The HangOut (THO) Safeguarding and Child Protection Policy

Policy Statement

THO recognises our responsibility to safeguard and protect the welfare of all children, young people and vulnerable adults, and is committed to practice which protects them.

This policy has been produced with reference to the DSCB and the DSAB.

Contacts

THO's designated Safeguarding Officer (SGO) is our CEO Pat Holt. For any safeguarding concerns the SGO can be contacted on 07946280593 or by emailing thehangoutwales@gmail.com .

If concerns need to be raised outside the organisation, there is a single point of contact in Carmarthenshire: Children's Advice and Duty Service 01554 742322. And for adults, Delta Wellbeing on 03003332222 or make a referral through the website www.carmarthenshire.gov.uk

If you believe someone is in immediate danger, then please call 999.

Definitions, Safeguarding Training Levels and Supervision requirements

(duplicated in SR policy)

Staff and Volunteers

Staff: an adult who is employed to work for us in a paid capacity. All staff must go through our full safer recruitment process, including DBS checks and references and must complete level 3 safeguarding training before working unsupervised, updated every 3 years. Our designated Safeguarding Officer must in addition have safer recruitment training and update training every 2 years.

Volunteer: an adult who is donating their time to work for us in an unpaid capacity. We differentiate between types of volunteers as follows:

- **Independent Adult Volunteers:** These volunteers have been through the entire safer recruitment process including references and DBS checks and internal level 2 safeguarding training (updated annually), before they can work unsupervised. Any contact they have with young people or participants is supervised.
- **Trustees:** Members of the community or ex-participants who sit on our board, governing all aspects of the organisation. Those who will ONLY have supervised contact with *Participants* have Level 1 safeguarding training, updated annually; those who have unsupervised contact must undertake level 2 training, and the designated Safeguarding Trustee must have level 3 safeguarding training, updated every 3 years.
- **Visitors and Service Users (adults or children over 8yrs):** These help with yard, pasture or garden management as a way of improving their wellbeing or employment skills. These are supervised at all times by *Staff*. All adults and children will undertake internal level 2 safeguarding and safer culture training within 1 month of first attendance, updated annually. These may be:
  - Service users seeking to progress and give back;
  - Community members wanting to be useful whilst improving their own wellbeing;
  - Visiting groups (e.g. Corporate CSR) engaged in a self-contained project;
  - Those who have applied to be an independent volunteer but have not yet completed all the safer recruitment processes, and trainings.

  NB. Only adults can apply to progress from supervised to unsupervised volunteers.
- **Participants**: service users (adults or children over 8yrs) receiving intensive staff support. *Participants* are supervised at all times by a member of *Staff*.
- **Children:** any child or young person under the age of 18 years. We require children under 8yrs old to be supervised by a carer at all times. Children and young people from 8-18yrs old are supervised at all times by *Staff.*

Group sizes and supervision ratios: Children and young people are always supervised whilst in our care, as are our *Participants* and *supervised volunteers*. Our maximum number of participants to *Staff* is 8:1, or 6:1 if any are under 8yrs. Groups are dynamically risk assessed by *Staff* with managers on a continual basis taking account of individual needs and vulnerabilities, and groupings and/or support are altered accordingly. Individuals with specific vulnerabilities are provided with 1:1 support if a group setting is difficult for them.

Training delivery

Our staff and *SH* undertake level 3 Safeguarding training delivered by a recommended provider. All

other volunteers and *Heros* receive level 2 which is delivered in-house by our level 3 *Staff* or *SH*. Our level 2 training is based on our L3 online training with additional safer culture guidance on appropriate friendships, lifts, social media, photographs/video, gossiping and centre-specific information to inform trainees of our policies and processes, who to go to with concerns, how to escalate, whistleblow or complain and the contact information for our local safeguarding organisations

SAFEGUARDING CHILDREN

As an organisation we must:

- Be alert to potential indicators of abuse or neglect;
- Be alert to the risks which individual abusers, or potential abusers, may pose to children;
- Share and help to analyse information so that an assessment can be made of the child's needs and circumstances;
- Contribute to whatever actions are needed to safeguard and promote the child's welfare;
- Take part in regularly reviewing the outcomes for the child against specific plans;
- Work co-operatively with parents, unless this is inconsistent with ensuring the child's safety.

Our procedures are based on the Working Together to Safeguard Children Guidance 2018 and the **Keeping children safe in education Guidance 2020. Working Together to Safeguard Children** sets out what should happen in any local area when a child or young person is believed to be in need of support. Effective safeguarding arrangements should aim to meet the following two key principles:

- Safeguarding is everyone's responsibility: for services to be effective, each individual and organisation should play their full part; and
- A child-centred approach: for services to be effective, they should be based on a clear understanding of the needs and views of children.

The most up-to-date government definition of Safeguarding is:

- Protecting children from maltreatment;
- Preventing impairment of children's mental and physical health or development;
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable all children to have the best outcomes.

DEFINITIONS

The Concept of Significant Harm

Some children 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, and gives local authorities a duty to make

enquiries (Section 47) to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or likely to suffer, significant harm.

Additionally, a Court may only make a Care Order or Supervision Order in respect of a child if it is satisfied that:

- The child is suffering, or is likely to suffer, significant harm; and
- The harm, or likelihood of harm, is attributable to a lack of adequate parental care or control (Section 31).

In addition, 'harm' is defined as the ill treatment or impairment of health and development. This definition was clarified in section 120 of the Adoption and Children Act 2002 (implemented on 31 January 2005) so that it may include 'impairment suffered from seeing or hearing the ill treatment of another' for example, where there are concerns of domestic violence and abuse.

There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, the extent of premeditation, and the presence or degree of threat, coercion, sadism and bizarre or unusual elements.

Each of these elements has been associated with more severe effects on the child, and/or relatively greater difficulty in helping the child overcome the adverse impact of the maltreatment.

Sometimes, a single traumatic event may constitute significant harm (e.g. a violent assault, suffocation or poisoning). More often, significant harm is a compilation of significant events, both acute and longstanding, which interrupt, change or damage the child's physical and psychological development.

Some children live in family and social circumstances where their health and development are neglected. For them, it is the corrosiveness of long-term neglect, emotional, physical or sexual abuse that causes impairment to the extent of constituting significant harm.

From 21st March 2022, Physical punishment of a child is Illegal in Wales.

There are lots of types of physical punishment. It can mean smacking, hitting, slapping and shaking. But there are other types too. It isn't possible to give a set list of what makes up physical punishment because it can be anything where a child is punished using physical force.

Research suggests that any type of physical punishment could be harmful to children.

What's the law on physical punishment in Wales?

- All physical punishment is illegal in Wales.
- Children have the same protection from assault as adults.

- This means the law is clear - easy for children, parents, professionals and the public to understand.
- The new law applies to everyone - parents or anyone who is responsible for a child while the parent is absent.

And as with other laws, it applies to visitors to Wales too.

Physical punishment has been illegal in schools, children's homes, local authority foster care homes and childcare settings for some time.

Anyone who physically punishes a child:

- will be breaking the law
- risks being arrested or charged with assault
- may get a criminal record which is the same for any criminal offence

Definitions of Child Abuse and Neglect

The following definitions are based on those identified in Working Together to Safeguard Children 2015:

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 (e.g. via the internet). They may be abused by an adult or adults, or another child or children.

Physical Abuse

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

Assault of children is against the law.; and if any adult causes physical or psychological injury to a child, or mistreats a child, they could be prosecuted for committing a criminal offence.

Emotional Abuse

The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond a child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

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

Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Sexual Abuse

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

Neglect

The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

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

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

Children with special educational needs and disabilities

Children with special educational needs (SEN) and disabilities can face additional safeguarding challenges. Additional barriers can exist when recognising abuse and neglect in this group of children. These can include:

- Assumptions that indicators of possible abuse such as behaviour, mood and injury relate to the child's disability without further exploration;
- Being more prone to peer group isolation than other children;
- The potential for children with SEN and disabilities to be disproportionately impacted by behaviours such as bullying, without outwardly showing any signs; and
- Communication barriers and difficulties in overcoming these barriers.

Peer abuse

We are vigilant for peer on peer abuse. We provide appropriate supervision of all the young people in our care to prevent it happening; we record allegations in our safeguarding records, and report appropriately; we will offer appropriate support to any victim and will not tolerate abuse or pass it off as "banter", "just having a laugh" or "part of growing up". Concerns must be reported to the THC Safeguarding officer.

All staff and volunteers must be aware that safeguarding issues can manifest themselves via peer on peer abuse. This is most likely to include, but may not be limited to:

- Bullying (including cyberbullying);
- Physical abuse such as hitting, kicking, shaking, biting, hair pulling, or otherwise causing physical harm;
- Sexual violence and sexual harassment;
- Sexting (also known as youth produced sexual imagery); and
- Initiation / hazing type violence and rituals

Domestic Violence and Abuse

Research analysing Serious Case Reviews has demonstrated a significant prevalence of domestic abuse in the history of families with children who are subject of Child Protection Plans. Children can be affected by seeing, hearing and living with domestic violence and abuse as well as being caught up in any incidents directly, whether to protect someone or as a target. It should also be noted that the age group of 16 and 17 year olds have been found in recent studies to be increasingly affected by domestic violence in their peer relationships and Adolescent Parental Violence is also now recognised.

It should therefore be considered in responding to concerns that the Home Office definition of domestic violence and abuse (2013) is as follows: "Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence and abuse between those aged 16 or over, who are or have been intimate partners or family members regardless of gender and sexuality.

This can encompass, but is not limited to, the following types of abuse:

- Psychological;
- Physical;
- Sexual;
- Financial;
- Emotional.

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

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

The issue of domestic violence and abuse will only ever be raised with a child or mother when they are safely on their own and in a private place.

Information from the public, family or community members will be taken seriously. Recent research evidence indicates that failure to do so has been a contributory factor in a significant number of cases where a child has been seriously harmed or died.

We will never assume that somebody else will take care of domestic violence and abuse issues. If we receive a disclosure this may be the child, mother or abusing partner's first or only disclosure or contact with services in circumstances which allow for safeguarding action – we will make the appropriate referral.

Potential Risk of Harm to an Unborn Child

In some circumstances, we may be in a position to anticipate the likelihood of significant harm with regard to an expected baby (e.g. where there is information known about domestic violence, parental substance misuse or mental ill health). We will refer any such concerns.

OUR RESPONSE

Overview

We have a clear Code of Conduct, which is actively promoted and enforced, with a clear commitment to treat everyone fairly and with respect. This includes a commitment that under no circumstances should any staff member or volunteer inflict physical or psychological harm to a child.

We train and continually update staff, trustees and volunteers to take an active role in safeguarding. They must:

- Be alert to potential indicators of abuse or neglect;
- Be alert to the risks which individual abusers or potential abusers, may pose to children;
- Be alert to the impact on the child of any concerns of abuse or maltreatment;
- Be able to identify potential or actual harm to children;
- Record and discuss concerns with our safeguarding lead (able to offer advice and decide upon the necessity for a referral to Children's Social Care or other route).

We will make a referral to Children's social care if there are signs that a child or an unborn baby:

- Is suffering significant harm through abuse or neglect;
- Is likely to suffer significant harm in the future.

The timing of such referrals will reflect the level of perceived risk of harm, not longer than **within one working day** of identification or disclosure of harm or risk of harm.

Urgent Concerns

Where a child needs immediate protection prompt action will be taken.

We will contact local Children's Social Care or the police about their concerns directly and to complete the appropriate referral form, if there are urgent concerns.

In such circumstances a formal referral to Children's social care, the police or accident and emergency services (for any urgent medical treatment) must not be delayed by the need for consultation with management or the safeguarding children lead, or the completion of an assessment.

In urgent situations, out of office hours, the referral should be made to the Pole or Out of Hours Social Services.

Hearing and Observing the Child

Whenever a child reports that they are suffering or have suffered significant harm through abuse or neglect, or have caused or are causing physical or sexual harm to others, the initial response from all

practitioners should be to listen carefully to what the child says and to observe the child's behaviour and circumstances to:

- Clarify the concerns without questioning the child;
- Offer re-assurance about how the child will be kept safe if this is known and is certain;
- Explain what action will be taken and within what timeframe.

The child must not be pressed for information, led or cross-examined or given false assurances of absolute confidentiality, as this could prejudice police investigations, especially in cases of sexual abuse.

If the child can understand the significance and consequences of making a referral to Children's social care, they should be asked for their views.

It should be explained to the child that whilst their view will be taken into account, we have a responsibility to take whatever action is required to ensure the child's safety and the safety of other children.

Parental Consultation

Concerns which have been raised, should, where practicable, be discussed with the parent and agreement sought for a referral to Children's social care **unless** seeking agreement is likely to place the child at risk of significant harm through delay or from the parent's actions or reactions; For example in circumstances where there are concerns or suspicions that a serious crime such as sexual abuse, domestic violence or induced illness has taken place. If in doubt, seek advice from Children's Social Care staff.

Where a practitioner decides not to seek parental permission before making a referral to Children's social care, the decision must be clearly noted in the child's records with reasons, dated and signed and confirmed in the referral to Children's social care. Practitioners should consult with their line manager/designated/ safeguarding children lead, if at all practicable, for advice.

When a referral is deemed to be necessary in the interests of the child, and the parents have been consulted and are not in agreement, the following action should be taken:

- The reason for proceeding without parental agreement must be recorded;
- The parent's withholding of permission must form part of the verbal and written referral to Children's social care;
- The parent should be contacted to inform them that, after considering their wishes, a referral has been made.

A child protection referral from a practitioner cannot be treated as anonymous and where any court proceedings may follow, whether criminal or family court, the information may be made available.

Urgent Medical Attention

If the child is suffering from a serious injury, we will seek medical attention immediately from accident and emergency services and must inform Children's social care, and the duty consultant paediatrician at the hospital.

Making a Referral

Any suspicion, allegation or incident should be recorded and discussed with the THO Safeguarding Officer as soon as possible. If the Safeguarding Officer is not available then the individual must seek guidance from the most senior staff member available or the THO Trustee responsible for Safeguarding.

It is the responsibility of the Safeguarding Officer or the individual to inform the Childrens Advice and Duty Service without delay if deemed appropriate.

Referrals should be made to Children's social care for the area where the child is living or is found.

There is no written referral but records of all telephone calls will be kept by the consultant duty social worker. We should keep our own records of referrals we have made to the Childrens Advice and Duty Service.

Children's social care should within **one working day** of receiving the referral make a decision about the type of response that will be required to meet the needs of the child. This decision will be communicated to the referrer. If this does not occur within three working days, the referrer should contact these services again and, if necessary, ask to speak to a line manager to establish progress.

Concerns Raised by a Member of the Public

When a member of the public telephones or approaches us with concerns about the welfare of a child or an unborn baby, we will:

- Gather as much information as possible, to be able to make a judgement about the seriousness of the concerns;
- Take basic details:
    1. Name, address, gender and date of birth of child;
    2. Name and contact details for parent/s, educational setting (e.g. nursery, school), primary medical practitioner (e.g. GP practice), practitioners providing other services, a lead practitioner for the child.

- Discuss the case with our safeguarding lead to decide whether to:
    1. Make a referral to Children's social care;
    2. Make a referral to the lead practitioner, if the case is open and there is one;
    3. Make a referral to a specialist agency or practitioner e.g. educational psychology or a speech and language therapist;

Record the referral contemporaneously, with the detail of information received and given, separating out fact from opinion as far as possible.

Offer a face to face meeting or interview to the member of the public to clarify information. The member of the public will also be given the number for their local Children's social care and encouraged to contact them directly. We will however **always** make a referral to Children's social care and to the lead practitioner if there is one, in case the member of the public does not follow through (which can happen).

Some people may prefer not to give their name to Children's social care, or they may disclose their identity but not wish for it to be revealed to the parent/s of the child concerned. Wherever possible, we will respect the referrer's request for anonymity. However we will not give referrers any guarantees of confidentiality, as there are certain limited circumstances in which the identity of a referrer may have to be given (e.g. the court arena). Consideration for the referrer's safety may be an issue in some cases.

Thinking about Safeguarding Children whilst working with Adults

We will consider our adult service users' role as a parent. We will consider the impact of the adult's condition or behaviour on:

- A child's development;
- Family functioning;
- The adult's parenting capacity.

If we have concerns about the parent's capacity to care for the child and consider that the child is likely to be harmed or is being harmed, we will immediately refer the child to the police or Children's social care.

Requests for information about a child, from Children's Social Care will be directed to the correct member of staff and not dealt with by administrative staff or intermediaries.

Whistleblowing

Abuse can occur outside of the family and it is important that workers of THO are aware of this. No member of THO will:

- Fail to act upon and record allegations that a child makes;
- Visit a child in their home without another adult being present;
- Transport a child in their car unless prior arrangements have been made with a senior member of staff or in case of a medical emergency;
- Make any comments with sexual overtones, even in humour, or partake in any "horse play" with a child;
- Allow a child into their home;
- Engage in rough physical games;
- Engage in sexually provocative games;
- Allow or engage in inappropriate touching in any form;
- Allow children to use inappropriate language unchallenged;
- Do things of a personal nature for a child, that they can do themselves;
- Take photographs of a child without parental consent;
- Use their personal phone/camera/equipment to take/store images of children/at risk adults.

THO should be informed of all allegations that are made against a member of staff or volunteer. Allegations may be about poor practice rather than abuse. Advice can be sought from Delta Wellbeing.

THO would like to assure all parents/carers, staff and volunteers that it would fully support and protect anyone who, in good faith, reports his or her concerns that a member of staff or volunteer is or may be abusing a child or at risk adult. Staff and volunteers must take action quickly on their concerns so that problems do not escalate. This would include concerns that they have:

1. Behaved in a way that has harmed a child, or may have harmed a child;
2. Possibly committed a criminal offence against or related to a child;
3. Behaved towards a child or children in a way that indicates he or she would pose a risk of harm if they work regularly or closely with children

All allegations must be recorded and passed to our SGO.

Primary consideration will be given to supporting the child or young person and the person making the allegation.

Where there is a complaint of abuse against a member of staff there may be three types of investigation.

1. A criminal investigation
2. A child/at risk adult protection investigation
3. A disciplinary or misconduct investigation

There will be circumstances when these procedures may be used concurrently with other procedures such as Disciplinary and Complaints. In these circumstances the safeguarding process takes precedence over the others. Results of the police and social services investigation may well influence a disciplinary investigation, but not necessarily.

Every effort will be made to ensure confidentiality for everyone concerned.

If the Safeguarding Officer is the subject of the suspicion/allegation the report must be made to the Safeguarding Trustee. They are then responsible for taking the appropriate action.

Issues of misconduct will be dealt with by a panel appointed by the Board of Trustees. The Board has the right to suspend staff member/s during or following investigations. In instances of allegations of abuse THO will refer to the Carmarthenshire Safeguarding Policies and Procedures Manual.

Regular review of policies, procedures and actions

The THO Board of Trustees have a quarterly update from the SGO regarding safeguarding concerns and actions, and the Safeguarding Trustee must be promptly informed of:

- any allegations against staff or volunteers
- any formal referrals made to the Delta Wellbeing

THO's child, young person's and at risk adult's safeguarding policies and procedures are reviewed annually. Necessary changes that are identified in the interim period, as a result of amendment to legislation will be made as required.

Date updated	Updated by	Due for review
July 2021	PH & HC	July 2022
August 2022	HC	August2023
August 2023	PH	August 2024
January 2024	PH	January 2025

Internal Safeguarding Concern Form

The HangOut **Record of Safeguarding Concern**			
Name of Reporter:	Position and Location:	Date of concern/disclosure:	Time of concern/disclosure:
Details of concern/disclosure:			
How was the concern/disclosure responded to?			
Persons/organisation the concern/disclosure was reported to?	Outcome:		

Where the person of concern was referred to THO by a social worker or other professional, they may be the most appropriate first point of contact