1 Policy Statement

1.1 St Mungo’s has an ethical and a legal duty to act to prevent abuse. St Mungo’s also has a duty to act in the best interests of all clients.
1.2 St Mungo’s is committed to preventing, identifying, investigating, and responding to cases of abuse or suspected abuse of clients in our services.

1.3 St Mungo’s has clients who are children in a range of services and recognises that it needs to ensure that this responsibility is not abused at any time.

1.4 St Mungo’s is committed to a recovery and personalisation ethos which in the context of safeguarding involves an approach which is multi-disciplinary, client-centred and responsive to change to manage short and long-term risk.

1.5 St Mungo’s will contribute to effective inter-agency working and effective multi-disciplinary assessments and joint working partnerships, including with the police, local authorities, the Care Quality Commission and the NHS.


1.7 The Care Act 2014 state the six principles of safeguarding, which St Mungo’s follows:

   “1. Empowerment - presumption of person led decisions and informed consent
2. Prevention - it is better to take action before harm occurs
3. Proportionality - proportionate and least intrusive response appropriate to the risk presented
4. Protection - support and representation for those in greatest need
5. Partnerships - local solutions through services working with their communities
6. Accountability - accountability and transparency in delivering safeguarding”

2 Scope

2.1 This procedure is to be followed by all staff, volunteers, locums, trustees, agency workers and students on placement and details the process required when there is alleged or suspected abuse of a child who is:

2.1.1 a client of a St Mungo’s service

2.1.2 related or in contact with a client in a St Mungo’s service. Please see Working with Pregnant Clients and Clients with Children (B24).

2.1.3 in contact with a member of St Mungo’s staff, volunteers, locums, trustees and students on placement as part of their work

2.2 St Mungo’s services have a responsibility for the welfare of children in a range of services, including:

2.2.1 Services for clients aged 16 – 18 only
2.2.2 Services for both children and adults e.g. accommodation-based services for clients, aged 16 and older
2.2.3 Services for families (e.g. women and children fleeing domestic abuse)
2.2.4 Services which provide support to adult clients in the family home
2.2.5 Adult clients who have contact with children, e.g. family members
2.2.6 Adult clients who have contact with children in the community/public spaces.
2.2.7 Unborn children of pregnant clients

3 Definitions

3.1 Safeguarding
Safeguarding is more than ‘child protection’ in that it also includes prevention. Safeguarding is defined under the Children Acts 1989 and 2004 as:

3.1.1 protecting children from maltreatment
3.1.2 preventing impairment of children’s health or development
3.1.3 ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
3.1.4 enabling children to have optimum life chances and to enter adulthood successfully

3.2 A Child
A child is any person aged under 18 years and includes the unborn child when the lifestyle of a pregnant woman is thought to be detrimental to the health of the unborn child. With regard to clients who have learning difficulties or disabilities, it should be noted that the Mental Capacity Act 2005 Code of Practice, defines a child as anyone under the age of 16.

3.3 ‘Child in need’
A child in need may be:

3.3.1 a child who is disabled
3.3.2 a child who is unlikely to achieve or maintain a reasonable standard of health or development
3.3.3 a child whose health or development is likely to be significantly impaired

3.4 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. Consideration of the severity of ill treatment may include

3.4.1 The degree and extent of physical harm
3.4.2 The duration and frequency of abuse and neglect
3.4.3 The extent of premeditation
3.4.4 The presence or degree of threat coercion sadism and bizarre or unusual elements
3.4.5 The local authority is under a duty to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or likely to suffer significant harm.

3.4.6 Working Together 2015 defines significant harm as “any Physical, Sexual, or Emotional Abuse, Neglect, accident or injury that is sufficiently serious to adversely affect progress and enjoyment of life. Harm is defined as the ill treatment or impairment of health and development.”

3.5 Mental Capacity

This only applies to clients aged 16 or older. The presumption is that those aged over 16 have mental capacity to make informed choices about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in safeguarding. All interventions need to take into account the ability of the client to make informed choices about the way they want to live and the risks they want to take. All decisions taken in the safeguarding process must comply with the Mental Capacity Act 2005 Act.

3.6 Consent

3.6.1 It is essential in safeguarding to consider whether clients over 16 are capable of giving informed consent. If they are, their consent should be sought. This may be in relation to whether they give consent to:

- an activity that may be abusive – if consent to abuse or neglect was given under duress, for example, as a result of exploitation, pressure, fear or intimidation, this apparent consent should be disregarded. Common Law states that there are limits to behaviours that someone can give consent to.
- Investigation into the safeguarding issue and subsequent actions (e.g. a protection plan) going ahead in response to a concern that has been raised.

3.6.2 The role of consent in relation to safeguarding children at referral stage

- If the child is under 16 and can understand the significance and consequences of making a referral to LA children’s social care, they should be asked their view.
- However, it should be explained to the child that whilst their view will be taken into account, the professional has a responsibility to take whatever action is required to ensure the child’s safety and the safety of other children.
- Children aged 16 – 18 are deemed to have capacity with regard to information sharing and their permission should be obtained.

3.7 Abuse

From ‘Working Together to Safeguard Children (2015)’:

“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.”

3.8 Designated Officer (Formally known as LADO - Local Authority Designated Officer)
• Providing advice, information and guidance to employers and voluntary organisations around allegations and concerns regarding paid and unpaid workers and volunteers, recommending a referral as appropriate.
• Recommending actions and next steps
• Chairing/attending the strategy/joint evaluation meetings in cases where the allegation requires investigation by police and/or social care.
• Managing and overseeing individual cases from all partner agencies.
• Ensuring the child’s voice is heard and that they are safeguarded.
• Ensuring there is a consistent, fair and thorough process for all adults working with children and young people against whom an allegation is made.
• Monitoring the progress of cases to ensure they are dealt with as quickly as possible.
• Maintain a confidential database in relation to allegations
• Share learning from cases and serious case reviews

4 Responsibilities for implementation

4.1 All staff, volunteers, locums, trustees and students on placement

• Report any knowledge or suspicions of safeguarding or radicalisation concerns to one of the following: line manager or regional head, St Mungo’s safeguarding lead or deputy lead, the safeguarding children or MASH (Multi Agency Safeguarding Hub) team at the local authority which commissions the service or the service’s HR partner (if a colleague or volunteer is suspected).
• Contribute to whatever actions are needed to safeguard and promote the child’s welfare.
• 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.
• Work co-operatively with parents, when this is consistent with ensuring the child’s safety.
• Communicate with and participate fully in all meetings as necessary, with the client, staff, St Mungo’s safeguarding leads and external agencies e.g. local authority, Care Quality Commission, Police.
• Ensure safeguarding children is discussed regularly in client meetings and keywork sessions
• Ensure safeguarding children and child protection issues are discussed as part of key work sessions (where relevant to the client)
• Undergo checks by the Disclosure and Barring Service
• Work with clients to prevent or minimise circumstances which can lead to abuse, including isolation, unhealthy relationships, access to financial services.
• Be aware of individual and organisational liability under the Criminal Justice and Courts Act 2015 regarding wilful neglect or ill-treatment of clients in mental health services, registered care services and other services which provide a high level of support to clients.
• Empower clients to have open conversations about safeguarding, equalities and radicalisation, while challenging unacceptable views/attitudes/behaviours
• Offer clients multiple opportunities to provide feedback: email, phone, face-to-face and written surveys, quality audit feedback, participation in external reviews, staff appraisal feedback, client satisfaction survey, the complaints process.

4.2 All managers

• Be responsible for ensuring this procedure is implemented and reporting structures are used and followed
• Ensure all staff have an appropriate level of legal literacy in safeguarding, by completing training in current best practise and legislation, especially where and how it differs from practise around safeguarding adults.
• Ensure relevant leaflets and posters are put on display and restocked and updated whenever necessary, including the internal complaints procedure, contact details for the local police team and local authority safeguarding children team.
• Highlight and discuss the organisational and local safeguarding procedures with all new members of staff as part of the induction
• Ensure safeguarding and client protection issues are standing items on team meeting agenda and discussed during staff supervision sessions.
• Be familiar with the Local Safeguarding Children Board’s assessment protocol (based on the guidance in Working Together 2015), fulfilling information and other requests from the Board and the process for challenging lack of action or disagreement with the local authority (often called the escalation or dissent procedure).
• Ensure all interview panels for staff who will be working with children, include at least one manager who has completed appropriate training.
• Ensure they are aware of the service’s local contact for Prevent – who may work for the Local Authority or the Police, and know how to refer concerns about radicalisation to the appropriate Prevent Channel.

4.3 Staff in services with adult clients only

• Ask if a client is in contact with a child, begins contact with a child or gets back in contact with a child and ensure this is incorporated into support overview, action plan and safety and wellbeing plan, and inform the service manager.
• If a client is pregnant (or has a relationship with somebody who is pregnant), attention should be paid to issues such as substance misuse or engagement in other risky behaviours and how this may impact on the health of the unborn child.
• Record any safeguarding concerns as part of the support overview and ensure they are raised with the service manager.
• Where a client’s child is an open case to Children’s Social Care, the keyworker should ensure they have contact details for the child’s social worker.
• Refer to the Visitors procedure B20 for more guidance on child visitors to St Mungo’s adult services.

4.4 Staff in services with clients who are children or include children should in addition:

• Be aware that the service itself may be targeted by abusers, as a source of vulnerable children
• Be familiar with the Local Safeguarding Children Board’s procedures which contain:
o the process for the early help assessment
o the type and level of early help services to be provided
o thresholds for when a case should be referred to local authority children's social care for assessment and for statutory services
o details of the Designated Officer is in the local area and methods for contacting in case of an alert.

- Be familiar with local partnerships/multi-disciplinary teams (sometimes called Multi Agency Safeguarding Hub – MASH), e.g. Kingfisher in Oxfordshire.

4.5 I.T team
- Produce and implement staff and client I.T. policies so that staff and clients can use IT safely, securely and legally, with regard to safeguarding and Prevent duties.

4.6 Volunteer Services team
- Produce volunteer handbook which includes guidance on safeguarding and professional boundaries
- Produce written guidance to staff who manage volunteers on local induction and volunteer supervision
- Deliver volunteer management training to staff
- Deliver safeguarding training appropriate to volunteers in client-facing roles

4.7 Quality and Continuous Improvement team
- Produce policies and procedures for staff which are legally compliant, reflect best practice in the sector and updated as often as required and every 3 years as a minimum.
- Ensure staff are informed of new guidance or changes to existing policies and procedures through organisational methods e.g. all-staff, weekly Bulletin, staff intranet, emails to all managers

4.8 Safeguarding Lead and Deputy Lead
- Review safeguarding incident reports and provide advice and guidance, as required
- Support staff to make referrals to appropriate agencies with regard to concerns about safeguarding, including radicalisation, as required
- Support staff to work constructively with partners, including local authorities, police, NHS and other providers.
- Ensure internal safeguarding and professional boundaries (both face-to-face and e-learning) is comprehensive and compliant with our safeguarding and Prevent duties.

4.9 St Mungo’s Organisational Leads

Board Lead: Robert Napier, Chair
Safeguarding Lead: Dominic Williamson, Executive Director of Strategy and Policy
Safeguarding Deputy Lead and Information Governance Lead: Claire Tuffin, Deputy Director of Strategy and Policy
5 Types of Abuse

5.1 Physical Abuse
Physical abuse is 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.

5.1.1 Female genital mutilation includes any mutilation of a female's genitals, including the partial or total removal of the external genitalia.

5.1.2 You are under a legal duty to safeguard girls at risk of FGM. If you believe a girl is at risk, you can request that the girl's local authority make a Female Genital Mutilation Protection Order (a type of injunction). More information can be found here: http://rightsofwomen.org.uk/get-information/violence-against-women-and-international-law/female-genital-mutilation-and-the-law/

5.1.3 If you believe that a girl has experienced FGM has taken place, you must report this to the Police.

5.2 Neglect
Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.

5.3 Sexual Abuse
5.3.1 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.

5.3.2 The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing.

5.3.3 They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).

5.3.4 Child sexual exploitation is defined as 'involves exploitative situations, contexts and relationships where young people (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of them performing, and/or another or others performing on them, sexual activities.

5.4 Emotional Abuse
5.4.1 The persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development.

5.4.2 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.
5.4.3 For clients under the age of 18 in abusive relationships, see the domestic abuse policy and procedure.

5.5 Abuse via the internet
Information and communication technology (ICT)-based forms of child physical, sexual and emotional abuse can include bullying via mobile telephones or online with verbal and visual messages.

5.6 Self-neglect
5.6.1 This includes neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding.

5.6.2 If the client’s accommodation or environment is being severely neglected by the provider, this may constitute organisational abuse or neglect, as above.

5.6.3 Positively addressing self-neglect requires balancing the rights of the individual with a duty of care, and improvement will often be gradual. Addressing related issues such as such as isolation, fluctuating capacity, low self-esteem, and exploring longer-term goals and developing interests and activities is required.

5.6.4 If the client’s accommodation or environment is being severely neglected, this may constitute institutional abuse or neglect, as above.

5.7 Exploitation by radicalisers who promote violence
Children may be susceptible to exploitation into violent extremism by radicalisers who attempt to attract people to their cause using persuasion or charisma. The aim is to inspire new recruits and embed their extreme views.

Please see B37 S3 Preventing Radicalisation and Extremism for more detailed guidance. Call the Anti-Terrorist hotline on 0800 789 321 if you require further guidance.

5.8 Modern Slavery
5.8.1 Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment. Types of slavery can include sexual exploitation (mostly women and children), forced labour, domestic servitude and criminal exploitation, e.g. being forced to work in a cannabis farm or pick-pocketing.

5.8.2 If you think a person is in immediate danger you should call 999 and ask for the police. If you suspect slavery is happening and there is no immediate threat to life, report the issue as safeguarding. The Modern Slavery helpline can also be used to report if you suspect slavery is happening - 0800 0121 700.

5.8.3 Human trafficking is part of modern slavery. The Police are the lead agency in managing responses to adults who are the victims of human trafficking. The National Referral Mechanism is a framework to assist in the formal identification and help to coordinate the referral of victims to appropriate services.

5.9 Financial and material abuse
This is the use of a person’s property, assets, income, funds or any resources without their informed consent or authorisation.

Examples:

5.9.1 The withholding of money
5.9.2 The unsanctioned use of a person’s money or property
5.9.3 disposal or sale of possessions by another party
5.9.4 The entry of a person into contracts or transactions (e.g.: loans, gifts) that are not understood and which are to their disadvantage and/or which have been as a result of coercion of some kind

5.9.5 Staff must take steps to ensure clients’ property and finances are secure. For guidance, see B06 Handling clients’ money and valuables and B04 Accessing benefits and money advice.

5.10 **Self harm**
Self-harm is not a safeguarding issue on its own, although it may be a reaction to being abused – if this is the case, report the cause (i.e the abuse) as safeguarding and include details of the self-harm under impact on the client. See B45 Working with clients who self-harm for more information.

5.11 **Forced marriage**
5.11.1 A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage. It is a crime in the UK.
5.11.2 The Foreign Office’s Forced Marriage Unit can advise on tools available to tackle forced marriage, including legal remedies, overseas assistance and how to approach victims.
Call: 020 7008 0151 (Mon-Fri: 09.00-17.00)
Email: fmu@fco.gov.uk or for outreach work: fmuoutreach@fco.gov.uk
Web: www.gov.uk/forced-marriage
Address: Forced Marriage Unit, Foreign & Commonwealth Office, King Charles Street, London, SW1A 2AH
For all out-of-hours emergencies, please telephone 020 7008 1500 and ask to speak to the Global Response Centre.

5.12 **Organised and complex abuse**
5.12.1 Abuse involving one or more abusers and a number of related or non-related abused children. The adults concerned may be acting alone, with others or using an institutional framework or position of authority, e.g. teacher, coach, faith group leader or celebrity position.
5.12.2 It can occur as part of a network of abuse across a family or community and within institutions e.g. boarding schools, in day care, youth services, sports clubs, faith groups and voluntary groups
5.12.3 When receiving information or a referral, which may indicate complex and organised abuse, immediately refer the matter to the police and a manager in children’s social care services.
5.12.4 If you suspect that any managers currently employed by a social care agency or a member of the police are implicated, the matter should be referred to a
senior manager at the relevant local authority, Chair of the Safeguarding Children Board and a Senior Officer within the police.

5.13 **Recognising abuse**

5.13.1 Children can suffer abuse by a parent, a sibling, a relative, a carer, an acquaintance or a stranger. Abusers may be adults or other children. The abuse may be the result of a direct act, or a failure on the part of the carer to act or to provide proper care, or both.

5.13.2 Children may be abused or neglected through the infliction of harm or failure to act to prevent harm. Abuse can take place in a family or an institutional or community setting.

5.13.3 These categories of abuse overlap and a child may suffer more than one form of abuse.

5.13.4 It is often difficult to recognise abuse and exploitation. Staff should be alert to the following:

- changes in a child’s disposition or demeanour
- overhearing indications of abuse or exploitation from clients
- informed directly or indirectly by other clients, visitors, member of the public, carer or other professional

5.13.5 If indicators of abuse appear incrementally over time (and there is no disclosure of abuse by the client), it can be less clear that the client is being abused or at risk of abuse. In these cases, discuss the signs with your line manager, safeguarding leads or professionals at partner organisations who work with the client. Sharing relevant information promptly is a crucial part of harm reduction and managing safety concerns.

5.13.6 See B46S1, Guidance Document: Categories and Indicators of Child Abuse, for a detailed list of indicators of abuse.

6 **Responding to a Disclosure of Abuse**

6.1 Listen.

6.2 Assure the child making the allegation that they will be taken seriously.

6.3 Do not be judgmental, express disgust or jump to conclusions.

6.4 Explain that:

   6.4.1 you have a duty to report to your line manager (or their manager if they are implicated in the abuse)
   
   6.4.2 concerns raised will have to be shared with them and external agencies (including the police)
   
   6.4.3 you will take steps to protect them from further abuse.

6.5 Ask open questions e.g. tell me what happened?

6.6 Do NOT contaminate evidence and witnesses by:
6.6.1 discussing the allegation of abuse with the alleged perpetrator or anyone other than the relevant manager

6.6.2 moving or destroying articles that could be used in evidence

6.7 Consult procedure B48, Preventing and Responding to Sexual Assault, where relevant.

6.8 Ensure the victim is safe/not in immediate danger.

6.9 Contact the emergency services e.g. Police, Ambulance, if there is a threat to life, serious injury, or if a crime has been committed.

6.10 Secure the scene, if appropriate, to ensure that no forensic evidence is lost.

6.11 Consider whether there is a risk to other clients.

6.12 Manager or Senior Manager must contact the Designated Officer within 24 hours of disclosure if the allegation refers to a volunteer or staff member, HR must also be informed.

6.12 This section applies to all staff. If you are not a manager, inform the service manager or on-call manager if the service manager is absent or implicated in the abuse. The regional head or group manager can also be contacted.

7 If there are concerns that abuse may be occurring

7.1 Staff members should discuss this with the service manager and agree actions, which may include:

7.1.2 Speak with the client to establish whether there is reason to suspect abuse.

7.1.3 Take action to protect other clients.

7.1.4 Complete an incident report form (B07S1).

7.1.5 Review the client’s safety and wellbeing plan.

7.1.6 Seek advice from the regional head or group manager or St Mungo’s safeguarding lead or deputy lead.

7.1.7 Manager should contact the Designated Officer for advice and guidance if the perpetrator may be a staff member or volunteer, HR must also be informed.

7.1.8 If it is suspected that a client is being abused by another client in the same service, both clients’ safety and wellbeing plans must be reviewed.

7.2 Do not discuss concerns or suspicions with any person suspected to be causing the abuse as you could increase the risk to clients and could prejudice any later investigation.

8 Medical treatment and examination

8.1 In cases of physical abuse it may be unclear whether injuries have been caused by abuse or some other means (for example, accidentally or intentional self harm). Medical or specialist advice should be sought.

8.2 If medical treatment is needed, an immediate referral should be made to the person’s GP, Accident and Emergency (A&E) or a relevant specialist health team. If forensic
evidence needs to be collected, the police should always be contacted and they will normally arrange for a police surgeon (forensic medical examiner) to be involved.

8.3 The consent to the child being examined and treated may be given by the following people:

8.3.1 The child, if they are of sufficient age and understanding (Gillick competency/Fraser guidelines)

8.3.2 Clients aged 16 or 17 have a legal right to provide consent to surgical, medical or dental treatment and unless grounds exist for doubting their mental health, no further consent is required.

8.3.3 The local authority when the child is accommodated under s20 of the Children Act 1989, and the parent/s have abandoned the child or are physically or mentally unable to give such authority

8.3.4 The local authority when the child is the subject of a care order (though the parent should be informed)

8.3.5 When a child is looked after under s20 and a parent has given general consent authorising medical treatment for the child, legal advice must be taken about whether this provides consent for paediatric assessment for child protection purposes (the parent still has full parental responsibility for the child).

8.4 Should it be necessary as part of the investigation to arrange for a medical examination to be conducted, the following points should be considered:

8.4.1 the rights of the child

8.4.2 the need to preserve forensic evidence

8.4.3 the involvement of any family members or carers

8.4.4 the need to accompany and support the child and provide reassurance and the identification of someone appropriate to do so.

9 Parental consultation

9.1 For children’s services, the referral should be made to Children’s Social Care and it is the responsibility of the referring service to inform those with Parental Responsibility for the child, unless this would increase risk. A child protection referral from a professional cannot be treated as anonymous, so the parent may ultimately become aware of the identity of the referrer.

9.2 In adult services, where practicable, concerns should be discussed with the parent (or anyone else who has Parental Responsibility for the child) and agreement sought for a referral to LA children’s social care unless seeking agreement is likely to place the child at risk of significant harm through delay or the parent’s actions or reactions. Where a child is already experiencing or at risk of experiencing significant harm, then a child protection referral must be made to children’s social care irrespective of obtaining consent from those with Parental Responsibility for the child.
10 Abuse or allegations of abuse by a member of staff or volunteer against a client

10.1 All St Mungo’s staff and volunteers must abide by the organisation’s code of conduct. Abuse of a client is gross misconduct, as well as illegal under the Criminal Justice and Courts Act 2015.

10.2 The Whistle-Blowing procedure (A04) underlines the responsibility of staff to report staff actions which are abusive of clients, or which are unethical, and explains the process of reporting issues of concern to the Care Quality Commission or local authority. Staff can report concerns using whistleblowing@mungos.org

10.3 Incident management following an allegation of abuse against a staff member:

10.3.1 Inform the Safeguarding Lead and Safeguarding Deputy Lead

10.3.2 Inform the relevant HR partner for the service.

10.3.3 Contact the Police immediately if there are any suggestions that the allegation is criminal.

10.3.4 Manager or senior manager to contact the local authorities Designated Officer within 24 hours of allegation in line with Working Together to Safeguard Children 2015.

10.3.5 The manager tasked with investigating the allegation should be approved by the Safeguarding Lead and Deputy Lead to ensure an objective investigation.

10.3.6 The manager tasked with investigating the allegation should contact the local authorities’ Designated Officer.

10.3.6 If the client concerned has spoken to other clients, before or as well as speaking to staff regarding the allegations, staff will need to inform the clients concerned that the allegation has been taken seriously and an investigation is taking place. However, this must be done with sensitivity and with due regard to confidentiality. This will help to minimise rumours and maintain the stability and positive environment of the service.

10.3.7 Service management should also keep relevant staff members informed but, again with due regard to the sensitivity and confidentiality of the situation.

10.3.8 The service manager (or their line manager, if they are suspected) should decide if there is an on-going risk of further abuse or of pressure being brought to bear on the person making the allegation. If it is felt that this is possible, the staff member should be either suspended or reassigned to other duties while an enquiry takes place.

10.3.9 Operational decisions affecting a client who has made an allegation, e.g exclusions, warnings, evictions, should be discussed with Safeguarding Lead and Deputy Lead.

10.3.10 All recommendations following an investigation to be reviewed by the Safeguarding Lead and Deputy Safeguarding Lead.
10.3.11 Support should be offered to both the client and the staff member (from the Employee Assistance Programme, and the union, if appropriate) during the investigation.

10.3.12 Seek advice promptly from HR and the Safeguarding Lead and Deputy Lead, if you have any questions on any of the above actions.

10.4 All allegations about volunteers should be dealt with through volunteer services procedures. Contact the Head of Volunteer Services, in addition to the Safeguarding Lead and Deputy Safeguarding Leads for advice on relevant actions.

10.5 If allegation is substantiated and person dismissed or St Mungo’s ceases to use the person’s services, or person resigns, the Designated Officer will discuss with St Mungo’s and HR whether referral to DBS is required for consideration of inclusion on barred list. It is a legal requirement to refer to DBS where we think an individual has engaged in conduct that has harmed or likely to harm a child or person poses a risk of harm to a child. Referrals will be within one month of ceasing to use person’s service.

11. Formal communication with a person raising a concern

11.1 Following the report of a safeguarding concern, staff are to write to the person who has raised the concern, informing them of what action will be taken as a result. Provide general information only about how the matter will be investigated, within the limits of confidentiality.

11.2 Information to be sent can be checked with a manager, organisational Safeguarding Lead or Information Security.

11.3 Once the investigation has been concluded, write again to the person who raised the concern to advise them of the outcome, again providing general information only, within the limits of confidentiality.

12 Recording and making a referral

12.1 Accurate records must be made at the time of the disclosure or discovery giving details of the incident and/or the grounds for suspecting abuse. Use the Incident Reporting function on Opal (see B07 Incident Reporting for guidance) and mandatory reporting processes by the service’s commissioner (e.g. local authority). For safeguarding children, this includes being aware of the local authority’s ‘Golden Number’ – a public number which anyone with a query related to child protection can contact.

12.2 Recording and making a referral can be undertaken by all staff, with guidance from their line manager, or if the line manager is implicated, with guidance from the regional head or safeguarding lead or deputy lead.

12.3 The record of the report of suspected abuse should be passed to the relevant manager (if the record is being made by a staff member who is not a manager) within 4 hours of the disclosure of abuse being made.

12.4 You must include:

12.4.1 Full names (including aliases and spelling variations), date of birth and gender

12.4.2 Address and (where relevant) school / college attended

12.4.3 Identity of those with parental responsibility
12.4.4 Where available, the child’s NHS number and education UPN number
12.4.5 Ethnicity, first language and religion of children and parents
12.4.6 Any special needs of children or parents
12.4.7 Any significant / important recent or historical events / incidents in child or family's life
12.4.8 Cause for concern including details of any allegations, their sources, timing and location
12.4.9 Child's current location and emotional and physical condition
12.4.10 Whether the child needs immediate protection
12.4.11 Details of the alleged perpetrator, if known
12.4.12 Known involvement of other agencies / professionals (e.g. GP)
12.4.13 Information regarding parental knowledge of, and agreement to, the referral
12.4.14 The child’s views and wishes, if known
12.4.15 If you were present, record exactly what you saw

12.5 The service manager or staff member in consultation with the service manager will alert the local Social Services Safeguarding Children Team The regional head may be consulted in this regard.

12.6 The manager or senior manager will alert the local authorities’ Designated Officer if the alleged perpetrator is a staff member or volunteer.

12.7 Where the child is already known to local Social Services, the allocated social worker (or social care duty worker if not available) or other professional will be notified as well to expedite the process.

12.8 Factors which must be included in reporting to the Safeguarding Children Team are:
12.8.1 the vulnerability of the client.
12.8.2 the nature and extent of the abuse.
12.8.3 the period during which the abuse has been happening.
12.8.4 its impact on the victim.
12.8.5 The impact on others
12.8.6 the likelihood of repeated or increasingly serious acts and any escalation in abuse that appears to be happening.

12.9 Anonymous information or information from people who do not want to be identified should also be recorded

12.10 Information should be stored so that it is not accessible by anyone implicated in the safeguarding allegation.

12.11 All communication in relation to a safeguarding concern should be recorded and retained

12.12 Staff should comply with local information sharing protocols from the service’s commissioner.
12.13 At the end of the referral discussion the referrer and LA Children’s Social Care should be clear about proposed action, timescales and who will be taking it, or that no further action will be taken.

13 What happens after a referral is made

13.1 The local authority should lead on an assessment and complete it within the locally agreed time.

13.2 This assessment should establish:

13.2.1 The nature of the concern
13.2.2 How and why it has arisen
13.2.3 What the child's needs appear to be
13.2.4 Whether the concern involves abuse or neglect
13.2.5 Whether there is any need for any urgent action to protect the child or any other children in the community
13.2.6 The immediate response to referrals may be:
   • No further action at this stage
   • Signposting to other agencies and services
   • An assessment of needs with a stated timescale and plan including regular reviews
   • Emergency action to protect a child
   • Strategy meeting / discussion

13.3 The local authority must arrange a strategy meeting/discussion within 3 working days of the referral, if there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm. The purpose is to share information between professionals who work with the child and decide on responsibility for tasks related to the child’s welfare.

13.4 Designated Officer - Statutory Role will be involved if the allegation is about a staff member or volunteer.
   • Involved in management and oversight of cases
   • To provide advice and guidance to employers
   • To liaise with police and other agencies
   • To monitor progress of cases
   • Remains involved even if it is not Child Protection and until disciplinary investigations are complete
   • Reviews should be fortnightly or monthly depending on complexity.

13.5 The LA children's social care manager has a legal duty to authorise a s47 enquiry (an enquiry under Section 37 of the Children Act 1989) following a strategy discussion/meeting, where it has been established that a child is suffering, or is likely to suffer, significant harm.

13.6 A s47 enquiry may run concurrently with police investigations. When a joint enquiry takes place, the police have the lead for the criminal investigation and LA children's social care have the lead for the s47 enquiries and the child's welfare. St Mungo's
must cooperate with any request from a safeguarding board e.g. supply information, but Safeguarding boards must be mindful of the burden of such requests on organisations.

13.7 The outcomes of a s47 enquiry are as follows:

13.7.1 Concerns not substantiated. The LA children's social care manager must authorise the decision that no further action is necessary.

13.7.2 Concerns of significant harm are substantiated - the child is judged to be suffering, or likely to suffer, significant harm. There must be a child protection conference within 15 working days of the strategy discussion/s at which section 47 enquiries were initiated. Suitable multi-agency arrangements must be put in place to safeguard the child until such time as the Initial Child Protection Conference has taken place.

13.7.3 If there is dispute between professionals regarding the outcome, staff should use the local authority’s procedure for resolving them and the concerns, discussion and any agreements made should be recorded in each organisation’s files.

13.8 If concerns are substantiated, the local authority may authorise an initial child protection conference or a review conference (more common when the child is looked after, under the Children Act 1989, section 20). St Mungo’s staff should participate fully, according to local protocols.

14 Managing abuse allegations where the victim and abuser are clients in the same service

14.1 In cases where a client is allegedly being abused by another client the safety of the victim is paramount

14.2 Where the alleged abuser and victim are clients in the same service, the same processes are followed but the service manager will need to consider whether the service can manage the situation with both parties on site.

14.3 If this is not feasible, it may be necessary to arrange the transfer of one client while the situation is being investigated.

14.4 Decide if the alleged perpetrator needs to be represented during investigations (e.g.: by a relative, social worker or solicitor) to avoid a potential conflict of interest.

14.5 Decide if the matter is likely to come to the attention of the Police. If so, be aware of PACE (Police and Criminal Evidence Act 1984) regulations relating to the provision of an appropriate adult to accompany the child being investigated.

15 Sharing information internally

15.1 If any staff have any questions related to the sharing of information related to safeguarding, they should contact the Quality team on infosec@mungos.org

15.2 All information sharing internally should be undertaken by managers or staff members specifically tasked to do so by managers.

15.3 Sharing information with staff of St Mungo’s

15.3.1 Information given to an individual member of staff belongs to St Mungo’s and not to the individual staff member
15.3.2 Information will be shared internally on a need-to-know basis.

15.3.3 Information will only be shared in the best interests of the victim.

15.3.4 Confidentiality must not be confused with secrecy, that is, the need to protect the management interests of an organisation should not override the need to protect the child.

15.3.5 Staff reporting concerns at work (‘whistleblowing’) are entitled to protection under the Public Interest Disclosure Act 1998 and should consult the whistleblowing procedure (A04).

15.3.6 The Safeguarding Lead and Deputy Lead will be notified and kept informed on the progress of the investigation.

15.4 Sharing with the alleged victim

15.4.1 The child will be updated as to the progress of the investigation of the allegation and the next steps.

15.4.2 This should be done as soon as is reasonable so that the child is reassured that action is being taken.

15.4.3 It is a requirement under the Data Protection Act 1998 to explain to the child what information may be shared and under what circumstances, with other people and organisations.

15.5 Sharing with the alleged perpetrator

15.5.1 If the alleged perpetrator is a client, and an investigation is underway, guidance should be sought from the Information Security team as to what information can be disclosed.

15.5.2 If the alleged perpetrator is a staff member, locum, agency worker, volunteer or student on placement, guidance must be sought from an HR partner and the Information Security team as to what information should be communicated.

15.6 Sharing with other clients

15.6.1 Information will not be shared with other clients who are not involved in the safeguarding concern.

15.7 Children who are clients involved in safeguarding cases should be advised both by St Mungo’s staff and other professionals (e.g. social services) not to discuss this with friends, other clients or on social media. However, they may choose to disclose information, so staff and management should be aware of safety concerns related to this, as well as addressing the consequences of disclosure with the client, before it takes place and afterwards, if necessary.

16 What to do if a safeguarding referral is closed with no further action

16.1 At times, a safeguarding referral may be closed with no further action. If this happens, take the following steps:
16.1.1 Ask for a full explanation as to why the safeguarding referral has been closed with no further action being taken and the case not being allocated for further investigation.

16.1.2 Review the information in the referral for completeness and clarity. Was there something important which was omitted and were risks explicitly stated?

16.1.3 Did the Safeguarding Team have a full and proper understanding of the risks involved?

16.1.4 Pass any further relevant information to the team. This may be information which was missing from the original referral or additional information which is now available

16.1.5 Review the Safeguarding Team’s practice and decision against relevant procedures (often called threshold and/or criteria documents) which should be online. Are they working in accordance with these procedures or is there a gap between what their procedures require and what they have done?

16.2 If the above steps are taken and there is no change, contact the local authority’s lead for Safeguarding Children, or if there is no one in that position, another manager within the organisation. If the disagreement remains unresolved, a complaint can be made to the relevant local authority complaints officer.

16.3 For further details on escalating referrals closed with no further action, please see B08S18, Guidance Document Advocating for Clients.

16.4 If the referral is rejected on the grounds that a client has the capacity to make unwise decisions, consider the following questions:

16.4.1 Might the person have been coerced or subject to duress?

16.4.2 Could anyone else be at risk?

16.4.3 Has the person had a mental capacity assessment regarding the particular safeguarding issue?

16.4.4 Has the person recently been diagnosed, e.g. with a mental health need?

16.4.5 Have the person’s circumstances deteriorated or their needs increased?

16.4.6 Does the person have fluctuating or complex needs?

16.4.7 Is there a sudden change in the person’s behaviour indicating an escalating problem?

16.4.8 Has there been a safety and wellbeing plan been updated regarding the particular safeguarding issue?

16.4.9 Might the alleged abuser be at risk, or might they have care and support needs?

17 Supporting a child who makes repeated allegations

17.1 A child who makes repeated allegations that have been investigated and are unfounded should be treated without prejudice.

17.2 Each allegation must be responded to under these procedures.
17.3 A safety and wellbeing plan must be completed in full and measures taken to protect staff and others and a case conference convened, where appropriate.

17.4 Each incident must be recorded.

17.5 Responding to family members, friends and neighbours who make repeated allegations

17.5.1 Allegations of abuse made by family members, friends and neighbours should be investigated without prejudice. However, where repeated allegations are made and there is no foundation to the allegations and further investigation is not in the best interests of the child, refer to the A02 Complaints, Suggestions and Compliments procedure, for details on vexatious complaints.

18 Closing a child safeguarding alert

18.1 An alert is closed when relevant action has been taken to address the abuse, even if the abuse is ongoing. It will typically be closed after the process of reporting, external referral, case conferences and creating an action plan has taken place.

18.2 Recording on Opal and in the local safeguarding log should summarise the action taken and the closing of the alert, noting if there are ongoing actions or concerns and who will be responsible for addressing these.

18.3 After the alert is closed ongoing support arising from the alert should be recorded under the relevant action headings (e.g. health, external services).

18.4 A new alert should then be completed if circumstances change or a new incident occurs, even if it is a continuation of the previous abuse. The new form should refer to the previous case.

18.5 If the allegation is unfounded then the issue should be recorded in the client’s records. It may be that the client has made the allegation because they didn’t like the worker or was unhappy with something the worker did. They may need support around expressing their needs and/or dissatisfaction in more appropriate ways. If the allegation was made about their keyworker, it may be more appropriate for the manager to address this part of the action plan and consider a change of keyworker.

18.6 Closing a case relates to procedure, recording and review and prompts the manager to consider each case and reflect on practice. It is not intended to signify that a solution has been reached or that the abuse has ended.

19 Supporting clients who discuss safeguarding concerns about other people

Clients who raise concerns related to safeguarding should be supported by discussing their concerns with them, the options which are open to them and the implications of each course of action. Staff must not promise to keep information confidential.

20 Training and learning

20.1 All managers, staff, locums, volunteers and students on placement working in services must complete mandatory e-learning training on safeguarding provided by St Mungo’s and attend training around boundaries with clients as part of their induction.
20.2 Safeguarding training is provided by Learning & Development and should be renewed every three years.

20.3 Commissioners may specify more frequent renewal of the training they provide and this must be complied with.

20.4 Staff working in children or family services must also access safeguarding or other relevant training offered by local authorities or other specialist providers, as required the type of service in which they work. E.g. child sexual exploitation, bullying, young people’s sexual health and relationships.

20.5 All attendance at safeguarding training must be notified to the Learning & Development Department so that details of attendance can be noted on central staff records.

20.6 Managers should attend appropriate training related to the recruitment of staff who will be working with children, e.g. Safer Recruiting Training provided by DofE e-learning, as well as appropriate training in the management of safeguarding issues.

20.7 Persistent failure to complete safeguarding training and relevant updates will be treated as a capability and disciplinary issue.

20.8 Organisational safeguarding data and national learning will be discussed by the Safeguarding Leads, Organisational Learning Group and relevant operational managers at least quarterly, with recommendations for improvements implemented by Quality and Continuous Improvement, Learning and Development, Information Security or any other team, as necessary.

21. Monitoring

21.1 The Regional Head will review safeguarding cases with the Service Manager on a six monthly basis as part of the Local Operational Review Meeting.

21.2 All medium-high rated incident reports which are marked as safeguarding will be reviewed by one of the organisational Safeguarding Leads.

21.3 The Safeguarding Lead for the Board will meet with the organisational Safeguarding Leads on a six monthly basis and will be provided with a safeguarding summary which will include numbers of safeguarding cases, very serious cases, and lessons learned.

21.4 An annual safeguarding review will be provided to the Board and the Organisational Learning Group (the Safeguarding Lead for the Board will be provided with a draft copy in advance).

22 Diversity implications

St Mungo’s accepts the welfare of the child is paramount and all children without exception have the right to protection from abuse. Research evidence indicates that children who may be perceived as ‘different’, e.g. children with disabilities or children with differing sexual orientations are more vulnerable to abuse. Therefore all staff must promote equality of opportunity and anti-discriminatory practice as part of child protection.

23 List of relevant procedures

St Mungo’s Code of Conduct (applies to staff and volunteers)
Whistleblowing (A04)
Handling clients’ money and valuables (B06)
Keyworking, Action Planning and Client Safety (B08)
Records, Recording and Access to Records (B12)
Preventing and Responding to Violence (B14)
Responding to Bullying and Harassment of Clients (B15)
Sanctions and Appeals (B17)
Working with the Police (B18)
Visitors (B20)
Domestic Abuse (B23)
Working with Pregnant Clients and Clients with Children (B24)
Leaving accommodation, Abandonment and Storage of Belongings (B26)
Safeguarding Adults (B37)
Preventing Radicalisation and Extremism (B37S3)
Multi-Agency Public Protection Arrangements (MAPPA) (B37S4)
Working with Clients who Self harm (B45)
Safeguarding Children (B46)
Preventing and Responding to Sexual Assault (B48)
Induction checklists for new client-facing staff and new line managers
Supervision standard agenda and notes proforma
Disciplinary policy and procedure
Capability procedure
Learning and Development in St Mungo’s policy
Volunteer Policy
Volunteer Handbook
Staff Resource Pack for Volunteer Management
IT Systems Acceptable Use policy
Client IT Acceptable Use policy and Service Level Agreement

The following documents were consulted for the review of this policy and procedure:

2. Children and Families Act 2014
3. Working Together to Safeguard Children 2015
4. Care Act 2014
5. Health and Social Care Act 2012
7. Equality Act 2010
9. Mental Capacity Act 2005
12. The Protection of Freedoms Act 2012 N.B. St Mungo’s is not bound by this legislation, since it applies to public authorities, but nonetheless acts within its principles.


16. Serious Crime Act 2015

17. Female Genital Mutilation Act 2003

18. Counter-Terrorism and Security Act 2015

This policy and procedure was developed in consultation with:

1. St Mungo’s Safeguarding Lead and Deputy Lead
2. All staff in the services directorate
3. Internal Auditor
4. HR Director
5. Outside In
6. Young Persons and Children Matrix lead