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Summary of updates

Version 4.1 (January 2018): Minor addition to section D1.2 Group identification

Version 4 (September 2016): Restructured document and chapter markings. The revised structure is designed to complement a new training day for Safeguarding Leads.

3.1 December 2015. Updated section on room sharing (see Sleeping arrangements while in Lourdes, page 54) including the introduction of the “Risk assessment based room sharing plan”. Added a section on pre-pilgrimage day trips (page 50) Minor adjustments to reflect rebranding.

3.0 November 2014. Various references updated to reflect updated statutory regulations. Also added a description of the initial and refresher training (both for Safeguarding leads and helpers) – Chapter 6.

2.1 Feb 2014: The section on Group identification and supervision (page 53) has been updated to include a more detailed description of the ‘lanyard system’.
Section A. Terms of reference

Introduction

Safeguarding our people is a primary function of HCPT and as such is the responsibility of every one of us, whether volunteer acting on behalf of HCPT, or employed staff. HCPT’s safeguarding procedures exist for the protection both of the people in our care and for those who care for them. Whilst no safeguarding procedures can eliminate the totality of safeguarding risks, when properly applied these procedures should ensure that all of us are safeguarded as far as we can be.

These safeguarding procedures, like HCPT’s related risk management procedures, work best when they have become instinctive and second nature. When they are, they will not interfere with our mission to share God’s gifts of love, friendship and joy. Indeed they should underpin this mission as the procedures will be underlying and constant. It is vital that this enduring relevance of our safeguarding procedures is fully appreciated. A box has not been ticked when the procedures have been read or the associated training received, with the implication that they can be put to one side. In the same way, no box is ticked when risk assessments have been written or discussed within a group. Appropriate preparation in terms of safeguarding and risk management is absolutely vital, but the real value is in their proper application during the activities in question and across our pilgrimages as a whole.

The HCPT Safeguarding Guidebook is the product of a great deal of work by the HCPT Safeguarding Sub Committee, its Safeguarding Advisors and staff. It draws on the material produced by HCPT with the Athena Programme in 2011, as well as experience from the implementation of HCPT’s previous Safeguarding documentation.

Whilst any update will contain some adjustment and re-wording to ensure clarity of procedure it is very important to keep in mind that the fundamental principles behind the procedures themselves have not changed.

Once again, no fail safe procedure can protect against every eventuality but we must all do our utmost to apply these procedures to safeguard our people as far as possible. In so doing we will have the confidence to continue the work HCPT has been doing for generations, in offering those in need the opportunity to undertake a life changing pilgrimage to Lourdes.

Phil Sparke
Chief Executive

July 2013
Safeguarding Statement

HCPT is committed to safeguarding and promoting the welfare of children, young people and vulnerable adults. It expects all of its Trustees, helpers and staff to share this commitment.

HCPT recognises its responsibility for safeguarding children, young people and vulnerable adults whilst providing quality pilgrimage holidays and residential retreats. In particular it recognises the additional vulnerability of those disabled children and vulnerable adults who may be making their first holiday away from home and loved ones.

Trustees, helpers and staff undertake to create a safe environment for children, young people and vulnerable adults to experience an opportunity of pilgrimage to Lourdes. HCPT will collectively manage risks and reduce the possibility of abuse by:

- having robust safer recruitment and selection procedures;
- implementing safer working practices;
- providing induction and ongoing training for all staff and volunteers;
- providing up to date safeguarding policies and procedures that reflect current safeguarding legislation and guidance in respect of safeguarding children and vulnerable adults; and
- developing and maintaining a culture of risk management.

HCPT will also promote effective and early identification of:

- safeguarding concerns in children and vulnerable adults; and
- those children and vulnerable adults who are in need of additional services.

It will liaise closely with statutory agencies to ensure that any such concerns or allegations of abuse are promptly and properly referred to the appropriate local statutory safeguarding agencies, that victims are supported and that abusers are held to account.

HCPT will support and promote sound risk management for those situations that require more complex consideration. Such high risk activities will be robustly risk assessed, focussing on the needs of the individual, as well as the skills of the helper, to justify decisions made and actions taken.

As a registered charity, HCPT is regulated by the Charity Commission and the Office of the Scottish Charity Regulator ("OSCR"). The Charity Commission and OSCR have statutory objectives to ensure trustees comply with their legal obligations in managing charities and to increase public trust and confidence in charities.

HCPT is committed to providing support to all those involved with our work volunteering and working with children, young people and vulnerable adults and to provide a clear structure of safeguarding accountability.

HCPT will ensure that it has arrangements in place to fulfil its commitment to safeguard and promote the welfare of children, young people and vulnerable adults in the same way as statutory bodies and the public sector.
HCPT acknowledges that safeguarding children and vulnerable adults is everybody’s business and will benchmark policy and procedures against the following principles issued in the ‘Statement of Government Policy on Adult Safeguarding’ – Department of Health 2013:

1. Empowerment - presumption of person led decisions and informed consent;
2. Protection - support and representation for those in greatest need;
3. Prevention - it is better to take action before harm occurs;
4. Proportionality – a proportionate and least intrusive response, appropriate to the risk presented;
5. Partnership – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse;
6. Accountability - accountability and transparency in delivering safeguarding.

Aims of the safeguarding policies

The aim of these policies and procedures is to provide a safe environment for children, young people and vulnerable adults who come into contact with HCPT and to give confidence to members of staff and helpers, to allow healthy and supportive relationships to flourish without fear.

HCPT will strive to achieve this aim by:

1. Effective and rigorous recruitment and selection of suitable staff and helpers.
2. Raising awareness of safeguarding amongst staff and helpers through induction and preparation.
3. Providing information which enables staff and helpers to recognise possible signs of abuse, the need for additional support/services and to respond appropriately to these issues.
4. Describing the procedures to be followed when a member of staff or helper becomes aware that a child, young person or vulnerable adult may be experiencing abuse or is in need of additional services.
5. Providing helpers and staff with guidance, to reduce risks within Groups, by following safe practice guidelines.

Scope of the safeguarding policies

These policies and procedures apply to Trustees, staff, helpers and other support staff who may not necessarily be involved in service delivery directly.

They apply to all HCPT activities, regardless of location, and are therefore applicable to HCPT activities taking place in the UK and overseas and both on and off HCPT owned premises, including, but not limited to, HCPT head office, local community centres, churches, chartered trains and planes, hotels and Hosanna House.
A1: Roles and responsibilities

A1.1: Trustees

The Trustees have the legal responsibility for administering the charity. They are answerable to the Charity Commission, the OSCR, Companies House and HCPT’s beneficiaries for ensuring that all who work in the name of HCPT comply with company and charity law as well as legislation, for example relating to health and safety and safeguarding. The Trustees play a vital role in ensuring that HCPT is legally compliant in managing the charity’s resources effectively, providing a long-term vision, protecting the charity’s reputation and values and ensuring its beneficiaries receive the best possible care.

The Trustees rarely intervene on operational matters, as their main role is to decide on strategic or policy issues in order to meet current and future needs. They are ultimately responsible for:

- the approval of all safeguarding policies and procedures;
- providing adequate resources for effective safeguarding; and
- developing a culture that promotes effective safeguarding practices.

The Board of Trustees may delegate some or all of these responsibilities to the Safeguarding Committee.

A1.2: Safeguarding Committee

The Safeguarding Committee is responsible for ensuring that HCPT is fully compliant in all matters of safeguarding legislation and for promoting best practice in all matters pertaining to safeguarding. It should have ready access to the Board of Trustees in order to report or escalate safeguarding issues, in a timely manner.

The Safeguarding Committee will comprise of at least three Trustees and should meet at least three times a year, where possible. It is recommended that the Safeguarding Committee should include:

- a chair person, who is a Trustee;
- a senior manager, who will be responsible for the accurate recording of meetings; and
- a Safeguarding Advisor;

Specifically, the Safeguarding Committee will be responsible for:

1. ensuring understanding of and compliance with current legislation is shared and practiced in HCPT;
2. keeping the Trustees advised of any legislative changes which affect HCPT with regard to safeguarding;
3. reviewing the safeguarding policies and procedures annually;
4. updating the safeguarding policies and procedures when required;
5. auditing the safeguarding practices and processes on an annual basis to identify safeguarding themes and issues within HCPT;
6. ensuring compliance with the DBS and PVG regime for all HCPT staff, helpers and Trustees;
7. promoting safeguarding as core business;
8. overseeing the development and implementation of a training framework for staff and helpers to underpin current and future safeguarding needs;
9. supporting and advising the Safeguarding Advisors;
10. quality assuring the progress of all safeguarding incidents quarterly and ensuring a satisfactory outcome is achieved in a timely manner;
11. advising, responding and reporting to the Trustees about safeguarding matters including all reported incidents; and
12. developing a child and vulnerable adult centered participation in the evaluation of HCPT activities.
A1.3: Safeguarding Advisor

Safeguarding Advisors will receive additional enhanced safeguarding training in order to perform their role. They will be responsible for:

1. responding to staff or helpers’ safeguarding queries where necessary;
2. providing accessible advice and guidance to Group Leaders and helpers on safeguarding issues both in the UK and in France whilst on pilgrimage;
3. liaising with external statutory agencies over safeguarding concerns, in order to assist in the timely resolution of all safeguarding incidents;
4. reporting compliance issues in relation to DBS and PVG checks to the Safeguarding Committee;
5. updating the Safeguarding Committee with all safeguarding concerns and/or incidents;
6. enabling and supporting safeguarding monitoring and audits within HCPT;
7. maintaining accurate safeguarding records;
8. attending an annual safeguarding training event;
9. helping co-ordinate and deliver safeguarding training to all HCPT staff and helpers;
10. being available to provide and deliver advice and support in advance of the pilgrimage; and
11. providing an on-call support facility whilst pilgrims are at Hosanna House.

Other HCPT volunteers may be asked to provide support to the Safeguarding Committee or Safeguarding Advisors, for example the Chief Medical Advisor.

A1.4: HQ staff

All staff need to be aware of their responsibilities for safeguarding and promoting the welfare of children and vulnerable adults and of how they should respond to protection concerns.

HQ staff will support the Safeguarding Committee by processing the required DBS and PVG disclosure checks for all HCPT staff, Trustees and helpers. They will also assist in the safe recruitment and selection of staff and helpers by following the appropriate recruitment and selection procedures.

A1.5: Hosanna House Manager

The Hosanna House Manager supervises the work of all Hosanna House staff and provides practical assistance and support for visiting Groups as required.

The recruitment and appointment of all staff at Hosanna House is in line with HCPT’s recruitment and selection policies and French legislation and guidance. All Hosanna House staff and volunteers receive training about the safeguarding of children and vulnerable adults.

A1.6: Chief Medical Adviser/Doctors on Pilgrimage

The Chief Medical Officer works with the Regional Doctors to give local advice and guidance before the pilgrimage to Group Leaders, on the selection and care of the members of their Group. The Chief Medical Officer’s primary role is to be the contact for all Group doctors.

It is expected that, if appropriate and relevant, a specialist doctor will assist the Group Leader and other helpers when managing a safeguarding issue.

A1.7: Regional groups

Whilst it is the responsibility of each Group Leader to ensure that helpers receive adequate preparation to undertake the pilgrimage, some preparation may best be organised on a regional basis. The region will also co-ordinate any regional fundraising, channel sponsorship money to HQ and assist Group Leaders, if necessary, in locating and allocating helpers and pilgrims.
The usual officers of the regional group are chair, secretary and treasurer with further officers and sub committees formed at the region’s discretion. Typically these will be a fundraising committee and a committee to consider all applications from pilgrims (including a doctor).

A1.8: Regional Chaplain

The Regional Chaplain works with the Trust Chaplain and the Group Chaplains within their region to foster and develop the spiritual ethos within HCPT.

The Regional Chaplain’s safeguarding role is to:

1. abide by the Code of Conduct;
2. be aware of what safer working practices are and how this affects his/her role and responsibilities;
3. know what to do if he/she is concerned about a child or vulnerable adult;
4. be aware of the importance of involving and consulting children and vulnerable adults and promoting the benefits of participation to helpers, children and vulnerable adults; and
5. supporting helpers at the end of the pilgrimage and signposting them to sources of further support, if necessary.

A1.9: Group Leader

The concept of taking children and vulnerable adults to Lourdes by plane or train, arranging the programme whilst in Lourdes and the recruitment and selection of the team makes a great demand on the Group Leader.

The Group Leader has a pivotal position within HCPT. It is a position of trust and considerable responsibility and demands a very strong commitment. Group Leaders must be experienced HCPT helpers who have been approved by the region concerned and whose appointment is confirmed by the Trustees.

The Group Leader must set the tone and example for the year. The success of the pilgrimage for all the pilgrims in the Group will depend considerably on the personal qualities and dedication of the Group Leader.

The pilgrimage will be achieved only through hard work from the Group Leader and all Group members. A central feature, and a crucial factor in the success of a pilgrimage, is mutual support and encouragement. This should be promoted not just among the pilgrims but among those associated with them, for example, parents, guardians, relatives, well-wishers and friends. The Group Leader must develop and harness this support.

The Group Leader must seek out the talents of all Group members and arrange for them to be placed at the service of the Group. All Group members, without exception, have a contribution to make.

In exercising leadership, the Group Leader should always remember that all helpers are volunteers. At the same time, the helpers have obligations to those in their care. It is the primary duty of the Group Leader to make sure those obligations are fulfilled.

Although the principal interest of the Group Leader is the Group, they must also be involved in HCPT as an organisation. No Group or Group Leader can function in isolation. Each Group and Group Leader needs the support of its region and the wider organisation. The Group Leader must participate actively in the region by attendance at regional meetings as well as national meetings and events. In this way, everyone learns and benefits.

The Group Leader has a responsibility to share relevant information with helpers to ensure the welfare and safety of everyone in the Group. This information should be shared at the earliest opportunity and daily updates provided where necessary. For example, in relation to issues about drug or alcohol dependency, self-neglect or those who may pose a risk of harm to others through their behaviour.
A1.10: Safeguarding Lead

Group Leaders will perform the role of Safeguarding Lead. This role can be devolved only to a deputy Safeguarding Lead from within the group if for any reason the Group Leader is unable to perform the role of Safeguarding Lead. It must not be devolved to anyone else outside the Group.

The Safeguarding Lead will have responsibility for the welfare of each member of the Group and will have received enhanced safeguarding training commensurate with the role.

As Safeguarding Lead, a Group Leader is responsible for:

1. responding to initial concerns or disclosures from Group members;
2. liaising with statutory services in an emergency situation;
3. reporting all safeguarding incidents/concerns to a Safeguarding Advisor;
4. completing a safeguarding concerns report form;
5. making sure that they and all helpers are aware of and abide by the Code of Conduct;
6. explaining to helpers what safer working practices are and how this affects their roles and responsibilities;
7. being aware of child and vulnerable adult protection issues;
8. making sure that helpers have shared relevant information to raise awareness;
9. making sure that helpers know what to do if they are concerned about a child, young person or vulnerable adult;
10. with the Group Nurse, completing all risk assessment forms in relation to safeguarding, children or vulnerable adult’s additional needs, night time care etc;
11. supporting helpers by holding Group meetings prior to and following the pilgrimage;
12. making sure they provide the right support to any helper who has reported a case of suspected abuse;
13. providing support and supervision to helpers generally;
14. having an “open door” policy where helpers feel they can talk to their Group Leader about any concerns they have prior to, during and after pilgrimage;
15. being aware of the importance of involving and consulting children, young people and vulnerable adults and promoting the benefits of participation to helpers, children, young people and vulnerable adults;
16. making sure that helpers involve children, young people and vulnerable adults in participation activities;
17. supporting helpers to encourage children, young people and vulnerable adults to make their own individual record of their experience of the pilgrimage;
18. supporting helpers at the end of the pilgrimage and signposting them to sources of further support if necessary;
19. keeping themselves up to date with HCPT policies and procedures to enable them to fulfil their role;
20. acting as a focal point for staff and helpers’ safeguarding concerns;
21. delivering HCPT safeguarding induction information locally;
22. ensuring that all helpers are aware of the safeguarding policy and procedures and know how to recognise and refer any concerns;
23. ensuring that detailed and accurate written records of concerns about a child or vulnerable adult are kept, even if there is no need to make an immediate referral;
24. ensuring that all safeguarding records are kept confidentially and securely and are separate from other information stored locally;
25. knowing how and where to access any necessary emotional or professional support, both personally and in relation to helpers involved in safeguarding children or vulnerable adult protection cases.

If an individual has a safeguarding concern that involves their Group Leader, he or she should raise the concern directly with a Safeguarding Advisor.
A1.11: Deputy Safeguarding Lead

A Deputy Safeguarding Lead will be identified from within Groups by the Group Leader. This role will usually be performed by another experienced helper. The Deputy Safeguarding Lead will have the same safeguarding responsibilities as the Group Leader, as set out above, and should be available to respond to safeguarding issues in the absence of the Group Leader.

A1.12: Group Nurse

The Group Nurse is a key member of the Group and must work closely with the Group Leader and families to ensure that the nursing needs of the Group are met. The role of the Group Nurse is the assessment, planning and implementation of nursing care within the Group. The Group Nurse should use the skills of all helpers to ensure optimum care is provided. The Group Nurse also has a shared responsibility (with the Group Leader as Safeguarding Lead) for safeguarding.

The Group Nurse’s safeguarding role is to:

1. ensure they are aware of and abide by the HCPT and NMC Code of Conduct;
2. know what safer working practices are and how this affects their role and responsibilities;
3. be aware of safeguarding issues;
4. ensure they know what to do if they are concerned about a child, young person or vulnerable adult;
5. with the Group Leader, complete all risk assessment forms in relation to safeguarding, children or vulnerable adults’ additional needs, night time care etc;
6. ensure they provide the right support to any helper who has reported a case of suspected abuse;
7. be aware of the importance of involving and consulting children, young people and vulnerable adults and promoting the benefits of participation to helpers, children, young people and vulnerable adults;
8. support helpers to encourage children, young people and vulnerable adults to make their own individual record of their experience of the pilgrimage.

A1.13: Group Chaplain

The Group Chaplain is a key member of the Group and works with the Group Leader to set the spiritual ethos of the Group.

The Group Chaplain’s safeguarding role is to:

1. abide by the Code of Conduct;
2. be aware of what safer working practices are and how this affects his/her role and responsibilities;
3. know what to do if he/she is concerned about a child or vulnerable adult;
4. be aware of the importance of involving and consulting children, young people and vulnerable adults and promoting the benefits of participation to helpers, children, young people and vulnerable adults; and
5. support helpers at the end of the pilgrimage and signposting them to sources of further support if necessary.

A1.14: Helper

A helper is someone who assists a pilgrim on behalf of HCPT. As a helper in a Group, they may be asked to help in any way required, for example, by cleaning, feeding, caring, supervising, providing medical treatment, transporting or entertaining pilgrims, during all stages of the pilgrimage, as required.

All HCPT members of staff and helpers who come into contact with children, young people and vulnerable adults have a shared responsibility to:

1. abide by the Code of Conduct;
2. promote the welfare of children, young people and vulnerable adults;
3. safeguard any child or adult who is considered to be at risk;
4. recognise and respond to any potential or actual safeguarding situations and concerns and act appropriately;
5. develop a culture of listening and engaging children and vulnerable adults.

If any helper has a concern about a child or vulnerable adult, they must refer to the safeguarding procedures and refer the matter to the Group’s Safeguarding Lead or Deputy Safeguarding Lead, in the first instance.

From the start of the pilgrimage, the emphasis is very much on ensuring that everyone in the Group has a wonderful fun filled week. Each helper will have an overall responsibility for caring and helping the children or vulnerable adults within their Group.

All helpers are carefully vetted, by completing a registration form, undergoing an interview and reference process, as well as DBS/PVG checks to ensure that the children and vulnerable adults receive the highest level of care and attention while away from home. Helpers will also be expected to attend a regional preparation day, as well as a number of Group meetings.

A1.15: Young helpers

A young helper is a person aged 16 or 7 years of age and who assists adult helpers in providing care, companionship, entertainment and supervision to all people in the Group. Young helpers also have a shared responsibility for safeguarding, as set out above in relation to helpers, and should be supervised by an adult helper at all times and for all activities.

Group Leaders should be able to identify young helpers easily and should remember that young helpers are still children and that they can be vulnerable in their own right. Young helpers should not be asked to perform roles or given responsibility beyond their capabilities and they should be supervised at all times.

The Group Leader has overall responsibility for the welfare of young helpers within their Group as well as their standards of behaviour.

For those travelling as a young helper, parent/carer consent must be obtained and signed for on the pilgrimage registration form.

A1.16: Juniors & Adults

‘Adults’ are autonomous group members aged 18 or over who do not require assistance but who are not assigned specific responsibilities as helpers, although they may occasionally be requested to assist by Group Leaders and helpers within groups. They are therefore subject to the same recruitment procedures in terms of qualifying certificates, and also receive safeguarding awareness training.

Those aged 16 or under (at the time of the pilgrimage) who are not beneficiaries are registered as ‘Juniors’ and it is expected that the group leader has identified someone to supervise all ‘Juniors’ in the group and that they may be accompanied by parents or else someone else in the group is there in loco parentis.

A1.17: Vulnerable adults who are also helpers

Group Leaders need to be aware of the additional needs of some helpers who have physical or mental disabilities, sensory impairment or are of an older age. Some of these helpers may be so vulnerable that they have difficulty in making their wishes and feelings known and therefore fall within the definition of a vulnerable adult themselves.

Group Leaders should ensure that all vulnerable helpers are able to safely fulfil the role of a helper and should acknowledge that they may need additional care and protection if their behaviour causes concern.
In relation to vetting vulnerable adults who are also helpers, the requirement is not about the vulnerability but on whether such an individual helper provides personal care, health care, first aid or supervision.

Decisions about the capability of any such person are entirely subjective and cannot be based on a tick-list. A useful guideline is to consider if it would be appropriate for this person to supervise a child moving through the busy traffic in Lourdes. If this would not be safe and appropriate then the person should not be registered as a Helper.

A1.18: Unauthorised helper

An unauthorised helper is anyone:

1. whose application to be a helper has been unsuccessful; or
2. who has been accepted as a helper but has been advised that they cannot travel due to an invalid/non-qualifying DBS/PVG disclosure; or
3. who was a helper on a previous year’s pilgrimage and is not registered for the current year’s pilgrimage but is in Lourdes at the same time as an HCPT pilgrimage and is believed to be misrepresenting themselves as a member of an HCPT pilgrimage.
4. Anyone who misrepresents themselves as a member of a current HCPT pilgrimage.

The presence of an unauthorised helper on pilgrimage, is a serious matter and should be reported immediately to a Safeguarding Advisor.

All unauthorised helpers falling within 1 or 2 above will be known before the pilgrimage and therefore should be advised in person, and in writing, that they are not permitted to take part in HCPT activities.

If an unauthorised helper has independently acquired accommodation in a hotel also being used to accommodate an HCPT pilgrimage then, in order to reduce risk, the Group Leader should, where possible, prevent any access by the unauthorised helper to any children or vulnerable adults. Most adults would respond to a request to relocate away from HCPT Groups. The owner of the hotel could also be consulted and asked for help to provide alternative accommodation either for one person or a Group.

A1.19: Carers, guardians, family members and friends of pilgrims

HCPT recognises that some pilgrims will want or need to be accompanied by their own carer, guardian, personal assistant, family member or friend while on pilgrimage. An individual travelling to Lourdes in such circumstances, will be living and residing in close proximity to other children and/or vulnerable adults as well as caring for a specific pilgrim.

In these circumstances, the carer, guardian, family member, or friend should meet all appropriate requirements in terms of:

- appropriate vetting checks in line with HCPT guidelines and procedures;
- clarity about their role;
- understanding who has overall responsibility for the Group; and
- understanding relevant good practice guidance and the Codes of Conduct.

When a carer, guardian, family member or friend attends a pilgrimage, it is recognised that the individual’s paramount responsibility will be towards one pilgrim and that this has the potential to conflict with Group activities, particularly for key personnel such as Group Leaders and Group Nurses. Therefore, the key Group roles should not be undertaken by helpers who are compelled to care for one pilgrim, unless they can recruit a full time carer or personal assistant, not otherwise involved in Group duties.

HCPT has a duty of care to all pilgrims and therefore all carers, guardians, family members and friends of pilgrims will need to follow the current HCPT helper application process which includes the requirement to complete a helper application form and have a satisfactory enhanced DBS/PVG certificate prior to travel.
A1.20: Personal assistants

A personal assistant is someone who is employed by an individual to provide some of the personal and domestic everyday support needed to enable that individual to lead an independent personal and social life in and from their own home. Occasionally, a pilgrim may wish to travel to Lourdes with a personal assistant.

Whilst there is no legal requirement for an individual employer to request a DBS/PVG check on any potential personal assistant, most people are advised that it is best practice. This means that some personal assistants may have an existing satisfactory enhanced DBS/PVG disclosure but that others will not.

If a personal assistant travels to Lourdes, there may be times when he or she comes into contact with other vulnerable people whilst on pilgrimage. For example, they may actually help to provide care or assistance to other pilgrims.

Personal assistants will need to complete the same application process as helpers to ensure that a satisfactory enhanced DBS/PVG disclosure check is obtained prior to travel, regardless of whether that individual already has one.

A1.21: Visitors attending pilgrimage

All visitors to helpers, staff or Trustees while on pilgrimage, should be provided with a Friend of HCPT badge by HQ. As these people are not vetted or monitored by HCPT, if they join any HCPT activity, they must be supervised at all times by other authorised helpers.

By giving a person a Friend of HCPT badge, HCPT is not conferring any responsibility on that person, nor giving any Group Leader any reason to view this person any differently to any other non-Group member. HCPT staff will not keep a record of who Friend of HCPT badges have been issued to and HCPT takes no responsibility for the people wearing such badges.

Friends of HCPT are welcomed because they have been great supporters of HCPT through the year, and many of them have given many years’ service as Group Leaders, regional officers, helpers and Trustees. Friend of HCPT badges will not be issued to helpers.

In relation to Summer Pilgrimages, Friend of HCPT badges will be kept at Hosanna House and will be issued on request by the House Manager or another member of staff. Staff and volunteers have a responsibility to challenge people in Hosanna House who do not have an approved HCPT badge or people that they do not recognise.

In relation to Easter Pilgrimages, Friend of HCPT badges will be kept at the HQ administration office and will be issued on request by the PA to Chief Executive or another manager.

Whilst most of Lourdes and the associated town venues are public places, care must be taken in locations where visitors are allowed to visit which is within the responsibility of helpers, staff or Trustees. Non-resident visitors, who are visiting helpers in a hotel or at Hosanna House, should be restricted to public rooms e.g. strictly no access to bedrooms or dayrooms.

A1.22: Children and vulnerable adults – those in our care

Those in our care do not provide care and supervision to children and/or vulnerable adults and therefore are not engaged in regulated activity. Whilst there is no legal requirement for pilgrims to undergo an enhanced DBS/PVG check, HCPT acknowledges that they have a duty of care to ensure the safety of everyone travelling on pilgrimage.
A2: Safeguarding training and preparation

HCPT has designed a comprehensive programme of safeguarding training and preparation. This is delivered by Safeguarding Advisers to the Safeguarding Leads (Group Leaders and Deputy Group Leaders), and by the Safeguarding Leads to their volunteer helpers.

A2.1: Training for Safeguarding Leads

Initial training. This is a one full day course, often delivered at HQ on the Sunday following a Group Leader Induction Day. Specific dates are advertised in the HCPT Group Leaders newsletter. Attendance at one of these courses is mandatory for everyone who wishes to be appointed as Group Leader or Deputy Group Leader. All those who attend this course are marked as ‘Safeguarding Lead’ for a period of three years from the date of the course.

Refresher training. This is a one-off session designed to last about 2.5hrs, the first round of delivery of this course occurred through the autumn of 2014 and it is expected that this will be run again in 2017. It is designed to update and refresh the knowledge and confidence of the Safeguarding Leads. All those who attend this course are marked as ‘Safeguarding Lead’ for an additional period of three years.

A2.2: Training for Helpers

Initial training. A series of five training sessions are available to download from the intranet for Safeguarding Leads to cascade knowledge to their helpers. Each session has one or two exercises, which are all based on the exercises from the full day initial training. These sessions can be delivered over a number of sessions, or all at once. A register of attendance is to be taken, and all helpers must receive this initial training.

Refresher training. From January 2015 a refresher training session will be available for Safeguarding Leads to use with returning helpers. This will be designed to be delivered in two 45 minute sessions. A register of attendance is to be taken, and all helpers must receive this refresher training if they have already received the initial training. Alternative versions of the refresher training will be made available in future years.

A3: The Code of Conduct

The many different types of activities run on pilgrimage, brings helpers into contact with children, young people and vulnerable adults. Helpers need to set good examples of appropriate conduct by treating all those in their care with respect and dignity. The Code of Conduct protects both the children and vulnerable adults, as well as maintaining a safe working environment for helpers.

All helpers must:

1. Work within the principles and guidance of HCPT.
2. Treat all in their care equally according to need, with respect and dignity.
3. Engage and interact appropriately with those in their care and fellow helpers alike.
4. Challenge unacceptable behaviour and provide an example of good conduct they wish others to follow. Bullying or inappropriate shouting or any form of discrimination is unacceptable.
5. Respect a child or vulnerable adult’s right to personal privacy.
6. Recognise that particular discretion is required in moments when they are discussing sensitive issues with those in their care, e.g. maintain appropriate boundaries.
7. Avoid situations that compromise their relationship with those in their care, and are unacceptable within a relationship of trust. This rule should apply to all such behaviours including those which would not constitute an illegal act.
8. Keep all confidential data on those in their care secure and confidential at all times.
9. Follow HCPT’s Social Networking Policy, Alcohol Policy and Anti-Bullying Policy (all available from your Group Leader).
10. Follow your own regulatory professional standards and guidance.
All helpers must not:

1. Discuss topics or use vocabulary with those in their care which could not be used comfortably in the presence of parents or another adult.
2. Take a chance when common sense suggests another more prudent approach.
3. Dress in a manner that could be considered inappropriate.
4. Physically, emotionally or sexually abuse, maltreat or exploit anyone in their care.
5. Provide or supply alcohol to a child on pilgrimage or allow a child to consume alcohol on pilgrimage (this includes young helpers).
6. Provide or supply controlled (illegal or recreational) drugs to a child or vulnerable adult (this includes young helpers).
7. Administer prescribed or non-prescribed drugs without the consent and knowledge of a parent and medical professional on pilgrimage.
8. Use, or give to another, any controlled drug.

Group Leaders should guide inexperienced or new helpers by acting as a role model and reinforcing conduct standards at Group meetings.

The Code of Conduct will be issued when a Group Leader confirms a helper’s place on the pilgrimage and a record made of its issue. By signing and returning the helper registration form, the individual is agreeing to maintain the standards of behaviour expected by all helpers and abide by the Code of Conduct at all times when undertaking an HCPT activity.

Helpers are accountable to their Group Leader. Other volunteers, not formally attached to a Group and all Group Leaders, are accountable to the Chief Executive. A separate policy exists in relation to staff.

A4: Breaches of the Code of Conduct and other HCPT policies and procedures

All breaches of the Code of Conduct or other HCPT policies and procedures will be dealt with swiftly and fairly. In the event of a helper, including a Group Leader breaching the Code of Conduct or another policy or procedure, a sliding scale of measures may be applied, as seen fit by the Trustees, depending on the gravity of the transgression, as follows:

1. support and retraining;
2. a verbal warning;
3. the issuing of a written reprimand;
4. the helper being given restricted duties on pilgrimage; or
5. the helper being asked to leave the pilgrimage.

A verbal warning would be appropriate for minor or low level breaches of discipline and in the first instance. Any subsequent breaches would have more serious consequences, as set out above.

In any situation where a criminal act is suspected, local statutory authorities will be notified.

Further information in relation to the suspension process can be found at Chapter F4: Allegations against staff or helpers.

All incidents and sanctions should be recorded and retained in a central file at HQ.
A5: Vulnerable adults

The term ‘vulnerable adult’ which originates from previous adult protection guidance ‘No Secrets- DoH 2000’ has been replaced by the term ‘Adults at Risk of abuse or neglect’ in the Care Act 2104. Both terms are interchangeable and mean the same.

The Care Act also introduced a new term ‘adult at risk of abuse or neglect’ to replace the previously used term ‘Adult at Risk’ used in adult protection. These two terms are now used by a host of different agencies and are inter-changeable.

“Adult safeguarding” is the process of protecting adults with care and support needs from abuse or neglect. It is an important part of what many public services do, and a key responsibility of local authorities. - Care Act 2014.

The aims of adult safeguarding are to:

- stop abuse or neglect wherever possible;
- prevent harm and reduce the risk of abuse or neglect to adults with care and support needs;
- safeguard adults in a way that supports them in making choices and having control about how they want to live;
- promote an approach that concentrates on improving life for the adults concerned;
- raise public awareness so that communities as a whole, alongside professionals, play their part in preventing, identifying and responding to abuse and neglect;
- provide information and support in accessible ways to help people understand the different types of abuse, how to stay safe and what to do to raise a concern about the safety or well-being of an adult; and
- address what has caused the abuse or neglect

A5.1: What is adult abuse?

Abuse is a violation of an individual’s human and civil rights by any other person or persons. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological. It may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

Somebody may abuse or neglect a vulnerable adult by inflicting harm, or by failing to act to prevent harm. Vulnerable adults can be abused in a family, or in an institutional or community setting and by those known to them, including those with a duty to care for them, or more rarely by a stranger.

(‘No Secrets’ - Department of Health 2000).

In Scotland – the protection of vulnerable adults is governed by the Adult Support and Protection (Scotland) Act 2007. It has the same requirements for local authorities in making enquiries into vulnerable adults at risk of abuse or neglect. A notable and fundamental difference is that the Scottish legislation recognises 16 years upwards as adults rather than 18 years upwards as in England and Wales. In Wales – Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse- 2013 Reflects definitions from In Safe Hands 2009 which was derived from No Secrets.

A5.2: Categories of Adult Abuse

Local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered; although the definition/criteria of who is a vulnerable adult will need to be met before the issue is considered as a safeguarding concern. Exploitation, in particular, is a common theme in the following list of the types of abuse and neglect.
1. Physical abuse – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions. Domestic violence – including psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence.

2. Sexual abuse – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

3. Psychological abuse – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

4. Financial or material abuse – including theft, fraud, internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

5. Modern slavery – encompasses slavery, human trafficking, forced labour and domestic servitude. 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. (Modern Slavery Bill awaiting Royal Assent)

6. Discriminatory abuse – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion

7. Organisational abuse – including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

8. Neglect and acts of omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating

9. Self-neglect – this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding.
Section B. How we stay safe in HCPT - understanding what Safeguarding means

B1: Recognising abuse in vulnerable adults

There are a number of indicators, which could, in some circumstances, in combination with other possibly unknown factors, suggest the possibility of abuse. Abuse may be more likely to happen where the following problems exist:

- environmental problems – overcrowding/poor housing conditions/lack of facilities;
- financial problems – low income and a dependent vulnerable adult may add to financial difficulties, inability to work due to caring role, debt arrears or full benefits not claimed;
- psychological and emotional problems – family relationships over the years have been poor and there is a history of abuse in the family or where family violence is the norm;
- communication problems - the vulnerable adult or their carer has difficulty communicating due to sensory impairments, loss or difficulty with speech and understanding, poor memory or other conditions resulting in diminished mental capacity; this also includes people for whom English is a second language;
- dependency problems – increased dependency of the person, major changes in personality and behaviour, carers not receiving practical and/or emotional support;
- organisational culture – services which are inward looking, where there is little staff training/knowledge of best practice and where contact with external professionals is resisted, this increases the vulnerability of service users. High staff turnover or shortages may also increase the risk of abuse.

B1.1: Patterns of abuse

Patterns of abuse and abusing vary and reflect very different dynamics. These include:

- serial abuse in which the perpetrator seeks out and ‘grooms’ vulnerable adults. Sexual abuse may fall into this pattern, as do some forms of financial abuse;
- long term abuse in the context of an ongoing family relationship, such as domestic violence between spouses or generations;
- opportunist abuse such as theft as a result of money being left around;
- situational abuse which arises because pressures have built up and/or because of difficult or challenging behaviour. For example, neglect of a person’s needs because those around him or her are not able to be responsible for their care, if, for example, the carer has difficulties attributable to such issues as debt, alcohol or mental health problems;
- stranger abuse where vulnerable adults are targeted by strangers. This may be an individual, a gang, or people offering services. For example, the conman who tells the older person he will repair their roof, taking a large amount of money but actually doing nothing. Different forms of abuse can be inflicted in these situations. For example, financial, physical and emotional. ‘No Secrets’ states that: ‘stranger abuse will warrant a different kind of response from that appropriate to abuse in an ongoing relationship or in a care location. Nevertheless, in some instances it may be appropriate to use the locally agreed inter-agency adult protection procedures to ensure that the vulnerable person receives the services and support that they need. Such procedures may also be used when there is the potential for harm to other vulnerable people’.
B1.2: Physical abuse

Physical abuse is the non-accidental infliction of physical force that results (or could result) in bodily injury, pain or impairment.

Examples of physical abuse include:
- hitting;
- slapping;
- pushing;
- burning;
- physical restraint;
- harassment;
- enforced sedation;
- inappropriate use of medication;
- inappropriate use of restraint;
- catheterisation for management ease.

Indicators of physical abuse include:
- a history of unexplained falls, minor injuries or malnutrition;
- unexplained bruises in various stages of healing;
- unexplained fractures in various stages of healing;
- injuries reflecting the shape of an object;
- unexplained burns, particularly to the soles of the feet, palms of the hands or back;
- immersion burns, rope burns or cigarette burns;
- injuries to the head, face or scalp;
- varicose ulcers or pressure sores;
- being left in wet clothing or bedding;
- signs of under or over use of medication.

B1.3: Sexual abuse

Sexual abuse is the direct or indirect involvement in sexual activity, without consent, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting.

Examples of sexual abuse include:

Non-contact abuse:
- looking;
- photography;
- indecent exposure;
- harassment;
- serious teasing or innuendo;
- pornography.

Contact abuse:
- coercion to touch breasts/genitals/anus/mouth;
- masturbation of either self or others;
- penetration or attempted penetration of vagina/anus/mouth with or by penis/fingers/other objects

Indicators of sexual abuse include:
- a significant change in sexual behaviour;
- sexually implicit/explicit behaviour around certain individuals;
- unexplained changes in behaviour;
- unusual difficulty in walking or sitting;
- torn, stained or bloody underwear;
- sexually transmitted disease;
- urinary tract or vaginal infection;
- full or partial disclosure or hints of sexual abuse.

B1.4: Psychological abuse
Psychological or emotional abuse is that which impinges on the emotional health and development of individuals. It also presents with other forms of abuse and includes threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

Examples of psychological abuse include:
- shouting;
- swearing;
- insulting;
- ignoring;
- threats;
- intimidation;
- harassment;
- humiliation;
- depriving an individual of the right to choice and privacy.

Indicators of psychological abuse include:
- the person appearing to be withdrawn, agitated or anxious in general; slavery
- the person appearing to be intimidated or subdued in the presence of another
- the person appearing to be frightened of making choices or expressing his/her wishes;
- the person appearing to be fearful or flinches on approach;
- changes in the person’s sleep patterns;
- the person being tearful;
- threats of medical or legal consequences if an individual does not comply with desired behaviour.

B1.5: Neglect

Neglect and acts of omission, include ignoring medical or physical care needs, failing to provide access to appropriate health, social care or educational services and withholding the necessities of life, such as medication, adequate nutrition and heating.

Examples of neglect include:
Failure to provide:
- appropriate food;
- shelter;
- heating;
- clothing;
- medical care;
- hygiene;
- personal care; and
- inappropriate use of medication or over-medication.

Indicators of neglect include:
- inadequate food, fluids, heating or lighting;
- poor physical condition, poor hygiene, varicose ulcers, pressure sores;
- clothing in a poor condition;
- failure to seek medical advice or summon assistance when required;
- failure to access dentistry or chiropody services etc;
- refusal to allow access to appropriate callers or visitors.

B1.6: Financial abuse

Financial abuse includes theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits. It is the unauthorised, fraudulently obtained or improper use of funds, property or any resources of a vulnerable adult.

Examples of financial abuse include:
- misappropriating money, valuables or property;
- forcing changes to a will;
- denying the vulnerable adult the right to access personal funds.

Indicators of financial or material abuse include:
- disparity between assets and apparent living conditions and a reluctance to incur expenses when finances should not be a problem. For example, little food in the house or wearing worn out clothes;
- denying the assistance of someone who may be competent to handle financial affairs;
- unexplained withdrawals from bank and building society accounts;
- unexplained disappearance of financial documents;
- sudden inability to pay bills;
- a carer asking financial questions of the vulnerable adult but not asking about that person’s care or well-being;
- the person managing the vulnerable adult’s finances being uncooperative;
- a carer or other professional failing to account for expenses incurred on a person’s behalf.

B1.7: Discriminatory abuse

The principles of discriminatory abuse are embodied in legislation including the Equality Act 2010. Abuse of an individual’s rights by any other person or persons, is a violation of human and civil rights. Discriminatory abuse can consist of abusive or derogatory attitudes or behaviour based on a person’s gender, sexuality, ethnic origin, age, disability, or religion.

**Indicators of discriminatory abuse include:**
- inappropriate remarks or comments;
- poor quality of care to certain groups of vulnerable adults;
- the vulnerable adult preferring not to be cared for by certain helpers;
- a helper appearing to avoid caring for certain groups of vulnerable adults.

Indicators could also include any of the indicators mentioned in the forms of abuse identified above.

B1.8: Institutional abuse

Institutional abuse is mistreatment or abuse by a regime or the individuals within an institution. It occurs when the routines, systems and norms of an institution, compel individuals to sacrifice their own preferred lifestyle and cultural diversity to the needs of the institution.

Institutional abuse involves the collective failure of an organisation to provide an appropriate and professional service to vulnerable people. It can be seen or detected in systems, routines, processes, attitudes and behaviour that amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and stereotyping. It includes a failure to ensure the necessary safeguards are in place to protect vulnerable adults and maintain good standards of care in accordance with individual needs, including the training of staff, supervision and management, record-keeping and liaising with other providers of care.

Neglect and poor professional practice also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as institutional abuse.

**Indicators of institutional abuse include:**
- unkempt and dirty;
- unusually subdued;
- lack of aids to support daily life;
- anxiety and fear in the presence of social care workers;
- drowsiness;
- poorly paid or insufficient staff;
- poorly trained staff;
- crowding;
- inadequate responses to questions about care;
- evidence of over or under-medication.
B1.9: Local Safeguarding Adult’s Board (LSAB)

The Care Act 2014 Act requires local authorities to set up a Safeguarding Adults Board (SAB) in their area, giving these boards a clear basis in law for the first time.

The Act says that the SAB must:

- include the local authority, the NHS and the police, who should meet regularly to discuss and act upon local safeguarding issues;
- develop shared plans for safeguarding, working with local people to decide how best to protect adults in vulnerable situations;
- publish this safeguarding plan and report to the public annually on its progress, so that different organisations can make sure they are working together in the best way.

SABs must also arrange a Safeguarding Adults Review in some circumstances – for instance, if an adult with care and support needs dies as a result of abuse or neglect and there is concern about how one of the members of the SAB acted.

The Reviews are about learning lessons for the future. They will make sure SABs get the full picture of what went wrong, so that all organisations involved can improve as a result.

Mental Capacity Act 2005, Capacity Test and Best Interests Checklist - Accurate for England and Wales

The Adults with Incapacity (Scotland) Act 2000 provides ways to help safeguard the welfare and finances of people who lack capacity. It protects adults (people aged 16 or over) who lack capacity to take some or all decisions for themselves because of a mental disorder or an inability to communicate.

It allows a person - such as a relative, friend or partner - to make decisions on someone's behalf.

The Act also lets you make arrangements for another person or persons to make decisions and manage affairs on your behalf if you lose capacity in the future. i.e. power of attorney

B2: Safeguarding vulnerable adults who are particularly vulnerable

B2.1: Mental Capacity Act 2005

The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable adults who are not able to make their own decisions. It makes clear who can take decisions, in which situations, and how they should go about this.

A person’s capacity (or lack of capacity) refers specifically to their capacity to make a particular decision, at the time it needs to be made.

There are five statutory principles as follows:

1. a person must be assumed to have capacity unless it is established that they lack capacity;
2. a person is not to be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success;
3. a person is not to be treated as unable to make a decision merely because he makes an unwise decision;
4. an act done or decision made under the Mental Capacity Act 2005, for or on behalf of a person who lacks capacity, must be done, or made, in his or her best interests; and

1 http://www.scotland.gov.uk/Topics/Justice/law/awi
5. before the act is done, or the decision is made, regard must be had to whether the purpose for which it is
needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of
action.

B2.2: Capacity test
If a Group Leader believes or suspects that a vulnerable adult is unable to make a decision to accept an
invitation to travel to Lourdes with HCPT, the Group Leader must take all practical steps to help that person
reach their own decision. For example, by providing relevant information and choices or by asking someone
else to help support them e.g. carer, family member or advocate.

Group Leaders should ask if the adult has had any recent capacity tests and if they can have a copy of any
paperwork relating to this.

Lack of capacity may be temporary or permanent, and can fluctuate depending on various factors, for
example, the time of the day or the individual’s wellbeing. If a helper suspects that a vulnerable adult is:

- getting upset and frustrated;
- acting out of character;
- changing behaviours or appearance;
- getting confused; or
- taking time to process requests,

it may be that they need help to make a decision.

Any helper can assess capacity using the two part test below. However, helpers should report any such
concerns to their Group Nurse or Doctor.

**Part 1:**
1. Does the person have an impairment of the mind or brain, or is there some sort of disturbance
   affecting the way their mind or brain works? It does not matter whether the impairment or
   disturbance is temporary or permanent.
2. If so, does that impairment or disturbance mean that the person is unable to make the decision in
   question at the time it needs to be made?

**Part 2 - decision making assessment:**
1. Does the person have a general understanding of what decision they need to make and why they
   need to make it?
2. Does the person have a general understanding of the likely consequences of making, or not making,
   this decision?
3. Is the person able to understand, retain, use and weigh up the information relevant to this decision?
4. Can the person communicate their decision by talking, using sign language or any other means?
   Would the services of a professional such as a speech and language therapist be helpful?

A lack of ability to communicate a decision, at 4 above, on its own, would not demonstrate a lack of capacity. A
lack of ability to communicate a decision, must be accompanied by either, 1, 2 or 3 above to confirm an
assessment of a lack of capacity.

All Group Leaders and helpers who are required to make a decision on behalf of a pilgrim who lacks capacity,
will do so in that person’s best interests, using the common checklist of factors in the Mental Capacity Act
Code of Practice, as set out below. In such circumstances, the decision and any capacity test should be
recorded on the pilgrim’s medical notes, including particular reference to the checklist below.
Adults who are deemed to have capacity may also make what may be thought of as ‘unwise’ decisions. When making serious or complex decisions within an HCPT Group environment additional help should be sought from a professional expert or doctor and contact a Safeguarding Advisor for guidance and support.

**B2.3: Best interests checklist**

The following factors should be taken into consideration when determining what is in an individual’s ‘best interests’:

1. all the relevant circumstances of which the decision maker is aware and those which it is reasonable to regard as relevant;
2. can the decision be put off until the person regains capacity?
3. permitting and encouraging participation – this may involve finding the appropriate means of communication or using other people to help the person participate in the decision making process;
4. special considerations for life-sustaining treatment – the person making the best interests decision must not be motivated by the desire to bring about a person’s death;
5. the person’s wishes, feelings, beliefs and values especially any written statements made by the person when they had capacity;
6. the views of other people for example, family and informal carers and anyone with an interest in the person’s welfare or appointed to act on the person’s behalf;
7. the views of any Independent Mental Capacity Advocate (IMCA) or any attorney appointed by the person or deputy appointed by the Court of Protection;
8. whether there is a less restrictive alternative or intervention that is in the person’s best interests.

*Mental Capacity Act 2005 Section 5; Code of Practice, 5.13.*

The Mental Capacity Act 2005 also introduced the IMCA service whereby an independent advocate can be appointed to support and represent an individual who does not have family or friends and lacks capacity to make decisions. An IMCA will only be involved if the individual who lacks capacity has no family or friends who can be consulted. An IMCA must be involved in all adult protection cases and is normally notified by the safeguarding adults team managing the investigation.

**B2.4: Lasting Power of Attorney**

A Lasting Power of Attorney is a legal document that allows an individual to appoint someone that he or she trusts, as an ‘attorney’, to make decisions on their behalf either when that individual no longer wishes to make decisions or when the individual lacks the mental capacity to do so. A Lasting Power of Attorney cannot be exercised until it is registered with the Office of the Public Guardian.

There are two different types of Lasting Power of Attorney:

- health and welfare – an attorney can be appointed to make decisions in relation to, for example, the medical treatment received by another. However, it can only be used if the maker lacks the ability to make such decisions for themselves; or
- property and financial affairs – an attorney can be appointed to make property and financial affairs decisions on behalf of another, for example, decisions about paying bills or selling property. Such an attorney can be appointed at any time but a provision could be included that only allows the attorney to make decisions when the appointer loses the ability to do so themselves.

In Scotland, there are two types of Power of Attorney that can be granted. These are a Continuing Power of Attorney (which allows your Attorney to deal with your financial affairs) and a Welfare Power of Attorney (which allows your Attorney to make decisions about your personal welfare). It is also possible to combine a Continuing and Welfare Power of Attorney into one legal document. Scottish Powers of Attorney are registered and governed by the Office of the Public Guardian in Scotland.
Further information can be found at:
England and Wales - http://www.justice.gov.uk/about/opg.htm
Scotland - http://www.publicguardian-scotland.gov.uk/

B2.5: Vulnerability factors

The ‘No Secrets’ paper produced by the Department of Health in 2000, makes reference to the concept of ‘significant harm’, a definition that originated in the Children Act 1989, as a useful starting point to determine how serious or extensive abuse to a vulnerable adult must be, to justify intervention and assessment.

The concept of ‘significant harm’ refers to:

- ill treatment including sexual abuse and non-physical ill treatment;
- the impairment of, or an avoidable deterioration in, physical or mental health; and/or
- the impairment of physical, intellectual, emotional, social or behavioural development.

There are no absolute criteria upon which to rely when judging what constitutes significant harm. For example, sometimes, a single traumatic event may constitute significant harm.

However, more often, significant harm is a compilation of significant events, both acute and long standing, which interrupt, change or damage a vulnerable adult’s physical and psychological development. For example a change of:

- behaviour;
- ability to make decisions;
- financial ability; or
- appearance.

All HCPT staff and helpers should be aware that ‘vulnerability’ and ‘risk of harm’ is increased when other factors are present in abuse cases. Victims may need additional safeguarding and protection when one or more of these factors are involved.

The following checklist should be used by staff and helpers to assess risks and check care plans in order to inform the immediate actions required to promote the welfare and safeguarding of the vulnerable adult:

- lack of capacity;
- abuse by partner/family member – power relationship;
- abuse by carer – power relationship;
- repeat incidents;
- alcohol and/or substance dependence/misuse;
- dominant race/culture issues;
- dependence on one person for care;
- isolation or withdrawal from services or support networks;
- low self esteem;
- mental illness/confusion/dementia;
- lack of capacity/dementia
- intimidation/threats/harassment;
- physical disability/lack of mobility;
- decreased ability to communicate;
- vulnerable adult employing their own personal assistants;
- unsafe environments.

All references to risk assessments and the identification of any factors that increase risks, should be recorded on the HCPT safeguarding concerns report form and the information made available to statutory services at the time of referral.
**B2.6: Adults with dementia**

**What is dementia?**

The term 'dementia' is used to describe the symptoms that occur when the brain is affected by specific diseases and conditions. Symptoms of dementia include loss of memory, confusion and problems with speech and understanding. The most common cause of dementia is Alzheimer’s disease when the chemistry and structure of the brain changes, leading to the death of brain cells.

When a person with dementia finds that their mental abilities are declining, they often feel vulnerable and in need of reassurance and support. Group Leaders, helpers, family and friends need to do everything they can to help the person retain their sense of identity and feelings of self-worth.

**Continuing support**

Group Leaders and helpers should ensure that anyone involved in the caring of a person with dementia has as much background information as possible, as well as information about the current situation. This information should be sought from the pilgrim and carers on the first home visit and details recorded on the person’s individual care plan or home visit record.

A clear care plan will assist in helping Group Leaders and helpers to:

- avoid activities or situations in which the person is more likely than not to fail, as this can be humiliating. Simple, enjoyable and manageable tasks are key;
- split activities into small steps so the completion of a part of a task feels like a sense of achievement;
- encourage self-respect and pride in the individual’s appearance, and compliment them on how they look;
- advise others not to correct what the person says. The importance of any communication and what a person is saying should be valued, rather than its accuracy.

**B2.7: Adults in care homes or hospital**

The Deprivation of Liberty Safeguards (DoLS), referred to as 'safeguards', are part of the Mental Capacity Act 2005. They aim to protect people in care homes and hospitals, who are unable to make decisions for themselves but who are not detained under the Mental Health Act 1983, from being inappropriately deprived of their liberty. The safeguards have been put in place to make sure that a care home or hospital only restricts someone's liberty safely and correctly, and that this is done when there is no other way to take care of that person safely.

The Deprivation of Liberty Safeguards (Dols) applies to England and Wales only.

In Scotland the two pieces of legislation that cover the same areas are the Mental Health (Care and Treatment) (Scotland) Act 2003 and the Adults with Incapacity - Act 2000 Scotland.

The Adults with Incapacity (Scotland) Act 2000 provides a framework for safeguarding the welfare and managing the finances of adults (people aged 16 or over) who lack capacity due to mental illness, learning disability or a related condition, or an inability to communicate.

The Mental Welfare Commission has supervisory, investigative and advisory duties under this Act in relation to welfare guardianship and welfare powers of attorney.

The Mental Health (Care and Treatment) (Scotland) Act 2003 applies to people who have a mental illness, learning disability or related condition. The Act calls this mental disorder.

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The Mental Health Act sets out:

- When and how people can be treated if they have a mental disorder
- When people can be treated or taken into hospital against their will
- What people's rights are, and the safeguards which ensure that these rights are protected

If a Group Leader or helper becomes aware that any pilgrim has a deprivation of liberty safeguard authorisation, they must contact a Safeguarding Advisor for further guidance.

B2.8: Adults with a drug or alcohol dependency

A vulnerable adult’s substance misuse or abuse can mean many things, including the use of drugs that can change the individual’s mood, for example, alcohol, tranquillisers, or illegal drugs.

Substance misuse also includes “risky drinking” or unsafe use of medications. Any substance misuse or abuse can cause serious health problems and problems with family and friends, money, and the law.

“Risky drinking” is when someone drinks alcohol in ways that may not have caused problems yet, but may cause problems if the same drinking pattern is kept up. For some people, this can mean drinking more than the recommended amounts. For some older adults with certain health problems or who take certain medications, this can mean drinking any alcohol.

Drinking alcohol or using medications unsafely can make many physical and mental health problems worse. Some of the physical conditions that are made worse by drinking alcohol are liver disease, cardiovascular disease, diabetes, ulcers, other gastrointestinal problems, and sleep problems. Alcohol can also make it harder for doctors to correctly diagnose some medical conditions, as well as slowing the healing process from injuries.

Depression, memory or thinking problems, and anxiety, can place a person in greater danger of developing problems with alcohol or other drugs. For example, an older person, who is a little depressed, may start to drink more. This causes their depression to get worse and increases the risk of developing a serious problem with alcohol. Alcohol can also make the symptoms of dementia, such as memory loss or difficulty concentrating, get worse.

Some dementia type illnesses are caused by alcohol dependency, for example Korsakoff’s syndrome. The symptoms include memory loss, invented memories and loss of interest.

Warning signs of alcohol or medication related problems:

- anxiety or irritability, feeling worried or “crabby”;
- memory loss;
- difficulty making decisions;
- difficulty concentrating or paying attention;
- lack of interest in usual activities;
- sadness or depression;
- mood swings;
- chronic pain;
- problems with money or the police;
- falls, bruises, burns;
- incontinence;
- headaches;
- dizziness;
- poor hygiene, for example not combing hair or, bathing;
- poor nutrition or changes in eating habits, for example eating junk food only;
- out of touch with family and friends;
- suicidal thoughts;
- strange response to medication.

All helpers must comply with the Code of Conduct and the alcohol and drug policy.

Group Leaders should seek advice from the Group Nurse or Doctor if they have any concerns about a pilgrim’s or other Group member’s alcohol consumption.
**B2.9: Adults who self-neglect**

Helping those who neglect themselves can prove an impossible task for experienced health and social workers let alone HCPT helpers.

Managing the balance between protecting vulnerable adults from self-neglect and their right to determine their own fate is a serious challenge for public services. It may be that some vulnerable adults are unable to understand or agree to help because they lack capacity to make this decision.

When a Group Leader identifies that a vulnerable adult has been subject to serious self-neglect which could result in significant harm and the vulnerable adult has capacity to make relevant decisions but has refused essential help without which their health and safety needs cannot be met and the care management process/care plan approach has not been able to mitigate the risk of this serious self-neglect that could result in significant harm then the Group Leader should report such concerns to a Safeguarding Advisor using the HCPT safeguarding concerns report form.

**B2.10: Vulnerable adults and domestic abuse**

Domestic violence is defined as ‘any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members regardless of gender or sexuality’. Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family (Association of Chief Police Officers, 2004).

Whatever form it takes, domestic abuse is rarely a one-off incident and should instead be seen as a pattern of abusive and controlling behaviour through which the abuser seeks power over the victim. Domestic abuse occurs across society, regardless of age, gender, race, sexuality, wealth and geography.

Effective safeguarding is achieved when agencies share information to obtain an accurate picture of the risk and then work together to ensure the safety of the vulnerable adult is prioritised. While the vulnerable adult should always remain at the centre of the safeguarding adults process and be involved in their own safety planning, this does not preclude the sharing of information without their consent, particularly where the risks are considered to be high (Data Protection Act 1998 (Schedules 2 and 3), the Crime and Disorder Act 1998 and the Human Rights Act 1998).

If a Group Leader suspects that a vulnerable adult has been subjected to, or is at risk of domestic abuse, a referral should be made, using these procedures to a Safeguarding Advisor or the police, in the case of an emergency.

Where the person causing the harm is also a vulnerable adult, the safety of the person who may have been abused is paramount. If the abuser is a HCPT helper, personal assistant, or family member travelling with the vulnerable adult, HCPT will also have responsibilities towards the person causing the harm. In this situation, it is important that the needs of the vulnerable adult, the alleged victim, are addressed separately from the needs of the person causing the harm.

Specialist domestic violence services provide support and advocacy to domestic violence victims in relation to safety planning, housing options, legal options (that is, how to obtain an injunction) and counselling. Those not aware of the specialist services available in their borough can contact their local domestic violence coordinator who is based within the local authority or the National Domestic Violence Helpline on 0808 2000247 or at www.nationaldomesticviolencehelpline.org.uk.
B3: Children

B3.1: Definition of a “child”

There is no single law that defines the age of a child across the UK. The UN Convention on the Rights of the Child, ratified by the UK government in 1991, states that a child “means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier” (Article 1 Convention on the Rights of the Child, 1989).

Throughout this document references are made to "children and young people". These terms are interchangeable and refer to children who have not yet reached their 18th birthday.

B3.2: The Children Act 1989

The Children Act 1989 is designed to help keep children safe and well and, if necessary, help a child to live with their family by providing services appropriate to the child's needs. The Act imposes a general duty on local authorities to provide a range of services to children in need in their area, if those services will help keep a child safe and well.

B3.3: Parental consent

It is essential that the following information is kept in mind when the consent section of a child’s registration and medical form is signed.

A mother always has parental responsibility for her child. If the parents of a child are married to each other at the time of the birth, or if they have jointly adopted a child, then they both have parental responsibility. Parents do not lose parental responsibility if they divorce, and this applies to both the resident and the non-resident parent.

From 1 December 2003, a father, who is not married to the mother when the child is born, can acquire legal responsibility for his child by either:

- jointly registering the birth of the child with the mother; or
- a parental responsibility agreement with the mother; or
- a parental responsibility order, made by a court.

Living with the mother, even for a long time, does not give a father parental responsibility.

If the parents are not married, parental responsibility does not always pass to the natural father if the mother dies.

Further information in relation to parental responsibility can be found on the following website:
http://www.direct.gov.uk/en/Parents/ParentsRights/DG_4002954

B4: Recognising abuse in children

Safeguarding and promoting the welfare of children is defined for the purpose of this guidance as:

- Protecting Children from Maltreatment
- Preventing impairment of children’s health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- Taking action to enable children to have the best outcomes

*From Working Together to Safeguard Children – HM Government 2013*

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National Guidance for Child Protection in Scotland\(^5\) was published in 2010 and refreshed in 2014 to ensure that it remains relevant and up to date for local agencies and practitioners working together to safeguard and promote the wellbeing of children.

This guidance refers to child protection rather than Safeguarding and it has its own definition of ‘child abuse’ which says “Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting, or by failing to act to prevent, significant harm to the child. Children may be abused in a family or in an institutional setting, by those known to them or, more rarely, by a stranger”\(^6\).

This definition was used previously in English versions of Working Together to Safeguard Children 2006.

When making difficult judgements around possible signs and symptoms of abuse and neglect, it is crucial that the available information and injuries or behaviours are presented in the appropriate context. Consideration should also be given to other sources of information which may be important but to which immediate access is unavailable.

Safeguarding Children is the process of protecting children and young people (under 18 years) from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.

A child is someone who has not yet reached their 18th birthday.

In ‘Working Together to Safeguard Children 2015\(^6\) Safeguarding and promoting the welfare of children is defined as:

- protecting children from maltreatment;
- preventing impairment of children’s health or development;
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and
- taking action to enable all children to have the best outcomes.

Research suggests that there are particular risk factors that, when present, have the potential to lead caregivers or parents to harm their children\(^7\). These risk factors can be divided into three different categories:

1. **community/societal** – for example, high crime rate, lack of or few social services, high poverty rate and high unemployment rate;
2. **parent related** – for example, the parent having a history of physical or sexual abuse as a child, teenage parents, single parents, emotional immaturity, poor coping skills, low self esteem, poverty, poor education standards, substance abuse, known past history of child abuse, isolation (lack of social support from the community or extended family), domestic violence, lack of parenting skills or poor parent/child relationship, parental stress and distress, lack of preparation for the stress of a new child, depression or other mental illness, multiple young children, unwanted pregnancy or a denial of pregnancy;
3. **child related** – for example, prematurity, age of child (children under 4 are at a greater risk of severe injury or death), low birth weight or child disabilities which may increase the pressure the care giver is under.


\(^7\) McCoy & Keen (2009) – Risk factors for child Maltreatment
B4.1: Signs and symptoms of child abuse

Lists of possible signs and symptoms of abuse must never be considered to be comprehensive or definitive ‘checklists’. Children may behave strangely or appear unhappy or distressed for a number of reasons as they move through the stages of development, and as their family circumstances and experiences change. The presence of one or more of any of the commonly cited possible signs and symptoms do not ‘prove’ that a child has been or is being abused. HCPT’s role is not to investigate or prove abuse but to observe, gather and share information where concerns are raised.

In HCPT’s work with children and young people with disabilities, it should be remembered that all children, regardless of age, sex, ethnicity, disability, race or culture, are entitled to the same level of protection and, as such, racial, cultural, religious or similar factors can never be used to ‘explain’ or justify abuse or maltreatment.

From child protection fact sheet - definitions and signs of child abuse © NSPCC 2009

B4.2: Physical abuse

Physical abuse may involve hitting, shaking, throwing, poisoning, burning, 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.

Most children will collect cuts and bruises as part of the rough-and-tumble of daily life. Injuries should always be interpreted in light of the child’s medical and social history, developmental stage and the explanation given. Most accidental bruises are seen over bony parts of the body, e.g. elbow, knees, shins, and are often on the front of the body. Some children, however, will have bruising that is more than likely inflicted rather than accidental.

Important indicators of physical abuse are bruises or injuries that are either unexplained or inconsistent with the explanation given, or visible on the ‘soft’ parts of the body where accidental injuries are unlikely, e.g., cheeks, abdomen, back and buttocks. A delay in seeking medical treatment, when it is obviously necessary, is also a cause for concern. However, this can be more complicated with burns, as these are often delayed in presentation due to blistering taking place sometime later.

Physical signs of abuse may include:
- unexplained bruising, marks or injuries on any part of the body;
- multiple bruises in clusters, often on the upper arm or outside of the thigh;
- cigarette burns;
- human bite marks;
- broken bones;
- scalds with upward splash marks; and
- multiple burns with a clearly demarcated edge.

Changes in behaviour that can also indicate physical abuse include:
- fear of parents being approached for an explanation;
- aggressive behaviour or severe temper outbursts;
- flinching when approached or touched;
- reluctance to get changed, for example in hot weather;
- depression;
- withdrawn behaviour; or
- running away from home.

B4.3: Emotional abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may include not giving the child opportunities to express their views, deliberately silencing them or ‘making fun’ of what they say or how they communicate.
It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child’s developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction. It may involve seeing or hearing the ill-treatment of another. It may involve serious bullying (including cyber bullying), causing children frequently to feel frightened or in danger, or the exploitation or corruption of children. Some level of emotional abuse is involved in all types of maltreatment of a child, though it may occur alone.

Emotional abuse can be difficult to measure, as there are often no outward physical signs. There may be a developmental delay due to a failure to thrive and grow, although this will usually only be evident if the child puts on weight in other circumstances, for example when hospitalised or away from their parents’ care. Even so, children who appear well-cared for may nevertheless be emotionally abused by being taunted, put down or belittled. They may receive little or no love, affection or attention from their parents or carers. Emotional abuse can also take the form of children not being allowed to mix or play with other children.

Signs of emotional abuse may include:
- Neurotic behaviour e.g. sulking, hair twisting, rocking
- Being unable to play
- Fear of making mistakes
- Sudden speech disorders
- Self-harm
- Fear of parent being approached regarding their behaviour
- Developmental delay in terms of emotional progress

B4.4: Sexual abuse

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

The organisation has become increasingly aware of the criminal activity of viewing or downloading abusive images of children from the Internet. This is not a “victimless” crime but is both evidence of abuse taking place and is a criminal offence. It should be reported as a concern in all cases.

Adults who use children to meet their own sexual needs abuse both girls and boys of all ages, including infants and toddlers. Usually, in cases of sexual abuse it is the child’s behaviour that may cause you to become concerned, although physical signs can also be present. In all cases, children who tell about sexual abuse do so because they want it to stop. It is important, therefore, that they are listened to and taken seriously.

The physical signs of sexual abuse may include:
- Pain or itching in the genital area
- Bruising or bleeding near genital area
- Sexually transmitted disease
- Vaginal discharge or infection
- Stomach pains
- Discomfort when walking or sitting down
- Pregnancy
- Changes in behaviour which can also indicate sexual abuse include:
- Sudden or unexplained changes in behaviour e.g. becoming aggressive or withdrawn
- Fear of being left with a specific person or group of people
- Having nightmares
- Running away from home
- Sexual knowledge which is beyond their age, or developmental level
- Sexual drawings or language
- Bedwetting
- Eating problems such as overeating or anorexia
- Self-harm or mutilation, sometimes leading to suicide attempts
- Saying they have secrets they cannot tell anyone about
- Substance or drug abuse
- Suddenly having unexplained sources of money
- Not allowed to have friends (particularly in adolescence)
- Acting in a sexually explicit way towards adults

B4.5: 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. Once a child is born, neglect may involve a parent or carer failing to:

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

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

Neglect can be a difficult form of abuse to recognise, yet have some of the most lasting and damaging effects on children.

The physical signs of neglect may include:
- Constant hunger, sometimes stealing food from other children and young people
- Constantly dirty or ‘smelly’
- Loss of weight, or being constantly underweight
- Inappropriate clothing for the conditions.

Changes in behaviour which can also indicate neglect may include:
- Complaining of being tired all the time
- Not requesting medical assistance and/or failing to attend appointments
- Having few friends
- Mentioning being left alone or unsupervised.

B4.6: Domestic abuse and young people
In March 2013 the definition of domestic abuse extended to recognise and include victims aged 16 and 17 yrs.

Prolonged and/or regular exposure to domestic violence can have a serious impact on children’s safety and welfare, and can impact on them in a number of ways. Children are at increased risk of physical injury during an incident, either by accident or because they attempt to intervene. Even when not directly injured, children are greatly distressed by witnessing the physical and emotional suffering of a parent. Children’s exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress which may express itself in anti-social or criminal behaviour. Although separating from a violent partner should result in women and children being safe from harm, the danger does not automatically end.
Section 31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002 States: ‘harm’ means ill-treatment or the impairment of health or development, including, for example, impairment suffered from seeing or hearing the ill-treatment of another;

This means that when a child is exposed to or witnesses domestic abuse of another (parent) they are likely to suffer significant harm (emotional abuse) and it should result in a safeguarding referral being made to Children’s Social Services.

B4.7: ‘Significant harm’

Sometimes a single traumatic event may constitute significant harm. More often, however, significant harm is a compilation of significant events, both acute and longstanding, which interrupt, change or damage a child’s physical and psychological development.

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 the child and gives local authorities, a duty to make enquiries to decide whether they should take action to safeguard or promote the welfare of a child who is suffering, or is likely to suffer significant harm.

This has been clarified in 2002 with the Adoption of Children Act 2002 making additions that refer to seeing or hearing the ill treatment of others.

‘Significant Harm is 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. This definition was clarified in section 120 of the Adoption and Children Act 2002 (implemented on 31 January 2005) so that it may include, “for example, impairment suffered from seeing or hearing the ill treatment of another”.

This definition has been removed from “Working Together to Safeguard Children 2013”, but it is still included in the Scottish guidance8.

Definitions

Section 31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002, contains the following definitions:

- ‘Development’ – means physical, intellectual, social, emotional or behavioural development;
- ‘Harm’ - means ill-treatment or the impairment of health or development, including for example, impairment suffered from seeing or hearing the ill-treatment of another;
- ‘Health’ - means physical or mental health; and
- ‘Ill-treatment’ - includes sexual abuse and forms of ill-treatment which are not physical.

In accordance with section 31(10) of the Children Act 1989, where the question of whether harm is suffered by a child is significant turns on the child’s health or development, his/her health or development shall be compared with that which could reasonably be expected of a similar child.

Examples of significant harm include:

- refusing medical care which endangers the child’s life;
- suspected non accidental injury;
- pregnancy of a child aged under 16 years;
- dangerous sexual activity;
- deteriorating mental health;
- child presenting with self-harming behaviour;
- substance misuse;
- severe child obesity;
- sexual exploitation or involvement in prostitution;
- child at risk of suffering physical or sexual abuse;
- child whose basic needs are chronically neglected;
- regular involvement in anti-social or criminal behaviour;
- deliberate fire setting;
- parents/young person refusing support;
- poor abusive relationships with siblings or parents;
- person identified as posing a risk to children living in the home;
- child not coping as a young carer;
- child not in full time education;
- family has experienced serious domestic violence/substance misuse;
- parents have received custodial prison sentence;
- dangerous house or accommodation which places child in danger;
- homelessness;
- child subject to emotional abuse with no self-esteem or sense of worth;
- extreme poverty;
- young person living alone and not coping;
- chronically socially excluded/extreme isolation.

If a Safeguarding Advisor makes an assessment that the concern reaches the threshold of ‘significant harm’, in accordance with section 47 of the Children Act 1989, the concern should be referred to the statutory authorities, for example, statutory services/children’s services or the police, for further investigation. The safeguarding concern report form should be used although some authorities may require the completion of local referral forms.

B4.8: ‘Child in need’ / Child at risk of harm: concerns and referrals

If a Safeguarding Advisor makes an assessment that the concern raised by the group safeguarding lead reaches the threshold of ‘significant harm’, or has the child has additional unmet needs that would meet the threshold where the child could be categorised as a ‘child in need’ in accordance with section 47 or section 17 of the Children Act 1989, the concern should be referred to the statutory authorities, for example, statutory services/children’s services or the police, for further investigation. The safeguarding concern report form should be used although some authorities may require the completion of local referral forms.

All children deserve the opportunity to achieve their full potential (Working Together to Safeguard Children DCSF 2013). The five ‘Every Child Matters’ outcomes that are key to children and young people’s wellbeing are to:

- be healthy;
- stay safe;
- enjoy and achieve;
- make a positive contribution; and
- achieve economic well being

HCPT will therefore ensure that the duty to safeguard and promote the welfare of children is carried out in such a way as to contribute to improving all five Every Child Matters outcomes. HCPT aims for every child, whatever their background or circumstances, to have the support they need to attain the above outcomes.

Most children can achieve their potential through the provision of universal services e.g. education, GP services, health visitors etc. However, some children need additional services to help them meet their needs.
Children in need - section 17 The Children Act 1989

A child in need may be:

- disabled;
- unlikely to have, or to have the opportunity to have, a reasonable standard of health or development without services from a local authority; or
- unlikely to progress in terms of health or development; or
- unlikely to progress in terms of health or development, without services from a local authority

Most children in need and their families are supported through a Common Assessment Framework (“CAF”). Working Together to Safeguarding Children 2013 replaced the statutory CAF process but required local authorities to make local arrangements and protocols to replace CAF to deal with early interventions assessments for children in need. It introduces a new phrase ‘early help assessment to identify those children in need who need additional services.

The CAF process has been designed to help practitioners assess needs and then work with families, alongside other practitioners and agencies, to meet them. Children who have a CAF will not have an allocated social worker but each CAF is managed by a “lead professional” with whom it may appropriate for the group leader to liaise with prior to travel. The person who takes on the role of Lead Professional will vary according to the specific needs of the child. Many practitioners could take on the Lead Professional role, as the skills, competence and knowledge required to carry it out are similar regardless of professional background. The role is therefore defined by the functions and skills, rather than by particular professional or practitioner groupings.

For example, the Professional Lead could be a personal adviser, health visitor, midwife, youth worker, family worker, substance misuse worker, nursery nurse, educational welfare officer, community children’s nurse, school nurse or a member of support staff such as learning mentors working in schools. For most children and young people with additional needs requiring support from a Lead Professional, it is anticipated that the person will be drawn from the range of practitioners who are currently delivering effective early intervention support.

Children at risk - section 47 The Children Act 1989

Section 47 of The Children Act 1989 puts a duty on local authorities to investigate any cases where a child (who either lives in or is found in their area) is either

1. the subject of an emergency protection order; or
2. is in police protection; or
3. is suspected to be suffering, or likely to suffer, significant harm.

Sometimes a single traumatic event may constitute significant harm. More often, however, significant harm is a compilation of significant events, both acute and longstanding, which interrupt, change or damage a child’s physical and psychological development.

When children are found to be at significant risk of harm they are placed on a child protection plan (formally known as the child protection register) and will have an allocated social worker.

It should be noted that some children on pilgrimage will have an allocated social worker when they are not regarded at risk of significant harm but have such complex health and social needs that a social worker is required to manage (and fund) the services needed.

Most children attending a pilgrimage will either meet the child in need threshold and have a CAF in place or will have an allocated social worker. It is vital that the group leader gathers this information before travel to ensure they know why these other professionals are in place and they how to liaise with the relevant professional either before during or after the pilgrimage, to assist with this there are questions relating to this on the child’s registration form.
B4.9: Local Safeguarding Children’s Board (LSCB) and Area Child Protection Committee (Scotland)

Safeguarding and promoting the welfare of children requires effective co-ordination in every local area. The Children Act 2004 required each local authority to establish a Local Safeguarding Children’s Board (LSCB). It is the key statutory mechanism for agreeing how the relevant organisations will co-operate to safeguard and promote the welfare of children in their locality, and for ensuring the effectiveness of what they do.

They are responsible for developing multi-agency policies for safeguarding children in their area and together with the Children’s Trust Board ensure that there are clear local arrangements for early help assessments.

Additionally, LSCB’s are responsible for raising awareness standards for all professionals and volunteers working with children and for monitoring and evaluating especially in undertaking reviews of child deaths.

B5: Safeguarding children who are particularly vulnerable

B5.1: Disabled children

Disabled children have exactly the same human rights as non-disabled children to be safe from abuse and neglect, to be protected from harm and achieve the Every Child Matters outcomes. However, disabled children do require additional attention because they potentially experience a greater vulnerability as a result of negative attitudes, unequal access to services and resources, and because they may have additional needs relating to physical, sensory, cognitive and/or communication impairments.

When working with children and young people with disabilities, it is important that HCPT staff and helpers understand their role and responsibility, focussing on the child’s strengths and abilities and not just the effects of their disability.

Disabled children are more vulnerable to abuse because:

- many disabled children are at an increased likelihood of being socially isolated with fewer outside contacts than non-disabled children;
- their dependency on parents and carers for practical assistance in daily living, including intimate personal care, increases their risk of exposure to abusive behaviour;
- they may have an impaired capacity to resist or avoid abuse;
- they may have speech, language or communication needs which makes it difficult to tell others what is happening;
- they may not have access to someone they can trust to disclose that they have been abused;
- they may be especially vulnerable to bullying and intimidation;
- looked after disabled children are not only vulnerable to the same factors that exist for all children living away from home, but are particularly susceptible to possible abuse because of their additional dependency on residential and hospital staff for day to day physical care needs.

What does this mean for HCPT helpers?

1. Helpers must be aware that the belief that disabled children are not abused or beliefs that minimise the impact of abuse on disabled children, can lead to the denial of, or failure to report abuse or neglect.
2. Disabled children at risk of or who have experienced abuse should be treated with the same degree of professional concern accorded to non-disabled children.
3. Additional resources and time may need to be allocated, if an investigation of potential or alleged abuse is to be meaningful. This is a basic premise and should not be ignored at any stage of the safeguarding process.
4. Basic preparation and awareness raising of the susceptibility of disabled children to abuse is essential for all those working with disabled children.

5. Reporting safeguarding concerns needs to be encouraged at all levels and prompt and detailed information sharing is vital.

6. The impairment with which a child presents should not detract from early multi-agency assessments of need that consider possible underlying causes for concern.

7. Where a criminal offence is alleged, investigation by the police needs to be handled sensitively and in accordance with Achieving Best Evidence in Criminal Proceedings: Guidance on vulnerable or intimidated witnesses including children (2000). In Scotland: Guidance on Joint Investigative Interviewing of Child Witnesses in Scotland

8. Parents and carers need to be made aware, if they are not already, of the vulnerability of their child to abuse or neglect, but also of their potential role in the safeguarding process.

Where there are safeguarding concerns about a disabled child, there is a need for greater awareness of the possible indicators of abuse and/or neglect, as the situation is often more complex. However, it is crucial when considering whether a disabled child has been abused and/or neglected that the disability does not mask or deter an appropriate investigation of child protection concerns.

When making a judgement and considering whether significant harm might be indicated, Staff and helpers should always take into account the nature of the child’s disability.

The following are some indicators of possible abuse or neglect in disabled children:

- a bruise in a place that might not be of concern on an ambulant child, such as the shin, might be of concern on a non-mobile child;
- not getting enough help with feeding leading to malnourishment;
- poor toileting arrangements;
- lack of stimulation;
- unjustified and/or excessive use of restraint;
- rough handling;
- extreme behaviour modification;
- deprivation of liquid, medication, food or clothing;
- unwillingness to try to learn a child’s means of communication;
- ill-fitting equipment e.g. callipers, sleep boards or inappropriate splinting;
- misappropriation of a child’s finances; or
- invasive procedures which are unnecessary or are carried out against the child’s will.

HCPT staff and helpers may find it more difficult to attribute indicators of abuse or neglect, or be reluctant to act on concerns in relation to disabled children, because of a number of factors, which they may not be consciously aware of. These could include:

- over identifying with the child’s parents/carers and being reluctant to accept that abuse or neglect is taking or has taken place, or seeing it as being attributable to the stress and difficulties of caring for a disabled child;
- a lack of knowledge about the impact of disability on the child;
- a lack of knowledge about the child, e.g. not knowing the child’s usual behaviour;
- not being able to understand the child’s method of communication;
- confusing behaviours that may indicate the child is being abused with those associated with the child’s disability;
- denial of the child’s sexuality;
• behaviour, including sexually harmful behaviour or self-injury, may be indicative of abuse; or
• being aware that certain health/medical complications may influence the way symptoms present or are interpreted. For example, some particular conditions cause spontaneous bruising or fragile bones, causing fractures to be more frequent.

Where a staff member or helper has concerns about a disabled child, they should speak to their Safeguarding Lead or Safeguarding Advisor for guidance and follow the procedures for making a safeguarding referral.

Further guidance is available in the following government publications:
‘Safeguarding Disabled Children’- DCFS 2009

In Scotland there is a Child Protection with Disability Toolkit issued as a supplement the National Guidance for Child Protection in Scotland 2014.

B5.2: Children at risk of domestic violence or abuse

Children may suffer both directly and indirectly if they live in households where there is domestic violence. Domestic violence includes any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, or young people, who are or have been intimate partners, family members or extended family members, regardless of gender and sexuality.

Where there is evidence of domestic violence, the implications for any child in the household should be considered, including the possibility that the child may themselves be subject to violence or may be harmed by witnessing or overhearing the violence.

Domestic violence is likely to have a damaging effect on the health and development of a child as well as his or her safety and welfare, despite the best efforts of parents to protect their child. Therefore, it will often be appropriate for such a child to be regarded as a child in need. Children are at increased risk of physical injury during an incident, either by accident or because they attempt to intervene. Even when not directly injured, children are greatly distressed by witnessing the physical and emotional suffering of a parent. A child’s exposure to parental conflict, even where violence is not present, can lead to serious anxiety and distress which may express itself in anti-social or criminal behaviour, low self esteem, depression, absenteeism, ill health, bullying, drug or alcohol misuse or self-harm.

Women are more likely to experience the most serious forms of domestic violence but it is important to acknowledge that there are female perpetrators and male victims and that domestic violence also occurs within same sex relationships. Although separating from a violent partner should result in adults and children being safe from harm, the danger does not automatically end.

HCPT staff and helpers are in a position to identify or receive a disclosure about domestic violence. Helpers should ask direct questions about domestic violence and be alert to the signs that a child or parent may be experiencing domestic violence or that a parent may be perpetrating domestic violence.

As soon as a helper becomes aware of domestic violence within a family or a young person’s relationship, they should contact their Safeguarding Lead and or Safeguarding Advisor for help and guidance.

Dependent on the age and understanding of a child or young person, advice can be given to the child about safety plans which emphasise that the child should not intervene in any potential domestic abuse situation but that they should keep safe and, where appropriate, get away and seek help.

A referral using the safeguarding concern report form should be made in respect of all children who are exposed to domestic violence or abuse. Local authorities will then consider the likelihood of serious harm to any child or adult victim and may refer into the Multi-Agency Risk Assessment Conference (“MARAC”). HCPT will co-operate with all statutory agencies in relation to anyone who is at risk of serious harm from domestic abuse.
Specialist domestic violence services provide support and advocacy to domestic violence victims in relation to safety planning, housing options, legal options (that is, how to obtain an injunction) and counselling. Those not aware of the specialist services available in their borough can contact their local domestic violence coordinator who is based within the local authority or the National Domestic Violence helpline on 0808 2000247 or at www.nationaldomesticviolencehelpline.org.uk, or 0800 027 1234 in Scotland.

B5.3: Multi-Agency Risk Assessment Conference

A MARAC, is a local multi-agency meeting which has the safety of high risk victims of domestic abuse as its focus. Due to the nature of their work, the police are the main agency responsible for identifying victims at high risk of serious harm from domestic abuse. Information about the risks faced by those victims, the actions needed to ensure safety, and the provisions available locally is shared and used to create a risk management plan involving all agencies.

Where children are identified as being at risk of serious harm as a result of exposure to domestic abuse, the Safeguarding sub-committee will ensure a referral is made.

B5.4: Multi-Agency Public Protection Arrangements

Multi-Agency Public Protection Arrangements (“MAPPA”) provide a national, statutory framework in England and Wales for the assessment and management of the risk of serious harm posed by specified sexual and violent offenders, including those who are considered to pose a risk, or potential risk, of serious harm to children.

These arrangements were introduced in 2001 and bring together the police, probation and prison services into what is known as the MAPPA Responsible Authority in order to establish and monitor the arrangements. A number of other agencies, including children’s and adult’s social care services, health, housing, YOTs, Jobcentre Plus and electronic monitoring providers, are under a statutory duty to co-operate with the Responsible Authority.

The risks posed to the public by dangerous people (both convicted and un-convicted) can never be completely eliminated, but the public is entitled to expect the authorities to take reasonable action to keep risk to a minimum. No single agency has the capacity to provide public protection alone. Success depends on sustained and proactive participation in effective partnerships. These multi-agency meetings provide a forum for sharing information and taking action to reduce future harm to very high-risk victims or potential victims in the community.

The exchange of information is essential for effective public protection. The MAPPA guidance details how MAPPA agencies may/should exchange information among themselves to better manage offenders. It also explains why and how information may be disclosed to those not involved in the MAPPA management of the offender. The expectation is that information on offenders will be disclosed to others, for example, partners, employers, schools, where this is required to manage the risks posed by the offender.

There are three categories of offender eligible for MAPPA:

- **registered sexual offenders (category 1)** – sexual offenders who are required to notify the police of their name, address and other personal details and notify any changes subsequently;
- **violent offenders (category 2)** – offenders sentenced to imprisonment/detention for 12 months or more, or detained under hospital orders (in relation to murder or offences specified in Schedule 15 of the Criminal Justice Act 2003). This category also includes a small number of sexual offenders who do not qualify for registration, and offenders disqualified from working with children; and
- **other dangerous offenders (category 3)** – offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm, there is a link between the offending and the risk posed, and they require active multi-agency management.
HCPT is committed to identifying those that pose a risk of serious harm to others, and will co-operate with the Responsible Authority, as well as social care, health, housing and education services.

HCPT staff members and helpers must follow these safeguarding procedures if they become aware that any child, parent, guardian or helper poses a ‘risk to children’. The Safeguarding Lead or Safeguarding Advisor should be informed, with onward referral to the police, or probation service, whichever agency is the most appropriate. HCPT will ensure that anyone who poses a risk of serious harm to children, vulnerable adults or other members of the public is referred to the MAPPA process.

**Section C. How we stay safe in HCPT - safer recruitment and preparation**

**C1: Preparation for pilgrimage**

**C1.1: Recruitment of helpers**

Group Leaders should recruit all helpers in a timely fashion bearing in mind the time restraints imposed by the need for satisfactory enhanced DBS/PVG check. They should follow HCPT’s robust safer recruitment procedures and liaise closely with regional officers and HCPT HQ to ensure that only suitable people are appointed as helpers.

All volunteers travelling on the pilgrimage must have a qualifying enhanced DBS/PVG check. Group Leaders should ensure that applications for enhanced disclosures are made in sufficient time to be received back at HQ by the stated due date. The due date and qualifying date are set annually and stated in the invitation to travel issued to each Group, and on the helper registration forms.

Group Leaders should consider the makeup of the helpers within the Group and where possible recruit helpers whose gender and skill base reflect the gender and caring needs of the children and vulnerable adults travelling with the Group.

When recruiting helpers, the following steps should be undertaken. The prospective helper should:

- have an interview with the Group Leader and another current member of the Group. In the interview, particular reference should be made to the importance of a helper’s suitability to work with children and/or vulnerable adults, as appropriate;
- complete the appropriate registration form containing a statement that being an HCPT helper is a regulated activity and as such is not exempt from the Rehabilitation of Offenders Act 1974 and therefore, the prospective helper will be subject to an enhanced DBS/PVG disclosure check;
- provide two satisfactory written references;
- Request a DBS certificate / PVG Scheme Membership or Scheme Record Update
- be given information about HCPT.

HCPT will seek to ensure that all staff, Trustees and helpers are:

- safe and trustworthy to work with children, young people and vulnerable adults by enforcing robust recruitment procedures; and
- prepared to the appropriate standards in safeguarding.
C1.2: Safer recruitment

Whilst seeking to provide a working environment in which all staff and helpers are treated equally, HCPT also recognises its responsibility to prevent those that are considered unsuitable to work with children and vulnerable adults from working in a regulated activity.

Therefore, any individual wishing to participate in an HCPT pilgrimage to Lourdes must have undertaken satisfactory vetting procedures before being able to travel. The appropriate procedures will vary depending on the potential helper’s country of residence.

It should be borne in mind that the vetting process can take time and so the appropriate application should be submitted well in advance of the pilgrimage.

C1.3: Potential helpers resident in England and Wales – The Disclosure & Barring Service

On 1 December 2012 and in accordance with the provisions of the Protection of Freedoms Act 2012, the Criminal Records Bureau and Independent Safeguarding Authority merged to become theDisclosure and Barring Service (“DBS”). As its name suggests, the DBS has both a disclosure and barring function.

Disclosure

The DBS searches police records and barred list information.

The role of an HCPT helper in working with children and vulnerable adults, falls within the new definition of ‘regulated activity’ as set out in the Safeguarding Vulnerable Groups Act 2006. Therefore, subject to the next paragraph, all helpers resident in England and Wales, must apply to the DBS for and obtain, an enhanced DBS certificate before being able to travel to Lourdes with HCPT.

The minimum age for applying for an enhanced DBS certificate is 16. Therefore, there is no requirement for young helpers aged under 16 on 31st January on the year of the Easter Pilgrimage to apply for an enhanced DBS certificate.

All satisfactory enhanced DBS certificates, issued for HCPT purposes, will be valid for a period of three years. Any helper or member of staff who wishes to travel on an HCPT pilgrimage and who has an expired enhanced DBS certificate i.e. more than three years old, will be required to apply for a new one before being able to travel.

Referrals

DBS also has a role in helping to prevent unsuitable people from working with vulnerable groups including children and vulnerable adults. As a regulated activity provider, if HCPT has a concern that a person has caused harm or poses a future risk of harm to vulnerable groups, it legally must make a referral to the DBS.

Barring

The DBS places individuals on the barred list either:

- in automatic barring cases, where a person has been cautioned or convicted of a relevant offence. Depending on the circumstances, the individual may or may not be able to make representations; or
- following a referral from an organisation with a legal duty or power to make referrals to the DBS i.e. when an employer has dismissed or removed an employee or helper from working in regulated activity, following harm to a child or vulnerable adult or where there is a risk of harm.

An assessment as to whether it is appropriate to put an individual on the barred list must be made by the DBS, as an appropriate response to the harm that has occurred and to the risk of harm posed.
What happens if a DBS certificate is returned with safeguarding concerns?

If an enhanced DBS certificate is returned with relevant safeguarding concerns, this should be referred to the Safeguarding Lead for consideration, and discussion with the Chief Executive and Safeguarding Committee.

If the enhanced DBS certificate returns any information that identifies that a member of staff or helper appears on the DBS barred list, the following immediate action must be taken:

1. notify the relevant Safeguarding Advisor and the Chief Executive;
2. notify the Safeguarding Committee Chair and, in the case of staff, the chair of the HR and Remuneration Committee;
3. immediately suspend the member of staff or helper;
4. consider notifying the police; and
5. contact the DBS.

Subject to the section below, “storage of DBS forms”, all registration application documentation should be retained in the event that such documentation is required, by the police, as evidence in any criminal investigation and prosecution.

It is a criminal offence for anyone on the DBS barred list to work or continue to work as an HCPT helper or member of staff and for HCPT to knowingly allow an individual on the DBS barred list to so work. If HCPT is unable to satisfy itself that an individual does not appear on any barred lists, they will not be allowed to travel on pilgrimage as a helper.

C1.4: Storage of DBS forms

HCPT complies with the “Code of Practice for registered persons and other recipients of DBS check information”. This Code covers aspects such as the safe storage, handling, use, retention, disposal and disclosure of confidential information relating to DBS documentation.

Also, as part of HCPT’s obligations under the Data Protection Act 1998 and other relevant legislation, all such confidential information will be kept secure, in lockable, non-portable cabinets or secure electronic folders with access strictly controlled and limited to those who need to see it as part of their role.

The information will be kept as long as necessary and only for the specific purpose for which it was requested and for which the applicant has given full consent. The retention period for DBS disclosures is generally up to six months, to allow for any disputes or complaints. In very unusual circumstances, HCPT may keep disclosure information for longer than six months in consultation with the DBS.

When HCPT disposes of any disclosure information, it will be immediately and securely shredded before it is destroyed. HCPT will not keep any photocopy or other image of the disclosure or any copy or details of the contents of a disclosure, after the retention period has ended. The only information retained by HCPT will be a record of the date of issue of a DBS disclosure, the name of the subject, the job the disclosure was requested for, the unique reference number, the suitability, fitness or recruitment decision and the type of disclosure i.e. standard or enhanced.

C1.5: Potential helpers resident in Scotland: Protecting Vulnerable Groups Scheme

Potential pilgrimage helpers who reside in Scotland will need to apply to register with the Protecting Vulnerable Groups Scheme (“PVG Scheme”) which is managed and delivered by Disclosure Scotland, an executive agency of the Scottish Government (http://www.disclosurescotland.co.uk/help/).

The PVG Scheme will:

- help to ensure that those who have regular contact with children and protected adults, through paid and unpaid work, do not have a known history of harmful behaviour;
be quick and easy to use, reducing the need for PVG Scheme members to complete a detailed application form every time a disclosure check is required; and

strike a balance between proportionate protection and robust regulation and make it easier for employers to determine who they should check to protect their client group.

Disclosure Scotland will take decisions, on behalf of Scottish Ministers, about who should be barred from working with vulnerable groups.

If a PVG Scheme Record is returned with safeguarding concerns, the same procedure, as set out under the heading “what happens if a DBS check is returned with safeguarding concerns?”, should be followed.

C1.6: Potential helpers resident overseas

Potential helpers currently resident overseas or who have been resident overseas for a period of no less than three months in the past five years (preceding the date of departure for the pilgrimage) must:

- follow the appropriate procedure set out above and apply for either an enhanced DBS/PVG certificate
- In addition, it will also be necessary for the applicant to provide HCPT with a recent (no more than 6 months old) local check from the relevant country / countries

Potential helpers who are resident in the Republic of Ireland must complete a Garda check. This is managed in co-operation with the Irish Pilgrimage Trust. Further information in relation to this process can be obtained from HQ.

C1.7: Induction packs and helper preparation

HCPT recognises that preparation and raising awareness of safeguarding issues, policies and procedures is fundamental to the development and maintenance of a safe environment and safer organisation.

Continued vigilance is at the heart of developing a safer culture, safer environment and safer organisation. It is important that all HCPT staff and helpers have appropriate preparation and induction so that they understand their roles and responsibilities for safeguarding and are confident about carrying them out. Everyone needs to feel confident that they can raise issues or concerns about the safety or welfare of a child or vulnerable adult and be confident that they will be listened to and taken seriously.

All new members of staff and helpers will receive an induction sufficient and commensurate to the role that is being performed and the individual’s level of responsibility. This will cover at least:

- raising safeguarding awareness;
- safeguarding policies and procedures;
- skills in safeguarding;
- creating safe environments;
- safer recruitment; and
- recognising and responding to concerns and allegations of abuse;

Additionally, all helpers will be provided with a copy of the Code of Conduct (and be required to sign to confirm issue and compliance) and the names and contact details of their Group Leader and Safeguarding Advisor.

Safeguarding training will not be regarded as a ‘once only’ activity, but as an on-going development of skills and knowledge.

C1.8: The selection of children or vulnerable adults

HCPT actively seeks children disadvantaged by social, emotional and environmental factors without necessarily any physical disability or learning difficulty. Experience has shown that such children derive particular benefit from the pilgrimage. Group Leaders should be cautious about accepting children and vulnerable adults who have serious and complex emotional and behavioural needs. Expert advice suggests that the pilgrimage experience can be profoundly disorientating for such children and vulnerable adults who may take months to recover. As the presence of a familiar carer is strongly recommended, HCPT may not even offer the benefit of respite at home.
It is the responsibility of the Group Leader and helpers, advised by the Group Nurse, to identify and select suitable children and vulnerable adults in the locality and issue application forms. HQ passes all prospective applications to Groups.

Prior to pilgrimage, full background information should be obtained from school and/or social services in relation to any child or vulnerable adult identified with a safeguarding concern, for example, a child identified as being on a child protection plan or common assessment framework, in order to assist the selection process.

Some pilgrims will have such a reduced mobility and communication ability that they do not pose a risk to any other vulnerable adult or child. Other pilgrims may, however, have significant behavioural problems and therefore, pose an increased risk of causing harm or distress to others. Group Leaders need to complete a risk assessment to establish if it is safe for the pilgrim to travel with an HCPT Group.

Risk assessments should take account of the following:

- information provided by the pilgrim for example in the application form;
- personal observations for example following a home visit;
- community knowledge;
- the individual’s ability to cause harm or distress e.g. capacity, mobility, communication, supervision and care requirements;
- information from other agencies e.g. health or social services;
- any predictable conditions or behaviours that may arise from a particular disability e.g. verbal or physical aggression; and
- the likely effect of travel and strange surroundings on the pilgrim.

If for any reason a Group Leader believes that a pilgrim may pose a risk of harm to other vulnerable people, they should contact their Safeguarding Advisor for guidance.

Some pilgrims who pose a risk, may still be allowed to travel, depending on the arrangements that can be made to minimise any risks. For example, increasing supervision levels, ensuring appropriately trained staff are available, or implementing prevention strategies to avoid behavioural problems.

**C1.9: Group meetings**

All helpers should attend a Group meeting, prior to pilgrimage, to:

- gain an awareness and understanding of safeguarding procedures and policies and the use of a code word;
- understand what to expect from pilgrimage;
- understand what is expected in terms of personal performance;
- familiarise themselves with the Code of Conduct and HCPT policies and procedures including in relation to social networks, whistle blowing, DBS/PVG compliance, use of personal phone, videos and photographs; and
- be informed of helper/child assignment.

In relation to the Code of Conduct, all helpers attending Pilgrimage shall be required to sign to acknowledge receipt and confirm compliance.

During the pilgrimage, Group Leaders may hold regular daily meetings with their helpers, at a time which is convenient for all helpers. Such meetings should have an agenda to cover the needs of both the children or vulnerable adults and the helpers. These should be brief and are not intended to add to the workload of the Group but are a useful mechanism of proactively managing any emerging issues as well as monitoring ongoing issues.
Regular Group meetings both before, during and after pilgrimage, will assist the Group Leader in assessing the ability of his or her helpers. In such meetings, consideration should be given to including safeguarding as a standing agenda item to allow helpers to discuss any safeguarding issues, in a free and unchallenged environment, which will enable the Group Leader and other helpers to provide any support that may be needed.

**C1.10: Home visits**

All Group Leaders and Nurses are expected to conduct at least two home visits to all children and vulnerable adults who have applied to attend a pilgrimage, with their Group, for the forthcoming year. The purpose of the visit is to:

- familiarise themselves with the child or vulnerable adult;
- understand the child’s or vulnerable adult’s needs and wishes for example in relation to helper assignment;
- develop an appropriate relationship and build a rapport with the child or vulnerable adult prior to pilgrimage;
- check the accuracy of information supplied on the pilgrimage registration form;
- obtain accurate up to date information;
- identify any significant nursing/medical needs;
- obtain written parental/carer consent;
- provide information leaflets on safeguarding issues;
- check validity of passport and obtain confirmation of citizenship i.e. same name as on registration form; and
- help with any appropriate visa applications for travel, should these be necessary.

Under no circumstances should any helper (1) visit a child or vulnerable adult outside the above agreed pilgrimage preparation home visits or (2) invite a child or vulnerable adult to their own home or that of a family member, colleague or friend when not part of a prearranged Group activity or (3) undertake a home visit alone.

If in an emergency, such a one-off arrangement is required, the helper must have a prior discussion with their Group Leader and a clear justification for such arrangement be agreed and recorded.

If such a visit is agreed then a risk assessment should be completed in advance of the visit which includes an evaluation of any known factors regarding the child or vulnerable adult and others living in their household. Risk factors such as hostility, safeguarding concerns, complaints or grievances can make staff members and volunteers more vulnerable to an allegation. Specific consideration should be given to visits outside of ‘office hours’ or in remote or secluded locations.

Following an assessment, which involves considering the need for parental, guardian or carer consent, appropriate risk management measures should be in place before visits are agreed. Where little or no information is available, visits should not be made alone. There will be occasions where risk assessments are not possible or not available, e.g. when emergency services are used. In these circumstances, a record must always be made of the circumstances and outcome of the home visit. Such records must always be available for scrutiny.

**C1.11: Visits to Respite care provision**

Some of the children, young people and vulnerable adults that apply to travel on an HCPT pilgrimage may have significant physical or learning disabilities. In addition to conducting a home visit, it may be necessary for a Group Leader, Group Nurse or other helpers to visit the potential pilgrim during a period of respite. Group Leaders must ensure that a sufficient number of helpers, with the right level of skills, attend the respite visit in order to support the potential pilgrim.
A respite visit allows for a more accurate assessment of the potential pilgrim’s needs and provides Group Leaders with a better understanding of an individual’s likely reaction, behaviours and responses on pilgrimage.

The written consent of a parent or carer must be obtained in advance of a respite visit.

Relevant information obtained from a residential visit must be recorded on the pilgrim’s medical record.

The HCPT safeguarding policies and procedures should be followed in the event that a respite visit is appropriate.

C1.12: Day trips

It is strongly encouraged that all children / vulnerable adults are invited to a day trip (away from family environment) before the pilgrimage. This is intended to allow for helpers to become more confident in providing the appropriate care and support, and also to observe behaviours which may be prompted by less familiar environments.

C1.13: Residential trips

The needs of some potential pilgrims or identified risks can only be properly assessed when the pilgrim actually takes a trip away from their family members and familiar surroundings. Therefore, in some instances, it is recommended that a trial shorter trip, for example for a weekend, is taken in the UK and much nearer to the pilgrim’s home. This means that any serious concerns or insurmountable problems can be resolved quickly and without as many logistical obstacles as a pilgrimage to Lourdes. Additionally, a trial residential trip should minimise any stress or anxiety to all parties.

Group Leaders must ensure that a sufficient number of helpers, with the right level of skills, attend the residential visit in order to support the potential pilgrim.

The written consent of a parent or carer must be obtained in advance of a respite visit.

Relevant information obtained from a residential visit must be recorded on the pilgrim’s medical record.

The HCPT safeguarding policies and procedures should be followed in the event that a residential visit is appropriate.

C1.14: Helper/child and vulnerable adult assignment

HCPT is an inclusive organisation that aims to give all children, young people and vulnerable adults, regardless of their abilities, the opportunity to enjoy a pilgrimage holiday where they can relax and feel comfortable, safe and secure. It understands that part of creating safety and security for children, young people and vulnerable adults involves pairing them with a helper who is able to meet their physical, emotional, social and, if appropriate, medical needs. When assigning helpers to children, young people and vulnerable adults attending pilgrimage, the following factors will be taken into consideration.

The needs of those in our care

The Group Leader will allocate a specific helper to a child or vulnerable adult using the information about his or her needs outlined in their registration form. Where possible the Group Leader will allocate a helper who has the skills and the experience to meet the specific needs of an individual child or vulnerable adult.

HCPT aims to take an individual approach in meeting the needs of children and vulnerable adults who travel on pilgrimage. Particular attention will be given to factors identified by risk assessments, for example, providing extra levels of support to meet the needs of a child or vulnerable adult with challenging behaviour.

If a child or vulnerable adult has a history of abuse or is the subject of a child protection plan, where possible, Group Leaders should allocate that pilgrim a helper who has experience in safeguarding issues.
Unless there is a specific demonstrable reason not to, children, young people and vulnerable adults will be allocated helpers of the same sex.

The requests of those in our care

HCPT recognises that some of the pilgrims who have previous experience of an HCPT pilgrimage, may have developed a bond with a particular helper who has supported them previously. A child’s or vulnerable adult’s request to have a specific helper will be considered, subject to the availability of the helper and the needs of other children or vulnerable adults.

Section D. How we stay safe in HCPT - supervision & room sharing

D1: Group identification and supervision

D1.1: Pilgrimage badges

It is essential that Group members can be quickly identified, especially while looking after children and vulnerable adults and acting in the name of HCPT. The safest way this can be achieved is by ensuring that everyone who is a member of a Group has an official pilgrimage badge, and that the badge is worn at all times.

While HCPT does not want to stifle the uniqueness and creativity of Groups and while it is recognised that many Groups are able to produce their own name badges, it is vital that the pilgrimage badge is used for the correct purpose.

The pilgrimage badges are issued by HQ, to Group Leaders and are slightly different for each pilgrimage season. One badge is issued for each Group member for whom the appropriate paperwork has been submitted. It is the Group Leader’s responsibility to ensure that only those people entitled to a pilgrimage badge are issued with one. If a badge is damaged or lost, a replacement badge can be requested via HQ.

Group Leaders must ensure that all Group members wear their pilgrimage badges at all times, even if a Group has its own identity system in addition.

The pilgrimage badge serves several purposes:

- it gives the name of the person, their Group number, their hotel and the fact that they are a member of the HCPT pilgrimage for that year. This is very important especially if a child gets lost or there is an accident involving a helper or a child;
- on the rear of the badge, there are emergency telephone numbers, and space for the Group Leader’s mobile phone number and the hotel telephone number etc;
- only people who have a qualifying enhanced DBS/PVG check, have completed an application form, provided references and provided evidence of an interview, where appropriate, should be issued with a badge, making it quick and easy to verify that they have fully completed HCPT checks;
- it indicates that, as a bona fide helper, another Group could ask that individual for assistance; and
- enables the wearer to be recognised by HCPT stewards who will give admittance to HCPT events.

D1.2: Group identification

Group identification is a key process by which a Group can be kept safe, together and under control thus reducing the risk of members getting lost or separated from each other.

The following are all strongly recommended as examples of best practice:
• issuing unique (coloured) sweatshirts to Group members denoting the Group number;
• using a lanyard system (see below)
• regular head counts; and
• nominating front and back markers
• take steps to ensure that anyone not a registered member of the group is not wearing ‘group kit’ while visiting the group

Any lost Group member should be reported immediately to the Group Leader, HQ or Hosanna House Manager.

D1.3: ‘Lanyard system’
Each child or vulnerable adult is identified on a badge connected to a lanyard, either by their name or an image they would recognise. These lanyards are then worn by the helper or helpers responsible for their supervision at the time.

It is recognised that for many children or vulnerable adults it would be relevant for them to have more than one helper looking after them, but while arranging supervisions Group Leaders should avoid allowing a situation to arise where any one helper has more than two supervision lanyards.

When handing over responsibility for supervision, helpers must also hand over their lanyard – this slows down the process and helps ensure that everyone is aware of their responsibilities.

D1.4: Head counts
It is difficult to be prescriptive as to when head counts should be done. It is important that these are considered for all age groups and all outdoor activities and, specifically, when disabled children or vulnerable adults are moving about as a Group. Best practice would suggest that a head count should be done when there is a change of environment or when overcoming a particular hazard e.g. when moving about in a crowded public area or at the Baths in the Domaine. Routine head counts should be the norm at meal and bed times.

D1.5: Supervision of Groups
Group identity can assist in the supervision and management of Groups. Group Leaders need to be aware of those unauthorised individuals who may try to infiltrate a Group by using the same Group identity method to portray official status e.g. helpers from previous years not vetted or authorised by HCPT for the current year, attempting to act as a helper.

The supervision of Groups whilst on the move is more challenging than at a static venue. Group Leaders need to ensure that their Group is fully accounted for before moving to the next activity or area.

D1.6: Helper/supervision ratios
The following guidelines are recommended by the NSPCC Child Protection in Sport Unit.

It is important to ensure that, in planning and running pilgrimage activities for children, young people and vulnerable adults, Group Leaders give consideration to providing an appropriate supervision ratio of helpers to participants. This will minimise any risks to the children, young people and vulnerable adults while on pilgrimage, enhance the benefits they draw from the activity, reassure parents and carers and provide some protection for those responsible for providing the activity, in the event of concerns or incidents arising.

Due to the number of potential variables, it is not possible to recommend “one size fits all” guidance to cover all activities involving children, young people and vulnerable adults. There are, however, a number of key principles that should underpin good practice:
1. It is the responsibility of the Group Leader who organises, plans or provides activities to ensure that the helpers running the activity are suitable to do so.

2. Young helpers should not be given full or lead responsibility for managing groups of children or vulnerable adults. Young helpers should only supplement those appropriate adult helpers with responsibility for supervising the activity. HCPT’s duty of care and safeguarding policy extends to all people under 18, regardless of their role in the organisation. Group Leaders should therefore ensure that, among the volunteers in the Group, there are a suitable numbers of helpers for any young helpers as well as the necessary supervision of all children.

3. In the planning of all activities, and regardless of any other assessments that may be required, for example of equipment or for health and safety purposes, a risk assessment should be undertaken which specifically informs decision-making about appropriate supervision levels.

Key factors to assess in assessing appropriate supervision ratios include the:

- age of any child;
- additional supervision/support needs of some or all participants. For example due to disability;
- competence/experience of participants for the specific activity;
- nature of the activity. For example outdoor activities may require higher levels of supervision than relaxing in accommodation; and
- nature of venue. For example, whether closed and exclusive, or open and accessible to members of the public.

HCPT expects all Groups to ensure that, at all times, no helper is alone with a child or vulnerable adult.

In the event that a helper is unable to perform their role and their absence would compromise HCPT supervision ratios then the Group Leader should either:

- replace the individual with another helper from within the Group; or
- contact HQ in Lourdes or the Hosanna House Manager to request support.

**HCPT Groups should have a ratio of between 1.5 to 2.5 helpers per sponsored child / vulnerable adult. In calculating this ratio, Group Leaders can include both Helpers (incorporating chaplains and nurses) and Young Helpers.**

**D2: Sleeping arrangements while in transit to and from Lourdes**

Where overnight travel is required to transport Groups to and from Lourdes, this will happen on chartered trains or planes thereby reducing the risk to all pilgrims from being exposed to members of the public who are not vetted.

The Group Leader is responsible for planning sleeping arrangements in advance and completing risk assessments for all children and vulnerable adults in the Group. The same considerations and arrangements should be implemented as for hotel room allocations e.g. gender, age and vulnerability, see further below. It should be remembered that sleeping facilities on trains and planes can be less private and secure than hotel rooms and so privacy and security are priority factors to consider on any risk assessment.

**D3: Sleeping arrangements while in Lourdes**

HCPT uses approximately sixty hotels in Lourdes at Easter each year. All bookings are made by HQ. Most Summer groups stay at Hosanna House, though there may be occasions when Summer Groups stay in Hotels.
When staying in a Hotel, each Group Leader is responsible for ensuring that the requested facilities are appropriate for their Group, for example in relation to security and the visiting or sharing of bedrooms, and do not compromise the ability of any helper to follow the safeguarding procedures. The HCPT intranet includes layout plans for the Hotels to help Group Leaders request the most suitable composition of bedrooms.

If on arrival, a hotel is unable to provide what has been agreed in advance, the Group Leader should review what is proposed. If there are any concerns, the Group Leader should call for the assistance of HQ before accepting a set of rooms which could compromise the safeguarding procedures.

At Hosanna House and in hotels, the Group Leader’s careful allocation of bedrooms is crucial to everyone’s enjoyment of the week. He or she will consider many factors in finding the best mix, taking into account the different needs and risks and the fact that it is potentially a new experience for the child or vulnerable adult, in very different circumstances from those at home.

There are a number of general principles that are applicable in relation to a child’s or vulnerable adult’s bedroom: Helpers will:

- respect the child’s, young person’s or vulnerable adult’s right to privacy;
- knock on the child’s, young person’s or vulnerable adult’s door before entering his or her bedroom and only enter with permission, unless the following exceptional circumstances apply. It is necessary to:
  - enter to wake a heavy sleeper, undertake cleaning or return or remove soiled clothing (although, in these circumstances, the child or vulnerable adult should have been told/warned that this may be necessary);
  - make a physical intervention, including forcing entry to protect the child, vulnerable adult or others from injury or to prevent likely damage to property;
  - look for information which may help to find the whereabouts of a missing child or vulnerable adult.

When entering a child’s or vulnerable adult’s room in their absence, their privacy should be respected. For example, if documents or a diary have been left out, they should not be routinely inspected, unless a specific risk has been identified and recorded;

- only enter a child’s, young person’s or vulnerable adult’s bedroom in the presence of another helper. The only exception to this is in the case of an emergency i.e. self harm, fire setting, or concern that the child, young person or vulnerable adult is being abused or is ill. In these circumstances, the helper may enter the child’s, young person’s or vulnerable adult’s room while calling for immediate assistance;
- at all times be aware of issues regarding safe care, in respect of physical touch/contact with children, young people and vulnerable adults; and
- be aware of risk factors and ensure that appropriate boundaries are in place, balancing this alongside the child’s, young person’s or vulnerable adult’s rights and the need for appropriate physical attention/affection.

Forenames of children can be used to personalise and designate rooms but these should not include the child’s surname nor any child’s photo or image.

**D3.1: Rooming**

Ensuring appropriate accommodation arrangements for groups during all HCPT Pilgrimages is a central factor towards enabling all group members to experience an enjoyable pilgrimage in an environment that is as safe as possible. The allocation of group members within rooms is a complicated exercise, and can never be an exact science, as it needs to balance the size and needs of the group with the physical realities of hotel or Hosanna House room configurations. It is also the point at which the two disciplines of Safeguarding and Risk Management meet, with a very fine balance to be struck by Group Leaders in that regard.

**Context**

The ways in which groups should be accommodated include:
• children sharing bedrooms with other children of the same gender and (as far as practical) with children of similar age,
• vulnerable adults sharing bedrooms with other vulnerable adults of the same gender
• young helpers sharing bedrooms with other young helpers of the same gender,
• adult helpers sharing with other adult helpers.

If the risk assessment of the needs of a child or vulnerable adult concludes that close supervision through the night is required, the Group Leader should balance the needs with the wider dynamics of the group and such practical issues as room layouts. Ideally, such supervision is to be delivered through a “waking night supervision” arrangement where two adult helpers are able to supervise all the children / vulnerable adults while they are asleep. This should consist of two adult helpers (if possible male and female) and cover the silent hours until the group is woken in the morning. In planning such an arrangement, Group Leaders should consider:

• the ratio of helpers to helped (children / vulnerable adults) in the group,
• the possibility of cooperation with other groups in the hotel OR the other Group at Hosanna House,
• during the Easter Pilgrimage the possibility of seeking assistance from Regional or Central Services Groups (on the basis of one CSG helper supporting an adult helper from the Group).

D3.2: Hotel room keys

It is extremely important that at all times the people in our care – and their possessions – are kept as safe as possible.

There are particular risks associated with hotel accommodation and although each hotel is different these points of guidance are common and should be followed by all groups.

Following this guidance should help ensure that access to rooms is only granted to those who have good reason, that personal privacy, dignity and liberty is maintained and respected without undue risk, and that appropriate levels of safety are maintained for personal possessions.

The Group Leader, along with the Group Nurse and other key helpers, should make a judgement on a child-by-child basis to decide who should be responsible for the keys for each hotel room.

Doors must be kept open at all times when the group is present on the group corridor, when this does not compromise the child’s or vulnerable adult’s privacy or dignity, for example, when washing or getting dressed.

Door locks (hotels)

There are two types of door locks in the Lourdes hotels – traditional key locks, and key cards.

Doors should never be locked while occupied if doing so restricts the liberty of movement of those in the room. Doors should always be locked while the Group are away from the Hotel.

The Group Leader should determine if rooms should be locked while the Group are in the hotel away from their rooms (e.g. mealtimes)

For hotels with automatically locking bedroom doors (typically those with the key card system), extra keys should be obtained and held centrally by the group.

D3.3: Hosanna House room keys

The House Manager is able to provide the Group with keys for each door if requested.

D3.4: Bedroom security

Open door standard

Rooms for children or vulnerable adults should never normally be locked from the inside except in a few specific circumstances:
- if a visually impaired person may not know the layout of the hotel / Hosanna House and so his/her safety is at risk,
- if the overall safety and protection of a person is assessed to be better assured if the door is locked and s/he is accompanied by at least two responsible persons.

Other considerations:
The Group Leader, as the person responsible for the welfare of each member of the Group, has authority to enter any group bedroom at any time, as long as it is in a respectful and dignified way. The Group Leader would expect to gain almost immediate access unless there is an appropriate reason for this not to happen. This includes the bathroom and toilet areas. Unless it is impossible in an emergency, the Group Leader should be accompanied by another helper when entering any child or vulnerable adult’s room.

At all times accommodation arrangements should be such that the maximum security and safety are assured as is practically possible.

D3.5: Examples of acceptable and non-acceptable rooming arrangements

<table>
<thead>
<tr>
<th>Acceptable</th>
<th>Non-acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>One child or vulnerable adult</td>
<td>One Helper plus one child / vulnerable adult</td>
</tr>
<tr>
<td>Two or more children</td>
<td>One Helper plus more than one child / vulnerable adult</td>
</tr>
<tr>
<td>Two or more vulnerable adults</td>
<td>Young helpers plus children / vulnerable adults</td>
</tr>
<tr>
<td>Young helpers + young helpers</td>
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<tr>
<td>Young helpers + helpers</td>
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<tr>
<td>Helpers + helpers</td>
<td></td>
</tr>
<tr>
<td>Two or more helpers + one or more children³</td>
<td></td>
</tr>
</tbody>
</table>

³ ‘Child’ or ‘Children’ refers to sponsored children, if a helper is accompanied by their own child (sponsored or not) and they wish to share then that is acceptable and outside the scope of this guidance.

D4: Night time care and supervision

HCPT recognises that most parents and carers do not sleep in the same room as a child or vulnerable adult, even in circumstances where the individual has additional needs. Children and vulnerable adults with additional needs, including those requiring night time care, should be entitled to have sufficient rest at night, in the privacy of their own room, with minimum disturbance.

Children and vulnerable adults who require personal and night time care are more vulnerable to abuse. Any child or vulnerable adult who requires night time care should undergo a risk assessment to establish their needs and assess how helpers can deliver such care safely. A night time care plan will be agreed with the child’s or vulnerable adult’s parent or carer and the Group Leader, prior to pilgrimage and recorded on the medical record card.

If night time care is agreed on a care plan, a minimum of two helpers should be on night support duty to provide the care, recording details of all care given and all interactions with the child or vulnerable adult. Such level of supervision should be identified early during the home visits that take place prior to travel. Group Leaders should ensure that sufficient helpers are available to provide night time care.

If in an emergency only one helper becomes available to provide night support, the Group Leader should be informed immediately and the assistance of another helper should be sought.

³ Subject to conforming with the procedure as described in the section Risk assessment based arrangement for helpers sharing with children on page 58
It is expected that helpers will respond to any emergency during night-time hours. Helpers should use their professional judgement as to the appropriate response to the particular need, ensuring that the Group Leader is alerted. If assistance is required, a helper may need to seek the assistance of another helper who is sleeping.

To allow helpers to meet a child’s or vulnerable adult’s night time care needs, wherever possible, Groups may use basic “baby” alarms. Groups may also consider taking more sophisticated alarm systems provided by parents or carers, as long as they are compatible with the accommodation’s systems. The alarms will be used at the helpers’ discretion to ensure the safety and welfare of all children and vulnerable adults requiring support during night-time hours. Where it is necessary to install or use listening or other strategies to monitor a child or vulnerable adult, these arrangements must be set out in the individual child’s or vulnerable adult’s care plan.

- When checking on the children/young people during the night-time, at least two helpers together should make rounds of each bedroom. No-one should be locked into a room from outside.
- Doors to occupied children’s rooms, whether locked or unlocked, should never be out of sight of supervisors while night-time supervision is being undertaken.

**D4.1: Examples of night time supervision methods**

**Partial waking night**

Two helpers on duty until 2am, making frequent visits to check on all children / vulnerable adults.

From 2am to 6am, door alarms are active and if activated they alert two other helpers.

From 6am until the rest of the Group are awake, two helpers are on duty.

**Two shifts**

Two helpers on duty from midnight to 3.30am, making frequent visits to check on all children / vulnerable adults.

Two other helpers on duty 3.30am until 7.00am, making frequent visits to check on all children / vulnerable adults.

**Three shifts**

Two helpers on duty from 10pm until 1am, making frequent visits to check on all children / vulnerable adults.

Two helpers on duty from 1am until 4am, making frequent visits to check on all children / vulnerable adults.

Two helpers on duty from 4am until 7am, making frequent visits to check on all children / vulnerable adults.

**Young Helpers cannot participate in waking night supervision rota.**

**CSG assistance**

Group Leaders may request the assistance of CSG members to help with night time duties, CSG leaders will co-operate so long as their duties and numbers allow. However, this is subject to the following:

- Only CSG (adult) Helpers may assist with night time duties (no Young Helpers)
- CSG helpers may support an adult helper from the family group in question to provide a team of two, but there must always be one adult helper from the family group present as part of the night time duty team.
- It is recommended that only CSG Helpers who have already met the children in the Group should help.

**D4.2: Risk assessment based arrangement for helpers sharing with children**
If the Risk Assessment of a child concludes that their night time safety is best provided with helpers sharing the room, then the following steps must be taken:

- The document ‘Risk assessment based room sharing plan’ must be completed
- This must include a copy of the Risk Assessment which demonstrates the need
- The proposed arrangement for each night of the pilgrimage must be described
- Parents / guardians of the child must be asked to sign to show their acceptance of the proposed arrangement
- The relevant helpers must also sign to show their acceptance of the proposed arrangement
- The Group Leader should keep the original, and send a copy to HQ

Any room sharing arrangement which is not supported by a fully completed ‘Risk assessment based room sharing plan’ will be viewed by the Safeguarding committee as a breach of our safeguarding policy and may invalidate our insurances should an incident arise.
Section E. How we stay safe in HCPT - interactions between group members

E1: The provision of personal care

HCPT attaches the highest importance to developing a culture that values the privacy and dignity of all children and vulnerable adults who are cared for whilst on pilgrimage. Group Leaders and helpers are accountable for their actions, have a professional duty of care, and have responsibilities to act in the child’s or vulnerable adult’s best interests. Group Leaders and helpers must be sensitive to differing expectations associated with race, ethnicity, age, gender, disability, religion/faith and sexual orientation.

This policy applies to the care of children and vulnerable adults who require personal care and support. HCPT recognises that intimate and personal care is an important part of a child’s or vulnerable adult’s self-image and respect. The apparent nature of personal care, if not practised in a sensitive and respectful manner, can lead to misinterpretation and occasionally allegations of abuse. Not understanding a child’s or vulnerable adult’s specific needs can lead to confusion and misunderstanding. It is therefore important that Group Leaders and helpers are sensitive to these issues and alert to the potential for individuals, especially children, young people and vulnerable adults to become the victims of abuse.

E1.1: What is personal care?

Intimate care covers all areas of personal care that most children, young people and adults learn to carry out independently, as they grow and develop. However, some are unable to do so because of impairment or disability, age, understanding or communication difficulties. Children, young people or vulnerable adults may require help with eating, drinking, washing, dressing and toileting.

E1.2: At risk groups

Any child or adult dependent on others for care is vulnerable. Factors, which may increase this vulnerability, include:

- reduced control over their lives or decisions due to their disability or lack of understanding;
- lack of sex education which can lead to difficulty in children and vulnerable adults recognising abusive behaviour;
- reduced communication skills to let someone know they are unhappy;
- multiple carers due to hospital admissions or respite/residential care;
- differences in appearance or behaviour being attributed to a child’s or vulnerable adult’s disability/age and not to the possibility that something may be wrong;
- discrimination against disabled children and adults in society;
- first language is not English;
- pre-verbal infants and children;
- mental illness including dementia.
- A history of previous abuse (known or unknown to us)

E1.3: Principles of good practice

- Group Leaders and helpers must get to know the child or vulnerable adult before being involved in any intimate or personal care. They must also reach agreement with the child and family on the names used for intimate body parts.
- Allow the child or vulnerable adult to care for him/herself as far as possible.
- Allow the child or vulnerable adult, wherever possible, to express a preference for his/her carer.
Group Leaders and helpers must ensure that they promote and enable each child or vulnerable adult to be part of the decision making process in relation to their intimate and personal care to ensure informed consent has been obtained wherever appropriate.

Where the child or vulnerable adult is unable to give consent, discussions must take place with their parent/carer or other legally appointed representative as to their preferences and/or needs.

Details of and the scope of the personal care to be given to the child or vulnerable adult must be outlined and documented in the home visit section of the ‘Nursing and Medical Record Card’.

Allow the child or vulnerable adult a choice in the sequence of care they receive, where possible.

Ensure the privacy and dignity of the child or vulnerable adult.

Be aware of and responsive to the child’s or vulnerable adult’s reactions.

If carrying out intimate care away from the Group’s accommodation ensure the privacy and safety of the child or vulnerable adult.

Any individual carrying out intimate personal care to children and vulnerable adults must have a qualifying DBS/PVG check.

If any personal care is to be given by a member of the opposite sex the child or vulnerable adult must be offered a chaperone. The chaperone must be, wherever possible, the same sex as the individual receiving the care. The name of any chaperone must be documented in the child’s or vulnerable adult’s care plan. If a chaperone is not available and care is not urgent, this must be explained to the child or vulnerable adult to ascertain if they would prefer to proceed without a chaperone or delay the care until a chaperone is available.

In situations where intimate personal care may be given on a regular basis by members of the opposite sex, information must be given and where possible discussion and agreement should take place with the child’s or vulnerable adult’s parent/carer or, where appropriate, a legally appointed representative. This information must be recorded in the child or vulnerable adult’s care plan.

In addition, a brief note should be made in the child’s or vulnerable adult’s medical record card for each occasion and must include the date, time, care given, immediate necessity that led to opposite sex personal care being given or details of what care was omitted or delayed plus the reason why a member of same gender was not available.

The religious views of the child or vulnerable adult must be taken into account. It may be the case that males can only have intimate care provided by another male, therefore involvement of the family in the care of the individual is important.

Under no circumstances should any helper be alone with a child or vulnerable adult when undertaking personal care. This is to avoid misunderstanding and, in rare cases, false accusations of abuse. If child or vulnerable adult prefers to undergo personal care without the presence of a chaperone, this should be respected and it should be made clear why this is not appropriate.

Whilst children and vulnerable adults must be protected from receiving inappropriate touches, it is important that touch is not withdrawn completely from those with profound disabilities for whom it will always be essential for providing reassurance and personal and social development.

Consent for a child can be given by a variety of individuals depending on the circumstances. In most cases, consent can be given by the child’s mother, father or a legally appointed guardian. Group Leaders and helpers working with children must also be aware that a person under the age of 16 years shall have legal capacity to consent on his or her own behalf to any personal care under the Frazer Guidelines in circumstances where he or she is capable of understanding the nature and possible consequences of what he or she is being asked to consent to. Frazer Guidelines refer to a series of questions used by health agencies to assess the competence of children under 16 years in relation to consent issues.

The HCPT safeguarding procedures should be followed if a:

- Group Leader or helper thinks that their actions have been misinterpreted by a child or vulnerable adult whilst providing personal care;
• Group Leader or helper thinks that their actions have been misinterpreted by another adult whilst providing personal care to a child or vulnerable adult;
• child or vulnerable adult becomes upset or angry whilst receiving personal care; or
• Group Leader or helper has reason to suspect that a child or vulnerable adult they are providing personal care for has been abused.

E2: Travelling home from Lourdes

At the end of the pilgrimage, all children and vulnerable adults will be returned to the custody of their parent/carer or other nominated person named on the registration form. Helpers responsible for returning children and vulnerable adults to nominated drop off points must satisfy themselves that the person collecting the child or vulnerable adult is the person named on the registration form.

In circumstances where an adult other than the named person attends and wishes to collect a child or vulnerable adult, diligent and thorough independent checks should be made by telephone with the named parent, guardian or carer to confirm that the adult has their permission to collect the child or vulnerable adult.

The name of the individual who actually collects the child or vulnerable adult, should be recorded on the child’s or vulnerable adult’s medical record card and a signature obtained.

E3: Community based activities

Local and regional Groups hold community based events and activities throughout the year in order to raise funds or prepare for a pilgrimage. These activities are, in the main, organised and led by the Group Leader and supported by helpers and friends of HCPT.

Safeguarding is a continuing responsibility throughout the year and not just when on pilgrimage in Lourdes.

E3.1: Closed meetings or events

At closed meetings or events, the Group Leader has control over who attends and attendance is by direct invitation either by telephone, email or in writing. The Group Leader and/or helpers will have prior knowledge of the individuals attending. This therefore assists in assessing any risks associated with holding the meeting or event. Helpers must not invite any unknown individuals to such events, without the express permission of the Group Leader.

Such meetings could include a:

• “getting to know you” meeting prior to travel in order to build a rapport;
• logistics meeting in order to support travel plans;
• reunion meeting; or
• fundraising event specific to the Group members.

The Group Leader will be responsible for arranging the venue, completing any relevant risk assessments and ensuring that an attendance register is completed.

Some pilgrims will have significant physical and/or mental disabilities which will require their parent or carer to remain for the duration of the meeting/event. The Group Leader will be responsible for identifying these pilgrims and any other potential behavioural or safety issues i.e. identifying pilgrims with a history of violent outbursts or conduct. Group Leaders will gather relevant information from pilgrim’s registration forms, home visits, respite visits, residential trips and any other professional involved in the child/adult’s life in order to make an assessment of needs.

Group Leaders are responsible for ensuring pilgrims’ safety and welfare at all times during the meeting or event especially if they have been allowed to attend the meeting unsupervised by a parent or carer. The Group Leader is responsible for ensuring that pilgrims are safely re-united with their parent or carer at the conclusion of the meeting.
E3.2: Open meetings or events

At open meetings or events, the Group Leader does not have any control over who attends and may not have any prior knowledge about the individuals who ultimately attend. Invitations are circulated more widely than with closed meetings or events and are more usually advertised through community or church newspapers and circulars, local press or posted flyers. Official HCPT websites, Facebook and Twitter could also be used to promote the event or meeting in the local community but HCPT’s social networking policy (See page 67: Social networking policy) should be followed.

Open meetings or events could include:

- fundraising events, for example a cake sale or a race night;
- recruitment events, for example to recruit new helpers;
- sponsored events; or
- seasonal or religious events, for example a Christmas Bazaar or a Halloween party.

Some spontaneous events may not have any pre planned advertisement at all. These may include:

- collections at train stations/sporting events;
- church collections following mass; or
- door to door collections.

The Group Leader is responsible for arranging the venue, obtaining any permissions or licences, completing any relevant risk assessments and ensuring that, where possible, an attendance register is completed.

Group Leaders and helpers must show extra vigilance during an open meeting and identify any safeguarding concerns or risks at an early stage. Inappropriate conduct or behaviour should be challenged in a firm and assertive manner and the HCPT safeguarding policies and procedures followed.

E3.3: Dealing with safeguarding concerns

Most HCPT community based meetings or events are pre-planned organised activities. Group Leaders and helpers easily recognise their safeguarding responsibilities at such events when they are performing the role of an HCPT volunteer. However, it is more difficult for an individual to distinguish when a professional safeguarding responsibility becomes a personal responsibility, i.e. when an individual is not formally performing the role of an HCPT helper.

Pilgrims who display challenging behaviour which is directly attributable to a disability should be managed in a supportive manner. Advice and guidance from parents, carers or Group Nurses/Doctors should be sought in these cases.

Helpers may meet children, young people, vulnerable adults and their families going about their normal day today business. For example, this could happen at:

- charity coffee mornings;
- church;
- shopping at the local supermarket;
- in the street; or
- at work.

If a helper has a safeguarding concern about a child, young person or vulnerable adult and they are aware that the child, young person or vulnerable adult has had prior involvement with HCPT, they must inform their Safeguarding Lead.
If a helper has a safeguarding concern about a child, young person or vulnerable adult and they are not aware that the child, young person or vulnerable adult has had any prior involvement with HCPT, local safeguarding agencies should be informed.

Group Leaders should encourage and support helpers who report concerns about children, young people and vulnerable adults that arise from unplanned contacts outside formal HCPT activities. Further help and guidance should be sought from a Safeguarding Advisor where needed.

If a helper has any concerns that a child or vulnerable adult is at risk of harm or further harm by being returned to their parent, guardian or carer at the end of an HCPT meeting or event, they must inform their Group Leader immediately, using the agreed code word or phrase, and before returning the individual to their parent/guardian or carer. If the parent, guardian or carer insists on removing a distressed child or vulnerable adult before the helper has satisfied themselves as to the risks, the local police must be contacted immediately.

E4: First aid and Medical Support

E4.1: First aid
From the 2015 season onwards all Groups should include at least one person who has a current ’Emergency First Aid at Work’ certificate.

Group Leaders should check within their Group which helpers have identified themselves as a qualified first aider, and satisfy themselves that their qualification is in date. Group Leaders should then only allow such qualified first aiders to act when such a situation arises as calls for this help.

When administering first aid, the first aider should always follow their training and not act outside their scope.

Any incident of first aid should be recorded on an incident form and handed to Medical HQ as soon as possible.

All other HCPT helpers and staff will not be expected to administer first aid. Whilst most staff and helpers will have a basic awareness of first aid techniques, they are not sufficiently experienced and trained to provide first aid while undertaking HCPT activities.

E4.2: Medical support
Requests for medical support during the Easter Pilgrimage which cannot be managed by the Group nurse and which are not an emergency can usually be managed through the Medical Hub.

The contact numbers for the Medical Hub are provided to each Group and are in Tatler each day.

The Medical Hub staff will identify the most appropriate Doctor on the pilgrimage to assist with the case in hand.

In addition, Medical HQ is located on the first floor of the Hôtel Solitude.

During the Summer Pilgrimage, if the Group is at Hosanna House then they should contact the House manager or another member of staff to call for medical help.

E4.3: Medical emergencies
If an emergency occurs at any time on Pilgrimage which requires urgent medical attention, please phone 112 to call an ambulance, and then also advise Medical HQ or the Hosanna House manager as appropriate.
E5: Appropriate behaviour towards pilgrims

E5.1: Making a professional judgement

There may be occasions and circumstances in which helpers and staff have to make decisions, using their professional judgement, to act in the best interests of a child or vulnerable adult.

If a staff member or helper has difficulty in making a decision and there is scope for there to be a misunderstanding, advice should be sought from the Group Leader, Regional Nurse or Doctor, Safeguarding Advisor or Chief Executive, as appropriate to the situation. All actions considered should be warranted, proportionate, safe and applied equitably. Full details of the decision and decision making process should be recorded and attached to the Medical Record Card as soon as possible.

E5.2: Power and positions of trust

As a result of their knowledge, position and/or the authority vested in their role, all staff and helpers working with children and vulnerable adults are in a position of trust in relation to those in their care.

Broadly speaking, a relationship of trust can be described as one in which one party is in a position of power or influence over another by virtue of their work or the nature of an activity in which they participate. All helpers and staff need to understand the power this can give them over those children and vulnerable adults in their care and therefore the responsibility they must exercise as a consequence of this relationship.

Helpers and staff will not use their position to gain access to information for their own or others’ advantage or use their position to intimate, bully, humiliate, threaten, coerce or undermine those in their care, including young helpers. They must not use their status and standing to form or promote relationships which are of a sexual nature, or which may become so.

E5.3: Propriety and behaviour

All helpers and staff working with children and vulnerable adults have a responsibility to maintain public confidence in their ability to safeguard the welfare and best interests of those in their care. It is therefore expected that they will adopt high standards of personal conduct in order to maintain the confidence and respect of the public in general and all those with whom they work.

There may be times when a helper’s behaviour or actions in their personal life come under scrutiny from local communities, the media or public authorities. This could be because their behaviour is considered to compromise their position in their workplace or indicate an unsuitability to work with children or vulnerable adults. Misuse of drugs, alcohol or acts of violence would be examples of such behaviour. Helpers and staff, in contact with children and vulnerable adults, should therefore understand and be aware, that safe practice also involves using judgement and integrity in respect of behaviours in places other than the pilgrimage setting.

E5.4: Photography and videos

While on pilgrimage, a helper may take or record images of others, including children and vulnerable adults. It is inappropriate for staff or helpers to take photographs of children and vulnerable adults for their personal use.

It is understandable that photographs may be taken to help create a photographic record of the event, and to preserve memories. Staff and helpers should be mindful that such photographs should only be taken will be with the full written consent of the child, vulnerable adult, parent, guardian or carer. Images of children and vulnerable adults, should always be taken with due regard to the law and the need to safeguard the privacy, dignity, safety and well being of those involved.

HCPT staff and helpers need to remain sensitive to any child or vulnerable adult who appears uncomfortable, for whatever reason, and should recognise the potential for such activities to raise concerns or lead to misunderstandings.
Therefore, HCPT staff and helpers should:

1. be clear about the purpose of the activity and what will happen to the images when the activity is concluded;
2. be able to justify images of children and vulnerable adults in their possession;
3. ensure the child or vulnerable adult understands why the images are being taken, has agreed to the activity and that they are appropriately dressed;
4. report any concerns about any inappropriate or intrusive photographs found;
5. always ensure they have written consent to take and/or display photographs; and
6. store any image, picture or video of a child or vulnerable adult in a secure and locked place to ensure they are not freely available for viewing, use, publishing or distribution by any unauthorised person.

HCPT staff and helpers should not:

1. display or distribute images or pseudo-photographs/images of children or vulnerable adults unless they have the child’s, vulnerable adult’s, parent's or carer’s written consent;
2. use images which may cause distress;
3. take images in secret, or take images in situations that may be construed as being secretive;
4. display the name of any child or vulnerable adult next to his/her image; or
5. put any pictures or videos of any child or vulnerable adult on any social media or internet forum (even if the individual thinks they have consent to do this). The only place to display pictures is on the official HCPT or Group website and only then with the express permission of the parent/carer and the Group Leader.

E5.5: Dress and appearance

HCPT helpers and staff should not dress in a manner which could be considered as inappropriate or could render them vulnerable to criticism or allegations. An individual’s dress should:

- be appropriate to their role;
- not be viewed as offensive, revealing, sexually provocative, distracting, embarrassing or capable of giving rise to misunderstanding;
- be absent of any political or otherwise contentious slogans; and
- not be considered discriminatory or culturally insensitive.

E5.6: Gifts, rewards and favouritism

HCPT staff and helpers must to be aware that the giving of gifts can be misinterpreted by others as a gesture either to bribe or groom a child or vulnerable adult.

The provision of gifts might also be construed by others, or lead the giver to expect preferential treatment. The giving of gifts or rewards by helpers and staff to individual children or vulnerable adults i.e. not a group-wide activity should be avoided, unless it forms part of an agreed policy for supporting positive behaviour or recognising particular achievements. In such circumstances, a full record should be made of the gift, the reason for the gift and to whom and by who it was given.

HCPT staff and helpers should exercise care when selecting children or vulnerable adults for specific activities or privileges to avoid perceptions of favouritism or unfairness. Methods and criteria for selection should always be transparent and subject to scrutiny.

Gifts provided on a regular basis or of any significant value are not allowed and should be discouraged.

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10 A pseudo-photograph is "an image, whether made by computer-graphics or otherwise howsoever, which appears to be a photograph"
E5.7: Financial advice and guidance

From time to time HCPT helpers and staff may feel the need to, or may be asked to provide financial assistance to children, vulnerable adults or their families. Staff and helpers of HCPT should not seek to provide support outside the context of our activities, but should instead refer the child, vulnerable adult or their family, to other agencies. In urgent situations, staff should discuss the issue with their line manager and helpers should discuss matters with their Group Leader or Regional Chair.

E5.8: Infatuations

Occasionally, a child or vulnerable adult may develop an infatuation with a helper who works with them. Helpers should deal with these situations sensitively and appropriately to maintain the dignity and safety of all concerned. However, it should be remembered that, where a child or vulnerable adult develops an infatuation, there is a high risk that the words or actions of the helper concerned will be misinterpreted and therefore every effort should be made to ensure that the helper’s behaviour is beyond reproach.

Any helper who becomes aware that a child or vulnerable adult is developing an infatuation, should discuss this at the earliest opportunity with their Group Leader in order to ensure that appropriate action is taken to avoid any hurt, distress or embarrassment.

E5.9: Access to inappropriate images and internet usage

Accessing, making and storing indecent images of children on the internet is illegal. This act will lead to a criminal investigation and, if it is proven, the individual will be barred from working with children and young people.

Staff and volunteers should not use equipment belonging to HCPT to access any inappropriate images. Personal equipment containing such images or links to them should not be brought into the HCPT office, or any location used for HCPT activities as this would raise serious concerns about the suitability of any adult to continue to work with children.

HCPT staff and volunteers should ensure that any material placed on the web in the name of HCPT, for example, on websites and any social media channel, do not expose children or vulnerable adults to any inappropriate images or web links i.e the name of a child or vulnerable adult should not appear on the webpage or linked to any photographs of that individual.

HCPT Group Leaders, Regional officers, trustees and staff are provided with unique ‘log on’ passwords which should be used at all times when accessing the HCPT intranet. These passwords should be kept confidential at all times.

This guidance is in addition to the social networking policy and the data security policy.

E5.10: Social networking policy

Social networking refers to the latest generation of online services such as blogs, discussion forums, podcasts and instant messaging for example on Facebook and Twitter. It is an evolving form of communication that allows people to take part in online communities, generate content and share information with others.

HCPT recognises that it has a safeguarding responsibility to the children, young people and vulnerable adults that it helps as well as members of staff and helpers. It will manage its social networking responsibilities, by ensuring that its social network sites are established and managed, to allow safe continued contact between parties. It will:

- follow UK legislation and good practice guidelines on child and adult protection and the internet;
- follow the requirements of the Data Protection Act 1998 in respect of the collection and use of personal data;
- appoint a moderator to review content;
- report concerns;
- encourage the use of appropriate privacy settings;
- adopt the Child Exploitation Online Protection (CEOP) ‘Report Abuse Now’ button;
- provide safety tips; and
- provide clear complaints procedures.

HCPT believes the use of social networking sites can be very advantageous to helpers, both professionally and personally. However, it can also be something with numerous potential dangers and difficulties. HCPT also understands the value of ongoing friendships and community based activities, which grow from the experience of a shared pilgrimage.

The following guidance has been produced to manage and monitor any continued contact on social networking sites between helpers and other pilgrims:

- on Facebook, only official HCPT pages should be used for contact with children, vulnerable adults and their families pre and post pilgrimage. HCPT encourages helpers to ‘like’ a Group Facebook page and to encourage the children and vulnerable adults within a Group, who wish to use Facebook as a method of contact, to do the same rather than making a direct friendship connection. This ensures that all contact is open and transparent;
- Groups are encouraged to use a general email address and telephone for contact with children, vulnerable adults and their families, rather than giving out personal phone numbers and e-mail addresses. To support this we have issued each Group with an Office 365 account which includes an email facility in the format groupxyz@hcpt.org.uk;
- prior to the pilgrimage, parents, carers and vulnerable adults, will be informed of the acceptable communication methods for contact.

If a helper identifies themselves as an HCPT helper, it is a requirement that any personal blogs and other personal posts contain disclaimers that make it clear that the opinions expressed are solely those of the author and do not represent the views of HCPT.

Social networking communications are somewhat informal. It is easy for people to develop “loose lips”, especially when they think they are only discussing matters amongst themselves. Social networking sites have varying levels of security and, as public sites, all are vulnerable to security breaches. Sensitive or personal information must not be discussed or referred to on such sites, even in private messages between site members who have authorised access to the information.

**E5.11: Communication including the use of technology**

Any communication between staff or helpers and children or vulnerable adults should take place within clear and explicit professional boundaries. This includes the use of technology such as text messages, e-mails, digital cameras, videos, web-cams, websites and blogs.

Helpers and staff should not request, or respond to any request for personal information received from a child or vulnerable adult, other than that which might be appropriate as part of their role as helper. Helpers and staff should ensure that all communications are transparent and open to scrutiny.

**E5.12: Social contact**

HCPT staff and helpers should not seek to have social contact with the children or vulnerable adults that they work with, unless the reason for this contact has been firmly established and agreed with their Safeguarding Lead.

If a child or vulnerable adult seeks to establish social contact with a member of staff or a helper, or if this occurs coincidentally, the member of staff or helper should exercise their professional judgement in making a response but should always discuss the situation with their Group Leader or line manager. Helpers should be aware that, in certain situations, social contact with children or vulnerable adults, could be misconstrued as grooming.
Where social contact is an integral part of work duties, e.g. pastoral work in the community, care should be taken to maintain appropriate personal and professional boundaries. This also applies to social contact made through interests outside of HCPT or through the helper’s own family or personal networks.

Helpers and staff should not have secret contact with children or vulnerable adults and should notify Group Leaders of all contact that falls outside of this guidance.

No child or vulnerable adult should be in or invited into the home of any helper or member of staff where the relationship between the child or vulnerable adult and the helper or staff member exists exclusively in the context of HCPT.

All HCPT staff and helpers should be vigilant in maintaining their privacy and mindful of the need to keep professional boundaries and avoid placing themselves in vulnerable situations.

**E5.13: Physical contact**

There are some occasions when it is entirely appropriate for HCPT staff or helpers to have some physical contact with the children and vulnerable adults with whom they are working. However, it is crucial that, in all circumstances, such contact is appropriate to their professional or agreed role and responsibilities.

Not all children and vulnerable adults feel comfortable about physical contact. Staff and helpers should not make the assumption that it is acceptable practice to use touch as a means of communication. Preparation with the child’s or vulnerable adult’s family or carer, in advance of the pilgrimage, is essential to ensure that this is correctly planned and managed.

When physical contact is made with a child or vulnerable adult, this should be (1) in response to their needs at the time, (2) of limited duration and (3) appropriate to their needs and abilities. It is not possible to be specific about the appropriateness of each physical contact, since an action that is appropriate with one child or vulnerable adult in one set of circumstances may be inappropriate in another, or with a different child or vulnerable adult.

Nevertheless, staff and helpers should use their professional judgement at all times, observe and take note of the child’s or vulnerable adult’s reaction or feelings and, so far as is possible, use a level of contact and/or form of communication which is acceptable to the child or vulnerable adult, for the minimum time necessary.

This means that helpers and staff should:

1. be aware that even well intentioned physical contact may be misconstrued by the child or vulnerable adult, an observer or by anyone to whom this action is described;
2. never touch a child or vulnerable adult in a way which may be considered indecent;
3. always be prepared to report and explain actions and accept that all physical contact be open to scrutiny;
4. not indulge in horseplay;
5. work within health and safety regulations;
6. be aware of cultural or religious views about touching and always be sensitive to issues of gender; and
7. understand that physical contact, in some circumstances, can be easily misinterpreted. This therefore requires a greater awareness and vigilance to act and behave appropriately at all times.

If a member of staff or helper believes that their action could be misinterpreted, or if an action is observed by another as being inappropriate or possibly abusive, the incident and circumstances should be reported to the individual’s line manager or Safeguarding Lead, as outlined in the procedures for handling allegations.

Where a child or vulnerable adult seeks or initiates inappropriate physical contact with a member of staff or helper, the situation should be handled sensitively and care taken to ensure that contact is not exploited in any way. Careful consideration must be given to the needs of the child or vulnerable adult and advice and support given to the staff member or helper concerned.

It is recognised that some children or vulnerable adults who have previously experienced abuse, may seek inappropriate physical contact. HCPT staff and helpers should be particularly aware of this when it is known
that a child or vulnerable adult has suffered previous abuse or neglect. In the child’s or vulnerable adult’s view, physical contact might be associated with such experiences and lead to some actions being misinterpreted. In all circumstances, where a child or vulnerable adult initiates inappropriate physical contact, it is the responsibility of the staff member or helper to sensitively deter the child or vulnerable adult and help them understand the importance of personal boundaries. Such circumstances must always be reported and discussed with the individual’s line manager or Safeguarding Lead.

E5.14: Other activities that require physical contact

HCPT staff and helpers may have to initiate some physical contact with a child or vulnerable adult in certain settings, for example to demonstrate a technique in the use of a particular piece of equipment, adjust posture, or perhaps to support a child or vulnerable adult so they can perform an activity safely or prevent injury. Such activities should be carried out in accordance with existing codes of conduct, regulations and best practice.

This means that helpers and staff should:

1. treat all children and vulnerable adults with respect and dignity and avoid contact with intimate parts of the body at all times, except where personal care is required (See Chapter E1: The provision of personal care);
2. explain in advance the reason for the contact and what form it will take;
3. consider alternative options;
4. conduct such activities where they can be seen by everyone else; and
5. be aware of gender, cultural or religious issues that may need to be considered prior to initiating physical contact.

E5.15: Sexual contact

All HCPT staff and helpers should clearly understand the need to maintain appropriate boundaries in their contact with children and vulnerable adults. Intimate or sexual relationships between children or vulnerable adults and staff or helpers that work with them will be regarded as a grave breach of trust. Allowing or encouraging a relationship to develop in a way which might lead to a sexual relationship is also unacceptable.

Any sexual activity between a member of staff or helper and a child or vulnerable adult with whom they work, will always be a matter for disciplinary action and may be regarded as a criminal offence.

Sexual activity also includes non-contact activities, such as causing a child or vulnerable adult to engage in or watch sexual activity or the production of pornographic material.

HCPT staff and helpers should be aware that consistently conferring inappropriate special attention and favour upon a child or vulnerable adult might be construed as being part of a ‘grooming’ process and as such will give rise to concerns about their behaviour.

HCPT staff and helpers should not:

1. act in breach of any law regarding sexual offences including the Sexual Offences Act 2003, the Sexual Offences (Northern Ireland) Order 2008 and the Sexual Offences (Scotland) Act 2009;
2. have any form of communication with a child or vulnerable adult which could be interpreted as sexually suggestive or provocative i.e. verbal comments, letters, notes, electronic mail, phone calls, texts or physical contact;
3. make sexual remarks to, or about a child or vulnerable adult;
4. discuss their own sexual relationships with or in the presence of a child or vulnerable adult; or
5. behave in any other manner which may reasonably be interpreted as sexual.
E5.16: One to one situations

One to one situations have the potential to:

1. make a child or vulnerable adult more vulnerable to harm by those who seek to exploit their position of trust; and
2. put the helper at risk of a false allegation being made against them.

For these reasons, one to one situations should be avoided at all times and in all circumstances, including at pre-pilgrimage preparation events, and while on pilgrimage.

If, in the performance of appropriate activities as a helper, an individual finds themselves in an unplanned one to one situation, the helper should:

- look for a means of contacting other members of their Group, another Group or HQ;
- make an immediate assessment of the relative risks and decide if it is possible or appropriate to move to a more public location e.g. a hotel foyer; and
- try to attract any other possible attention.

E5.17: Contact between children, vulnerable adults and helpers post pilgrimage

Whilst on pilgrimage, many helpers will, without their knowledge, make a significant impact on the children and vulnerable adults they care for in their Group. The helper’s caring and responsible role is identified as a position of trust because of this power and influence the role can generate over the child or vulnerable adult.

This trust relationship needs to be managed carefully both for the protection of the children and vulnerable adults and the helpers. All future contact between helpers and children or vulnerable adults who have attended pilgrimage must only be for official HCPT business. Helpers must comply with HCPT’s safeguarding procedures and social networking policy.

Helpers should not make any unsolicited contact with a child or vulnerable adult or invite them to future HCPT fundraising or reflection meetings, without the express permission of the Group Leader.

Unless staff or helpers know a child or vulnerable adult prior to the pilgrimage (through family friendships, community activities etc) the end of a HCPT relationship with a child, young person or vulnerable adult and their parents or carers is deemed to finish with the post pilgrimage reunion. After this, future contact should be in the confines of Community based activities (see page 62). Any other contact is not deemed to be within the context of HCPT activities and this should always be made clear.

E6: Managing the behaviour of those in our care

HCPT staff and helpers will not use any form of degrading treatment to punish a child or vulnerable adult. The use of sarcasm or the making of demeaning or insensitive comments towards a child or vulnerable adult, is unacceptable in any situation. The use of physical punishment, as a way of managing the behaviour of a child or vulnerable adult, is also unacceptable. It is also unlawful and constitutes a criminal offence of assault.

Where a child or vulnerable adult has specific needs in respect of particularly challenging behaviour, e.g. alcohol or drug dependency or previous violent behaviour towards other children, vulnerable adults or helpers, a positive handling plan should be considered and agreed by all relevant parties.

E6.1: Use of control and physical intervention

There are circumstances in which adults working with children displaying extreme behaviours can legitimately intervene by using either non-restrictive or restrictive physical interventions. This is a complex area and staff and helpers must be aware of the guidance and legislation.

The use of physical intervention should, wherever possible, be avoided. It should only be used to manage a child’s or vulnerable adult’s behaviour, if it is (1) necessary to prevent personal injury to the child, other
children or an adult, (2) to prevent serious damage to property or (3) in what would reasonably be regarded as exceptional circumstances. When physical intervention is used, it should be undertaken in such a way that maintains the safety and dignity of all concerned.

The scale and nature of any physical intervention must be proportionate to both the behaviour of the individual to be controlled and the nature of the harm they may cause. The minimum necessary force should be used and the techniques deployed in line with recommended policy and practice.

Under no circumstances should physical force or intervention be used as a form of punishment. The duty of care that applies to all adults and organisations working with children and young people requires that reasonable measures are taken to prevent children being harmed. The use of unwarranted physical force is likely to constitute a criminal offence.

In settings where restrictive physical interventions may need to be employed regularly, i.e. in relation to children with extreme behaviours associated with learning disability or autistic spectrum disorders, the use of such interventions should be considered in consultation with the child’s parents/guardians and where appropriate, the child. Strategies and techniques to be used and those to be avoided, should be agreed. Risk assessments should be carried out where it is foreseeable that restrictive physical intervention may be required.

In all cases where physical intervention is employed by staff or helpers, the incident and subsequent actions should be documented and reported to the Safeguarding Lead or Safeguarding Advisor. This should include written and signed accounts of all those involved, including the child, young person or vulnerable adult. The child’s or vulnerable adult’s parents/guardians or carer should be informed on the same day.

All staff and volunteers should:

- adhere to HCPT’s physical intervention guidance;
- always seek to defuse situations;
- always use minimum force for the shortest period necessary; and
- record and report as soon as possible after the event, any incident where physical intervention has been used.

**E6.2: Management of children and vulnerable adults who display sexually inappropriate behaviour**

The information and advice in this section should only be used in conjunction with the safeguarding procedures and policies. Helpers and staff should always refer concerns about a child’s or vulnerable adult’s inappropriate sexual behaviour, to their Safeguarding Lead.

It is important to consider the following:

- Children of all ages become involved in sexual behaviour. The vast majority of children’s sexual behaviour is seen as healthy and normal.
- It is not only adults who can abuse and hurt children and young people. It is therefore very important not to ignore inappropriate sexual behaviour as children, young people and vulnerable adults sometimes need to be protected from each other.
- Sexually inappropriate behaviour may include undressing in public, fondling genitals or touching someone inappropriately. This behaviour could also be a direct result of a health condition or disability.
- If a helper is unsure of what is sexually inappropriate behaviour, they should speak to their Safeguarding Lead or Group Nurse.
- Children or vulnerable adults who have been abused, will sometimes act out what has been done to them.
- Sexually inappropriate and/or abusive children and vulnerable adults may have been abused themselves.
- A helper may not be able to stop a person engaging in inappropriate sexual behaviour but there are ways that such behaviour can be addressed.
- For helpers who have direct contact with a child or vulnerable adult displaying inappropriate sexual behaviour, it is important to convey that whilst their behaviour is unacceptable, they are not being
condemned as a person. The helper must show respect and understanding and should not let the child or vulnerable adult know that they are shocked or offended. It is important to avoid confrontation.

All staff and volunteers should:
1. make sure they are aware of and follow the HCPT safeguarding policies and procedures;
2. if they think the child’s or vulnerable adult’s behaviour is related to an health condition or disability, speak to the Safeguarding Lead and obtain advice about how to manage their behaviour. The Safeguarding Lead will have information about the child or vulnerable adult and may give advice on what things to be aware of when looking after them. The helper or member of staff will need to know how to respond and keep the child or vulnerable adult and other members of the Group safe;
3. if a child or vulnerable adult they are caring for acts inappropriately in public, refer to the individual’s management plan for guidance;
4. tell the child or vulnerable adult to stop their behaviour because it is unacceptable. An explanation should also be given as to why their behaviour is unacceptable;
5. be clear and direct in their communication, using language that is appropriate to the child’s or vulnerable adult’s age and their level of understanding;
6. remain calm, being firm but keeping control of any emotions;
7. give the child or vulnerable adult a chance to explain their behaviour;
8. think about or ask the child or vulnerable adult why they are acting in a certain way. For example, if they start to undress in public, are they hot or uncomfortable?
9. if applicable, try to treat the situation with humour rather than sounding angry, but remember to be aware of the child’s or vulnerable adult’s feelings at all times. He or she may find the behaviour very difficult to control;
10. try to distract the child’s or vulnerable adult’s attention rather than being confrontational. For example consideration should be given to offering them a different activity or reminding them that it’s nearly lunchtime.
11. if other people are present, consider whether it is appropriate to explain to them that the individual’s behaviour is due to an illness and is not directed at them personally;
12. ensure that any children or vulnerable adults who have been adversely affected are made safe, and are looked after and supported by the Group;
13. record any incidents of inappropriate sexual behaviour and report any behaviour that requires immediate further advice;
14. write down the facts of what was observed as soon as possible after the incident; and
15. speak to the Group’s Safeguarding Lead if they are having difficulty managing the behaviour of a child or vulnerable adult.

All staff and volunteers should not:
1. panic;
2. be judgemental as the individual displaying sexually inappropriate behaviour may have been abused by others;
3. put pressure on a child or vulnerable adult by persistent questioning about their behaviour when they are clearly reluctant or unable to speak about it; or
4. allow any embarrassment or discomfort they might feel dealing with sexually inappropriate behaviour to prevent them from taking the right action to protect other people from harm.

If an individual finds themselves having to respond to sexually inappropriate behaviour, they might find the intensity of their own emotions difficult to cope with. It is important that they try and stay calm in order to keep a clear head and make the right decisions about how to protect the child or vulnerable adult who is exhibiting the inappropriate behaviour and/or children or vulnerable adults who may be at risk.

Helpers should look after themselves and remember that the Group’s Safeguarding Lead is there to help if support is needed after dealing with an incident of sexually inappropriate behaviour.
Section F. How we stay safe in HCPT - Recognising what should be reported and how

F1: Responding to a safeguarding concern

HCPT recognises its ultimate responsibility to keep children and vulnerable adults safe from harm and therefore places its safeguarding responsibility above that of not reporting a concern for fear of bringing a relationship to an end. Common sense should be used and advice obtained from a Safeguarding Advisor. Those at risk should be always protected and safeguarded.

In deciding what action to take, consideration must be given not only to the immediate impact on and risk to the person, but also to the risk of future, longer-term harm. The seriousness of the harm or the extent of the abuse, is not always clear at the point of the alert or referral. All reports of suspicions or concerns should be approached with an open mind and could give rise to action under these policies and procedures.

This flowchart shows the process to be followed in the event of a safeguarding concern or disclosure.
It is not our job to investigate but to pass on information to the relevant agencies.

'No Secrets' puts forward the following factors to be taken into account when making an assessment of the seriousness of the risk to a person. The:

- vulnerability of the person;
- nature and extent of the abuse or neglect;
- length of time the abuse or neglect has been occurring;
- impact of the alleged abuse on the child or vulnerable adult;
- risk of repeated or increasingly serious acts of abuse or neglect;
- risk that serious harm could result if no action was taken; and
- illegality of the act or acts.

F1.1: Responding to disclosures of abuse

In responding to a disclosure of abuse, a helper should:

1. listen to the information and accept what they hear without passing judgment or minimising the information;
2. not put words into the child's or vulnerable adult's mouth or make judgmental statements about any person;
3. take into account the child's or vulnerable adult's level of understanding, their culture and use of language;
4. not interrogate the child or vulnerable adult as it is not their responsibility to investigate but should instead be calm and reassuring;
5. not make promises that cannot be kept, for example that the helper will not tell anyone else;
6. be clear about what they are going to do next and when;
7. tell the child or vulnerable adult who the helper will need to contact i.e. the Safeguarding Lead;
8. not promise total confidentiality but explain that the information will be treated with great care and, where necessary shared, on a need to know basis only, to safeguard the child or vulnerable adult;
9. make careful notes, using the safeguarding concern report form if possible, as soon as feasible including dates, times, details of the incident, when the recording was made, who was present etc. These records or notes must be kept securely;
10. contact the Safeguarding Lead, or, in their absence, a Safeguarding Advisor as soon as possible to inform and consult with them about the need for action, including the need to make a referral to adult’s or child’s services or the police;
11. if a Safeguarding Advisor is unavailable, it is possible to consult adult’s or child’s services or the police directly, without giving personal details of the vulnerable adult or child. The advice given may be that a referral must be made in which case this must be done immediately;
12. provide the child or vulnerable adult or their carer/guardian with some means of contact and be clear about how and when they will be contacted with feedback as to what will happen next;
13. never leave a child or vulnerable adult or their carer/guardian to wait to hear from someone else, e.g. a police officer or social worker, without any idea of timescale or place;
14. not contact the person about whom the allegation or concern is being raised to tell them about the allegation or concern because this could put the child or vulnerable adult in serious danger, for example, where there is domestic violence taking place, and/or prejudice any investigation; and
15. where the concerns or allegations are about a HCPT member of staff, a helper or another adult in a position of trust, do not inform the person in question because, again, this might prejudice any police investigation - always contact a Safeguarding Advisor.
**F1.2: Responding to observations that give rise to safeguarding concerns**

It is more difficult to identify safeguarding concerns through observations or a possible change in behaviour of a child or vulnerable adult. When making difficult judgements around possible signs and symptoms of abuse and neglect, it is crucial that all available information and presenting injuries or behaviours are seen in context e.g. is the change in behaviour a result of a sudden illness? Lists of possible signs and symptoms of abuse, must never be considered to be comprehensive or definitive checklists.

All safeguarding concerns should be referred to a Group’s Safeguarding Lead in the first instance before onward referral to a Safeguarding Advisor. In all circumstances, the HCPT safeguarding procedures should be followed.

**F1.3: Alerting other helpers to safeguarding concerns**

During the pilgrimage it is expected that helpers will be in constant contact and communication with the children and vulnerable adults in their Group. There may be occasions when a helper is engaged in a conversation or just ‘having a chat’ with a child or vulnerable adult and a safeguarding concern is highlighted. This may be as a result of the child or vulnerable adult making a disclosure of abuse or the helper making an assessment that there are concerns which need to be dealt with.

Such conversations are likely to happen in a public area, and in circumstances when both the helper and child or vulnerable adult are expected to carry on with, or move onto other Group activities. Where the helper feels that it would be detrimental to end the conversation with the child or vulnerable adult in order to keep up with the Group’s programme, the helper, in an attempt to minimise any distress to the child or vulnerable adult, should alert other helpers to the sensitivity of such an incident by using of a code word.

Each Group should agree a code word in advance of the pilgrimage which, if used, would indicate to all other helpers that an individual helper needs time to finish their conversation with a child or vulnerable adult. For example, “I may need the blue key” or “I may need the red book”.

If a Group needs additional helper cover in order to carry on with its intended activities, HQ staff should be contacted in the case of the Easter Pilgrimage and the Hosanna House Manager should be contacted in the case of Summer Pilgrimages. Remember a helper should not be left alone in this instance.

**F2: Reporting a safeguarding concern**

If a helper or member of staff receives a disclosure of abuse or has any safeguarding concerns about a child or vulnerable adult, the concern must be reported, in person or by telephone, to the Group’s Safeguarding Lead or Deputy Safeguarding Lead.

The Safeguarding Lead or Deputy Safeguarding Lead shall then report the concern to the Group’s Safeguarding Advisor again, either in person or by telephone, as soon as possible though always within 24 hours of the helper or member of staff becoming aware of the concern. The verbal report should be followed with the completion of an HCPT safeguarding concern report form. The helper who first received the disclosure or raised the concern should have input in the completion of the report form.

All safeguarding concerns reported to a Safeguarding Advisor will, wherever possible, be assessed on the same day or within 24 hours and a decision made on the threshold of concern about the child or vulnerable adult.

If the Safeguarding Advisor makes an assessment that the concern reaches the threshold of significant harm, the concern should be referred to the statutory authorities, for example, statutory services, adult’s/child’s services or the police, by the Safeguarding Advisor, for further investigation. In addition to completion of the HCPT safeguarding concern report form, some statutory authorities may require the completion of local referral forms. These reporting procedures are the same in France and in Scotland.
If the Safeguarding Lead and/or Deputy Safeguarding Lead and Safeguarding Advisor make an assessment that the concern does not reach the threshold of significant harm or the need for intervention, the concern and any decisions or actions taken should still be recorded and the record passed to HCPT HQ to be retained.

If a Group’s allocated Safeguarding Advisor is unavailable, details of another available Safeguarding Advisor can be obtained by contacting HCPT HQ directly.

If there are immediate concerns about a child’s or vulnerable adult’s safety and it is not possible to contact a Safeguarding Advisor, the emergency situations procedure, set out below (page 78: Emergency situations) should be followed.

Details of all reported safeguarding incidents will be forwarded to the Safeguarding Committee by the Safeguarding Advisors for discussion and quality assurance at regular Safeguarding Committee meetings.

**F2.1: How to report a matter to the local statutory services**

1. Telephone the local statutory services/adult’s/child’s services. The referral information will be collated and advice given as to how to forward it to the relevant team manager for consideration and action.

2. The HCPT safeguarding concern report form and, possibly, a locally agreed referral form should be submitted via secure e-mail. If there are any previous safeguarding concerns about the same child or vulnerable adult, this should also be included in the new report together with any outcomes from previous referrals.

3. In the case of a vulnerable adult, efforts should be made to obtain their consent to make a referral, if they have suffered, or are at risk of suffering significant harm. If a child is the subject of the concern, it is not necessary to obtain their consent to make a referral, if they have suffered or are at risk of suffering significant harm.

4. It is not necessary to obtain the vulnerable adult’s consent to make a referral when the adult is at risk of serious harm. However, carers or guardians should be notified only when it is safe to do so, when it is clear that they are not suspected in the abuse or concern and where it does not put the adult at further risk. It is not necessary to obtain consent from a parent or guardian to make a referral when a child is at risk of significant harm (see Chapter F2: Reporting a safeguarding concern).

In assessing whether or not to inform the subject of a complaint about the complaint, the criteria for not informing him or her are because:

a) this would increase the risk of significant harm to the child or vulnerable adult; or

b) in the referrer’s professional opinion, to do so might impede an investigation that may need to be undertaken; or

c) there would be an undue delay caused by seeking consent which would not serve the child’s or vulnerable adult’s best interests; or

d) to do so would place the child or vulnerable adult at an increased risk of harm.

**F2.2: Actions by statutory services following referrals**

In response to a referral, statutory services may decide to:

1. provide advice to the referrer, child, vulnerable adult, carer, parent or guardian;

2. refer the matter to another agency that can provide services;

3. convene a strategy meeting;

4. provide support services;

5. undertake an assessment of needs (completed within local timescales);

6. convene an adult protection conference/meeting (within local timescales after a strategy meeting);
7. arrange a safe placement by consent or court order or make an application for an interim care order in care proceedings;
8. take no further action.

During all initial discussions, statutory services should make it clear to the Safeguarding Advisor what the proposed course of action will be in response to the referral. Additionally, they should indicate, who will be taking the action, the timescales, or if no further action is to be taken.

Statutory services should acknowledge a written referral within one working day of receiving it. If the Safeguarding Advisor has not received an acknowledgement within three working days, he or she should contact statutory services again.

F2.3: Feedback to helpers making initial referrals

After a member of staff or helper reports their concerns to a Safeguarding Advisor, it is unlikely that they will be informed about the progress of the safeguarding investigation as it unfolds. Initial referrers should be reassured by their Safeguarding Advisor that they have done the right thing in telling someone about their concern, and that other professionals are now taking their concerns forward.

If a child or vulnerable adult about whom a safeguarding referral has been made in the past, attends another pilgrimage, it is appropriate for the relevant Safeguarding Lead to be made aware of how the previous concern was resolved. The relevant Safeguarding Advisor should be contacted for such information and all communications recorded.

F2.4: Emergency situations

In some circumstances, there may be immediate concerns about a child’s or vulnerable adult’s safety arising from the information disclosed or observed. For example:

1. a child or vulnerable adult may disclose recent physical abuse by a carer and be frightened to go home;
2. information may be obtained that a child or vulnerable adult could be subjected to further abuse if they go home; or
3. information may be obtained that an abuser poses a risk to other vulnerable adults, children or helpers, even if the victim or person making the disclosure is not at further risk because they will not have any further contact with the alleged abuser.

The Safeguarding Lead should make an urgent telephone referral to the local statutory services, the adult’s/child’s services and/or the local police. If the Safeguarding Lead is absent, the Group’s Safeguarding Advisor should be contacted immediately for advice. In respect of the Easter Pilgrimage, the Group’s Safeguarding Advisor’s contact details, while in Lourdes, should be made available. In respect of the Summer Pilgrimage, for incidents arising during business hours, the Group’s Safeguarding Advisor should be contacted via HQ staff. Outside of business hours, an emergency mobile number will be made available for these purposes via the Hosanna House manager or night porter.

If neither the Group’s Safeguarding Lead or Safeguarding Advisor can be contacted, the helper initiating the concern must take any necessary immediate action to safeguard the child or vulnerable adult, including making an urgent telephone call to the statutory services, adult’s/child’s services and/or the police. The emergency duty team at social services should be available and their contact number can be found on the relevant local authority’s website and in telephone directories. The helper should provide details of the concern or disclosure received or observed.

In an emergency situation and unless otherwise agreed, the person making the referral should contact the duty social worker, before the end of the working day on which the referral was made, to establish what actions are being taken.
The Group’s Safeguarding Lead will need to be informed, as soon as possible after an emergency referral, in order to continue the liaison with the statutory services, adult’s/child’s services and/or the police. If the detail of the concern has not already been recorded on an HCPT safeguarding concerns report form, the Safeguarding Lead should, at this stage, complete the form, with the assistance of the helper who initiated the concern.

F3: Recording a safeguarding concern

Safeguarding concerns shall be recorded on the HCPT safeguarding concerns report form which can be found at on the intranet under the ‘safeguarding’ tab.

The report form has an on-going chronological event log attached to it and the Safeguarding Lead or Safeguarding Advisor, shall record all discussions, actions taken and decisions made in the log accurately and timely. Any future discussion about the child or vulnerable adult referral should be noted in the log.

All safeguarding concerns report forms should be kept in a secure drawer or locker whilst on pilgrimage and forwarded to HCPT HQ, either in person or by registered delivery, upon return to the UK.

The following steps should be observed in recording a safeguarding concern. The individual should:

1. whenever possible and practical make contemporaneous notes during any conversation;
2. ask for permission to take notes before doing so and explain the importance of recording the information;
3. explain that the person giving the information can have access to the records made in respect of their own information;
4. where it is not appropriate to take notes at the time, make a written record as soon as possible afterwards and always before the end of the day.
5. only record details of the injuries associated with a safeguarding concern in a pilgrim’s medical diary. Other safeguarding information should be recorded on a safeguarding concern report form. Sufficient information must be entered on the pilgrim’s daily medical diary, to indicate that there is a current safeguarding incident and where that information is held;
6. record the time, date, location, format of information (e.g. letter, telephone call, direct contact) and the names of the persons present when the information was given;
7. ensure that the record is signed and dated by the person making it;
8. include as much information as possible, but, be clear about what information is fact, hearsay or, opinion and must not make assumptions or speculate;
9. include the context and background leading to the disclosure;
10. maintain a log of actions and decisions and record times, dates and the names of people contacted and spoken to as well as their contact details;
11. include full details of previous concerns or referrals to statutory services and the police, if known;
12. ensure all original notes or documents are retained if notes are made somewhere other than the safeguarding concern report form. These original notes will form part of the evidence chain in any criminal investigation;
13. within 24 hours, pass all original records, including rough notes, to the Safeguarding Advisor. If this has to be done by post, the documents should be sent via registered delivery; and
14. if any original document is urgently needed, scan and forward it via secure email. Originals and electronic documents must be retained securely in the safeguarding file.
F4: Allegations against staff or helpers

The vast majority of staff and helpers who work with children and vulnerable adults, act professionally and seek to provide a safe and supportive environment, which secures the well-being and best outcomes for vulnerable people and their families. However, it is recognised that the achievement of these outcomes is not always straightforward.

Employers, social services and professional regulators are under a legal duty to notify the DBS of relevant information, so that individuals who pose a threat to vulnerable groups can be identified and barred from working with such groups (see Safer recruitment, page 46).

If any HCPT staff member or helper becomes aware that another HCPT staff member or helper who works with a child or vulnerable adult has:

- behaved in a way that has harmed or may have harmed a child or vulnerable adult; or
- possibly committed a criminal offence against or related to a child or vulnerable adult; or
- behaved towards a child or vulnerable adult in a way that indicates they are unsuitable to work with children and/or vulnerable adults

that individual must notify their Safeguarding Lead/Safeguarding Advisor immediately.

In all cases where safeguarding allegations are made against HCPT staff or helpers, which indicate that they may be unsuitable to continue working with children or vulnerable adults, that person will automatically be suspended, pending investigation. This will be the case, even if the concern or allegation is not linked to an activity or behaviour conducted within working hours or while working as a volunteer for HCPT.

Such action does not presume guilt and the decision to suspend will not be made lightly. It will only be made after careful consideration of the initial facts by the Safeguarding Advisor, the Safeguarding Committee and the Chief Executive. For staff members, HCPT disciplinary procedures will be followed and will be clearly separated from safeguarding enquiries and criminal investigations.

HCPT recognises that it has a continuing duty of care to a suspended member of staff or helper. Therefore, it is important to provide support for the person against whom the allegation is made during the investigative process and action should be taken to reinstate them quickly, if the allegations are found to be false. A named support person, not connected with the investigation, will be allocated in each case by the Safeguarding Advisor. That support person’s role will be purely pastoral and guidance will be provided as to their remit that is relevant in each case. The support person will be in a position to signpost suspended staff and helpers to other external support networks, for example, local GPs or the Samaritans.

HCPT will, via a Safeguarding Advisor or member of the Safeguarding Committee, also refer any safeguarding concerns or allegations about its staff or helpers immediately to local authority services via the Local Authority Designated Officer (LADO) in England & Wales. The role of the LADO is set out in the Government guidance ‘Working Together to Safeguard Children 2013’. The LADO is usually located with children’s social services. The police may also be involved at this time. In Scotland the procedure is as described in the National Guidance 201411.

F4.1: Suspension process for helpers while in the UK

The Chief Executive or nominated officer is responsible for suspending any helper. If a decision is made to suspend a helper while in the UK, the person suspended should:

1. be informed, by the Chief Executive or nominated representative, as soon as possible;
2. receive a personal visit by two HCPT representatives who should deliver a written notice of suspension advising the suspended person that they are prevented from continuing the work of HCPT or giving anyone the impression that they represent HCPT;

3. sign a copy of the notice of suspension to confirm that they have received the notice and understand the terms;
4. be removed from all HCPT premises and activities;
5. surrender any current HCPT identification badges;
6. be told that their Group Leader and Regional Chair will be informed of the suspension; and
7. be advised if an investigation has been triggered into their conduct. For example, the police, social services or an internal disciplinary process.

The Chief Executive or nominated representative should also:

1. inform the relevant Group Leader/Regional Chair of the suspension;
2. if the person suspended is a Group Leader or Regional Chair, ensure that arrangements are commenced to identify a replacement. This would usually be the Deputy Group Leader; and
3. ensure an investigation has been triggered into the suspended person’s conduct e.g. by the police, social services or by utilising the internal disciplinary procedures.

F4.2: Suspension process for helpers on pilgrimage

The arrangements for suspending a helper whilst on pilgrimage are complicated because of its geographic location. However, in addition to the above steps, if a decision is made to suspend a helper while on pilgrimage, the Chief Executive must consider whether it is appropriate to do any of the following:

1. to request the removal of the helper from accommodation in which HCPT children or vulnerable adults are resident. In the event that the suspended person poses a serious risk to children or vulnerable adults, the local police (gendarmerie) should be contacted in order to effect the person’s arrest and removal.
2. to make arrangements for the suspended helper’s return travel to the UK. This may pose difficulties if the suspended person has a scheduled return ticket with a Group. Dependent on the risks posed to children and vulnerable adults by the suspended helper, consideration may have to be given to arranging alternative return travel;
3. to notify the relevant authorities in the UK. For example, social services, the police, the Local Authority Designated Officer or the DBS. Any notification should be made as soon as reasonably practicable, and, in any event, before the individual returns to the UK.

F5: Missing child or vulnerable adult emergency action procedure

Whilst it is highly unlikely that children and vulnerable adults will go missing while on pilgrimage, it is important to have formal procedures in place to cover such a situation.

The most important time in a missing person incident is the very first hour or “golden hour”. The Safeguarding Lead must be informed at once when any staff member or helper has concerns that a child or vulnerable adult is missing and a systematic search of any premises should be undertaken, as soon as possible, to establish if the child or vulnerable adult is in the vicinity. However, such a search should only be conducted if it is safe to do so and should be dependent upon the circumstances, for example, the time of year, the location, the weather conditions, the time of day and the age and vulnerability of the missing person.

If an initial search is inappropriate or the person is still missing following such a search, it is of the utmost importance that the following tasks are completed in the first hour.

The Safeguarding Lead should:
• secure the site/hotel/location;
• carry out a formal roll call;
• ensure the welfare of the remaining children or vulnerable adults;
• make sure that all are accounted for and properly/adequately supervised;
• contact the local police without delay, including French authorities when in France (HQ can assist with this). The responsibility for conducting enquiries and a proper search rests with the police because they have the experience, knowledge and resources;
• when the police are contacted, ensure that the missing person’s parent’s/guardian’s/carer’s contact details are readily available as it is the police’s responsibility to make contact with the missing person’s parent/guardian/carer;
• be prepared to assist with information that will help with the enquiries such as:
  o the missing person’s name, age and description including a photo, if available;
  o when and where the person was last seen and by whom;
  o any known reason for the missing person’s absence and whether the absence is out of character;
  o any known places to be searched or people to be contacted; or
  o any known medical conditions or medication required.

If a missing person returns while on pilgrimage, the Safeguarding Lead must inform the local police (gendarmerie). It is likely that the police will visit the missing person to ascertain the reason for them going missing and to ensure they are safe and well.

Return interviews for people who have gone missing are a crucial element in exploring the reasons they ran away and referring on, or linking into, care planning, as appropriate. Where there is the possibility that a person has gone missing as a result of a safeguarding concern, the Safeguarding Lead must follow the HCPT safeguarding procedures.

**F6: Risk assessment**

Risk is a key concern and a preoccupation for helpers in the safeguarding and protection of children and vulnerable adults on pilgrimage. Life without risk would be bland and would limit positive experiences being achieved by those attending the pilgrimage.

All helpers are risk managers, taking decisions every day on pilgrimage, often without thinking about it. Without realising it, helpers may be taking unnecessary or excessive risks, or may be too timid to take reasonable risks that offer a better experience on pilgrimage.

Risk taking and management has to be balanced against exposing oneself, and others, to unnecessary harms and dangers. The continual use of risk assessments will help reconcile the two positions.

All pilgrimage activities are organic. People and places are constantly changing and moving, alongside any associated risks which may change from reasonable to unnecessary or excessive. Regular re-assessment of familiar activities will allow those running the activity to identify changes in the risks over time. All Group Leaders should assist helpers to manage such changes by continually:

• risk assessing;
• planning and introducing control measures; and
• reviewing risk assessments.

Group Leaders are responsible for risk assessments for both Group activities and individual vulnerable pilgrims. If a Group Leader identifies that the risk for a particular pilgrim to engage in a particular activity is excessive and the pilgrim is likely to come to harm, the activity cannot go ahead.
Essentially, Group Leaders need to be duly diligent in preparing a management plan for their pilgrimage visit, but they do not have to demonstrate superhuman powers of pre-cognition. They simply have to deal with what is reasonably foreseeable and respond within a reasonable range of measures.

Group Leaders should concentrate on significant risks. There is no expectation that insignificant risks should be included in a formal risk assessment. Professional judgement, particularly when backed by experience, is sufficient to deal with such situations when participating in pilgrimage activities and it is no different when in France.

Where examples of current good practice exist, Group Leaders should refer to the HCPT risk management documentation. If an alternative practice is to be followed, it should be of an equivalent standard or better, not worse.

It is recommended that at least two or more helpers participate in the risk management planning process. If two helpers consider a range of options, this strengthens the argument that the measures taken have been reasonable.

Finally, the natural discipline of writing down agreed plans and the potential need to evidence the process, are good reasons to ensure decisions are recorded formally. It also means that the risk assessment documents can be readily shared as an active dynamic document.

**F7: Welfare and support**

All HCPT staff and helpers who work with, and on behalf of children and vulnerable adults, are accountable for the way in which they exercise authority, manage risk, use resources, and safeguard those in their care. Whether working in a paid or voluntary capacity, HCPT staff and helpers have a duty to keep children and vulnerable adults in their care safe and to protect them from sexual, physical and emotional harm. Children and vulnerable adults have a right to be treated with respect and dignity. It follows that trusted adults are expected to take reasonable steps to ensure the safety and wellbeing of the most vulnerable members of HCPT. Failure to do so may be regarded as neglect.

Additionally, HCPT has a duty of care towards both members of staff and helpers in accordance with the provisions of the Health and Safety at Work Act 1974. This Act requires HCPT to provide a safe working environment and guidance about safe working practices. HCPT also has a duty of care for the wellbeing of its employees and to ensure that employees are treated fairly and reasonably in all circumstances.

HCPT staff and helpers have a duty to take care of themselves and anyone else who may be affected by their actions or failings. All HCPT staff and volunteers will be made aware of these safeguarding procedures:

- at their induction;
- in Group meetings;
- during staff appraisals; and
- through publication on the intranet.

**Victim Support**

Victim Support provides free and confidential support for victims and witnesses of crime in England, Wales and Scotland including the provision of information, emotional support and practical advice, to family, friends and anyone else affected by crime. Help can be accessed either directly from local branches or through the Victim Support helpline 0845 3030900 or, in Scotland 0845 6039 213.

**F8: Confidentiality**

HCPT staff and helpers will receive personal and sensitive information about pilgrims in managing the administration of the pilgrimage. This information will be treated in a discreet and confidential manner in accordance with HCPT’s data security policy.
Personal information held by HCPT is subject to a legal duty of confidentiality and should not normally be disclosed without the consent of the pilgrim, their parent or carer, as appropriate.

However, the right to confidentiality and respect for private and family life (Article 8 of the European Convention on Human Rights) is not absolute. Information sharing is vital in safeguarding and promoting the welfare of children and vulnerable adults. A key factor in many serious case reviews has been a failure to record information, to share it, to understand the significance of the information shared, and to take appropriate action in relation to known or suspected abuse or neglect.

HCPT will ensure that staff and helpers are clear about situations when they can share information with appropriate agencies and professionals i.e. when it is believed that a child is suffering or is likely to suffer significant harm, or a vulnerable adult is likely to suffer serious harm. HCPT staff and helpers will give due regard to relevant legislation when making decisions on sharing information complimented by robust recording of decisions made and actions taken. Any safeguarding concerns will be treated as confidential and passed to the Safeguarding Lead without delay in accordance with these procedures. HCPT staff and helpers should seek advice from a senior member of staff or their Safeguarding Lead, if they are in any doubt about sharing information they hold or which has been requested of them.

The Department for Education has produced guidance in relation to information sharing which can be found at the following link: https://www.education.gov.uk/publications/standard/Integratedworking/Page1/DCSF-00807-2008.

F9: Whistle blowing policy

The Public Interest Disclosure Act 1998 introduced protection for workers from reprisals for disclosing information in the public interest. It emphasises the importance whistle blowing can play in deterring and detecting malpractice and abuse of children and vulnerable adults.

HCPT will promote practical arrangements for whistle blowing to enable staff and helpers to voice their concerns, made in good faith, without fear of repercussion. Any member of staff or helper who uses the whistle blowing procedure will be made aware that their rights are protected.

Staff members and helpers will be supported in their individual responsibility to bring matters of concern to the attention of senior management and/or relevant external agencies. This is particularly important where the welfare of children, young people and vulnerable adults may be at risk. HCPT will:

- ensure it has an appropriate whistle blowing policy in place;
- ensure it has clear procedures for dealing with allegations against staff and helpers (See Chapter F4: Allegations against staff or helpers); and
- encourage and support staff and helpers to report any behaviour by colleagues that raises concern, regardless of the source.

All safeguarding concerns raised via the whistle blowing pathway must be referred to a Safeguarding Advisor for consideration and assessment.

F10: Anti-bullying policy

HCPT is committed to providing a caring, friendly and safe environment for all pilgrims so that they can develop in a relaxed and secure atmosphere. Bullying of any kind is unacceptable and will not be tolerated either on pilgrimage or during any other HCPT activity. If bullying does occur, all pilgrims should be able to tell someone and be confident that incidents will be dealt with promptly and effectively. This means that anyone who knows that bullying is occurring is expected to tell their Safeguarding Lead or a Safeguarding Advisor.

F10.1: What is bullying?

Bullying is not always easy to recognise as it can take a number of forms. It is the use of aggression, with the intention of hurting another person. Bullying results in pain and distress to the victim.
Bullying can be:

1. emotional: for example, being unfriendly;
2. physical: for example, pushing, kicking, hitting, punching or any use of violence;
3. racist: for example, racial taunts;
4. sexual: for example, unwanted physical contact or sexually abusive comments;
5. homophobic: for example, bullying because of, or focusing on, the issue of sexual orientation;
6. verbal: for example, name calling, sarcasm, spreading rumours or teasing;
7. discriminatory: for example, related to a child’s or vulnerable adult’s impairment or disability and may include name calling or ridiculing;
8. cyber-bullying: for example, the use of mobile phones, instant messaging, e-mail, chat rooms or social networking sites such as Facebook and Twitter to harass, threaten or intimidate someone.

F10.2: Why is it important to respond to bullying?

1. Bullying hurts. No one deserves to be a victim of bullying. Everybody has the right to be treated with dignity and respect.
2. Individuals need to learn different ways of behaving.
3. HCPT has a responsibility to respond promptly and effectively to incidents of bullying.

F10.3: Objectives of this policy

1. Bullying will not be tolerated.
2. All pilgrims involved in an activity or event, should have an understanding of what bullying is.
3. All pilgrims involved in an activity/event must know what the HCPT policy is on bullying, and follow it when bullying is reported.
4. All pilgrims should be assured that they will be supported when bullying is reported.

F10.4: Signs and symptoms of bullying

A pilgrim may indicate, by signs or behaviour, that he or she is being bullied. All pilgrims should be aware of these possible signs and should consider the possibility that a fellow pilgrim is being bullied.

However, it is important to remember that many pilgrims may exhibit signs that they are being bullied but this should not be taken as proof that bullying is occurring. There may well be other reasons for changes in behaviour such as a death, the birth of a new baby in the family or relationship problems between parents/carers.

F10.5: Prevention

The following strategies may be adopted, as appropriate, in order to prevent bullying:

- writing a set of Group rules;
- signing a behaviour agreement;
- writing stories or poems or drawing pictures about bullying;
- reading stories about bullying or having them read to the Group;
- making up role plays; or
- having discussions about bullying and why it matters.

F10.6: Anti-bullying procedures

1. All bullying should be reported to the Group’s Safeguarding Lead.
2. In cases of serious or persistent bullying, the incidents should be recorded on the child’s or vulnerable adults’ medical record.

3. In cases of serious or persistent bullying, the carers or guardians of the bully shall be informed and asked to come to a meeting, if appropriate, to discuss the problem.

4. If it is thought that an offence has been committed, the police should be contacted.

5. The bullying behaviour or threats of bullying must be investigated and all bullying stopped quickly.

6. An attempt will be made to help the bully change their behaviour.

**F10.7: Outcomes**

1. In serious cases, suspension or even exclusion from the pilgrimage will be considered.

2. If possible, the victim and the bully will be reconciled.

3. After the incident/incidents have been investigated and dealt with, each case will be monitored to ensure repeated bullying does not take place.

4. After the incident/incidents have been investigated, carers/guardians should be informed of the action taken.

**F11: Publicity**

HCPT encourages all Groups to seek opportunities to gain positive press attention to increase funding and raise awareness of the charity. The responsibility for publicising a local event would fall to the organisers; however, assistance may be sought from the Fundraising and Communications Department.

If any HCPT helper or member of staff is asked to comment or give information in respect of a sensitive issue e.g. regarding a subject currently under investigation within HCPT or by the police, they must not engage with the query independently. Sensitive press queries must be referred to HQ for the attention of the Chief Executive. If an individual is in doubt as to the nature of the external query, they should contact HQ as soon as possible and not attempt to satisfy the query without advice. Any statements given to the media in relation to sensitive issues, must only be given with clearance from the Chief Executive.

**F12: Storage of records**

There are many records that contain confidential and sensitive information about safeguarding or medical matters, for example registration forms and safeguarding concerns report forms. These records should either be securely filed in electronic safeguarding folders in the HCPT database or kept as paper copies in locked cabinets at HCPT HQ.

Best practice advises that, prior to pilgrimage, the Group Leader should keep all such information in a locked and secure place.

Whilst on pilgrimage, it will be the responsibility of the Safeguarding Lead to ensure secure storage of completed safeguarding files either:

- in a fastened bag, in the constant possession of the Safeguarding Lead; or
- stored in the locked bedroom of the Safeguarding Lead or Group Nurse; or
- stored in a locked cabinet at the HCPT HQ in Lourdes; or
- stored in a locked cabinet at Hosanna House

It will be the responsibility of the Group Nurse to ensure secure storage of all medical record cards, care plans and medical diaries. They should be kept in the possession of the Group Nurse at all times and upon return to the UK, should be forwarded to HCPT HQ within four weeks by registered delivery in a securely sealed envelope. Any concerns highlighted by the Group Nurse should be shared with the Group’s Safeguarding Lead at the earliest opportunity.
Access to all safeguarding files will be strictly limited to a Group’s Safeguarding Lead, a Group’s Safeguarding Advisor, the Safeguarding Committee and the Chief Executive.

Any loss or theft of records containing confidential information should be reported immediately to a member of HQ staff.

**F13: Complaints**

All complaints that are received about the conduct or behaviour of staff or helpers will be dealt with in accordance with the HCPT complaints policy.

If any complaint is identified as a potential safeguarding concern, issue or risk, the HCPT safeguarding procedures should be followed, as set out in *Chapter F1*: *Responding to a safeguarding concern*.

HCPT has always looked to provide the best care and service to everyone who has been involved with us. However, complaints do arise for all sorts of reasons.

If a helper receives a complaint from another pilgrim, a parent or carer or any other interested party, their Group Leader should be notified.

The best and first way to resolve a complaint is to talk it through with the complainant. The Group Leader should try to resolve the issue in a friendly and understanding way. This informal procedure is usually more likely to lead to a resolution compared to a formal process.

If an informal resolution has been tried and is unsuccessful or the complainant remains dissatisfied, the Group Leader should advise the complainant of the next stage in the complaint procedure which is to forward the complaint to the Chief Executive either by:-

- letter to HCPT Head Office, Oakfield Park, 32 Bilton Road, Rugby, Warwickshire CV22 7HQ; or
- telephoning 01788 564646 (usual office hours are 9am – 5pm Monday to Friday excluding bank holidays); or
- faxing 01788 564640 (please be aware that HCPT cannot guarantee the confidentiality of incoming faxes); or
- emailing the Chief Executive at ce@hcpt.org.uk.

The complainant should include:

- his/her full address;
- his/her daytime telephone number;
- full details of the complaint, including the name of the person who the complainant originally spoke to; and
- copies of any documentation relating to the complaint.

All complaints will be handled in confidence, as far as possible, but information may need to be shared with other people, who need to know about the complaint, in order to resolve the issues. HCPT will handle information in line with the Data Protection Act 1998.

All complaints will be acknowledged in writing, as far as possible, within 10 working days of receipt. Complainants will be provided with the name of the appointed investigator and timescales for resolution.

Any complaints about the Chief Executive should be forwarded to the HCPT Board of Trustees for consideration.
Section G. How we stay safe in HCPT - external references and the legal basis of our policies

G1: Legal framework

The HCPT safeguarding policies and procedures have been written with reference to the following legislation and guidance:

G1.1: England and Wales

The Protection Freedoms Act 2012

Wales- Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse- 2013
- This manual is intended to guide the safeguarding work of all those concerned with the welfare of vulnerable adults employed in the statutory, third (voluntary) and private sectors, in health, social care, the police and other services.


The Care Act 2014
The Care Act is a new law about care and support for adults in England that came into action from April 2015. It includes clear and simple rules and guidance about the law. It defines:
- what people should be able to get
- what councils will have to do

The main themes of the Care Act are around promoting:
- Independence and wellbeing: having greater choice and control in the what care and support you receive so that you can live your life the way you want to
- Prevention: thinking about things that will help to stop problems before they start, or to stop them getting worse as early as possible.
- Integration – working with other organisations to provide the support that you need
- Choice and control – your care and support plan will help you to do the things that are important to you
- Information and advice: having good quality information to help you choose the right care and support for you
- Carers entitlements and rights: carers will be entitled to their own assessments to see if they are eligible for support
- A lifetime cap on care costs: there will be a limit to the amount you will have to pay for care in your lifetime (this will not come into force until April 2016)
- A national eligibility criteria and changes to assessment for care: there will be the same rules about who can get care and support all over the country
Advocacy: If you find it very difficult to be involved at any stage of your assessment or care planning, and there is no-one else to speak for you, then the council must find you an independent advocate who will help you to say what you want to say and represent your best interests to get the services you need.

Keeping adults safe: This is the first time we have had a law telling councils what to do to help keep adults safe from abuse or neglect.


Children Act 1989
This Act places a legal duty on a local authority to make enquiries if they have reasonable cause to suspect a child is suffering or is likely to suffer significant harm, to enable them to decide whether to take any action in order to safeguard or promote the child’s welfare.


Children Act 2004
This Act placed a new duty on agencies to co-operate to improve the well-being of children and young people. It integrated children’s services, to enable young people’s needs to be identified early to allow timely and appropriate intervention before their needs become more acute.

Common Assessment Framework for Children and Young People
All children who need additional services to achieve or maintain a reasonable standard of health and development will be identified using the common assessment framework.

Deprivation of Liberty Safeguards
The Mental Health Act 2007 amended the Mental Health Act 1983 and introduced the Deprivation of Liberty Safeguards into the Mental Capacity Act 2005. The safeguards cover the safe treatment of vulnerable adults, who lack capacity, in hospital and care home settings.

Every Child Matters
Government guidance which sets out the national framework for local change programmes to build services around the needs of children and young people to maximise opportunity and minimise risk.

Mental Capacity Act 2005
Provides a statutory framework to empower and protect vulnerable people who are unable to make their own decisions. The Act makes it clear who can take decisions, in which situations, and how they should go about this. It enables individuals to plan ahead for a time when they may lose capacity.


National Framework – Safeguarding Adults (Association of Directors of Social Services, 2005)
Issued national standards for multi-agency responses to protect and safeguard vulnerable adults. It covers the need for raising awareness as well as the need for multi-agency procedures.


No Secrets, Department of Health, 2000
Named local authorities as the lead agency to create a framework for action so that all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults. The publication defines the different categories of adult abuse and provides a definition of a vulnerable adult. It gives guidance to local
agencies that have a responsibility to investigate and take action when a vulnerable adult is believed to be suffering abuse. It offers a structure and content for the development of local inter-agency policies, procedures and joint protocols which will draw on good practice nationally and locally.


**Safeguarding Vulnerable Groups Act 2006**

Created the Disclosure and Barring Service to help prevent unsuitable people from working (paid or otherwise) with children and vulnerable adults.

http://www.legislation.gov.uk/ukpga/2006/47/contents

**Sharing Information 2008**

This guidance is for front-line practitioners from all sectors who have to make decisions about sharing personal information, on a case-by-case basis, whether they are providing services to children, young people, adults or families. The guidance is also for managers and advisors who support these practitioners in their decision-making and for others with responsibility for information governance.

http://webarchive.nationalarchives.gov.uk/20100113202026/dcsf.gov.uk/everychildmatters/strategy/deliveringservices1/iw/

**United Nations Convention on the Rights of the Child**

Every child has the right to be loved and cared for, to be safe and well, to be offered a good standard of education, to be protected from exploitation and to have opportunities for rest and play (1991) regardless of age, race, culture, gender, disability, or social/economic background.

http://www.unicef.org/crc/

**Working Together to Safeguard Children – HM Government 2013**

Statutory guidance that sets out how:

- organisations and individuals should work together to safeguard and promote the welfare of children
- how practitioners should conduct the assessment of children

**G1.2: Scotland**

_________________________________________________________


- This document provides a national framework for agencies and practitioners at local level to understand and agree processes for working together to safeguard and promote the wellbeing of children.

http://www.scotland.gov.uk/Publications/2014/05/3052

**Children and Young People (Scotland) Act 2014**

- It became law on the 27th of March, 2014 and contains several changes to how children and young people in Scotland will be cared for. These changes will come into force in Scotland over the next two to three years.

http://www.scotland.gov.uk/topics/people/young-people/legislation
The Protection of Freedoms Act (Scotland) 2012

Adult Support and Protection (Scotland) Act 2007
- This Act seeks to protect and benefit adults at risk of being harmed. The Act requires councils and a range of public bodies to work together to support and protect adults who are unable to safeguard themselves, their property and their rights.

http://www.scotland.gov.uk/Topics/Health/Support-Social-Care/Adult-Support-Protection

Adult Support and Protection (Scotland) Codes of Practice 2014
The Act makes provision intended to protect those adults who are unable to safeguard their own interests and are at risk of harm because they are affected by disability, mental disorder, illness or physical or mental infirmity. Harm means all harm including self-harm and neglect.

http://www.scotland.gov.uk/Publications/2014/05/6492/0

Children (Scotland) Act 1995
Centres on the needs of children and their families and defines both parental responsibilities and rights in relation to children. It sets out the duties and powers available to public authorities to support children and their families and to intervene when the child’s welfare requires it.


Getting it right for children in Scotland
This aimed to introduce a way of working consistently and supportively with all Scotland's children, young people, and their families and acting quickly if they need help.

http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright

Protection of Children (Scotland) Act 2003
Aims to improve the safeguards for children by preventing unsuitable people from working with them.

Protection of Vulnerable Groups (Scotland) Act 2007
Introduced a new membership scheme to replace and improve upon the current disclosure arrangements for people who work with vulnerable groups.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Adult at Risk</td>
<td>This term was introduced by the Care Act 2014. It means adults who need community care services because of mental or other disability, age or illness and who are, or may be unable, to take care of themselves against significant harm or exploitation. The term replaces ‘vulnerable adult’. HCPT has elected to maintain the term ‘vulnerable adult’ in this document, although the meaning is as above.</td>
</tr>
<tr>
<td>Bullying</td>
<td>Bullying is deliberately hurtful, including aggressive, conduct, repeated often, over a period of time for which it is difficult for the victim to defend themselves against. A systematic abuse of power</td>
</tr>
<tr>
<td>Child</td>
<td>Someone aged between 0 and 17 years of age</td>
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<tr>
<td>Child protection</td>
<td>The process of protecting individual children identified as either suffering or at risk of suffering significant harm as a result of abuse or neglect</td>
</tr>
<tr>
<td>Child Protection Conference</td>
<td>A meeting of family members, the child (where appropriate) and those professionals most involved with the child and their family, following investigations into concerns about a child’s welfare. The meeting considers all information about a child and the likelihood that they are, or are likely to suffer, significant harm. If issues of significant harm exist then their name may be placed on a Child Protection Plan.</td>
</tr>
<tr>
<td>Children’s Trust</td>
<td>The term is used loosely to define local arrangements for commissioning integrated services and pooling budgets where it makes sense to do so. Children’s Trust arrangements may be conducted through a children and young people’s strategic partnership, a more formal trust arrangement or for example, through a joint commissioning unit <a href="http://www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders">www.everychildmatters.gov.uk/strategy/childrenstrustpathfinders</a></td>
</tr>
<tr>
<td>Common Assessment Framework (CAF)</td>
<td>The CAF is a standardised approach to assessing a child’s need for services. It has been designed for practitioners in all agencies to help them communicate and work together more effectively with the aim of identifying and addressing problems before they become serious <a href="http://www.everychildmatters.gov.uk/deliveringservices/caf">www.everychildmatters.gov.uk/deliveringservices/caf</a></td>
</tr>
<tr>
<td>Disclosure &amp; Barring Service</td>
<td>The body formed following the merger of the Criminal Records Bureau and Independent Safeguarding Authority on 1 December 2012</td>
</tr>
<tr>
<td>Disclosure of abuse</td>
<td>When a child or vulnerable adult informs another person that they have been or are being abused or that someone else has been abused</td>
</tr>
<tr>
<td>Domestic abuse</td>
<td>Threatening behaviour, violence or psychological, physical, sexual, financial or emotional abuse between adults who are or have been intimate partners or family members, regardless of gender or sexuality. Evidence shows that children can suffer long term damage from living in a household where domestic violence takes place. Domestic violence is now included in the definition of harm</td>
</tr>
<tr>
<td><strong>Duty of care</strong></td>
<td>General duty on all those working with children and vulnerable adults to share some degree of responsibility for promoting their welfare and acting to protect them</td>
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<tr>
<td><strong>Duty to safeguard and promote welfare</strong></td>
<td>Section 11 of the Children Act 2004 gives named agencies a duty to safeguard and promote the welfare of children and young people.</td>
</tr>
<tr>
<td><strong>Forced marriage</strong></td>
<td>A marriage conducted without the full consent of both partners and where duress is a factor</td>
</tr>
<tr>
<td><strong>Grooming</strong></td>
<td>The way perpetrators of sexual abuse select and establish a relationship of trust with a child or vulnerable adult which they then manipulate to exercise power over the victim and their family, organisation or professional setting</td>
</tr>
<tr>
<td><strong>HCPT</strong></td>
<td>HCPT (Hosanna House and Children’s Pilgrimage Trust), registered charity number: 281074.</td>
</tr>
<tr>
<td><strong>Independent Mental Capacity Advocate (IMCA)</strong></td>
<td>Introduced by the Mental Capacity Act 2005 and is an independent advocate to support and represent someone who lacks capacity to make decisions</td>
</tr>
<tr>
<td><strong>Information sharing</strong></td>
<td>The sharing of information between agencies and professionals in the best interests of the child or vulnerable adult. Effective local arrangements should be in place to ensure all agencies understand their responsibilities and the limits of confidentiality</td>
</tr>
<tr>
<td><strong>Local Authority Designated Officer (LADO)</strong></td>
<td>County land unitary local authorities should have a Local Authority Designated Officer (LADO) to be involved in the management and oversight of individual cases. The LADO should provide advice and guidance to employers and voluntary organisations, liaising with the police and other agencies and monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process;</td>
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<td></td>
<td>• Any allegation should be reported immediately to a senior manager within the organisation. The LADO should also be informed within one working day of all allegations that come to an employer’s attention or that are made directly to the police; and</td>
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<tr>
<td></td>
<td>• if an organisation removes an individual (paid worker or unpaid volunteer) from work such as looking after children (or would have, had the person not left first) because the person poses a risk of harm to children, the organisation must make a referral to the Disclosure and Barring Service. It is an offence to fail to make a referral without good reason.</td>
</tr>
<tr>
<td><strong>Local Safeguarding Children’s Boards (LSCB’s)</strong></td>
<td>A statutory agency created by the Children Act 2004, the LSCB is the key statutory mechanism for agreeing how the relevant organisations in each local area will cooperate to safeguard and promote the welfare of children in that locality, and for ensuring the effectiveness of what they do</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Looked after children</td>
<td>Children who are cared for by the local authority, either through a legal order or voluntary agreement with their parents</td>
</tr>
<tr>
<td>Multi agency public protection arrangements (MAPPA)</td>
<td>Local panels which bring together police, probation, social services and other agencies to monitor violent offenders and sex offenders in the community once they are released from prison</td>
</tr>
<tr>
<td>Multi agency risk assessment conference (MARAC)</td>
<td>A meeting of local agencies to discuss the highest risk victims of domestic abuse in their area. Information about the risks faced by those victims, the actions needed to ensure safety, and the provisions available locally is shared and used to create a risk management plan involving all agencies</td>
</tr>
<tr>
<td>Multi-agency training</td>
<td>The joint training of staff from various agencies to ensure that staff across various agencies have a common understanding of safeguarding issues. This also promotes the establishment of networks between professionals</td>
</tr>
<tr>
<td>National Offender Management Service (NOMS)</td>
<td>An executive agency of the Ministry of Justice, and bringing together HM Prison Service and the Probation Service to enable a more effective delivery of their services. It is responsible for commissioning and delivering offender management services in custody and in the community, helping to deliver punishments and reparation and co-ordinating rehabilitative, health, educational, employment and housing opportunities for offenders to reduce the chances of re-offending</td>
</tr>
<tr>
<td>Parents and carers</td>
<td>Includes anyone with parental responsibility or who undertakes day-to-day care for a child. It may include step-parents, grandparents or other members of the family (including siblings), foster carers or residential staff</td>
</tr>
<tr>
<td>Partner agencies</td>
<td>In the context of the Children Act 2004, this refers to all the agencies engaged in a partnership with the local authority to ensure children are safeguarded and their welfare promoted</td>
</tr>
<tr>
<td>Personal assistant</td>
<td>Someone who is employed to provide some of the personal and domestic everyday support needed to enable people to lead an independent personal and social life in and from their own home</td>
</tr>
<tr>
<td>Police protection</td>
<td>The police have powers under the Children Act 1989 to remove a child, in an emergency, into police protection for up to 72 hours</td>
</tr>
<tr>
<td>Private foster care</td>
<td>A private fostering arrangement is essentially one that is made privately (that is to say without the involvement of a local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative with the intention that it should last for 28 days or more</td>
</tr>
<tr>
<td>Protecting Vulnerable Groups (PVG) Scheme</td>
<td>The Scheme, managed by Disclosures Scotland and introduced in Scotland for those working with vulnerable groups (unpaid or otherwise)</td>
</tr>
<tr>
<td>Risk assessment</td>
<td>The process of assessing whether or not a person or situation may present a risk to the welfare of a child, young person or vulnerable adult</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
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<td>--------------------------------------------</td>
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<tr>
<td>Safeguarding Adult Protection Boards (SAPs)</td>
<td>A multi-agency partnership to lead safeguarding adults work. Each partnership should include senior representation from all the appropriate statutory agencies</td>
</tr>
<tr>
<td>Safer working practices</td>
<td>It is important that all adults working with children understand that the nature of their work and the responsibilities related to it, place them in a position of trust. Department for Education practice guidance provides clear advice on appropriate and safe behaviour for all adults working with children in paid or unpaid capacities, in all settings and in all contexts</td>
</tr>
<tr>
<td>Serious case review</td>
<td>LSCBs and SAPs hold reviews of practice in cases when a child or vulnerable adult dies, and abuse or neglect are known or suspected to be a factor in the death. They must also consider reviews in circumstances when a child or a vulnerable adult sustains a potentially life threatening injury or serious and permanent impairment of health and development or has been subjected to particularly serious sexual abuse and the case gives rise to concerns about inter-agency working</td>
</tr>
<tr>
<td>Serious harm</td>
<td>Death or serious injury to a person’s physical or mental health (Department of Health, 2008)</td>
</tr>
<tr>
<td>Significant harm</td>
<td>Introduced in the Children Act 1989 but, also applied to the abuse of vulnerable adults, as a threshold that justifies compulsory intervention in family life, in the best interests of the child or vulnerable adult</td>
</tr>
<tr>
<td>Staff, helpers</td>
<td>Anyone in paid or unpaid work who provides services or activities on behalf of HCPT</td>
</tr>
<tr>
<td>The Children and Family Court Advisory and Support Service</td>
<td>CAFCASS is an independent national organisation which exists to safeguard and promote the welfare of children in court proceedings, to give advice to the court and provide information, advice and support for children and their families <a href="http://www.cafcass.gov.uk">www.cafcass.gov.uk</a></td>
</tr>
<tr>
<td>Vulnerable adult</td>
<td>See ‘Adult at Risk’</td>
</tr>
<tr>
<td>Whistle blowing</td>
<td>Each employer should have a clear and accessible whistle blowing policy that meets the terms of the Public Interest Disclosure Act 1998</td>
</tr>
<tr>
<td>Youth offending teams</td>
<td>Multi-agency teams responsible for the supervision of children and young people who have committed offences or are likely to offend</td>
</tr>
</tbody>
</table>
G3: APPENDIX 1: 'Child in Need' examples

Examples of 'children in need' situations:

Be healthy
- Slow reaching development milestones (e.g. below percentile chart height and weight)
- Early/unsafe sexual activity
- Missing/poor attendance at medical appointments
- Not registered with a GP
- Frequent illnesses and infections/minor health injuries/problems
- Unnecessarily accessing health services e.g. walk in clinics/A&E
- Children for whom there are emotional, physical/behavioural health concerns
- Vulnerability to mental health problems due to family history or circumstances
- Delayed speech or language/poor concentration
- Experimenting with substances/drugs
- Insecurities about identity
- Clothing out of need/none/inappropriate school uniform
- Poor development of self care skills
- Parents struggling to address own emotional needs
- Poor home routines
- Families with poor hygiene
- Carers with chronic ill health or terminal illness
- Children who appear hungry in school
- Eating disorders

Children at risk of entering the youth justice system- engaging in petty crime
- History of dysfunctional family
- Children who have started to go missing from home
- Children/young people involved in contact/resident disputes
- Families where there are concerns about domestic violence/substance misuse

Enjoy and achieve
- Young carers
- Children who miss important education appointments
- Some difficulties in building/sustaining relationships with peers and adults
- Low/threatened self-esteem and confidence
- Below educational levels/not meeting learning milestones
- On special codes of practice at school (school action/school action plus)
- Limited access to age appropriate leisure facilities and/or quality education including nursery
- Irregular attendance and significant unauthorised absence from school (> 10%)
- Fixed term exclusion
- Low expectations from community, school and parents/carers
- Presents challenging behaviour in school or refuses to go to school

Make a positive contribution
- Bullied or bullying behaviour
- Lack of positive role models
- Inappropriate responses and actions
- Finds managing change difficult
- Does not always understand how actions impact on others
- Sometimes engages in petty crime
- Presents increasing management problems to parents
• Some relationship difficulties (e.g. hostile divorce/separation, bereavement)
• Conflicts within the community
• Family has recently moved from out of/into the area
• From migrant families whose first language is not English

Achieve economic well being
• Attitudes are affecting their ability to achieve economic well being
• Withdrawing from peers and/or parents
• Disengaging with family, school and peers
• At risk of making ill informed/inappropriate progression decisions
• Not settled in employment, education or training post 16

• Not in education, employment or training for less than 6 weeks
• Not completing education/college plan
• Has isolated or unsupported carer
• Spends a lot of time alone
• High number of children or more than two under 5
• Low income may affect wider family unit
• Periods of unemployment may affect wider family unit
• Inadequate or poor housing/home conditions due to overcrowding, lack of heating or structure
Staying safe with HCPT:
Risk assessment based room sharing plan

HCPT places great importance on the safety and welfare of all pilgrims – whether helpers or helped. We are proud of our safeguarding guidance procedures which can be viewed on-line at www.hcpt.org.uk/safeguarding.

The purpose of this document is to provide a clear guidance of what to do in the event that a child has such needs as are only best met by the child sharing a room with their helpers.

Our safeguarding guidance says:

The ways in which groups should be accommodated include:

- children sharing bedrooms with other children of the same gender and (as far as practical) with children of similar age,
- vulnerable adults sharing bedrooms with other vulnerable adults of the same gender
- young helpers sharing bedrooms with other young helpers of the same gender,
- adult helpers sharing with other adult helpers.

If the risk assessment of the needs of a child or vulnerable adult concludes that close supervision through the night is required, the Group Leader should balance the needs with the wider dynamics of the group and such practical issues as room layouts

If the Risk Assessment of a child concludes that their night time safety is best provided with helpers sharing the room, then the following steps must be taken:

- This document ‘Risk assessment based room sharing plan’ must be completed
- This must include a copy of the Risk Assessment which demonstrates the need
- The proposed arrangement for each night of the pilgrimage must be described
- Parents / guardians of the child must be asked to sign to show their acceptance of the proposed arrangement
- The relevant helpers must also sign to show their acceptance of the proposed arrangement
- The Group Leader should keep the original, and send a copy to HQ

The following pages will capture this information.

A completed copy of this document must be sent to pilgrimage@hcpt.org.uk no later than 10 days before departure. Group Leader should keep the original with their Risk Assessment file.
Risk assessment based room sharing plan

This is regarding ____________________ who has been invited to travel in Group ____________

1. For Group Leader to complete.
   Based on the attached Risk Assessment, it is the recommendation of the Leader, Deputy and Nurse of our Group that the child named should share a bedroom with helpers through the pilgrimage week in Lourdes. The relevant Risk Assessment is attached to this document.
   Comments:

   Signature (GL) ____________________
   Signature (DGL) ____________________  Signature (Nurse) ____________________

2. For parent to complete.
   I understand and agree with the conclusion of the attached Risk Assessment that the best way to provide for the needs of my child is for my child to share a bedroom with two or more helpers. I have received an explanation of why this is the case and I am happy for my child to attend the HCPT Easter pilgrimage with these arrangements in place. I further agree that it is not possible to confirm which helper(s) will be sharing with my child on any one night, and that the Group Leader may change this arrangement during the week according to circumstances. I have been given access to the HCPT Safeguarding policy document and so I can be confident of the standards all helpers will be working to.
   Comments:

   Name ____________________ Signature ____________________ Date ____________________

3. For helpers to complete.
   I understand and agree with the conclusion of the attached Risk Assessment that the best way to provide for the needs of the named child is for that child to share a bedroom with two or more helpers. I understand the implications this arrangement may have on me and my night time arrangements and I am willing to allow myself to be included in my Group’s plans for providing this arrangement.

   Name ____________________ Signature ____________________
HCPT (Hosanna House and Children’s Pilgrimage Trust)

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