Brighton PIP Limited Safeguarding and Child Protection Policy

February 2026

Date of next review: February 2027

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SECTION 1 – The Policy

1. Purpose of the Policy

This Safeguarding and Child Protection policy sets out how Brighton PIP Limited (Registered charity number 1177084) hereafter referred to as BrightPIP will meet our statutory duties and pastoral responsibilities for babies and children in accessing our service and refers to the procedures to be followed. A child is defined as anyone who has not yet reached their 18th birthday; this extends to the unborn child.

All agencies within Brighton & Hove are required to follow the Pan Sussex Child Protection & Safeguarding Procedures which are available online Pan-Sussex Child Protection and Safeguarding Procedures.

This policy applies to all children, parents/carers, staff, students and volunteers. It is the duty of all staff and volunteers' working in our service to promote the wellbeing of the children and safeguard them from harm. All staff have a responsibility to act in cases of alleged, or suspected child abuse, and to recognise that any adult or child may inflict abuse, including a member of staff or volunteer. This document details action that should be taken in respect of this.

2. Aims of the Policy

- To promote a culture of safety in which everyone is protected.
- To promote the child's right to be strong, resilient and listened to.
- To create an environment that encourages children to develop a positive, self-image which includes their heritage, ethnicity, languages spoken at home, their religious beliefs, cultural traditions and home background.
- To promote awareness of child abuse issues through regular training for staff and volunteers.
- To promote child safety through staff awareness of how to identify signs and symptoms of abuse and how to respond to a disclosure.
- To promote safe working practice and consistency of approach to child protection amongst staff.
- To clarify terms and inform parents/carers and centre users of the roles and responsibilities of everyone in keeping children safe from harm.
- To ensure safeguarding practice reflects emerging risks including online harm, contextual safeguarding, and exploitation beyond the family home.

3. Relevant Legislation / Guidance that Informs the Policy

3.1. Legislation

- The Children Act 2004, as amended by the Children and Social Work Act 2017, requires the police, clinical commissioning groups and the local authority to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area.

- The Children Act 1989 which states that the welfare of the child is paramount http://www.legislation.gov.uk/ukpga/1989/41/contents

- United Nations Convention on the Rights of the Child, 1989, Article 19 states that children have a right to protection from being hurt, violence, abuse and neglect Working together to safeguard children - GOV.UK (www.gov.uk)

- The Disclosure and Barring Service helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children Disclosure and Barring Service

- Working Together to Safeguard Children (2023). Emphasies a child-centered, multi-agency approach to safeguarding, which includes family-focused support, stronger joint working, and clearer, more consistent guidance on sharing information between agencies to protect children at risk.

- Stable Homes, Built on Love – Children's Social Care Reform Programme (2023) is the government strategy to overhaul Children's Social Care, shifting the focus from crisis intervention to early, family centered support.

- Online Safety Act (2023) places strict legal duties on social media and search platforms to protect users, particularly children, from illegal and harmful content.

- Information Sharing Guidance for Practitioners (DfE & ICO updated May 2024) confirms that GDPR and Data Protection Act 2018 are not barriers to justified information sharing for safeguarding.

- Revised Prevent Duty Guidance England and Wales (2023) Prevent duties should be integrated into existing safeguarding procedures. Guidance emphasizes that even very young children can be vulnerable to radicalization through their family environment.

3.2 Local Guidance Documents

See:

Pan-Sussex Child Protection and Safeguarding Procedures
https://www.sussexsafeguardingchildrenprocedures.co.uk/

Brighton and Hove Safeguarding Children Partnership Family Help Framework
https://www.brightonandhovesafeguarding.org.uk/bh-rs-rt-online-framework/

Local Neglect Strategy and NSPCC Graded Care Profile
https://learning.nspcc.org.uk/services-children-families/implementation-support-for-nspcc-services/graded-care-profile-2-gcp2

4. Policy Review

This policy and operational procedures will be reviewed on an annual basis. Any changes or updates to relevant legislation or linked policies will trigger an earlier review of the policy.
Date of next review: February 2027

5. Roles and Responsibilities

BrightPIP has a designated person (DP) and deputy designated persons (DDP) for all child protection and safeguarding matters:

Designated Person		
Dr. Laura Williams	Clinical Director	Contact details not published externally
Deputy Designated Persons		
Dr. Bea Birtwell	Deputy Clinical Director	Contact details not published externally
Dr. Isobel Gammer	Clinical Psychologist	Contact details not published externally

The Designated Person is responsible for:

Recruitment

- Implementing rigorous recruitment procedures and checks
- Ensuring all staff, including temps and volunteers are given induction information regarding safeguarding on their first day, are told who the designated person is, and are given the safeguarding policy to read.

- Ensuring all staff undertake safeguarding training appropriate to their role within the first 3 months of their employment and update as per the schedule in part 15 of this policy.
- Carrying out regular supervisions with staff where matters of safeguarding are a standing item.
- Supporting colleagues in their involvement and action in individual cases.

Awareness raising

- Ensuring parents are informed of the safeguarding policy through the handbook and having the full document available.
- Coordinating the implementation of local child protection procedures
- Maintaining up to date knowledge of current issues relating to child protection and safeguarding, and cascading that knowledge as appropriate

Managing referrals

- Providing a point of contact for staff who have concerns or information about a child
- Deciding when to make a referral and make contact with the Front Door For Families or Single Point of Access The Local Authority Designated Officer, or the police
- Ensuring the referrals to Front Door For Families or Single point of Access, The Local Authority Designated Officer or the police are made in a timely and appropriate manner
- Liaising with other agencies on matters relating to child protection and to form good working relationships with them
- To ensure that the correct records are maintained and stored in compliance with Data Protection Laws

Responsibilities of ALL staff and volunteers

- Being alert to the signs of abuse and neglect
- Following the child protection procedures
- Reporting serious concerns on the same day to their designated person
- Reporting concerns about the behaviour of colleagues or volunteers to their designated person
- Recording low level concerns within case notes and raising them with parents and carers
- Recording low level concerns on a ‘pink sheet’ and saving these both in case notes, and as a service to review and monitor for emerging patterns and need for escalation.
- Keeping accurate records.

SECTION 2 – Child Protection and Safeguarding Procedures

1. Categories of Abuse

Abuse and neglect are forms of maltreatment of a child. Somebody may neglect a child by inflicting harm, or by failing to act to prevent harm. www.gov.uk/government/publications/working-together-to-safeguard-children includes the following definition of the different categories of abuse:

Children may be vulnerable to neglect and abuse or exploitation from within their family and from individuals they come across in their day-to-day lives. These threats can take a variety of different forms, including:
➢ Sexual abuse ➢ Physical and Emotional abuse ➢ Neglect ➢ Exploitation by criminal gangs and organised crime groups ➢ Trafficking ➢ Online abuse ➢ Sexual exploitation ➢ The influences of extremism leading to radicalisation

These categories overlap and an abused child frequently suffers more than one type of abuse. Abuse may occur within families, communities, peer groups, and online environments, including exploitation and peer-on-peer harm.

For recognition of significant harm and definitions, and the required response please go to section 3 of the Pan Sussex Child Protection & Safeguarding procedures on the website: Recognition of Abuse and Neglect

2. Procedure for Urgent Referral

- Actual physical injury, disclosure of abuse and severe neglect justifies an urgent referral to Front Door for Families, or Single point of Access. If the child needs urgent medical treatment, seek this first.

- Physical injury may take the form of bruising or marks to the child's body. If a member of staff sees any bruising or marks on a child they should ask the parent how the bruises or marks were caused. Refer to flowchart in (Appendix 1). An accident form must be completed. (Appendix 2)

- If the explanation is inconsistent with the bruising, the bruises are unusual in appearance or location on the body, or if the member of staff has any doubt about the causes of the bruises or marks then they should discuss their concerns with the Designated Person immediately.

- Record the location of the bruise or mark and the explanation given using the Safeguarding concern form (Appendix 3)

- All bruises or marks to immobile babies need to be reported. Refer to the referral flowchart for bruising and skin marks (Appendix 4) Pan-Sussex 2025 briefing on bruising in infancy here: Pan-Sussex-Bruising-Briefing-Jan-2025.pdf

- It is not the role of children's centre or nursery staff to investigate the validity of any allegations or concerns raised. Pass the information on to the relevant person and ensure that all discussions and information are appropriately recorded.

3. Procedures and Principles to be Followed when a Child Chooses to Share Information about Abuse

- Listen to the child and seek information with tact and sympathy. Avoid direct questioning. Staff should be aware that the way in which they talk to a child can have an effect on the evidence put forward if there are subsequent criminal proceedings. It is important that the child does not have to repeat or elaborate on what s/he has said, e.g. to the designated person.

- Reassure the child that they are believed and are doing the right thing in telling you.

- Never stop a child who is freely recalling significant events unless it is necessary to find a more private place or time. In this situation it is important that the child realises why they have been interrupted.

- Inform the designated person as soon as possible. If the designated person is unavailable, a senior member of staff should be informed. In cases of suspected or alleged physical abuse, it is important that the designated person is informed immediately as Children's Services will need time to assess the case before the child leaves the Children's Centre or nursery at the end of the session.

- Make a note of the discussion, taking care to record the timing, setting and people present as well as what was said as accurately as possible in the child's own words. Try not to do this in front of the child unless you can explain what you are doing. Notes may need to be used in any subsequent child protection conference and court proceedings, so sign and date any notes taken.

- Never promise confidentiality or make other promises that you may not be able to keep. However, the child should be assured that the matter will be disclosed only to people who have to know about it in order to improve the situation.

- Never inform the child's parents before discussion with the designated person, who will decide the timing of this in consultation with the investigating agencies.

4. How we make decisions about level of need (previously referred to as 'threshold')

a. Brighton and Hove

Previously called the 'Threshold' document, the Family Help – Right Support at the Right Time Framework Guide BH-Family-Help-RSRT-Framework-Guide-Poster-Published-Sept-2024-FINAL_compressed-1.pdf seeks to provide a degree of clarity and guidance to support a consistent understanding and application of thresholds by professionals from across services, and serves to let parents, carers and children know what to expect. The key to identifying a child and family's level of need must always be an evidence-based judgment.

In addition to risks within the home of the child, practitioners will consider contextual risk from peers, the community and the wider environment, ensuring they are safeguarding beyond the home.

The organisational model of Universal, Family Help and Specialist Services to Address Acute and Chronic Need has been developed to illustrate how all children and families will continue to access Universal and Family Help services, even when in need of Specialist support to address acute and chronic needs

The needs of children and their families do not always easily fit into a category or a tick box. A child's circumstances can change quickly and over time and a child may move across the levels of need dependent on a number of different variables that are present at any one time

The 3 levels of need are summarised below.

Level 1: Universal Services

Description and Response: Most children in Brighton & Hove have their needs met by their parents and family members, where they are protected and growing up healthy. Children and families can access services and early support through universal services; a Midwife, Health Visitor, School Nurse, Family Hub, GP, and Schools are all available within the local community and a lot of support is available on-line. All children and families may need extra support and guidance at some point in their lives. Services are aimed at supporting children and families to find their own solutions to need and services are likely to signpost them to help within their local community.

Assessment: At this level services may use their own processes to help tailor provision.

Level 2: Family Help

Description & Response: Children and families can sometimes need more structured and focused help, sometimes through one professional or agency in order to prevent needs from escalating. The professional or agency may be able to provide the help that is needed or support the family to identify where they can access the right help. For example, access to benefits, debt advice, health issues or parenting strategies etc. Children and families may also require a more structured plan of support in order to co-ordinate help needed, in order that agreed outcomes can be reached. It might be that support from a

single agency is not sufficient to meet needs. The type and the number of challenges faced by a child or family might be preventing them from achieving and maintaining a reasonable standard of health or development but the concerns about the risk factors does not at this point need a Social Work intervention.

Assessment: This level of support may require a proportionate assessment and planning process, but services should use the Family Help guidance and assessment to help them understand if support is working to reduce need. In more complex circumstances a Family Help Strengthening Families Assessment should be undertaken to understand need and to co-ordinate work across agencies to best address this need. The assessment should trigger a Family Help Plan that is co-ordinated by a lead professional who takes responsibility in getting the professional group together to review with the family. In situations where Neglect is a feature the NSPCC Graded Care Profile should be used to help understand and analyse this and the impact on children. This Graded Care Profile is designed to follow the family so should Page 11 be shared between services to aid understanding and the need for support. The BHSCP has training on Neglect and the NSPCC Graded Care Profile available for all those working with children.

Level 3: Specialist Services to address Acute & Chronic Need
Description: A small minority of children and families will need specialist help and support that is led by children's social work or another specialist service (e.g. Tier 3 CAMHS) for those who are most vulnerable, where Family Help Plans have been tried but not able to make sufficient, tangible difference and children are at risk of long-term impairment to their health and development and where they are at risk of significant harm or have suffered significant harm.

Definition: Children in Need are defined '…under the CA 1989 as a child who is unlikely to achieve or maintain a satisfactory level of health or development, without provision of services; or a disabled child'. In these cases, consideration should be made for a social worker to complete a Strengthening Families Assessment under s.17 of the Children Act 1989. There will be some circumstances where the needs of the child and family are best served by this assessment and ongoing work being supported within Family Hubs with Social Work support. For example, when established professional relationships are in place that can meet the needs of the child. Working Together 2023 and Stable Homes, Built on Love - GOV.UK (www.gov.uk) are clear that it is important to consider change in how services for Children in Need are provided. Family Hubs are developed to work with Children in Need where it is appropriate to do so and therefore the services can be provided under Level 2 in this guidance.

Definition: Child Protection. Significant Harm is the key that justifies intervention into family life and forces all agencies to consider what is in the best interests of the children. Physical Abuse, Sexual Abuse, Emotional Abuse and Neglect are categories of significant harm. Sometimes significant harm is a single traumatic event but more often it is an accumulation of significant events both acute and longstanding over time e.g. neglect. This

can include Child Sexual Exploitation and Child Criminal Exploitation. All professionals working with children have a role to play in addressing significant harm through cumulative action and contextual safeguarding as often action taken to prevent needs arising in the first place can have a significant impact upon a child's overall outcomes in the long term.

Response: In cases where a child's health and development are being significantly impaired a social worker would complete a Strengthening Families Assessment under s.17 of the Children Act 1989. Assessments are multi-agency and consent based. Where there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm the local authority shall make enquiries as considered necessary to decide further action to safeguard or promote a child's welfare. Agencies are required in both circumstances to contact the Front Door for Families where a pathway decision will be made.

Assessment: If a decision is made that confirms suspicion of, or actual significant harm a social work Strengthening Families Assessment will be initiated. A strategy meeting with Police, Health and Education and any other agency required may also be held to consider what needs to happen next to address risk and harm and will consider the need for Section 47 (CA 1989) enquiries to be made. The Section 47 enquiry must consider the need for an Initial Child Protection Conference to be convened.

b. East Sussex

The continuum of need document Level indicators | East Sussex County Council sets out the needs of children and families at four levels:

Level 1: Achieving expected outcomes ('universal')
Children whose needs are fully met and are achieving expected outcomes. Parents or carers are meeting child's needs

Level 2: Children with additional needs ('universal plus')
Children with additional needs
Parents and child need provision of professional support or guidance to help them meet child's needs

Level 3: Children with multiple and complex needs ('universal partnership plus')
Children with multiple and complex problems.
Parents and child need targeted and specialist service response to help them meet the child's needs. This is organised via an Early Help assessment and plan.

Level 4: Children with acute needs including protection ('safeguarding')
Children with acute needs including those in need of protection.
Parents need multi-agency service response including specialist intervention from children's social care.
Social care family assessment completed under Section 47/14 enquiries.

- The continuum of need is intended to provide practitioners with a shared understanding and common language around needs and risks surrounding children and their families
- It is to be used alongside the continuum of need indicators which provide descriptors of need for each level
- The continuum doesn't replace professional judgement or assessment and planning tools
- In addition to risks within the home of the child, practitioners will consider contextual risk from peers, the community and the wider environment, ensuring they are safeguarding beyond the home.

5. Making a Referral to Front Door For Families or Single Point of Access

a. In Brighton and Hove

The designated person will decide whether a referral is appropriate, and if in any doubt will seek advice from the Front Door for Families. Where the child does not already have an allocated Social Worker, the referral should be made to Front Door for Families (link below). Where the child has an allocated Social Worker, safeguarding concerns should be shared directly with this worker or at the relevant social work pod duty telephone number (contact details via Front Door for Families main number).

b. In East Sussex

As above, the referral should be discussed with the designated person before referring to the Single Point of Access (SPOA) for level 3 or 4 concerns at: Contacting the Single Point of Advice (SPoA) | East Sussex County Council

Pan Sussex procedures apply and for both locations, concerns should always be discussed with a line manager prior to making a referral. Unless it is deemed that the referral will put the child at further risk, referrals should always be shared with parents. The designated person should also inform the child's allocated or duty Health Visitor or Midwife that a referral is being made.

Where possible the designated person should make the referral. If not available the member of staff who has identified the concerns should make the referral.

Ask for the name of the Social Worker you are speaking to. The Social Worker should ask for the following information. If all the information is not available do not delay in making the referral but give as much information as you can:

- Child's full name
- Date of birth
- Home address
- Ethnic origin
- Parents' names and contact numbers
- Any other children at home

- Name of school/nursery that child attends and schools that any siblings attend
- Names of other professionals involved with the child
- Description of any injuries and child's explanation for them if appropriate
- Anything you have observed or been told by child or others. Try to be specific and include dates and times
- Any action you have taken so far
- What, if anything, you have said to the child's parents
- Ask Social Worker what you should/should not say to parents
- Record the referral, including date and time and any action to be taken
- If the designated person is not making the referral, then they must be informed as soon as possible by the staff member reporting the incident.

The referrer should keep a written record of:

- Discussions with the child
- Discussions with the parent
- Discussions with supervisors
- Information provided to Front Door For Families or SPOA
- Decisions taken (clearly timed, dated and signed) For further details of procedures for making a referral and following referral, refer to the Pan Sussex Child Protection procedures Making a Referral

6. Low-Level Concerns about a Child's Welfare and Safer Safeguarding Culture

- Ongoing concerns regarding a child's welfare must always be discussed with the designated person. This is particularly important when there are concerns about possible neglect.
- Concerns should be discussed with parents and a record kept of these concerns kept within clinical case notes. If you feel it is necessary to discuss the concerns with other professionals you must inform the parent you intend to do this, unless it is thought this action may put the child in danger.
- If after recording and monitoring, a decision is made to refer to Front Door For Families or Single Point of Access the procedure for referral is the same as above.
- Low level concerns will be recorded, reviewed and monitored for emerging patterns, by the Designated person, and escalated as deemed necessary.

7. Female Genital Mutilation

There is a mandatory duty for those in a 'regulated profession' to report 'known' cases of Female Genital Mutilation (FGM) in girls under 18 to the Police; this duty has been in place since 31 October 2015. FGM is illegal in England and Wales under the FGM Act 2003 ("the 2003 Act"). It is a form of child abuse and violence against women. FGM comprises all procedures

involving partial or total removal of the external female genitalia for nonmedical reasons. Section 5B of the 2003 Act introduces a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s which they identify in the course of their professional work to the police. For the purposes of the Act, a person works in a 'regulated profession' if the person is a healthcare professional, a teacher, or a social care worker. If staff become aware that a child has been subject to female genital mutilation it is their responsibility to report this. A referral to Front Door for Families or Single Point of Access should be made after discussion with the Health Visitor and Designated Person.

Further information is available here Female Genital Mutilation

8. The Prevent Duty – Safeguarding Families from being Drawn into Terrorism

The Prevent Duty is the duty in the Counter-Terrorism and Security Act 2015 on specified authorities, including schools and childcare providers, to ensure through their policies, procedures and practice that every effort is being made to identify and support those vulnerable to potential radicalisation.

All staff should be aware of potential risks within the local community and be aware of the potential risks through use of online radicalisation through social media and the internet.

Staff are best placed to notice any changes in children's or families behaviour that gives them cause for concern and must take action when they have concerns. If a member of staff has concerns about radicalisation or terrorism they should contact Front Door For Families or Single Point of Access for advice.

Further information is available here:

Prevent Duty Guidance

and here:

Children and Young People Vulnerable to Violent Extremism

If staff are concerned that a family is at risk of being drawn into extremism then they must follow the procedure as set out in the ***Family Hub and Nursery Safeguarding Policy and Procedures.***

Promoting British Values - within the early years sector one way to build children's resilience to radicalisation is to help young children to build their self-esteem, help them to make choices and decisions, learn to respect each other and let them have a voice. All of this is implicit in the Early Years Foundation stage and supports promotion of the fundamental British Values of Democracy, Rule of Law, individual Liberty, mutual respect and tolerance. We can consider how they promote British Values in all of their work; providing a

warm welcome for all families and a place where families feel safe, valued and respected, have a voice and a sense of belonging.

Equality, Diversity and Safeguarding Practice

Safeguarding practice should be inclusive and antidiscriminatory, responsive to the diverse needs of children and their families.

9. Fabricated and Induced Illness

Fabricated or induced illness (FII) is a rare form of child abuse. It happens when a parent or carer exaggerates or deliberately causes symptoms of illness in the child. The parent or carer tries to convince doctors that the child is ill, or that their condition is worse than it really is. The parent or carer does not necessarily intend to deceive doctors, but their behaviour is likely to harm the child. For example, the child may have unnecessary treatment or tests, be made to believe they're ill, or have their education disrupted. Staff must maintain an awareness of the signs and symptoms of FII. If they suspect it is happening within a family they must make a referral to Front Door for Families or Single Point of Access, after discussion with the Designated Person.

10. Domestic Violence and Parental Conflict

Exposure to domestic abuse and parental conflict can have a serious impact on a child's development and emotional wellbeing. Children are recognised as victims under the Domestic Abuse Act 2021. Evidence shows that parents may find it difficult to raise the subject of domestic abuse themselves and that direct questions get more positive results than vague queries. Staff should be prepared to take a proactive approach.

- Never ask about domestic abuse when someone else is present. Find a way of seeing the parent alone.
- Ensure privacy and no interruptions. Consider that s/he might want to talk to someone else i.e. different gender, race.
- Be patient and understand that the parent may also have time pressures.
- Aim to have a supportive conversation and avoid pushing the parent into revealing domestic abuse
- Never accept culture as an excuse for domestic abuse.
- Treat a disclosure of domestic abuse in the same way as you would any other safeguarding disclosure. Babies in utero and early infancy will be affected by exposure to parental conflict, even if not directly present when conflict or abuse takes place.

11. Parental Mental Health

The majority of parents who suffer mental ill-health are able to care for and safeguard their children and/or unborn child. Some parents, however, will be unable to meet the needs and ensure the safety of their children and at the

most extreme, parental mental ill-health has been identified as a clear factor in a significant number of child deaths.

To safeguard children of parents, mental health practitioners should routinely record details of patients' responsibilities in relation to children and consider the support needs of patients and of their children, in all aspects of their work.

Parents with mental health difficulties may be at greater risk of neglecting their own wellbeing, which can impact their children's physical, emotional, and social needs. It's essential to prioritise protecting children from abuse and neglect over maintaining the privacy of those failing to safeguard them, in line with Information Sharing Advice for practitioners providing safeguarding services for children, young people, parents and carers. When planning care for parents with mental health difficulties, it is crucial to consider the needs and risk factors of the children involved. Children's Social Care, along with other relevant agencies, should participate in discharge planning, and any changes to risk assessments must be communicated to all involved agencies according to information-sharing guidelines. Practitioners should adopt a whole-family approach, recognizing that changes for one family member can affect others, including

Where BrightPIP professionals suspect a child and/or unborn child has suffered, or is at risk of suffering significant harm because of active intention or neglect on the part of the parent/carer, a referral to Front Door For Families or Single Point of Access must be made.

A referral **must** always be made where there is evidence of any of the following high-risk indicators in the adult:

- psychotic beliefs, particularly if focussed on or involving the child e.g. Command led hallucinations suggesting harm to the child.
- persistent negative views expressed about a child, including rejection.
- on-going emotional unavailability, unresponsiveness and neglect, including lack of praise and encouragement, lack of comfort and love and lack of age-appropriate stimulation.
- inability to recognise a child's needs and to maintain appropriate parent-child boundaries.
- on-going use of a child to meet a parent's own needs.
- suicide plans or thoughts.
- distorted, confusing or misleading communications with a child including involvement of the child in the parent's symptoms or abnormal thinking. For example, delusions targeting the child, incorporation into a parent's obsessional cleaning/contamination rituals, or a child kept at home due to excessive parental anxiety or agoraphobia;
- on-going hostility, irritability and criticism of the child or young person, inconsistent and/or inappropriate expectations of child.
- neglect of the child.

The following are other negative indicators that, if present, increase the risk of abuse:

- combination of depression, substance misuse and personality disorders at various points in time are the most frequently reported psychiatric conditions affecting parents who abuse their children.
- mental illness combined with a background of domestic abuse.
- both parents have a mental disorder or a lone parent with limited support has a mental disorder.
- poor compliance with treatment.
- lack of insight into the disorder and its likely impact on the child.
- self-harming behaviour and suicide attempts.
- parental learning difficulties and mental illness.

It is also important to consider the nature of the illness:

- Pattern: frequency of episodes, length of episodes. In general, an illness that has longer, and more frequent episodes will have a greater impact than illnesses of short duration.
- Severity: the impact of an illness will not be directly related to its severity, e.g. a parent with a short severe illness may be hospitalised and substitute care provided for the child with little impact on parenting.
- Chronicity: a less severe illness that is chronic may lead to substandard care or neglect of the child, if long term medication or the illness itself lead to cognitive and/or personality changes
- Specificity: what are the symptoms of the illness and their likely impact.

12. Child was not brought to appointment (Did not Attend, DNA)

- Many serious case reviews, both nationally and at a local level have featured DNAs as a precursor to serious child abuse and child death.
- Professionals should be child focussed and consider children and young people even when the DNA relates to the parents/carers, particularly when poor mental health or problematic substance misuse is a feature.
- All DNAs including cancelled appointments should be recorded in the clinical records and on the Chronology of Risk sheet to establish any emerging patterns. Regular DNA should always be discussed with the clinical director.
- DNAs should form part of an on-going assessment on whether there are safeguarding concerns. If the child has a Child Protection Plan, all DNAs should be reported to their social worker as soon as possible. If the named social worker is unavailable the information should be given to the team leader or duty team.

13. Suspicions/Disclosure Regarding Abuse by a Member of Staff, Volunteer or Visitor. Staff, volunteers and Visitors will be subject to ongoing suitability monitoring

These procedures should be applied when there is an allegation or concern that any person who works with children has:

- Behaved in a way that has harmed a child, or may have harmed a child

- Possibly committed a criminal offence against or related to a child; or
- Behaved towards a child or children in a way that indicates he or she may pose a risk of harm to children.

The person to whom an allegation or concern is first reported should treat the matter seriously and keep an open mind. He or she should not:

- Investigate or ask leading questions if seeking clarification;
- Make assumptions or offer alternative explanations; or
- Promise confidentiality, but give assurance that the information will only be shared on a 'need to know' basis.

He or she should:

- Make a written record of the information (where possible in the child/adult's own words), including the time, date and place of incident(s), persons present and what was said;
- Sign and date the written record; and
- Inform the designated person The Designated Person must:
    - Immediately report the matter to the Local Authority Designated Officer (LADO), ladoenquiries@brighton-hove.gov.uk or via SPoA SPOA@eastsussex.gov.uk and the Trustees (clinical/safeguarding lead) Dr Kerry Taylor (07971519821). If the concern is regarding the designated person, then a senior member of staff must immediately inform the Chair of Trustees and the LADO.
    - For urgent LADO matters outside of office hours, at weekends and on public holidays contact 01273 335905/6.

All conversations must be recorded and signed. It is the duty of all staff and volunteers to disclose any concerns they have in relation to the conduct of other staff and volunteers.

13.1 Staff who have Children with Social Care Involvement

Staff (including volunteers) must disclose any social care involvement with their children to the Designated Person prior to starting their role. Staff already in a role who have children who become subject to any child protection investigation, or proceedings, must inform the designated person

The Designated Person must:

- Immediately discuss the matter with the clinical and safeguarding Trustee, Dr Kerry Taylor, 07971519821. Advice will then be taken from The Local Authority Designated Officer (LADO) SPOA@eastsussex.gov.uk or ladoenquiries@brighton-hove.gov.uk.
- All conversations and subsequent decisions will be recorded and stored on the volunteer's personal file.

14. Good Practice Regarding Record Keeping

All records, will be confidentially kept, securely stored, properly maintained and reviewed annually by the Designated Person. Records should be clear and legible, signed and dated with specific reference to the circumstances in which the observations took place. Records should be concise and record where possible what was happening prior to the behaviour/disclosure. Where possible record the child's or adult's own words. Record:

- Date
- Time
- Place
- What was seen or heard by whom
- Person(s) present
- What action was taken and by whom

Records should be Relevant, Factual, Concise, Complete, Accurate, Objective, Dated, Signed, and Stored Securely.

Parents will be informed of records held on their child.

15. Staff Support

Staff and volunteers need to be aware that recognising abuse or being informed about a safeguarding issue. or receiving a disclosure. is emotionally very challenging and stressful. Confidential systems are in place through supervision, debrief opportunities and clinical supervision, so that staff, including managers, can discuss what support may be required.

It is important that support is given where necessary and that colleagues are aware of the effects upon staff when working with families involving safeguarding and child protection incidents

Although details should remain confidential, it is useful for people to be able to talk with someone and to express their feelings. It is likely that this support may need to be on going, especially if the case goes to court and the member of staff is a witness.

16. Parent Involvement

Staff aim to build trusting and supportive relationships with parents and carers and to ensure clear and open communication takes place.

Any concerns about a child's welfare will be discussed openly with the parents/carers unless it is judged that this will further endanger the child.

Staff will continue to welcome the child and family to the service during any investigation and will support the family whenever possible. Staff will help parents to understand their responsibility for the welfare of all children when they first contact families.

17. Safe Recruitment

All staff, trustees and volunteers will have an enhanced check by the Disclosure & Barring Service (DBS). This will always be in place before the person starts work

A central record of DBS numbers is maintained by the Project Coordinator.

All recruiting managers should follow Safer Recruiting procedures and must has completed training on it prior to being on a recruitment panel.

Staff must ensure that any changes to their personal circumstances in relation to their DBS are discussed immediately with their managers. They will also be asked whether they have any changes to their circumstances in each 1-1/supervision meeting.

17.1 Working with Third Parties

Where third parties work in the service, but are not directly employed by us, we ensure that the correct checks (enhanced DBS) have been carried out by the employing organisation. The third party provider should check their own staff and keep records. A record of each of these staff members DBS check will be kept on the central record.

Students
It is a requirement of the trainer provider to ensure that enhanced DBS disclosure for every student is applied for. DBS's should be checked at the point of starting any placement. Details of the student must be recorded in the central record as with all other staff. We do provide placements for young people under 18, or on school roll.

Volunteers
All volunteers must complete an enhanced DBS check before they can start work with us. They will receive a copy of this policy prior to starting and their induction plan will include safeguarding training/support.

18. Photography and Mobile Phones

- Staff will not use their mobile phones for personal use when delivering the service.

- Specified cameras and mobile phones may be used by staff to photograph, film or record sessions, but parents must provide their signed consent before any photographic or video images are taken of their children.

19. Training

All staff must comply with this schedule of Safeguarding and Child Protection and related training:

- Workers who do not have direct contact with children or their families - Update training every three years.

- Those who work directly with children and families, or who supervise, or advise workers - Need to evidence on an annual basis that they have accessed appropriate training according to their level of role in safeguarding children.

- Designated persons – should access at least one multi-agency training event annually.

Recording of Safeguarding personal development data

- Training attended will be recorded on the Single Central Record by the Project coordinator.

- Individuals and Clinical Leads hold the responsibility to maintain appropriate level of training/development.

- Managers must keep evidence of training in personnel files.

20. Safeguarding Practices

• When meeting families in person workers must adhere to safe working practices, as laid out in the Lone Working Risk Assessment. Workers must inform managers if they are meeting families face to face informing them of the following:

- The expected start and finish time of the appointment
- The location of the appointment
- Who they will be seeing
- How they can be contacted

Whilst considering the privacy of client's workers should also consider their safety, paying attention to the layout of rooms and whether they can be seen from outside the space. **At no point should anyone be left with a child.**

Workers are not permitted to accept private work, such as babysitting, for any families accessing services.
BrightPIP workers do not provide intimate care for children e.g bottle feeding, settle children to sleep or nappy changing.

20.2 Accident/Incident Recording

All accidents/incidents which happen on site should be recorded following the procedure as set out in the ***Family Hub and Nursery Safeguarding Policy and Procedures.***

21. Implementing the Policy

- The Designated Person and their Deputy will take responsibility for ensuring the policy is implemented and reviewing it annually.
- On the first day, all new workers, volunteers or trustees will be made aware of this policy and given the name of the designated person.
- Formal training will follow as soon as possible after this. Workers will be asked to sign their induction checklist to say they have read and understand the safeguarding policy. Workers will be involved in evaluating and reviewing the policy and made aware of any changes.
- Volunteers will receive induction into the safeguarding policy and procedures when they begin volunteering and will receive appropriate training.
- The policy will be made known to parents through a statement in the Client Therapy Contract and on the website. The full policy is available if requested.
- Safeguarding will be a standing item on the agenda at team and trustee meetings.

Signed off by Dr Laura Williams (23/02/2026)	
Reviewed and approved on behalf of BrightPIP board of Trustees by Dr Kerry Taylor (23/02/26)	

21. Confirmation of Reading

BrightPIP Safeguarding Policy
February 2025

For the BrightPIP Master Copy

The following staff have read and confirmed they have understood this policy

Name	Role	Date
Dr. Laura Williams	Clinical Psychologist	23/2/26
Dr. Bea Birtwell	Clinical Psychologist, Deputy Clinical Lead	23/2/26
Dr. Isobel Gammer	Clinical Psychologist	
Dr. Victoria Thornton	Clinical Psychologist	
Rosie Smith	Counselling Psychologist and Psychotherapist	
Francesca Rutherford	Psychotherapist	
Helen Jones	Infant Mental Health Worker	
Imogen		
Lara		

Appendices

Appendix	
1.	BHCC Pathway – Child Arrives at Nursery, Family Hub or Crèche with a Mark or Bruise (updated November 2024)
2.	BHCC Family Hub and Nurseries Accident Reporting Form (updated November 2024)
3.	Pink Safeguarding Concern Form BrightPIP and Nurseries (updated November 2024)
4.	BHCC Referral Flow Chart Bruises (updated May 2021)
5.	BHCC Pathway – Child Injures Themselves at Nursery, Family Hub or Crèche
6.	BHCC Family Hub and Nurseries Incident Log
7.	BrightPIP Staff Suitability Declaration

The Appendices Follow
(Available on in-house version)