



**Stand-by-me**  
Bereavement Support

# Safeguarding Policy

Approved by Trustees :01/06/23

Safeguarding Trustee Carol Read

Updated – 18/3/25  
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## 1. INTRODUCTION

Stand-by-me Bereavement Service for Children define Safeguarding as protecting children and young people (up to 18 years) from maltreatment, preventing impairment of health and/or development, ensuring that children and young people grow up in the provision of safe and effective care and optimising children and young people's life chances.

### **Purpose of our Safeguarding Policy**

- To inform staff, parents, volunteers, and trustees about Stand-by-me's responsibilities for safeguarding children, young people, families, trustees, volunteers, and employees.
- To enable everyone to have a clear understanding of how these responsibilities should be carried out.

### **Stand-by-me trustees volunteers and staff**

- All staff, trustees and volunteers are particularly well placed to observe outward signs of abuse, changes in behaviour and failure to develop because they have regular contact with children and young people.
- All staff, trustees and volunteers will receive safeguarding training, so that they are knowledgeable and aware of their role in the early recognition of the signs and symptoms of abuse or neglect and of the appropriate procedures to follow. The Designated Safeguarding Lead will deliver an annual update. All trustees, volunteers and staff are required to sign to confirm they have read and understood the Safeguarding Policy and Procedures.

#### **Safeguarding Lead:**

**Carol Read**

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### **Mission Statement**

- Establish and maintain an environment where children, young people, families, trustees, staff and volunteers feel secure, are encouraged to talk, and are listened to when they have a worry or concern.

- Ensure children and young people know there is a safeguarding lead and that there are adults within Stand-by-me whom they can approach if they are worried.
- Ensure that children and young people who have been abused will be supported in line with a Safeguarding plan, where deemed necessary.

### Implementation, Monitoring and Review of Safeguarding Policy

The policy will be reviewed annually by the Board of Trustees. It will be implemented through the Stand-by-me induction and training programme and as part of day-to-day practice. Compliance with the policy will be monitored by the designated Safeguarding Trustee and through staff, trustee, and volunteer performance measures.

All staff, trustees and volunteers have a copy of and understand the written procedures for managing allegations of harm to a child or young person. (Appendix 8). They know how to make a complaint and how to manage whistleblowing or other concerns about the practice of adults in respect of the safety and protection of children.

Parents/carers have access to our Safeguarding Policy as well as all other policies via our website. Hardcopies are provided on request.

## 2.0 STATUTORY FRAMEWORK

To protect, safeguard and promote the welfare of children and young people, Stand-by-me will act in accordance with the following legislation and guidance:

- The Children Act 1989
- The Children Act 2004
- Education Act (2002), section 175
- Hertfordshire Safeguarding Children Partnership Procedures Manual
- DfES guidance Safeguarding Children and Safer Recruitment in Education (2007)
- HM Government 'Working Together to Safeguard Children' (2023)
- Counterterrorism and Security Act 2015
- The Safeguarding Vulnerable Groups Act 2006

**Allegations:** Stand-by-me is aware of and follows the procedures established by the Hertfordshire Safeguarding Childrens Partnership (HSCP):

- Staff, trustees, and volunteers are alert to signs of abuse and know to whom they should report any concerns or suspicions.
- Stand-by-me has procedures (of which all staff, trustees and volunteers are aware) for handling suspected cases of abuse of children and young people, including procedures to be followed if a member of staff, trustee or volunteer supporter is accused of abuse, or suspected of abuse, the Safeguarding Trustee has responsibility for co-ordinating action and liaising with other agencies.
- Safeguarding Trustee has received appropriate training.
- Working together to safeguard children (2023) requires all agencies in Hertfordshire working with children and their families to follow the procedures for protecting children from abuse which are established by the Herts Safeguarding Childrens Partnership.

## 3.0 RUNNING SAFER ACTIVITIES & EVENTS

Stand-by me provides the following activities as part of their service:

- Psycho-educational Therapeutic Groupwork programme for children and young people
- Psycho-educational Therapeutic Groupwork programme for parents/carers
- Post-Group Counselling for Parents/Carers
- Young Ambassador Programme
- Remember-me Day
- Training & Events for Education and Health Professionals

These events are planned in advanced and follow our Health & Safety policy with regards to carrying out risk assessments of the venues used, the numbers permitted,

availability of trained first aiders and any other regulations as required or added to said policy.

Consent is gained from parents/carers prior to their child/young person attending a groupwork programme. (See Consent Policy 2.0). The parents/carer, Volunteers and Young Ambassadors (if 18 years or over) give consent for photographs to be used when they are attending events. School and Health Professionals are asked to sign in when attend training events and a sign-in process is used at our events to enable us to account for all attendees.

#### 4.0 WHEN TO BE CONCERNED

All staff, trustees, and volunteers are made aware that the main categories of abuse are:

- Physical abuse
- Emotional abuse
- Sexual abuse
- Neglect

All staff, trustees and volunteers should be concerned about a child or young person if they present with indicators or appear at risk of possible significant harm (see Appendix 2 for details). All staff, trustees, and volunteers should be made aware of any situation where the child or young person is at risk of grooming.

Generally, in an abusive relationship, the child or young person may:

- Appear frightened of the parent/s or other household members e.g. siblings or others outside of the home.
- Act in a way that is inappropriate to their age and development (full account needs to be taken of different patterns of development and different ethnic groups).
- Display an insufficient sense of 'boundaries', lack stranger awareness.
- Appear wary of adults and display 'frozen watchfulness'.

#### 5.0 DEALING WITH A DISCLOSURE

If a child or young person discloses that he or she has been abused in some way, the member of staff, trustee or volunteer supporter should:

- Listen to what is being said without displaying shock or disbelief
- Accept what is being said
- Allow the child or young person to talk freely

- Reassure the child or young person, but do not make promises that it might not be possible to keep.
- Not promise confidentiality – it might be necessary to refer to Children’s Services (See Appendix 4 for details of how to make a referral)
- Reassure them that what has happened is not their fault
- Stress that it was the right thing to tell
- Listen, rather than ask direct questions
- Not criticise the alleged perpetrator
- Explain what has to be done next and who has to be told
- Make a written record (see Appendix 1)
- Pass the written record to the group leader without delay who will liaise with the Safeguarding Trustee/Designated Safeguarding Lead.
- See Record of Concern Process (copy available on request).

## Support

Dealing with a disclosure from a child or young person, and a Safeguarding case in general, is likely to be a stressful experience. The member of staff, trustee or volunteer should, therefore, consider seeking support for themselves and discuss this with the Designated Safeguarding Lead.

## 6.0 CONFIDENTIALITY

Safeguarding raises issues of confidentiality that are clearly understood by all staff, trustees, and volunteers at Stand-by-me.

- All staff at Stand-by-me have a responsibility to share relevant information about the protection of children and young people with other professionals, particularly the investigative agencies (Children’s Services and the Police). This information will be shared in accordance with our GDPR Policy.
- If a child or young person confides in a member of staff, trustee or volunteer supporter and requests that the information is kept secret, it is important that the member of staff, trustee or volunteer supporter tell the child or young person in a manner appropriate to the child or young person’s age/stage of development that they cannot promise complete confidentiality – instead they must explain that they may need to pass information to other professionals to help keep the child, young person or other children safe.
- Staff, trustees and volunteers who receive information about children, young people and their families in the course of their work should share that information only within appropriate professional contexts.
- Communication with parents: Stand-by-me will undertake appropriate discussion with parents prior to the involvement of another agency unless doing so would place the child or young person at further risk of harm.

- Ensure that parents understand the responsibilities placed on the staff, trustees and volunteers safeguarding their children or young person.

## 7.0 RECORD KEEPING

When a child or young person has made a disclosure, the member of staff, trustee or volunteer supporter should:

- Make brief notes as soon as possible after the conversation
- Not destroy the original notes in case they are needed by a court
- Record the date, time, place and any noticeable non-verbal behaviour and the words used by the child or young person
- Draw a diagram to indicate the position of any bruising or other injury
- Record statements and observations rather than interpretations or assumptions

All records need to be given to the Group Leader and Designated Safeguarding Lead/Safeguarding Trustee promptly. No copies should be retained by the member of staff, trustee or volunteer.

## 8.0 ALLEGATIONS INVOLVING STAND-BY-ME STAFF, TRUSTEES OR VOLUNTEERS

Whenever it is alleged that a member of staff, trustee or volunteer supporter has:

- Behaved in a way that has, or may have harmed a child or young person\*
- Possibly committed a criminal offence against/related to a child or young person\*
- Behaved toward a child or young person\* in a way which indicates they are unsuitable to work with children or young people.

(\*This applies to any child or young person with whom the member of staff, trustee or volunteer has contact within their personal, professional or community life).

The person receiving the allegation will take it seriously and immediately inform the Designated Safeguarding Lead/Safeguarding Trustee.

To reduce the risk of allegations, staff, trustees and volunteers should be aware of safer working practices, should be familiar with the guidance in the Staff, Trustee or Volunteers Handbook and should have undertaken Safeguarding Training.

If any member of staff, trustee or volunteer has reason to suspect that another member of staff, trustee or volunteer supporter may have abused a child or young person at Stand-by-me, or elsewhere, they will immediately inform the Designated Safeguarding Lead/Safeguarding Trustee. They will also make a written record of the allegation using the informant's words - including time, date and place where the

alleged incident took place, what was said and anyone else present. This record should be signed and dated and immediately passed on to the Designated Safeguarding Lead/Safeguarding Trustee (See Appendix 6).

The Designated Safeguarding Lead/Safeguarding Trustee will report if deemed necessary to Children's Services.

If the concerns are about the Safeguarding Trustee, then the Chair of Trustees should be contacted.

In the absence of the Chair or where the concerns are about the Chair, the Vice-Chair should be contacted.

## 9.0 PEER ON PEER ABUSE

Children and young people can abuse each other. This can include (but is not limited to) bullying (including cyberbullying); sexual violence and sexual harassment; physical abuse such as hitting, kicking, shaking, biting, hair pulling, or otherwise causing physical harm; sexting; teasing; goading; unkind comments; peer influence and pressure; encouragement of others to join in.

Children and young people are vulnerable to abuse in a range of social contexts as they form different relationships.

Stand-by-me highlights to staff, trustees, group leaders and volunteers the importance of awareness of factors within the groups so they understand if a child or young person is at risk. Understanding the power dynamic that can exist between children and young people is very important in helping to identify and respond to peer-on-peer abuse within the groups.

If a member of staff, trustee, group leader or volunteer suspects peer-on-peer abuse a record of concern should be completed and the suspicions reported to the group leader, designated safeguarding lead/safeguarding trustee. The victim should always be made to feel safe and separated from the perpetrator if necessary, so the abuse does not continue.

At the beginning of each group session, the children and young people should be reminded that they should always feel comfortable in each other's company and if they feel this is not the case to speak to a member of staff or volunteer.

## 10.0 MOBILE PHONES

Mobile phones can be used to abuse each other and therefore are not allowed to be switched on during the sessions. The children and young people are informed of this at the start of each session and reminded to switch their phones off.

## 11.0 PREVENT DUTY

All staff, trustees and volunteers are given training to help them understand the duties placed upon the charity by the Counter Terrorism Security Act 2015.

## 12.0 ESCALATED SAFEGUARDING REFERRAL PROCESS

Should a referral be needed to Children's Services, the Safeguarding Lead/Safeguarding Trustee or Chair will use the online referral form (<https://www.hertfordshire.gov.uk/services/childrens-social-care/child-protection/professionals-report-a-concern.aspx>).

This form is to be used by Professionals wishing to make a referral to report concerns about a child or request support.

Stand-by-me will have a central account for all referrals which will be set up by the Safeguarding Lead/Safeguarding Trustee or Chair when needed.

Any immediate safeguarding concerns should be reported via the Customer Service Centre on **0300 123 4043** and then followed up using the online form within 24 hours, attaching any relevant documentation.

If for any reason we cannot send documents electronically, a copy of the form should be sent to the address below. Customer Service Centre, PO Box 153, Stevenage, Herts SG1 2GH

### STATEMENT

Stand-by-me Bereavement Services for Children operates a transparent policy. All volunteers, trustees and staff are encouraged to feel safe and comfortable to report any concerns about fellow volunteers, trustees or staff either towards children, young people, families or other volunteers, trustees and employees, including accusations of bullying, harassment or prejudice.

## RECORD OF CONCERN

Child/Young Person's Name :		
Child/Young Person's DOB :		
Gender :	Ethnic Origin:	Disability Y/N:
Date and Time of Concern:		
Your Account of the Concern: (what was said, observed, reported and by whom)		
Additional Information: (your opinion, context of concern/disclosure)		
Your Response: (what did you do/say following the concern)		
Your Name:		
Your Signature:		
Your Position:		
Date and Time of this Recording:		
Action and Response of Safeguarding Trustee		
Name: .....Date:.....		

## INDICATORS OF HARM

### *PHYSICAL ABUSE*

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

### Indicators in the child/young person

#### Bruising

It is often possible to differentiate between accidental and inflicted bruises. The following must be considered non-accidental unless there is evidence, or an adequate explanation provided:

- Bruising in or around the mouth
- Two simultaneous bruised eyes, without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive)
- Repeated or multiple bruising on the head or on sites unlikely to be injured accidentally, for example the back, mouth, cheek, ear, stomach, chest, under the arm, neck, genital and rectal areas
- Variation in colour possibly indicating injuries caused at different times
- The outline of an object used e.g. belt marks, handprints or a hairbrush
- Linear bruising at any site, particularly on the buttocks, back or face
- Bruising or tears around, or behind, the earlobe/s indicating injury by pulling or twisting
- Bruising around the face
- Grasp marks to the upper arms, forearms or leg
- Petechiae haemorrhages (pinpoint blood spots under the skin.) Commonly associated with slapping, smothering/suffocation, strangling and squeezing

#### Fractures

Fractures may cause pain, swelling and discolouration over a bone or joint. It is unlikely that a child or young person will have had a fracture without the carers being aware of the child or young person's distress.

If the child or young person is not using a limb, has pain on movement and/or swelling of the limb, there may be a fracture.

There are grounds for concern if:

- The history provided is vague, non-existent or inconsistent
- There are associated old fractures
- Medical attention is sought after a period of delay when the fracture has caused symptoms such as swelling, pain or loss of movement.

Rib fractures are only caused in major trauma such as in a road traffic accident, a severe shaking injury or a direct injury such as a kick.

Skull fractures are uncommon in ordinary falls, i.e. from three feet or less. The injury is usually witnessed, the child or young person will cry or show sign of pain if there is a fracture, there is likely to be swelling on the skull developing over 2 to 3 hours. All fractures of the skull should be taken seriously.

### **Mouth Injuries**

Tears to the frenulum (tissue attaching upper lip to gum) often indicates force feeding of a baby or a child/young person with a disability. There is often finger bruising to the cheeks and around the mouth. Rarely, there may also be grazing on the palate.

### **Poisoning**

Ingestion of tablets or domestic poisoning in children under 5 is usually due to the carelessness of a parent or carer, but it may be self-harm even in young children.

### **Fabricated or Induced Illness**

Professionals may be concerned at the possibility of a child or young person suffering significant harm as a result of having illness fabricated or induced by their parent/carer. Possible concerns are:

- Discrepancies between reported and observed medical conditions, such as the incidence of fits
- Attendance at various hospitals, in different geographical areas
- Development of feeding / eating disorders, as a result of unpleasant feeding interactions
- The child or young person developing abnormal attitudes to their own health
- Nonorganic failure to thrive - a child or young person does not put on weight and grow and there is no underlying medical cause
- Speech, language or motor developmental delays
- Dislike of close physical contact
- Attachment disorders
- Low self esteem
- Poor quality or no relationships with peers because social interactions are restricted
- Poor attendance at school and under-achievement

### **Bite Marks**

Bite marks can leave clear impressions of the teeth when seen shortly after the injury has been inflicted. The shape then becomes a more defused ring bruise or oval or crescent shaped. Those over 3cm in diameter are more likely to have been caused by an adult or older child.

A medical/dental opinion, preferably within the first 24 hours, should be sought where there is any doubt over the origin of the bite.

### Burns and Scalds

It can be difficult to distinguish between accidental and non-accidental burns and scalds. Scalds are the most common intentional burn injury recorded. Any burn with a clear outline may be suspicious e.g. circular burns from cigarettes, linear burns from hot metal rods or electrical fire elements, burns of uniform depth over a large area, scalds that have a line indicating immersion or poured liquid.

Old scars indicating previous burns/scalds which did not have appropriate treatment or adequate explanation.

### Scars

Many scars or scars of different sizes or ages, or on different parts of the body, or unusually shaped, may suggest abuse.

### Emotional/behavioural presentation

- Refusal to discuss injuries
- Admission of punishment which appears excessive
- Fear of parents being contacted and fear of returning home
- Withdrawal from physical contact
- Arms and legs kept covered in hot weather
- Fear of medical help
- Aggression towards others
- Frequently absent from school
- An explanation which is inconsistent with an injury
- Several different explanations provided for an injury

### Indicators in the parent/carer

- May have injuries themselves that suggest domestic violence
- Not seeking medical help/unexplained delay in seeking treatment
- Reluctant to give information or mention previous injuries
- Absent without good reason when their child or young person is presented for treatment
- Disinterested or undisturbed by accident or injury
- Aggressive towards child, young person or others
- Unauthorised attempts to administer medication
- Tries to draw the child or young person into their own illness.
- Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault
- Parent/carer may be over involved in participating in medical tests, taking temperatures and measuring bodily fluids
- Observed to be intensely involved with their children, never taking a much-needed break nor allowing anyone else to undertake their child or young person's care.

- May appear unusually concerned about the results of investigations which may indicate physical illness in the child or young person
- Wider parenting difficulties may (or may not) be associated with this form of abuse.
- Parent/carer has convictions for violent crimes.

### Indicators in the family/environment

- Marginalised or isolated by the community
- History of mental health, alcohol or drug misuse or domestic violence
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.

### *EMOTIONAL ABUSE*

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

*It may include not giving the child or young person opportunities to express their views, deliberately silencing them or 'making fun' of what they say or how they communicate.*

*It may feature age or developmentally inappropriate expectations being imposed on children or young people. These may include interactions that are beyond the child or young person's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.*

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

### Indicators in the child/young person

- Developmental delay
- Abnormal attachment between a child or young person and parent/carer e.g. anxious,
- Indiscriminate or no attachment
- Aggressive behaviour towards others
- Child or young person scapegoated within the family
- Frozen watchfulness, particularly in pre-school children
- Low self-esteem and lack of confidence
- Withdrawn or seen as a 'loner' - difficulty relating to others
- Over-reaction to mistakes
- Fear of new situations
- Inappropriate emotional responses to painful situations
- Neurotic behaviour (e.g. rocking, hair twisting, thumb sucking)
- Self-harm
- Fear of parents being contacted
- Extremes of passivity or aggression
- Drug/solvent abuse
- Chronic running away
- Compulsive stealing
- Low self-esteem

- Air of detachment – ‘don’t care’ attitude
- Social isolation – does not join in and has few friends
- Depression, withdrawal
- Behavioural problems e.g. aggression, attention seeking, hyperactivity, poor attention
- Low self-esteem, lack of confidence, fearful, distressed, anxious
- Poor peer relationships including withdrawn or isolated behaviour

### Indicators in the parent/carer

- Domestic abuse, adult mental health problems and parental substance misuse may be features in families where children/young people are exposed to abuse.
- Abnormal attachment to child or young person e.g. overly anxious or disinterest in the child/young person
- Scapegoats one child or young person in the family
- Imposes inappropriate expectations on the child or young person e.g. prevents the child or young person’s developmental exploration or learning, or normal social interaction through overprotection.
- Wider parenting difficulties may (or may not) be associated with this form of abuse.

### Indicators in the family/environment

- Lack of support from family or social network.
- Marginalised or isolated by the community.
- History of mental health, alcohol or drug misuse or domestic violence.
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Past history of childhood abuse, self-harm, somatising disorder, or false allegations of physical or sexual assault or a culture of physical chastisement.

### NEGLECT

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

*Once a child is born, neglect may involve a parent or carer failing to:*

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

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

### Indicators in the child/young person

#### Physical presentation

- Failure to thrive or, in older children, short stature
- Underweight
- Frequent hunger
- Dirty, unkempt condition
- Inadequately clothed, clothing in a poor state of repair
- Red/purple mottled skin, particularly on the hands and feet, seen in the winter due to cold
- Swollen limbs with sores that are slow to heal, usually associated with cold injury
- Abnormal voracious appetite
- Dry, sparse hair
- Recurrent / untreated infections or skin conditions e.g. severe nappy rash, eczema or persistent head lice / scabies/ diarrhoea
- Unmanaged / untreated health / medical conditions including poor dental health
- Frequent accidents or injuries

#### Development

- General delay, especially speech and language delay
- Inadequate social skills and poor socialization

#### Emotional/behavioural presentation

- Attachment disorders
- Absence of normal social responsiveness
- Indiscriminate behaviour in relationships with adults
- Emotionally needy

- Compulsive stealing
- Constant tiredness
- Frequently absent or late at school
- Poor self esteem
- Destructive tendencies
- Thrives away from home environment
- Aggressive and impulsive behaviour
- Disturbed peer relationships
- Self-harming behaviour

### Indicators in the parent/carer

- Dirty, unkempt presentation
- Inadequately clothed
- Inadequate social skills and poor socialisation
- Abnormal attachment to the child or young person. e.g. anxious
- Low self-esteem and lack of confidence
- Failure to meet the basic essential needs e.g. adequate food, clothes, warmth, hygiene
- Failure to meet the child/young person's health and medical needs e.g. poor dental health.
- Failure to attend or keep appointments with health visitor, GP or hospital; lack of GP registration; failure to seek or comply with appropriate medical treatment;
- Failure to address parental substance misuse during pregnancy
- Child or young person left with adults who are intoxicated or violent
- Child or young person abandoned or left alone for excessive periods
- Wider parenting difficulties may (or may not) be associated with this form of abuse.

### Indicators in the family/environment

- History of neglect in the family
- Family marginalised or isolated by the community.
- Family has history of mental health, alcohol or drug misuse or domestic violence.
- History of unexplained death, illness or multiple surgery in parents and/or siblings of the family
- Family has a past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.
- Dangerous or hazardous home environment including failure to use home safety equipment; risk from animals
- Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements, inadequate ventilation (including passive smoking) and lack of adequate heating
- Lack of opportunities for child to play and learn

### **SEXUAL ABUSE**

*Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child or young person is aware of what is happening.*

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

*They may also include non-contact activities, such as involving children or young people 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 or young person in preparation for abuse (including via the internet).*

*Sexual abuse is not solely perpetrated by adult males. Women can also commit acts of sexual abuse, as can other children or young people.*

### Indicators in the child/young person

#### Physical presentation

- Urinary infections, bleeding or soreness in the genital or anal areas
- Recurrent pain on passing urine or faeces
- Blood on underclothes
- Sexually transmitted infections
- Vaginal soreness or bleeding
- Pregnancy in a younger girl where the identity of the father is not disclosed and/or there is secrecy or vagueness about the identity of the father
- Physical symptoms such as injuries to the genital or anal area, bruising to buttocks, abdomen and thighs, sexually transmitted disease, presence of semen on vagina, anus, external genitalia or clothing

#### Emotional/behavioural presentation

- Makes a disclosure.
- Demonstrates sexual knowledge or behaviour inappropriate to age/stage of development, or that is unusually explicit
- Inexplicable changes in behaviour, such as becoming aggressive or withdrawn
- Self-harm - eating disorders, self-mutilation and suicide attempts
- Poor self-image, self-harm, self-hatred
- Reluctant to undress for PE
- Running away from home
- Poor attention / concentration (world of their own)
- Sudden changes in schoolwork habits, become truant
- Withdrawal, isolation or excessive worrying

- Inappropriate sexualised conduct
- Sexually exploited or indiscriminate choice of sexual partners
- Wetting or other regressive behaviours e.g. thumb sucking
- Draws sexually explicit pictures
- Depression

### Indicators in the parents/carers

- Comments made by the parent/carer about the child or young person.
- Lack of sexual boundaries
- Wider parenting difficulties or vulnerabilities
- Grooming behaviour
- Parent is a sex offender

### Indicators in the family/environment

- Marginalised or isolated by the community.
- History of mental health, alcohol or drug misuse or domestic violence.
- History of unexplained death, illness or multiple surgery in family
- Past history of childhood abuse, self-harm, somatising disorder or false allegations of physical or sexual assault or a culture of physical chastisement.
- Family member is a sex offender.

## INDICATORS FOR GIRLS AT RISK OF FEMALE GENITAL MUTILATION

- Any girl withdrawn from PSHE may be at risk as a result of her parents wishing to keep her uninformed about her body and rights
- Girls taken abroad at the start of the summer holidays, in order for there to be sufficient time for her to recover before returning to school
- Girls who have a female family elder visiting from a country of origin
- A professional may hear reference to FGM in conversation i.e. a girl may tell others about it
- A girl may confide that she is to have a 'special procedure' or to attend a special occasion to 'become a woman'
- A girl may request help from a teacher or another adult if she is aware or suspects she is at risk
- Parents state that they or a relative will take the child out of the country for prolonged periods
- A girl may have difficulty walking, sitting or standing
- A girl may spend longer than normal in the toilet due to difficulties urinating
- A girl may spend long periods of time away from the classroom during the day with bladder or menstrual problems
- A girl may have frequent urinary or menstrual problems
- There may be prolonged or repeated absences from school
- A prolonged absence from school with noticeable behaviour changes, withdrawal or depression
- A girl may be reluctant to undergo normal medical examinations
- A girl may confide in a professional
- A girl may ask for help but may not be explicit

### GILLICK COMPETENCY / CONSENT

*(information taken from SBM Consent Policy April 2020)*

Before a child or young person is deemed to be Gillick Competent, they will be assessed by a Stand-by-me professional in accordance with the principles laid out (below).

For a young person under the age of 16 to be competent, they should have:

- the ability to understand that there is a choice and that choices have consequences
- the ability to weigh the information and arrive at a decision
- a willingness to make a choice (including the choice that someone else should make the decision)
- an understanding of the nature and purpose of the proposed intervention
- an understanding of the proposed intervention's risks and side effects
- an understanding of the alternatives to the proposed intervention, and the risks attached to them
- freedom from undue pressure.

Competent under 16-year olds are sometimes referred to as being Gillick competent. In England, Wales and Northern Ireland children and young people who are aged 12 or over are generally expected to have competence to give or withhold their consent to the release of information.

If a child or young person passes the Gillick test, they are considered 'Gillick competent' to consent to decisions concerning their care. However, as with adults, this consent is only valid if given voluntarily and not under undue influence or pressure by anyone else. Additionally, a child or young person may have the capacity to consent to some care, interventions or treatments but not to others. The understanding required for different interventions will vary, and capacity can also fluctuate such as in certain mental health conditions. Therefore, each individual decision requires assessment of Gillick competence.

If a child or young person does not pass the Gillick test, then the consent of a person with parental responsibility (or sometimes the courts) is needed in order to proceed with treatment.

#### **Who should assess competence?**

Health professionals who assess competence need to be skilled and experienced in interviewing young people and eliciting their views without distortion. Stand-by-me professionals assessing competency will complete a Gillick Competency Assessment (see Appendix 4A) and this will then be added to the child/young person's record.

**Gillick Competency Assessment** *(to be saved to child's record)*

Name of Child / Young Person .....

Date of Birth.....

Following a comprehensive assessment, taking into consideration the principles laid out below and in accordance with our Safeguarding Policy, I assess the above named child to be deemed competent for the purposes of making decisions about their care being provided by Stand-by-me Bereavement Support.

- the ability to understand that there is a choice and that choices have consequences
- the ability to weigh the information and arrive at a decision
- a willingness to make a choice (including the choice that someone else should make the decision)
- an understanding of the nature and purpose of the proposed intervention
- an understanding of the proposed intervention's risks and side effects
- an understanding of the alternatives to the proposed intervention, and the risks attached to them
- freedom from undue pressure.

Name of professional assessing competency:.....

Role:.....

Date:.....

### Record of Concern (Staff/Trustee/Volunteer)

Name of Staff Member/Trustee/Volunteer	
Date and Time of Incident:	Concern raised by:
Incident (what happened):	
Action taken :	
Your Name:	Your Position:
Your Signature:	Date and Time Incident Recorded:
For Clinical Service Manager	
Action taken by Clinical Service Manager:	
Date Sent to Safeguarding Trustee	
Signature of Clinical Service Manager	Date signed:
For Safeguarding Trustee	
Action Taken by Safeguarding Trustee:	
Signature of Safeguarding Trustee	Date signed:

\*Allegations involving staff, trustees or volunteers

## **SAFEGUARDING DECLARATION**

June 2023

I confirm that I have read and understood the Stand-by-me Children's Bereavement Support **Safeguarding Policy** and I am committed to upholding this **policy**

Name: \_\_\_\_\_

Position: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**SAFEGUARDING CHILDREN & YOUNG PEOPLE – QUICK REFERENCE  
GUIDE** (see attached booklet

**MASH IN HERTFORDSHIRE – MULTI-AGENCY SAFEGUARDING**

(see attached booklet)

**THE 4 Rs OF SAFEGUARDING CHILDREN (see attached booklet)**