Safeguarding children & young people

Sonshine Club's Child Protection Policy follows The London Child Protection Procedures (Edition 2) produced by the London Child Protection Committee. It reflects current legislation, government statutory guidance and expectation, and accepted best practice. For more comprehensive information the full list of procedures kept in the office should be referred to. This organisational policy will be subject to an annual review.

1 Beliefs

Sonshine Club is committed to providing safe and secure services in all its dealings with children and families. All staff should display an attitude that shows children and adults they can feel confident about sharing any concerns they may have about their own safety or the well being of others.

The needs of the child are most important and all children deserve the opportunity to reach their potential. They have the right to be safeguarded from harm, whatever their race, religion, gender, age, health, disability, location or placement.

All staff, volunteers and anyone working with clients are required to report instances of both actual or suspected child abuse or neglect. Children can only be protected when everyone accepts their responsibility to co-operate with one another.

Statements about or allegations of abuse or neglect made by children must always be taken seriously. Their wishes and feelings are vital and must always be sought and given consideration, according to the level of understanding of the child.

In the event of an enquiry those with parental responsibility should be encouraged to be involved, unless doing so will affect the enquiry or the child's welfare.

2 Organisational intentions

Sonshine Club will make the best use of its resources so as to reduce the frequency and extent to which a child might suffer significant

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harm due to abuse or neglect. It will also ensure there is a prompt and effective 'needs led' response when it appears that a child may be at risk.

Policies and procedures will reflect the fact that all children in need of protection are 'children in need' and entitled to family support services. All staff will be adequately trained, managed and supervised so as to operate to agreed procedures.

Services will be provided in a manner which does not discriminate or is unprofessional, respecting the right to family life of all individuals involved and the confidentiality of all information.

3 Recruitment

All staff whether employed or volunteers, recruited by Sonshine Club will be subject to references and a criminal record check. They must also disclose at the time of recruitment, whether they have ever been convicted, including convictions which are spent, or been cautioned by the police for an offence which was admitted to at the time.

On joining Sonshine Club staff will be informed of our Child Protection Policy and Procedures.

4 Complaints or allegations made against staff

Sonshine Club takes seriously all complaints made against staff. Procedures are in place for clients to share any concern they may have about the actions of any member of staff. All such complaints will be brought to the immediate attention of the Supervisor who will take the appropriate measures.

Child protection procedures

Sonshine Club believes all children have an equal right to protection from abuse and neglect. Their safety whilst in our care is of utmost importance. These procedures draw upon the London Child Protection Procedures produced by the London Child Protection Committee.

1 Shared responsibility

1.1 Members of staff at Sonshine Club have an important role to play in recognising difficulties and referring concerns about child protection. The child's interests must be put first.

1.2 Seeing children in their own homes puts staff in a position to notice signs of abuse, or to mention concerns which may lead to abuse.

1.3 This responsibility applies to any employee or volunteer working on behalf of Sonshine Club.

2 Recognition of abuse

2.1 Child abuse and neglect is a generic term covering all ill treatment of children, as well as cases where the standard of care does not adequately support a child's health or development.

2.2 It includes physical, emotional, sexual abuse or neglect, the infliction of harm or the failure to act to prevent harm.

2.3 It can occur in a family, institution or community setting. The perpetrator may or may not be known to the child.

2.4 Every child will react differently to abuse. The following signs may arouse concern. However, there could be normal reasons for any of them.

2.5 Physical abuse:

2.5.1 This may take many forms, ie. hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating a child.

2.1.2 It may also be caused when a parent or carer feigns the symptoms of, or deliberately causes, ill health to a child. This unusual and potentially dangerous form of abuse is now described as fabricated or induced illness in a child.

2.6 Emotional abuse:

Emotional abuse is the persistent emotional ill treatment of a child such as to cause severe and persistent effects on the child's emotional development. Some level of emotional abuse is involved in most types of ill treatment of children, though emotional abuse may occur alone and involve:

2.6.1 Conveying to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of someone else.

2.6.2 Imposing developmentally inappropriate expectations.

2.6.3 Causing children to feel frightened or in danger, ie. witnessing domestic violence.

2.7 Sexual abuse:

This involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is

happening. It may include non-contact activities, ie. encouraging them to behave in a sexually inappropriate way.

2.8 Neglect:

2.8.1 Neglect involves 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 and development.

2.8.2 This may include failure to provide adequate food, shelter or clothing, failure to protect from physical harm or danger, or failure to ensure access to appropriate medical care or treatment. It may also include neglect of a child's basic emotional needs.

2.9 Identifying risk:

In an abusive relationship the child may:

2.9.1 Appear frightened of the parent/s

2.9.2 Act in a way that is inappropriate to his/her age and development

The parent or carer may:

2.9.3 Persistently avoid child health promotion services and treatment of the child's episodic illnesses

2.9.4 Have unrealistic expectations of the child

2.9.5 Frequently complain about/to the child and may fail to provide attention or praise (high criticism/low warmth environment)

2.9.6 Be absent

2.9.7 Persistently refuse to allow access on home visits

2.9.8 Be involved in domestic violence

2.10 Recognising physical abuse:

The following are often regarded as indicators of concern:

2.10.1 An explanation which is inconsistent with an injury

2.10.2 Several different explanations provided for an injury

2.10.3 Unexplained delay in seeking treatment

2.10.4 The parents/carers are uninterested or undisturbed by an accident or injury

2.10.5 Parents are absent without good reason when their child is presented for treatment

2.10.6 Repeated presentation of minor injuries (which may represent a 'cry

for help' and if ignored could lead to more serious injury)

2.10.7 Family use of different doctors and A&E departments

2.10.8 Reluctance to give information or mention previous injuries.

2.11 Bruising:
Children can have accidental bruising, but the following must be considered as non accidental unless there is evidence or an adequate explanation provided:

2.11.1 Any bruising to a pre-crawling or pre-walking baby

2.11.2 Bruising in or around the mouth, particularly in small babies which may indicate force feeding

2.11.3 Two simultaneous bruised eyes, without bruising to the forehead

2.11.4 Repeated or multiple bruising on the head or on sites unlikely to be injured accidentally

2.11.5 Variation in colour possibly indicating injuries caused at different times

2.11.6 The outline of an object used, ie. hand print or belt mark

2.11.7 Bruising or tearing around or behind the earlobes, indicating injury by pulling or twisting

2.11.8 Bruising around the face

2.11.9 Grasp marks on small children

2.11.10 Bruising on the arms, bottom or thighs

2.12 Bite marks:
Bite marks can leave clear impressions of the teeth. Human bite marks are oval or crescent shaped. Those over 3cm in diameter are more likely to have been caused by an adult or older child. A medical opinion should be sought where there is any doubt over the origin of the bite.

2.13 Burns and scalds:
It can be difficult to tell the difference between accidental and non accidental burns and scalds and will always require medical opinion. Any burn with a clear outline may be suspicious.

2.13.1 Circular burns from cigarettes (but may be friction burns if along the bony part of the spine

2.13.2 Line shaped burns from hot metal rods or electrical fire elements

2.13.3 Burns of the same depth over a large area

2.13.4 Scalds that have a line showing immersion or poured liquid (a child getting into hot water of its own accord will struggle to get out and cause splash marks)

2.13.5 Old scars from previous burns or scalds which did not have appropriate treatment or were explained properly

2.13.6 Scalds to the buttocks of a small child without burns to the feet, imply dipping into a hot bath or liquid

2.14 Fractures:
Fractures may cause pain, swelling and discolouration over a bone or joint. Non mobile children rarely sustain fractures. There are grounds for concern if:

2.14.1 The reason provided is vague, non existent or does not match the injury

2.14.2 There are associated old fractures

2.14.3 Medical attention is sought after a period of delay when the fracture has caused symptoms such as swelling, pain or loss of movement

2.14.4 There is an unexplained fracture in a baby under one year old

2.15 Scars:
Numerous scars or scars of different sizes or ages, or on different parts of the body, may suggest abuse.

2.16 Recognising emotional abuse:
Emotional abuse may be difficult to notice, as the signs are usually behavioural rather than physical. The signs of emotional abuse might also suggest other kinds of abuse. The following are examples to be aware of:

2.16.1 Developmental delay

2.16.2 Abnormal attachment between a child and parent/carer – this can range from separation anxiety to no attachment

2.16.3 Aggressive behaviour towards others

2.16.4 Scape-goated within the family

2.16.5 Frozen watchfulness, particularly in pre-school children

2.16.6 Low self-esteem and lack of confidence

2.16.7 Withdrawn or seen as a loner, difficulty relating to others

2.17 Recognising sexual abuse:
Children of all ages may be sexually abused and are often scared to say anything due to guilt and/or fear. This is particularly difficult for a child to talk about. Recognition can be difficult unless a child discloses and is believed. There may be no physical signs and indications are likely to be emotional or behavioural. Some behavioural indicators are:

2.17.1 Inappropriate sexual conduct

2.17.2 Explicit behaviour, play or conversation inappropriate to the child's age

2.17.3 Touching of the private parts excessively

2.17.4 Self harm (including eating disorder) or self mutilation

2.17.5 An anxious unwillingness to remove clothes
Some physical indicators are:

2.17.6 Pain or itching of the private parts

2.17.7 Blood on underclothes

2.17.8 Injuries to the private parts, bruising to the bottom, thighs or abdomen.

2.18 Recognising neglect:
Neglect can be noticed over a period of time and can cover different aspects of parenting. Signs may include:

2.18.1 Failure by parents or carers to meet the basic essential needs, ie. adequate food, clothing, warmth, hygiene and medical care.

2.18.2 A child seems to be listless, apathetic or unresponsive with no apparent medical cause.

2.18.3 Failure of a child to grow within normal expected pattern, with accompanying weight loss.

2.18.4 Child thrives away from their home environment.

2.18.5 Child is frequently absent from school

2.18.6 Child is abandoned or left alone for excessive periods.

3 Professional response

3.1 Consultation with other professionals:
Internal Sonshine Club policy is to talk to the designated supervisor who will decide if consultation with Social Services is required immediately. A formal referral or any urgent medical treatment must not be delayed by the need for consultation.

If a staff member notices something is definitely wrong, i.e. physical signs, they should make a written, dated note and report it straight away to their supervisor.

3.2 Listening to the child:

3.2.1 The responsibility to make enquiries and investigate allegations lies with the Social Services and the police Child Protection Unit.

3.2.2 Where abuse is alleged, the first response should be limited to listening carefully to what the child says so as to clarify concerns, offer reassurance about how he/she will be kept safe and explain what action will take place.

3.2.3 If the child can talk about the injury, you can ask briefly i.e. "Rachel, that's a big bruise, can you remember how you got it?" write down the child's answer and do not ask any more questions. The child must not be pressed for information, led, cross-examined or given false promises of complete confidentiality.

3.2.4 If the child can understand the significance and consequences of making a referral to Social Services, s/he should be asked his/her view. Whilst this view will be considered, it remains the responsibility of the professional to take whatever action is required to keep the child and any other children safe.

3.2.5 If a child has trusted you with their story, they may become attached to you and anxious. Let the child know you want to help and are not going to forget about their problem.

3.3 Parental consultation:

3.3.1 Where possible, concerns should be discussed with the family and agreement sought for a Social Services referral, unless this may, due to the delay or the response it prompts, places the child at risk of significant harm.

3.3.2 A decision not to seek parental permission before referring to Social Services must be recorded and reasons given. When a parent has agreed to a referral, this must also be recorded and confirmed in the referral.

3.3.3 Formal referrals from a named professional cannot be treated as anonymous and the parent will ultimately become aware of the identity of the referrer.

3.3.4 If the parent refuses to give permission for a referral, further advice should be sought from the supervisor, GP, teacher etc, and the outcome fully recorded unless this would cause undue delay.

3.3.5 If after consulting the parent it is still considered that there is a need for a referral, the reason for proceeding without parental agreement must be recorded. Social Services should be told the parent has withheld their permission and the parent should be contacted to inform them that after considering their wishes, a referral has been made.

3.4 Urgent medical attention:

3.4.1 If a child is suffering from a serious injury, inform the parents and call an ambulance immediately. If there is any suspicion that the injury is non-accidental, the supervisor must be informed, who will in turn contact Social Services and the Duty Consultant Paediatrician.

3.4.2 Except in cases where emergency treatment is needed, Social Services and the police are responsible to ensuring that any medical examinations required as part of enquiries are undertaken.

3.5 Duty to refer:

3.5.1 If there are signs that a child under the age of eighteen or an unborn baby is experiencing or may already have experienced abuse or neglect or is likely to suffer harm in the future, the supervisor must make a referral to Social Services.

3.5.2 The timing of such referrals must reflect the level of perceived risk, and should usually be within 1 working day of the recognition of risk.

3.5.3 In urgent situations, out of office hours the referral should be made to the Emergency Duty/Out of Hours Team.

Initiating the referral:

3.5.4 Referrals should generally be made to the Social Services office where the child is living.

3.5.5 If a child is known to have an allocated social worker, referrals should be made to him/her, or in their absence to the manager or duty officer. In other circumstances referrals are made to the duty officer.

3.5.6 *Where available the following information should be given at the time of referring, although the absence of information should not delay the referral:*

- Full names, dates of birth and gender of the child/ren
- Family address
- Names of persons with parental responsibility
- Names and dates of birth of all household members
- Ethnicity, first language and religion of children and parents/carers
- Any need for an interpreter, signer or other communication aid
- Any significant recent or historical incidents in the child of family's life
- The cause for concern including details of any allegations, their sources, timing and location
- The child's current location and emotional and physical condition
- The referrer's relationship and knowledge of the child and parents/carers
- Any known current or previous involvement of other agencies or professionals
- Information regarding the parental knowledge of and agreement to the referral.

3.5.7 The referrer should confirm verbal and telephone referrals in writing within 48 hours. If Social Services has not acknowledged receipt of this within 3 working days, the referrer should contact Social Services again.

Ensuring immediate iafety:

3.5.8 The safety of children is paramount in all decisions relating to their welfare. No child should be left in immediate danger as a result of any action taken by a staff member.

3.5.9 The law empowers those with actual care of a child to do all that is reasonable in the circumstances to safeguard his/her welfare.

3.5.10 *A Social Worker or supervisor/professional should take all reasonable steps to offer a child immediate protection from an aggressive parent, including:*

- getting the alleged abuser to leave the home
- removal of the alleged abuser
- voluntary agreement for the child/ren to move to a safer place with/without a protective person
- application for an Emergency Protection Order

- removal of the child/ren under police powers of protection
- gaining entry to the household under police powers.

3.5.11 Social Services are required to obtain legal advice before initiating legal action.

3.6 Recording:
The referrer should keep in a safe place written record of:

3.6.1 Discussions with the child

3.6.2 Discussions with the parent

3.6.3 Discussions with managers

3.6.4 Information provided to Social Services

3.6.5 Decisions taken (clearly timed, dated and signed)

4 Recognition of child protection issues in speifc circumstances

4.1 Racial and religious harassment:

4.1.1 Experience of racism is likely to affect how a child behaves, in particular when being assessed by a worker, or being cared for by a carer of a different ethnic origin.

4.1.2 Failure to protect a child from racism or take action when racism is being alleged is likely to undermine all other efforts being made to promote the welfare of the child.

4.1.3 Families may suffer religious and/or racial harassment to such an extent that it undermines their parenting. In responding to concerns about children in the family, full account needs to be taken of this and every reasonable effort made to end the harassment.

4.2 Disabled Children:
Any child with a disability is by definition a 'child in need' under Section 17 of the Children Act 1989. A disabled child is as vulnerable to physical, emotional or sexual abuse or neglect as any other child, although the level of risk may be raised by:

4.2.1 A need for practical assistance in daily living, including intimate care from what may be a number of carers

4.2.2 Carers and staff lacking the ability to communicate adequately with the child

4.2.3 A lack of continuity in care leading to an increased risk that behavioural changes may go unnoticed

4.2.4 Physical dependency with consequent reduction in ability to be able to resist abuse

4.2.5 An increased likelihood that the child is socially isolated

4.2.6 Lack of access to 'keep safe' strategies available to others

4.2.7 Communication or learning difficulties preventing them revealing if abuse has occurred

4.2.8 Parents'/carers' own needs and ways of coping may conflict with the needs of the child.

In addition to the descriptions of abuse listed above, the following abusive behaviours must be considered:

4.2.9 Force-feeding

4.2.10 Unjustified or excessive physical restraint

4.2.11 Rough handling

4.2.12 Extreme behaviour modification including the deprivation of liquid, medication, food or clothing

4.2.13 Misuse of medication, sedation or heavy tranquillisation

4.2.14 Invasive procedures against the child's will

4.2.15 Deliberate failure to follow medically recommended regimes

4.2.16 Misapplication of programmes or regimes

4.2.17 Ill fitting equipment, ie. callipers, sleep board which may cause injury or pain, inappropriate splinting.

4.2.18 Where a child is unable to tell someone of his/her abuse s/he may convey anxiety or distress in some other way, ie. behaviour or symptoms and care staff must be alert to this.

4.2.19 Some child abusers may target disabled children in the belief that they are less likely to be detected.

4.2.20 Staff should not undermine the ability of a child with disabilities to give credible evidence or withstand the rigours of an investigation.

4.3 Families where a parent has learning difficulties:
Where a parent with learning difficulties appears not to be able to

meet her/his child's needs, a referral should be made to Social Services, which has a responsibility to assess need and where justified, offer supportive or protective services.

4.4 Enduring and/or Severe Parental Mental Illness:
The majority of parents who suffer significant mental ill-health are able to care for and safeguard their children and/or unborn child. In some cases, enduring and/or severe parental mental ill health will seriously affect the safety, health and development of children. Where the supervisor believes this to be the case, a referral must be made to Social Services.

The following parental risk factors justify a referral to Social Services for an assessment of whether a child has suffered or is at risk of suffering significant harm:

4.4.1 Previous history of mental health problems

4.4.2 Predisposition to or severe post-natal illness

4.4.3 Delusional thinking involving the child

4.4.4 Self-harming behaviour and suicide attempts

4.4.5 Altered states of consciousness, ie. disassociation

4.4.6 Obsessive compulsive behaviours involving the child

4.4.7 Non compliance with treatment, reluctance or difficulty in engaging with necessary services, lack of insight into illness or impact on the child

4.4.8 Disorder designated 'untreatable' either totally or within time scales compatible with the child's best interests

4.4.9 Domestic violence and/or relationship difficulties

4.4.10 Unsupported and/or isolated parents

The following factors may also lead to the conclusion that a child might have suffered or is at risk of suffering significant harm:

4.4.11 A child acting as a young carer for a parent or a sibling

4.4.12 Impact on child's growth, development, behaviour and/or mental/physical 5.4.13 health, including self-harming behaviour

4.4.14 The parent's needs or illnesses taking precedence over the child's needs

4.4.15 Insufficient alternative care for the child within extended family.

Importance of working in partnership:

4.4.16 Adult and child mental health professionals, social workers and Sonshine Club staff must share information in order to be able to assess risks.

4.4.17 Care programme meetings about parents who have mental health difficulties must include consideration of any needs or risk factors for the children concerned. Child care agencies and Social Services should be involved in planning discharge arrangements.

4.4.18 Social Services may be requested to assess whether it is in the best interests of a child to visit a parent or family member in a psychiatric hospital.

4.5 Young caregivers:

A young caregiver is a young person under the age of eighteen who has a responsibility for caring on a regular basis for a relative (or very occasionally a friend) who has an illness or disability. This leads to a variety of losses for the young carer.

4.5.1 *Many young caregivers experience:*

- Low level of school attendance
- Some educational difficulties
- Social isolation
- Conflict between loyalty to their family and their wish to have their own needs met

4.5.2 Staff should consider if the child is in need of support services in their own right.

4.5.3 Social Services should consider whether any provision of the Children Act 1989 or Carers (Recognition and Services) Act 1995 should be applied.

4.5.4 If staff are concerned that the young caregiver is at serious risk of neglect, abuse or harm, this must be referred to Social Services, and if appropriate, a strategy meeting arranged.

4.5.5 Unless there is reason to believe a child would be put at risk, young caregivers should be told if there is a need to make a referral, in order that their trust in a worker is retained.

4.5.6 If possible, the young carer's consent should be sought through a discussion of the why the referral must be made and the possible outcomes.

4.5.7 In those situations where the child does not give consent, but it is still considered necessary to initiate a child protection enquiry, s/he should be kept informed of all decisions made and offered support throughout.

4.6 Self harming behaviour:

4.6.1 Self-harm, suicide threats and gestures by a child must always be taken seriously and may indicate a serious mental or emotional disturbance.

4.6.2 The possibility that self-harm including a serious eating disorder has been caused or triggered by any form of abuse or chronic neglect should not be overlooked.

4.6.3 This may justify a referral to Social Services for an assessment as a child in need and/or in need of protection.

4.6.4 Supervisors should refer to the relevant section of the London Child Protection Procedures for guidance on action to take when a child is known to have either made a suicide attempt or been involved in self-harming behaviour.

4.7 Looked after children:

4.7.1 Children in alternative care settings, ie. with a foster carer, may be vulnerable.

4.7.2 Such children may experience emotional abuse and neglect, in addition to other forms of abuse such as peer abuse and bullying by other children in the family.

5 The referral and assessment process

Managers and supervisors are required to read and follow the relevant section in the LCPP for detailed guidance on how the referral procedure should be progressed

6 Child protection enquiries

6.1 All staff have a duty to assist and provide information in support of child protection enquiries.

6.2 The police must be informed at the earliest opportunity whenever a criminal offence appears to have been committed, or is suspected of having been committed, against a child. The police are responsible for undertaking the criminal investigation.

6.3 Managers and supervisors are required to read and follow the relevant section on Strategy Discussion and/or Meeting in the LCPP for detailed guidance. Meetings should be held where:

6.3.1 There are allegations against staff, carers and volunteers or anyone professionally involved with the child

6.3.2 There is an allegation that a child has abused another child

6.3.3 There are ongoing cumulative concerns about the child's welfare and a need to share concerns and agree a course of action

6.3.4 There are direct concerns about the future risk to an unborn child

6.3.5 Direct communication between two or more agencies is required.

6.4 Criminal investigations:

Any suspected, alleged or actual crime must be referred to the Police Child Protection Unit. The following matters will always be investigated by police:

- All sexual assaults
- Physical abuse amounting to actual bodily harm or more serious assaults
- Serious neglect/cruelty offences
- Minor offences where there are aggravating features

6.5 Involving parents, family members and children:

6.5.1 In addition to being offered a verbal explanation of the child protection enquiry process parents should be provided with an explanatory leaflet.

6.5.2 Due consideration must be given to the capacity of the parents to understand this information in a situation of significant anxiety and stress.

6.5.3 Consideration must be given to those for whom English is not their first language, or who may have a physical/sensory/learning disability and may need the services of an interpreter.

6.5.4 It is also essential that sensitivity towards orthodox Jewish practice, together with issues arising from disability and health, are taken into account.

6.6 Meeting the child:

6.6.1 ALL children within the household must be directly communicated with during an enquiry. Those who are the focus of concern should

be seen alone, subject to age and preferably with parental permission.

6.6.2 Consideration must be given to the child's developmental stage and cognitive ability.

6.6.3 *Specialist help may be needed if:*

- The child's first language is not English
- S/he appears to have a degree of psychiatric disturbance but is deemed competent
- S/he has a physical/sensory/learning disability
- Where interviewers do not have adequate knowledge and understanding of the orthodox Jewish religion and way of life.

6.6.4 *In order to avoid undermining any subsequent criminal case, in any contact with a child prior to an interview, staff must:*

- Listen to the child rather than directly questioning him/her
- Never stop the child freely recounting significant events
- Fully record the discussion including timing, setting, presence of others, as well as what was said.

6.6.5 If a child tells a staff member something has happened the staff member must never promise to keep it a secret. Instead the child should be reassured that their problem is not going to be forgotten about.

6.7 Risk assessment:
Supervisors should liaise with Social Services providing all relevant information including changes in circumstances for consideration, when assessing child protection risks and planning a course of action.

6.8 Outcome of child protection enquiries:

6.8.1 *When the outcome is agreed, the original concerns may be:*

- Unsubstantiated
- Substantiated, but assessed as posing no continuing risk of significant harm
- Substantiated and at continuing risk of significant harm

6.8.2 Parents and children who have had a significant involvement should be provided with a written copy of the written record of the enquiry.

6.8.3 Managers and supervisors are required to refer to seek guidance on procedures in dealing with Social Services following an enquiry.

7 Child protection conferences

7.1 All staff in their commitment to child protection issues must understand the importance of sharing information, preparing carefully for conferences including the provision of reports, attending conferences, their contribution to decision making and following up agreed action to safeguard the child(ren).

7.2 It is the supervisor/managers' responsibility to familiarise themselves with LCPC guidelines on the subject of conferences. In addition they should ensure in their role as advocate with Social Services, sufficient consideration is shown at the conference for the orthodox Jewish religious and cultural way of life of our service users.

8 Implementing a child protection plan

8.1 When a child's name is placed on the child protection register a plan will be formulated. This is the responsibility of a key worker from Social Services. Staff must be prepared to notify their supervisor of any concerns related to the implementation of the plan and its effectiveness in protecting children from further harm.

8.2 Supervisors should assist parents or carers in understanding their role in ensuring the plan is effective in promoting their child(ren)s welfare.

9 Allegations against staff, carers and volunteers

9.1 The following procedures apply to suspicions or allegations by a staff member either paid or voluntarily, child minder or foster carer. Any such allegations must be dealt with quickly and sensitively.

9.2 All staff have a moral duty to report abusive or potentially abusive behaviour – the welfare and safety of children must come before protecting colleagues.

9.3 A staff member is not permitted to conduct an enquiry into abuse with respect to a relative, friend, colleague or supervisor or someone who has worked with him/her previously in any of these capacities.

9.4 Any child protection concerns must be referred to the Executive Director who has a responsibility to inform the police as a potential criminal investigation.

9.5 The staff member reporting the incident will be unable to have anonymity. But enquiries will be conducted in the strictest confidence so that any employee, volunteer, foster carer or childminder does not have to fear victimisation.

9.6 If a child requires immediate medical attention, he/she should be taken to hospital and the parents informed immediately. It may be necessary to equally ensure the member of staff is separated from the child(ren) to prevent further risk of harm.

9.7 Parents must be contacted on the day of the allegation being known, either by phone or in writing, and should be told in outline how the matter will be dealt with.

9.8 Written notes of key points made by the child and / or parents should be made. If there are any adult witnesses, they should make a written factual note of the incident in their own words, and sign and date it.

9.9 If the matter is very minor and is simply inappropriate behaviour, the staff member should be spoken to and advised of future conduct. It may be that the member of staff needs further training / input or be referred back to policy documents.

9.10 Further enquiries for the purpose of disciplinary or complaints procedures should avoid the repeated interviewing of children or other vulnerable witnesses.

9.11 If the supervisor decides the claim is unfounded, the staff member must be formally told. The parents must also be written to, telling them the reasons why it was decided the allegation was unfounded. A meeting with the parents should be made, to discuss the reasons the claim was made, and implications for the future.

9.12 *A staff member may be suspended if the circumstances show:*

9.12.1 The claims are so serious that dismissal for gross misconduct may be possible.

9.12.2 When it is necessary to carry out an investigation without the staff member's influence.

9.12.3 *When children are at risk.*

9.13.3 The decision to suspend will only be taken after advice has been sought and the staff member has had an opportunity to reply to the allegations.

9.14 A decision not to suspend, does not preclude a suspension later if the circumstances change.

9.15 Although all investigations should be conducted as quickly as possible, it may take time to establish all the facts. The staff member and the child's parents/carers should be contacted by their supervisor regularly with information in the progress of the case.

9.16 Any staff member who believes an allegation or suspicion which has been reported is not being investigated properly has a responsibility to report it to a higher level in the organisation.

10 Child protection training

10.1 All staff, including office administrative employees, must be trained to pass calls about the safety of children to the appropriate professional staff.

10.2 All care workers will receive comprehensive training as part of their induction and will be required to attend regular developmental training as a condition of their employment.

10.3.1 Supervisors and managers will be expected to attend seminars and training in order to maintain and update their knowledge of statutory requirements in this field.

11 Contact information

The responsible officer is:
Chana Lieber

The Senior Staff Officer (designated Child Protection Officer) is:
Rachel Gruber

The Nominated Deputy Child Protection Officer is:
Ruth Lewis

Hackney Social Services Child Protection Unit
020 8356 5935/2300

Haringey Social Services Child Protection Unit
020 8489 5402

Local Police **020 8808 1212**

NSPCC Helpline **0808 800 5000**

Childline **0800 1111**