguarding trustee will undertake an annual audit of safeguarding activities undertaken within RSACC and provide a report to the Board and CEO on findings.

7.1 Safeguarding Log

Every week the DSL checks the safeguarding spreadsheet and ensures that it is up to date. Where there are open safeguarding concerns logged, she contacts the individual who logged the concern and asks them to update with any progress. For some issues, the DSL may check the progress of a safeguarding issue on a daily basis with the individual that raised the concern.

On a monthly basis the DPMS Administrator will check that flags and SIS numbers have been correctly entered onto the DPMS system.

7.2 Training Log

It is the responsibility of the staff and volunteers to enter their safeguarding training dates (completed and expiry) into Breathe. The DSL will provide information about

safeguarding training opportunities. She will also check the safeguarding training spreadsheet on a monthly basis to ensure that safeguarding training is up to date and provide prompts to the relevant individuals if not.

7. Supervision

In addition to the support provided by the DSL and Safeguarding Team, all members of staff and volunteers should discuss any safeguarding concerns in clinical supervision. This is to provide the staff member/volunteer with support in relation to staff/volunteer welfare and also for reassurance regarding compliance to policy and best practice.

8. On-going Training

It is the responsibility of the staff, trustees and volunteers to ensure that safeguarding training is undertaken on an ongoing basis; a situation monitored by the DSL.

When the Safeguarding Policy is amended, all members of staff and volunteers must read the policy and are expected to seek support if they do not understand any issues raised.

The DSL may determine that ad-hoc safeguarding training is required to address specific issues raised in de-briefs or reviews. She will plan and organise that training.

Signed on behalf of the Board of Trustees by,

Chair: Katie Bradshaw
Dated: 18th October 2024

Appendix 1- Definitions of Abuse

This document sets out the definitions of abuse. It gives examples of the types of sexual abuse that children and young people may experience. It provides information on recognising signs of abuse and highlighting factors that might suggest an increased risk of abuse. Finally, it gives a definition of significant harm and imminent harm.

1. Abuse

Definitions and signs of child abuse according to the NSPCC 2010 are categorised into types and are defined in the UK Government guidance Working Together to Safeguard Children 2018, pages 103-107. The seven types are:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect
- Exploitation
- Criminal
- County Lines

For the purposes of this policy, RSACC also recognises Radicalisation and Discriminatory Abuse as forms of abuse.

1.1. Abuse

A form of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting by those known to them or, more rarely, by others. Abuse can take place wholly online, or technology may be used to facilitate offline abuse. Children may be abused by an adult or adults, or another child or children.

1.2. Physical abuse

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

1.3. Emotional Abuse

Emotional abuse is the persistent emotional maltreatment of a child/young person such as to cause severe and persistent adverse effects on the child/young person's emotional development. It may involve conveying to children/young people that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of

another person. It may include not giving the child/young person opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children/young people. These may include interactions that are beyond the child/young person's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child/young person participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another.

It may involve serious bullying (including cyber-bullying), causing children/young people frequently to feel frightened or in danger, or the exploitation or corruption of children/young people. Some level of emotional abuse is involved in all types of maltreatment of a child/young person, though it may occur alone.

1.4. Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child or young person is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children/young people in looking at, or in the production of, sexual images, watching sexual activities, encouraging children/young people to behave in sexually inappropriate ways, or grooming a child/young person in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children and young people.

1.5. Neglect

Neglect is the persistent failure to meet a child/young person's basic physical and/or psychological needs, likely to result in the serious impairment of the child/young person's health or development.

Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

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

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

1.6. Radicalisation and Extremism

Radicalisation is comparable to other forms of exploitation. Radicalisation is defined as the process by which people come to support terrorism and violent extremism and, in some cases, to then participate in terrorist groups.

There is no single obvious profile of a person likely to become involved in extremism.

Extremism goes beyond terrorism and includes people who target the vulnerable – including the young – by seeking to sow division between communities on the basis of race, faith or denomination; justify discrimination towards women and girls; persuade others that minorities are inferior; or argue against the primacy of democracy and the rule of law in our society.

Extremism is defined in the Counter Extremism Strategy 2015 as the vocal or active opposition to our fundamental values, including the rule of law, individual liberty and the mutual respect and tolerance of different faiths and beliefs. We also regard calls for the death of members of our armed forces as extremist.

1.7. County Lines

As set out in the Serious Violence Strategy, published by the Home Office, a term used to describe gangs and organised criminal networks involved in exporting illegal drugs into one or more importing areas within the UK, using dedicated mobile phone lines or other form of 'deal line'. They are likely to exploit children and vulnerable adults to move and store the drugs and money, and they will often use coercion, intimidation, violence (including sexual violence) and weapons.

1.8. Child criminal exploitation

As set out in the Serious Violence Strategy, published by the Home Office, where an individual or group takes advantage of an imbalance of power to coerce, control, manipulate or deceive a child or young person under the age of 18 into any criminal activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial or other advantage of the perpetrator or facilitator and/or (c) through violence or the threat of violence. The victim may have been criminally exploited even if the activity appears consensual. Child criminal exploitation does not always involve physical contact; it can also occur through the use of technology.

1.9. Discriminatory abuse

This occurs when values, beliefs or culture result in a misuse of power that denies mainstream opportunities to some groups or individuals. It includes discrimination based on race, culture, gender, sexuality, religion or disability. This is often called Hate Crime and includes forms of harassment, bullying, slurs, isolation, neglect, denial of access to services or similar treatment. Children and young people can be subject to this form of abuse.

1.10. Child sexual exploitation

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

2. Specific forms of sexual abuse that we may encounter at RSACC

2.1. Organised or multiple abuse

This consists of abuse involving one or more abusers and a number of related or unrelated abused children and young people. In some cases the abusers concerned are acting together to abuse children/young people, sometimes they are acting in isolation, or they may be using an institutional framework or position of authority to recruit children/young people for abuse.

Organised and multiple abuse occur both as part of a network of abuse across family or community and within institutions such as residential homes or schools. Such abuse is profoundly traumatic for the child/young person who becomes involved. Its investigation is time-consuming and demanding work requiring specialist skills from both police and social work staff.

2.2. Institutional abuse

This is the collective failure of an organisation to provide an appropriate and professional service to children/young people. It includes a failure to ensure the necessary safeguards are in place and abusive behaviour may be part of the accepted custom and culture within an organisation.

2.3. Intra-familial sexual abuse

This is sexual abuse that is perpetrated by a family member or that takes place within a family context or environment, whether or not by a family member.

These offences reflect the modern family unit and take account of situations where someone is living within the same household as a child and assuming a position of trust or authority over that child, as well as relationships defined by blood ties, adoption, fostering, marriage or living together as partners.

2.4. Child Sexual Exploitation

Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status of the

perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology.

Definition from Glossary to Working Together to Safeguard Children, Department for Children and Families, July 2018

2.5. Domestic Abuse, Forced Marriage and "Honour-based" Violence

Domestic abuse is defined by the Home Office as "any incident or pattern of incidents of controlling, coercive, 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".

The Crown Prosecution Service (CPS) suggests that a forced marriage is "a marriage conducted without the valid consent of one or both parties and where duress is a factor".

The CPS also suggest that 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."

Some children and young people may be at particular risk of forced marriage or "honour-based" violence. Children and young people may also suffer significant harm by seeing or hearing the ill treatment of others (S.120 Adoption & Children's Act 2002). It is important to be mindful of any exposure children and young people may have to domestic abuse or honour-based violence, even where they are not the immediate victims.

2.6. Female Genital Mutilation

The World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) define female genital mutilation as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. The procedure is typically performed on girls aged between 5 and 8, but in some cases, FGM is performed on new-born infants or on young women prior to marriage or pregnancy.

Appendix 2- Recognising Abuse

Abuse can take many forms and it may be regarded not only as the commission or omission of an act, but also as the threat or risk of such. If a child or young person is led to believe that they will be abused this is in effect the equivalent of the abuse taking place.

Abuse may be recent or non-recent.

1. External factors that can influence the risk of abuse

The following factors could increase the child/young person's risk of becoming subject to abuse.

- Parental substance misuse
- Parental mental health difficulties
- Domestic violence
- Social exclusion and isolation
- Stigma and discrimination
- Being the focus of anti-social behaviour (and bullying)
- Overcrowded living arrangements
- Insecure living conditions, homelessness
- Economic insecurity

2. Signs and indicators of abuse

Some of the more obvious signs of abuse may include the following:

- Unexplained or repeated injuries such as bruising, cuts or burns, particularly if situated on a part of the body not normally prone to such injuries.
- An injury for which the explanation seems inconsistent.
- Someone else expresses concern about their welfare.
- Unexplained changes in behaviour (e.g. becoming very quiet, withdrawn or displaying sudden outbursts of temper).
- Appears anxious or frightened
- Engagement in sexually explicit behaviour.
- Difficulty in making friends or is prevented from socialising with others.
- Displays variations in eating patterns including overeating or loss of appetite.
- Loses weight for no apparent reason; frequently hungry
- Becomes increasingly dirty or unkempt.

- Very low self esteem
- Self-harming behaviour

3. Signs and indicators of radicalisation

Indicators of vulnerability to radicalisation include:

- Distance from cultural heritage
- Experience of migration
- Experience of racism and discrimination
- Family members or friends associated with extremist groups
- Family tensions
- Sense of isolation and feelings of failure

4. Acting on signs and indicators

It should be recognised that these not definitive lists of the indicators or abuse or radicalisation. The presence of one or more of the indicators is not proof that abuse/radicalisation is actually taking place. It is not the responsibility of staff or volunteers to decide that abuse/radicalisation is occurring, but it is their responsibility to use their professional judgement and act on any concerns by reporting it.

5. The Concept of Significant Harm

Some children/young people are in need because they are suffering, or likely to suffer, significant harm. The Children Act 1989 introduced the concept of significant harm as the threshold that justifies compulsory intervention in family life in the best interests of children/young people. It gives local authorities a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child/young person who is suffering, or likely to suffer, significant harm.

In Section 31(9) of the Children's Act 1989, "harm" is defined as:

- ill-treatment or the impairment of health or development [including, for example, impairment suffered from seeing or hearing the ill-treatment of another];
- "development" means physical, intellectual, emotional, social or behavioural development;
- "health" means physical or mental health; and
- "ill-treatment" includes sexual abuse and forms of ill-treatment which are not physical.

Section 31(10) of the Children's Act 1989 suggested that the question of whether harm suffered by a child is significant turns on the child's health or development, her health or

development should be compared with that which could reasonably be expected of a similar child. This definition was clarified in section 120 of the Adoption and Children Act 2002 so that it may include, "for example, impairment suffered from seeing or hearing the ill treatment of another".

Every child/young person who is accessing RSACC's services is likely to have suffered harm in the form of sexual violence. Whether that harm has had a significant impact on the child's health and development is dependent on a number of factors all unique to the individual child. It is similarly difficult to assess how significant the impact of any subsequent harm will be on a child/young person.

There is no currently statutory requirement to report childhood sexual violence or abuse. Whilst this remains the case, it is a matter of personal judgment as to whether a child/young person accessing our services, who discloses sexual violence or abuse, is being, or is likely to be, subject to significant harm.

If you are unclear as to whether a child/young person has experienced significant harm, please discuss this with your service lead or supervisor.

6. Imminent harm/danger

A child/young person is considered to be in imminent harm if there is an immediate risk to their life.

RSACC
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Continuum of Need Indicators

DARLINGTON Safeguarding Children Board

	Level 1 – Achieving Expected Outcomes	Level 2 – Children with additional needs (Single Agency)	Level 3 – Children with multiple and complex needs (EHA + multi agency input)	Level 4 – Children with acute needs, including protection (Safeguarding)
Development Needs of unborn child, child and young person				
Health	Physically well	Susceptible to minor health problems	Severe/chronic health problems	Severe/chronic health problems & appropriate services not being accessed. Life threatening health problems. Fictitious illness.
	Balanced healthy diet/good hygiene/clothing	Adequate diet	Problematic diet e.g. obesity, faltering growth	Severe health effects from problematic diet
	Development checks/immunisations up to date, health appointments kept, incl. ante-natal	Slow in reaching developmental milestones. Starting to default on appointments	Slow in reaching developmental milestones. Non attendance for appointments	Developmental milestones unlikely to be met. Non organic faltering growth
	All physical health needs met	Minor concerns regarding diet/hygiene/clothing	Escalating concerns regarding diet/hygiene/clothing	Regularly unfed. Very unclean/dirty, clothing smell
	Speech & language development appropriate	Emerging speech & language difficulties	Failure to access / engage with some speech & language services	Significant impact of not accessing or engaging with speech and language support
	Dental and optical care as required	Defaulting on dental and optical appointments	Dental and optical concerns not being met	Severe impact from dental and optical concerns not being met
	Sexual activity and awareness appropriate for age	Emerging concerns around sexual language/ activity and awareness	Increasing risk of vulnerability from sexual activity and awareness (inc teenage pregnancy) Sexually inappropriate behaviour Risk of sexual grooming	Child Sexual exploitation/ evidence of sexual grooming Sexual abuse Sexually harmful behaviour
	Good state of mental health & emotional well-being	Emerging concerns around mental health & emotional well-being	Significant concerns not being met. Failure to access support and services	Serious mental health issues. Serious risk to self or others. Sustained bouts of depression/self-harm. Threats of suicide
	No use or exposure to substances	Exposure to substances which impact on health and development	Exposure to problematic use of substances. Experimental use by adolescent	Problematic and chaotic use of substances which impact significantly on the health and well-being of the child. Class A drug use or daily use of any substance by an adolescent
Learning and Education	Success/achievement. reaching educational potential	Not thought to be reaching educational potential. Some identified learning needs that require school-based support	Identified learning needs that are not being met. Evidence of non-engagement with appropriate support	
	Regular school attendance and good punctuality	Pattern of irregular school attendances	Some fixed term exclusions. Permanent exclusion. High percentage of non-attendance	Repeated permanent school exclusion. Permanent school exclusion with other risk factors
	Age appropriate cognitive development. Positive and stimulating environment	Reduced access to books/toys. Not always engaged in learning, e.g. poor concentration, low motivation & interest	No access to leisure activities/stimulation. No interests/skills displayed	Denied access to stimulation
Emotional and Behavioural	Feelings & actions demonstrate appropriate responses	Some difficulties with peer group relationships & adults (e.g. bullying and harassment). Evidence of inappropriate responses & actions	Difficulty coping with anger, frustration & upset. Involvement in anti-social behaviour	Regularly involved in anti-social/criminal activities
	Good quality attachment with caregivers	Disrupted attachment due to parental or child factors. Can be overfriendly or withdrawn with strangers	Disruptive/challenging behaviour by parent or child linked to poor attachment	Dysfunctional attachment between parent and child leading to significant harm
	Behavioural difficulties well managed	Emerging difficulties around managing challenging/disruptive behaviour	Challenging / disruptive behaviour impacting on daily life, achievement & relationships etc.	Challenging / disruptive behaviour putting others or self in danger Involvement in gang violence
	Child/ young person always where they are supposed to be	Occasional absences without permission from home/ care/ learning setting	Persistent/ pattern of absences from home/ care /learning setting	Missing from home/ care/ learning setting
Identity	Positive sense of self & abilities. An ability to express needs	Some insecurities around identity expressed, e.g. low self-esteem for learning	Subject to discrimination e.g. racial, sexual or due to disabilities. Demonstrates significantly low self esteem	Experiences persistent discrimination e.g. based on ethnicity, sexual orientation or disability. Alienates self from others
	No young caring responsibilities within family network	Some appropriate responsibility for providing care	Caring responsibilities impacting on daily life, achievement & relationships etc.	High level of caring task impacting on life chances and emotional well-being
	Good relationship with siblings	Has some difficulties sustaining relationships	Some level of risk to or from siblings	Family breakdown related to child's behavioural difficulties
	Positive relationships with peers	Has some difficulties sustaining relationships with peers	Isolated from peers. Peers also involved in challenging behaviour. Missing school or leisure activities	Isolation affecting development. or increasing risk of exploitation. No access to appropriate peer group
	Family support child in development of self-identity	Family struggling to accept child's self-identity	Family very negative about child's developing self-identity	Family's negative response to child's self-identity impacting significantly on child's well-being
Social Presentation	Appropriate dress for different settings	Frequently inappropriately dressed for setting	Presentation leads to isolation from peer groups and is impacting on development	Presentation is significantly impacting on development or leading to severe isolation
	Good level of personal hygiene	Level of hygiene causing concern	Poor hygiene manifesting in physical difficulties (e.g. sores)	Experiencing significant issues or clear impairments. No engagement with services to address concerns

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Self-care Skills	**Growing level of competencies in practical & emotional skills such as feeding, dressing and independent living skills**	Appears to be lacking appropriate self-care	Carer expectations or living circumstances not age or developmentally appropriate. Inappropriate young caring responsibilities	**Child or young person neglects to use self-care skills due to alternative priorities or parental factors such mental health or substance misuse**
Parenting Capacity				
Basic Care	**Provide for children's physical needs; food, drink, appropriate clothing, medical & dental care**	Inconsistent meeting of child's needs by parent	Parent failing to engage & sustain engagement with services that could assist in meeting child's needs. Parent consistently not meeting basic care needs. Parent resistant to change	**Parents unable to provide "good enough" parenting that is adequate and safe**
	Parenting history supporting positive parenting	Parental history beginning to impact on care of own children	Parental history impacting on ability to care for child	**Parental history impacting significantly on ability to care for child**
	Parents meeting own health needs	Parents failing to attend to own health needs	Parents' failure to attend to health needs impacting on child or unborn child	**Unmet health needs of parents which significantly impacts life chances of child or unborn child**
	No parenting issues identified	Parent requires advice on parenting issues	Parent is struggling to provide adequate care. No improvement despite provision of adequate early help service	**Parents unable to care for previous children. Parenting significantly impacting on child's well-being**
Ensuring Safety	**Able to protect from danger or significant harm in the home & elsewhere**	Some exposure to dangerous situations in home/community. Parental stresses starting to affect ability to ensure child's safety	Perceived to be a problem by parent. Family coming to the attention of agencies due to risk. Parents not acknowledging risk or responding to advice and support	**Instability & risk in the home continually. Parental lifestyle exposing child to significant risk. Lack of response to early help intervention leading to increased risk**
			Continued threats of physical abuse	**Physical abuse**
Emotional Warmth	**Shows warm regard, praise and encouragement**	Inconsistent responses to child by parents. Emerging attachment difficulties	Erratic/inconsistent care leading to negative impact on child. Parental instability affects capacity to nurture	**Parents inconsistent, highly critical or apathetic towards child or pregnancy**
	Able to develop positive relationships	Parent appears to be isolated in the community	Inability to retain positive relationships	**Parental isolation impacting significantly on child's emotional development and life chances**
Stimulation	**Facilitates cognitive development through interaction and play**	Limited development and failure to access universal services	Not receiving positive stimulation - lack of new experiences and activities. Engagement with support unsustained. Not attending pre-school setting	**Child development adversely affected by lack of stimulation and support**
Guidance & Boundaries	**Appropriate guidance and boundaries consistently in place**	Appropriate guidance and boundaries lacking or inconsistent	Absence of appropriate guidance or boundaries putting child at risk. Child experiencing difficulties or putting themselves at risk in other settings	**No effective boundaries or guidance set by parents placing child at significant risk. Beyond parental control**
Stability	**Consistent parenting leading to secure attachment**	Parents not prioritising child's needs due to parental stresses	Frequent change of care-giver leading to instability. Lack of focus on child	**Parent not prioritising child's needs above their own, significantly impacting on childs life chances**
Family and Environmental Factors				
Family History	**Good relationship with family, including where parents are separated**	Child not able to access full range of family relationships. Acrimonious divorce/separation	Dysfunctional relationships between family members,	**Significant parental discord e.g. persistent domestic violence, or serious physical or mental health difficulties**
		Child comes from a community which exercises female genital mutilation, breast pounding, breast ironing	Parental, family member experienced female genital mutilation, breast pounding, breast ironing	**Child fears or experienced Forced marriage, Honour based violence, Female genital mutilation (FGM) Breast ironing, breast pounding**
Wider Family	**Sense of larger family network. Good relationships outside the family**	Family has poor relationship with extended family/little communication	No effective support from extended family	**Destructive/unhelpful involvement from extended family**
Housing	**Accommodation has basic amenities and appropriate facilities**	Accommodation in poor state of repair, temporary or overcrowded	Physical accommodation impacting on child health and parents taking no action. Family at risk of becoming homeless (intentionally or other)	**Physical accommodation places child in danger and experiencing significant neglect. Family at immediate risk of homelessness**
Employment	**Parents are able to manage the working or unemployment arrangements & do not perceive them as unduly stressful**	Parents stressed due to overworking or unemployment	Chronic unemployment that has severely affected child & parent's aspirations and engagement with education & employment	**Parents choice of non-legitimate employment impacts on child**
Income	**Reasonable income over time, with resources used appropriately to meet individual needs**	Poor allocation of funds & resources that impact on child. Poor debt management. Lack of take-up of benefits and available resources	Serious debts/poverty impacting on ability to have basic needs met	**Extreme poverty/debt impacting on ability to care for child. Family requires emergency financial assistance. No access to public funds**
Social Integration	**Family feels integrated into the community**	Some tension exists preventing the family feeling fully integrated into the community Children/ young people accessing/ saying/ expressing intolerant/ inappropriate radical views Family/ community members holding extremist views	Family socially excluded and / or vulnerable in the community, e.g. are experiencing frequent or persistent anti-social behaviour or hate crime, Risk of ideological grooming/ child holding extremist views	**Family experiencing frequent or persistent anti-social behaviour/hate crime/racists incidents which is having a significant impact on family well-being** **Concerns about/ children at risk of Radicalisation**
	Good social network exists	Lack of support network	No supportive network	**Unaccompanied minors** **Child trafficked/ at risk of trafficking**
Community Resources	**Good use of available universal services in the neighbourhood.**	Poor use of available universal services in the neighbourhood.	Lack of access to universal services impacting on family.	

Appendix 3- A Child and Young Person's Legal Rights

1. Gillick Competency and Fraser Guidelines

When we are trying to decide whether a child or young person is mature enough to make decisions, we often talk about whether a child or young person is 'Gillick competent' or whether they meet the 'Fraser guidelines'. The Gillick competency test and Fraser guidelines help us all to balance children/young people's rights and wishes with our responsibility to keep children/young people safe from harm.

These are two different concepts: Fraser guidelines refers to specific guidance that must be followed by a health-care professional to provide specific treatment to a child; and Gillick Competency refers to the ability of the child to give consent to matters other than medical matters without the consent of their parents.

1.1. What do 'Gillick Competency' and 'Fraser Guidelines' refer to?

Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. But since then, they have been more widely used to help assess whether a child or young person has the maturity to make their own decisions and to understand the implications of those decisions.

In 1982 Mrs Victoria Gillick took her local health authority and the Department of Health and Social Security to court in an attempt to stop doctors from giving contraceptive advice or treatment to under 16-year-olds without parental consent. The case went to the High Court in 1984 where Mr Justice Woolf dismissed Mrs Gillick's claims.

> *"...whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent."* (Gillick v West Norfolk, 1984)

1.2. How is Gillick Competency assessed?

Lord Scarman's comments are often referred to as the test of "Gillick competency":

> *"...it is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved."*

He also commented more generally on parents' versus children's rights:

> *"Parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision."*

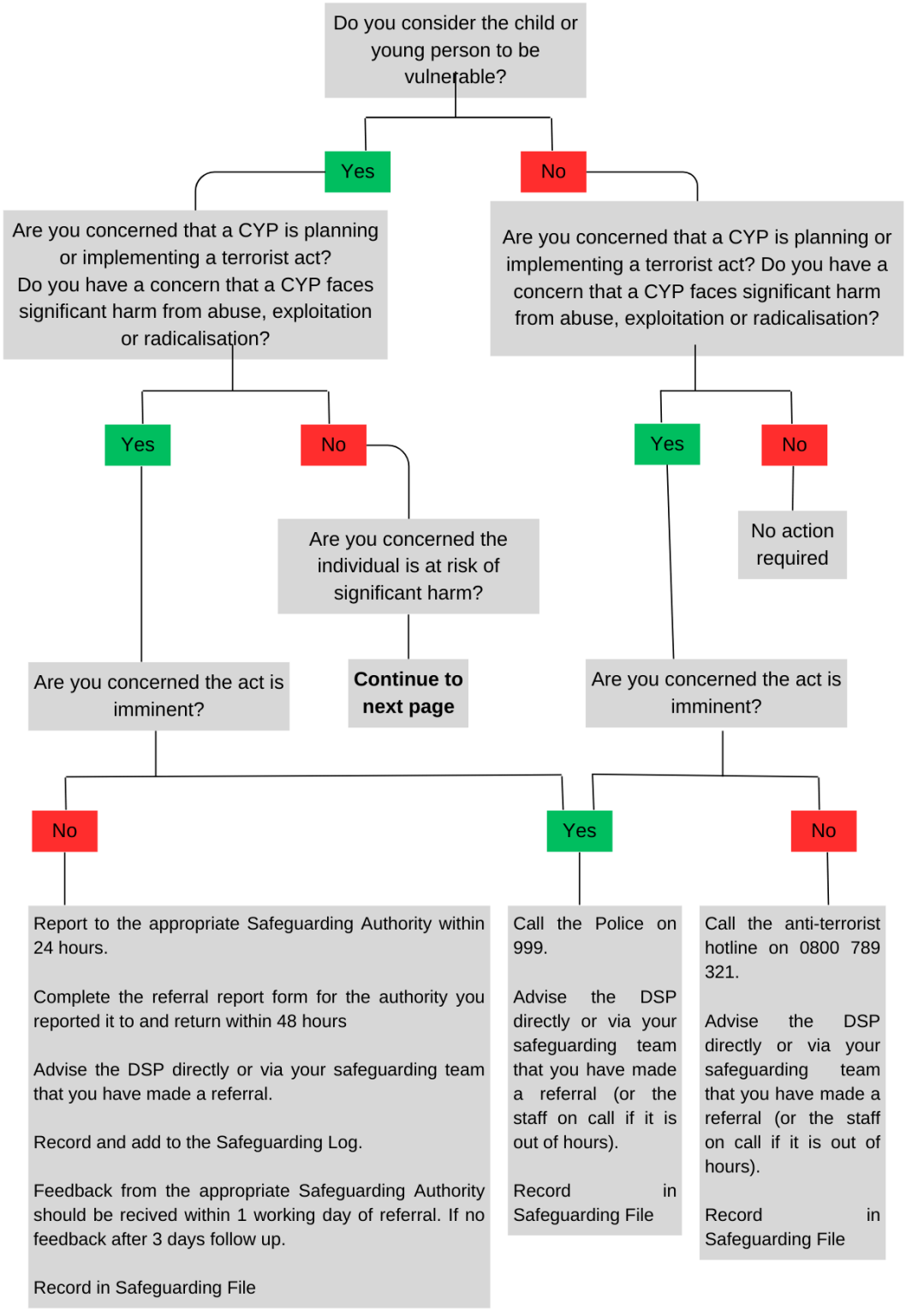
1.3. How are the Fraser Guidelines applied?

The Fraser guidelines refer to the guidelines set out by Lord Fraser in his judgement of the Gillick case in the House of Lords (1985), which apply specifically to contraceptive advice. Lord Fraser stated that a doctor could proceed to give advice and treatment "provided he is satisfied in the following criteria:

1. that the girl (although under the age of 16 years of age) will understand his advice;
2. that he cannot persuade her to inform her parents or to allow him to inform the parents that she is seeking contraceptive advice;
3. that she is very likely to continue having sexual intercourse with or without contraceptive treatment;
4. that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer;
5. that her best interests require him to give her contraceptive advice, treatment or both without the parental consent."

Although these criteria specifically refer to contraception, the principles are deemed to apply to other treatments, including abortion. Fraser Guidelines referred specifically to doctors, but it is considered to apply to other health professionals, including nurses. It may also be interpreted as covering youth workers and health promotion workers who may be giving contraceptive advice and condoms to young people under 16, but this has not been tested in court.

Appendix 4 - Safeguarding Flowchart



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Darlington and County Durham

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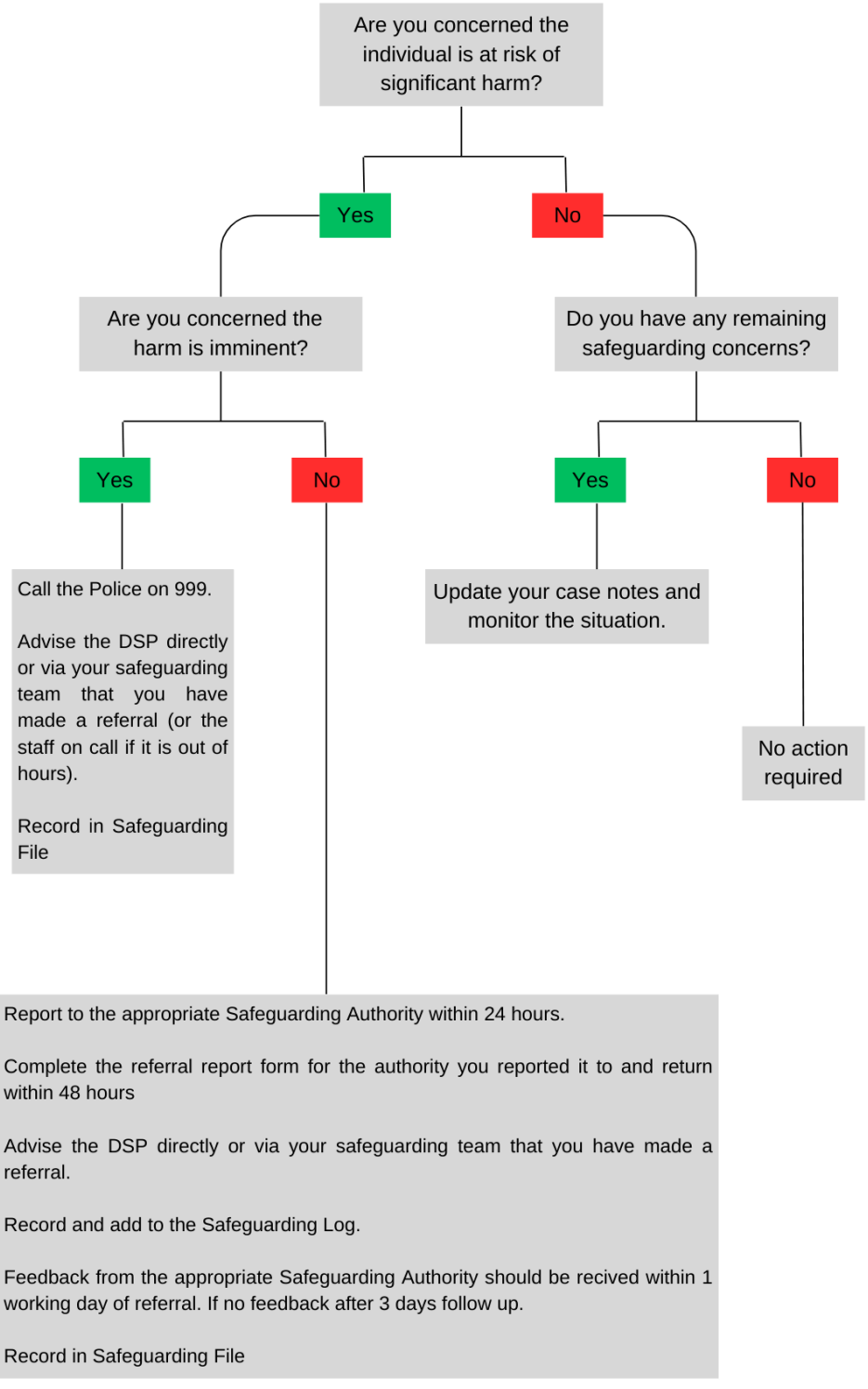

Appendix 5- Staff and Volunteer Conduct

1. Good practice guidelines

All staff and volunteers should demonstrate exemplary behaviour in order to protect themselves from allegations of misconduct and maintain their standards of behaviour therefore acting as a role model. The following are common sense examples of how to create a positive culture and climate.

1.1. Good practice means:

- Always work in a safe environment and place approved by RSACC, for example a designated outreach base.
- Never work with a child/young person without cover from a designated colleague (buddy) or approved person at your outreach base.
- Never make physical contact with a client. There may be occasions when a distressed client needs comfort. This should be done verbally and your boundaries should be sensitively relayed to the client in a way they can understand the reasons why you can't touch them / hug them so that the client does not feel rejected. This will minimise any hurt feelings. If a situation arises and you are concerned, you must report this to your line manager/clinical supervisor as soon as possible.
- Treat all children/young people equally with respect and dignity. RSACC will take positive action to eliminate discrimination against any person or group of people. Staff and volunteers should ensure that children/young people are protected from discrimination on any grounds, including ability and challenge discriminating comments and behaviour. All RSACC activities should be designed to include all children/young people (over the age of 13) and to promote positive attitudes towards differences.
- Be clear about what the objectives of the service you are providing before it begins and always put the welfare of each child/young person first. Always explain in language the individual can understand.
- Maintain a safe and appropriate distance with children/young people (e.g. it is not appropriate for staff or volunteers to have an intimate relationship with a child/young person or anyone using the RSACC services).
- Building balanced relationships based on mutual trust which empowers children/young people to share in the decision-making process.
- Conduct yourself in a manner that sets a good example to any child/young person involved in RSACC. Be an excellent role model.

- Giving enthusiastic and constructive feedback rather than negative criticism.
- If an incident occurs remain calm and get the attention and support of other staff. The incident should be recorded in writing, with a witness statement (where possible), immediately afterwards.
- Always adhere to the Safeguarding policies.
- Question any unknown adult who enters the RSACC premises with the child/young person and / or who attempts to engage with the child/young person.

1.2. Practices never to be sanctioned:

- Engaging in rough, physical or sexually provocative games, including horseplay.
- Engaging in any form of inappropriate touching.
- Children/young people's inappropriate use of language and/or behaviour: This should always be challenged.
- Sexually suggestive comments to a child/young person, even in fun.
- Reducing a child/young person to tears as a form of control.
- Allegations made by a child/young person being unchallenged, unrecorded or not acted upon.
- Having intimate relationships with children/young people or anyone using the RSACC services.

Appendix 6- Police & Local Authority Contact Details

Area	Tel no	Website & Address	Any other information
Durham Police	**999** **101 for non emergencies**	https://www.durham.police.uk/	
Darlington	Telephone: **01325 406252** (Professional) Telephone: **01325 406222** (Public) Out of hours call Emergency Duty Team on **01642 524552**	Children's Initial Advice Team (CIAT) www.darlington-safeguarding-partnership.co.uk/about-us/concerned-about-a-child/ Early help Effective early help relies upon local organisations and agencies working together to: •identify children and families who would benefit from early help •undertake an assessment of the need for early help •provide targeted early help services to address the assessed needs of a	The CIAT is open during the following hours: Monday – Thursday: 8:30am – 5pm Friday: 8:30am – 4:30pm Emergency Duty Team 01642 524552

		child and their family which focuses on activity to improve the outcomes for the child Email to send Part A & B www.childrensfrontdoor@darlington.gov.uk	
Darlington	**01325 406222** Out of hours call Emergency Duty Team on **01642 524552** Or minicom **01642 602346**	Children's Access Point (CAP) www.darlingtonsafeguardingboards.co.uk/children-safeguarding-board/concerned-about-a-child/ Email: **childrensaccesspoint@darlington.gov.uk**	The CAP is open during the following hours: Monday - Thursday: 8:30 am - 5:00 pm Friday: 8:30 am - 4:30pm
Durham	**First Contact/Social Care Direct** **03000 267 979** **Or minicom 0191 383 5752**	If you have a concern about a child or young person's welfare who lives in County Durham, call First Contact Email: scd@durham.gov.uk	First Contact is open from 8.30am until 5.00pm, Monday to Thursday and from 8.30am until 4.30pm on a Friday. In an **emergency situation**, a duty officer is available outside of normal office hours. If faxing or emailing outside of normal working office hours, please be aware that these enquiries will be

			dealt with on the next working day.

Appendix 7- Safeguard Check list

Please use this as guidance to gather the information you will need to make a safeguard referral if you don't have access or can't access the relevant Local Authority Safeguarding Referral Form.

As far as possible gather the information with the person present so that they are part of the process and so you know the information you will be passing on is accurate and relevant:

- Names of person(s) you have concerns about
- Age(s) and Date of Birth
- Ethnicity
- Disability
- Address(s)
- Any siblings details (regardless of concerns at this stage)
- Reason for the referral - accurate, factual information about what you have been told
- Who gave the information to you
- Date and time information was given
- If anyone else was present
- Has consent been given by the individual raising the concern (adult/ child or young person) for you to pass concerns on (and if not, state why not)
- Do the parent(s) / carer(s) know you are passing concerns on (and if not, state why not)

Appendix 8- Designated Safeguarding Lead Responsibilities

The DSL key responsibilities are as follows:

- To play a lead role in developing and establishing the organisations approach to safeguarding children & young people and provide advice, support and guidance to RSACC workers on safeguarding issues
- To manage referrals to local authority children's safeguarding team and the police
- To be a central point of contact for internal and external individuals and agencies for all issues relating to safeguarding
- To provide debriefing for any individuals who have made referrals
- To represent the organisation at external meetings relating to safeguarding, for example, Child Safeguarding Practice Reviews or Child Death Reviews
- To play a lead role in ensuring safeguarding requirements are met in relation to recruitment, training and induction.
- To play a lead role in maintaining and reviewing the RSACC safeguarding policies to ensure they are up to date with legislation and any learning has been identified and incorporated
- To ensure safeguarding standards are met and maintained and accurate records are filed appropriately and kept up to date.
- To ensure safeguarding training is provided to all individuals, staff, volunteers and trustees and that the training is repeated every 2 years.