RG-PK01 PAIRS Safeguarding Policy		Effective date: 30 July 2026	PAIRS Kent — Parent And Infant Relationship Service
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PAIRS Kent - Safeguarding Policy

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SECTION 1 – The Policy

1.1 Purpose

Real Group Ltd and all subsidiary enterprises believe all children and young people have the right to be protected from harm and to feel safe in all areas of their lives. We recognise the responsibilities and duty placed upon staff working for and on behalf of Real Group to undertake all work related activities with awareness of safeguarding, and the importance of promoting the welfare of every child, young person and vulnerable adult that we work with.

This Safeguarding and Child Protection policy sets out how Real Group Ltd and the Parent and Infant Relationship Service (PAIRS) project team will meet our statutory duties and pastoral responsibilities to safeguard all children, young people, and adults at risk who come into contact with our services. Because this project is funded by Kent County Council (KCC), all practitioners must follow the procedures laid out by the **Kent Safeguarding Children Multi-Agency Partnership (KSCMP)** and the **Kent & Medway Safeguarding Adults Board (KMSAB)**. Kent Safeguarding Children Multi-Agency Partnership (KSCMP) is the governing partnership that sets policies, guidance, and standards for protecting children across Kent. It is a statutory strategic partnership composed of key agencies across Kent, primarily Kent County Council, Kent Police, and local NHS Integrated Care Boards.

1.2 Aims

- To protect all children and vulnerable adults who receive Real Group PAIRS services from harm.
- To ensure staff have a clear understanding of Kent-specific child and adult protection procedures and thresholds through clarifying the overarching principles that guide our approach to safeguarding and child protection.
- To promote safe practice, challenge poor and unsafe practice, and promote a culture of professional curiosity.
- To develop effective multi-agency working relationships with KCC, local Family Hubs, and healthcare partners.

- To emphasise the need for good communication processes in matters relating to child protection and safeguarding, particularly in relation to communication with parents when there are safeguarding concerns
- To outline a structured procedure within the company that will be followed by all staff in cases of suspected abuse.
- To promote safe practice and challenge poor / unsafe practice.

1.3 Relevant legislation/guidance that informs the policy

1.3.1 Real Group takes seriously its responsibility to protect and safeguard children. This policy has been drawn up on the basis of legislation, policy and guidance that seeks to protect children, as outlined in the related documents listed in section 16 of this policy.

1.3.2 In addition to child protection legislation, this policy acknowledges the legal framework for safeguarding adults. For individuals aged 16 and over, Real Group demonstrates that consideration of the Mental Capacity Act (MCA) 2005 is an integral part of relevant decision-making and safeguarding processes, where applicable.

1.3.3 This policy is drawn up on the basis of legislation and guidance that seeks to protect children and adults at risk, including:

- The Children Act 1989 and 2004.
- Working Together to Safeguard Children 2026.
- The Care Act 2014 (for adults at risk).
- Kent Safeguarding Children Multi-agency Partnership (KSCMP) and KMSAB local multi-agency procedures (links in section 2.11)

1.4 Definitions

1.4.1 A child / an infant

A child is defined as anyone who has not yet reached their 18th birthday, including unborn children from the time of conception. Within this definition of a child, an ‘infant’ will be the specific term used to describe a child aged between conception to 2 years of age.

1.4.2 Safeguarding means

a. proactively promoting child wellbeing and protecting children from maltreatment. It is not just about parental capacity. *Child Protection* is part of safeguarding. Child protection involves noticing and protecting children at risk of, or experiencing, significant harm.
b. preventing impairment of children’s mental and physical health or development.

c. ensuring that children grow up in circumstances consistent with the provision of safe and effective care.
d. taking action to enable all children to have the best outcomes.
e. proactively supporting vulnerable adults to protect their right to live in safety, free from abuse, neglect, and exploitation. It involves proactive measures to prevent harm and reactive steps to stop abuse, focusing on empowering individuals with care and support needs while promoting their health, well-being, and, where possible, their autonomy and agency.

1.4.3 Abuse

(a) Abuse is a form of maltreatment of a child. Somebody may abuse or neglect an infant by inflicting harm or by failing to act to prevent harm. Infants may be abused in a family or in an institutional or community setting, by those known or unknown to them. It is recognised that technology may be used to facilitate abuse using online software with others, who may therefore not be physically present. Infants may be abused by an adult or by another child.
(b) Abuse of a vulnerable adult is the misuse of power, trust, or authority over an individual (18+) who has a physical/mental disability or impairment, or requires assistance with basic needs, causing them harm, distress, or violation of rights. It can be a single incident or a pattern of behaviour, including physical, sexual, psychological, financial, or discriminatory actions, as well as neglect. For adults at risk, abuse also encompasses domestic abuse, modern slavery, financial abuse, and self-neglect.

1.4.4 The indicators and definitions of types of abuse and neglect

The types of abuse and neglect are broadly defined below:

(a) **Physical abuse:** a form of abuse which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child. Physical harm to an unborn child may occur due to maternal substance misuse whilst pregnant. Within the perinatal period, physical abuse can occur due to loss of control related to extreme parental stress or frustration, untreated parental mental ill-health, or the presence of domestic abuse.
(b) **Emotional abuse**: the persistent emotional maltreatment of an infant such as to cause severe and adverse effects on the child's emotional development. It may involve behaviours by the adult that convey to a child that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person, such as ignoring communications or care needs. It may include not giving the

child opportunities to express their feelings or discomfort, through being silenced. It may feature inappropriate age or developmental expectations being imposed on infants. These may include interactions that are beyond a child's developmental capability as well as overprotection and limitation of exploration and learning, or preventing the child from participating in normal social interaction. It may involve removal of eye contact, care or nurturing behaviours from the infant as a form of punishment. It may involve actions that cause an infant to feel frightened or in danger. Some level of emotional abuse is involved in all types of maltreatment of an infant, although it may occur alone. Emotional abuse in adults is a pattern of non-physical behaviours such as intimidation, control, humiliation, and isolation designed to undermine a person's self-worth, identity, and mental health. It is often a tactic of power and control in relationships. Within the perinatal period, emotional abuse can occur due to severe, untreated parental mental ill-health, a pervasive emotional unavailability, jealousy between parents or where the infant is persistently rejected or subjected to hostile, critical interactions.

(c) **Sexual abuse:** involves forcing an infant to take part in sexual activities for the gratification of others. The activities may involve physical contact, including assault by penetration (for example rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. Sexual abuse can take place online, and technology can be used to facilitate abuse. Sexual abuse is not solely perpetrated by adult males, women can also commit acts of sexual abuse, as can other children. Female Genital Mutilation (FGM) is illegal and a form of child abuse. Staff in regulated professions have a **mandatory duty** to report 'known' cases of FGM in girls under 18 directly to Kent Police via 101, and must discuss this with the DSL.

(d) **Neglect:** the persistent failure to meet an infant's basic physical and/or psychological needs, likely to result in the serious impairment of the infant's health or development. Neglect may occur from conception and during pregnancy, for example, 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 an infant 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. Within the perinatal period, severe neglect can also occur due to maternal substance abuse or severe mental ill-health.

1.4.5 The wider context of abuse

There also needs to be consideration of wider contextual and specific forms of abuse, including but not limited to:

- Child Sexual Exploitation (CSE)
- Female Genital Mutilation (FGM)
- Anti-social or violent behaviour by parents
- Older child on infant abuse
- Adult safeguarding issues for parents
- Child trafficking
- Radicalisation or extreme parental ideologies in the context of culture, faith or extreme beliefs impacting on infant care.

Abuse and neglect are forms of maltreatment. Somebody may abuse an infant by inflicting harm or failing to act to prevent harm. Staff must be alert to all categories of abuse and neglect.

1.5 Roles and responsibilities

Real Group has designated leads for all child protection and safeguarding matters within the PAIRS team:

Designated Safeguarding Lead (DSL) for PAIRS team: Dr Siobhan Mellor (Tel: 01273 35 80 80)

Deputy DSL for PAIRS team: Dr Jo Wood (Tel: 020 7183 3318)

Responsibilities of Real Group: To ensure there are adequate, proportionate, and dedicated resources to meet safeguarding responsibilities. All staff have clear accountability for safeguarding responsibilities and are directly accountable to the organisation's named safeguarding persons (DSL/Deputy DSL).

The procedures contained within this policy will be monitored through supervision and line management, and the policy will be reviewed annually.

Responsibilities of the DSL include:

- Accountability for the safeguarding processes being followed in line with policy.
- Being alert and recognising any infant or vulnerable adult safeguarding issues
- Raising and sharing concerns they may have about an infant or vulnerable adult
- Recognising when it is appropriate to make a referral to social care and contacting them when necessary
- Where necessary, contributing to any plans and decisions regarding an infant
- Understanding the importance of safer recruitment
- Participating in regular training and ensuring that their knowledge is up to date
- Ensuring other staff members are trained adequately in safeguarding procedures and follow correct practices
- Challenging poor safeguarding practice in the workplace

- Maintaining accurate and secure records.

Responsibilities of the Deputy DSL: The Deputy DSL holds the same responsibilities and is an additional point of contact when the DSL has not been able to be the first point of contact, as well as undertaking the lead in deputised duties such as; policy updates, safer recruitment, monitoring and sourcing of staff training. The DSL and Deputy DSL work as a team.

Responsibilities of all employed staff and freelancers: To be alert to the signs of abuse and neglect; to report serious concerns on the same day to the DSL; to challenge poor practice; and to ensure robust, contemporaneous record-keeping on the Case Management System. All staff have a statutory duty to keep children safe and promote their welfare.

Responsibilities of the PAIRS Clinical Leads and Operations Manager: The PAIRS Clinical Leads and Operations Manager, supported by the DSL, are responsible for ensuring this policy and procedures are implemented and escalating issues to the DSL.

1.6 Principle of Parent Involvement

Real Group's PAIRS team are committed to building trusting relationships with parents/carers. Any safeguarding concerns will be discussed openly with parents prior to a referral being made, unless doing so would place the infant at increased risk of significant harm or compromise a police investigation.

SECTION 2 – Safeguarding Procedures

2.1 Procedure for making decisions about level of need

The prime concern of PAIRS Kent staff at all times must be the welfare and safety of the infant and/or vulnerable adult. Where there is a conflict between the needs of the infant and the parent/carer, the interests of the infant must be paramount (Children Act 1989, 2004).

2.1.1 Parental Mental Health concerns

Because PAIRS specialises in perinatal mental health, clinicians must maintain a "Think Family" approach, understanding that severe mental ill-health can profoundly impact parenting capacity and infant safety. The "Think Family" approach is a safeguarding strategy that shifts the focus from an individual (either the infant or the adult) to the entire household since an infant's safety is inseparable from the well-being and behaviour of their caregivers. Clinicians must ensure they do not suffer from "safeguarding drift" by over-identifying with the parent at the expense of seeing risks to the infant; mandatory clinical supervision is in place to challenge clinicians to "think baby". A referral to KCC Integrated Children's Services must be made if there are high-risk indicators, such as psychotic delusions targeting the

infant, persistent rejection of the infant, severe emotional unavailability/neglect, or active suicide plans.

2.1.2 'Did Not Attend' (DNA) / 'Was Not Brought' (WNB) concerns

An infant relying on a caregiver to attend an appointment is recorded as 'Was Not Brought' (WNB). DNA/WNBs will be monitored as this can be a precursor to serious child abuse.

- PAIRS staff will track DNA/WNBs via the PAIRS Kent case management system.
- If vulnerabilities are identified and a family misses three appointments, staff must consult the DSL to determine if a safeguarding referral to KCC is necessary. If the infant is under a Child Protection Plan, all DNA/WNBs must be reported to their social worker immediately.

2.1.3 Fabricated and induced illness (FII) concerns

FII occurs when a parent or carer exaggerates or deliberately causes symptoms of illness in the infant. If PAIRS staff suspect FII, they must discuss it immediately with the DSL and consider referral to KCC Integrated Children's Services.

2.1.4 Domestic abuse and parental conflict concerns

Pregnancy and the perinatal period are high-risk times for domestic abuse; 30% of domestic abuse begins during pregnancy. PAIRS staff should take a proactive approach, completing the DASH risk toolkit where appropriate. Never ask about domestic abuse when a partner or family member is present. Referrals should be made to local Kent services.

2.1.5 Low-level concerns and promoting safer culture

Ongoing or low-level concerns about a family's welfare must be discussed in clinical supervision and documented in the clinical case notes. If a pattern emerges, the DSL will review and escalate the concern as necessary. We recognise that abuse may occur within all cultures, religions and social groupings and that we need to be sensitive to the many differing factors that need to be taken into account in respect of these, whilst never allowing them to excuse behaviour that may be harmful, detrimental or illegal with regard to those groups covered by this policy.

PAIRS staff will refer to the support level guidance when considering levels of need: KSCMP Support Level Guidance Further information is also available at Kent Safeguarding Children Multi-Agency Partnership (KSCMP).

2.2 Procedure for managing safeguarding concerns

2.2.1 For urgent safeguarding concerns

- If there is an immediate risk of harm, or if an infant or adult requires urgent medical attention, staff must contact **Kent Police on 999**.
- For urgent safeguarding referrals where an infant is suffering or likely to suffer significant harm, complete a request for support form via the Kent Integrated Children's Services portal. This is a secure web-based IT portal maintained by Kent County Council (KCC). It serves as the digital "front door" for professionals (e.g., teachers, doctors, social workers) to submit formal requests for support for children needing Level 3 (intensive) or Level 4 (specialist/child protection) assistance, and for Local Authority Designated Officer (LADO) referrals regarding allegations against staff: https://www.kscmp.org.uk/guidance/worried-about-a-child
- For out-of-hours safeguarding referrals (from 5pm – 8.30am weekdays, weekends, bank holidays) contact the Out of Hours Service on **03000 41 91 91**. If an urgent report has been made to KCC, then the PAIRS clinician must: (a) inform the PAIRS/Real Group DSL/DDSL immediately (triggering a record of this activity being added to the PAIRS Safeguarding log) and (b) complete the the PAIRS/Real Group safeguarding concerns process within the digital case management system.

2.2.2 For all other safeguarding concerns

- Any concerns that are not immediately urgent should, in the first instance, be discussed with the Designated Safeguarding Lead (DSL) or Deputy Designated Safeguarding Officer (DDSL) who will refer to the KSCMP Support Level Guidance when considering levels of need.
- Where concerns are regarded as needing referral to Kent Integrated Children's Services, it will be agreed between the PAIRS practitioner and the DSL/DDSL who will make a referral via the KCC online portal (see section 2.3 in policy) and a record of the discussion and actions agreed will be made in the Kent Pairs Safeguarding Log by the DSL/DDSL and the PAIRS digital case management system.
- For a consultation about levels of need, the DSL/DDSL will contact the Kent County Council Integrated Children's Services (Front Door) on **03000 41 11 11** or find more information at: https://www.kscmp.org.uk/guidance/kent-support-levels-guidance.

2.3 Making a referral to Kent Integrated Children's Services

2.3.1 Request for support

Where intervention is required, the DSL (or the practitioner, supported by the DSL) will make a referral via the **KCC online portal** or by calling the **Integrated Children's Services on**

03000 411111. Referrers must provide comprehensive details, including the nature of the allegation, household details, and distinguish clearly between fact and opinion. Consent from the parent should be sought unless doing so would place the infant at increased risk of harm.

Where abuse or neglect is suspected, statutory intervention under the Children Act 1989 (Section 17 or 47) is required. Safeguarding concerns can be reported online through the Kent Integrated Children's Services Portal or by emailing: Frontdoor@kent.gov.uk

2.3.2 Front Door Service Consultation

KCC's Integrated Children's Services offer a consultation with a Social Worker at the Front Door. These are 'no named' consultations for professionals who believe an infant may be in need of support but are unclear whether a Request for Support (above) should be submitted. This service is available by calling 03000 41 11 11 between 10am - 4pm Monday to Friday (excluding Bank Holidays). Calls will initially be taken by a member of the contact centre team who will ask specific questions to determine where to direct the call. A consultation should not be made if an infant is suffering or likely to suffer significant harm, and instead an urgent referral should be initiated.

2.3.3 Universal / Early Help

For concerns not meeting the threshold of significant harm, signposting or a referral to Kent Family Hubs can be made for additional support. You can get in touch with the Early Help District team by email or phone. A district conversation is a method for professionals and families to understand what support is available within the Family Hub core offer, the network, including the digital offer. Family Hub staff will respond within five working days from the point of request and will offer advice to the professional or family as to the best level and type of support available.

2.3.4 Reporting Female Genital Mutilation (FGM) to Kent Police

FGM is illegal and a form of child abuse. Staff in regulated professions have a **mandatory duty** to report 'known' cases of FGM in girls under 18 directly to Kent Police via 101, and must notify the DSL.

2.4 Escalation process for professional agency disagreements

To ensure timely, respectful, and child-focused resolution of concerns in the event of professional disagreements about safeguarding risks, staff should refer to the Kent Safeguarding Children Escalation Procedure (March 2026) [accessed 28.7.26].

https://www.kscmp.org.uk/__data/assets/pdf_file/0007/233737/Kent-Safeguarding-Children-Escalation-Procedure-March-2026.pdf [accessed 30.3.26]. This procedure is separate from the escalation of response to individual children and families as a result of increasing risk.

2.5 Prevent Duty – safeguarding families from terrorism

Under the Counter-Terrorism and Security Act 2015, all staff have a statutory duty to prevent people from being drawn into terrorism. If a practitioner suspects a risk to infants from parental radicalisation, they must inform the DSL and refer to the Kent Prevent Team via: https://www.kent.gov.uk/about-the-council/strategies-and-policies/service-specific-policies/community-safety-and-crime-policies/counter-terrorism-strategy-contest/report-radicalisation-or-extremism-prevent [accessed 30.3.26]

2.6 Recognising disclosures in pre-verbal infants.

While infants under the age of two lack the linguistic capacity to make a formal verbal disclosure, they may communicate their lived experience through physiological and behavioural signals. In this service, a "disclosure" is defined as any persistent or acute change in an infant's presentation that suggests their physical or emotional safety is compromised. Practitioners must remain 'professionally curious' and document observations that may constitute a non-verbal infant communication of harm or neglect, whilst also mindful of these same behaviours potentially being part of attachment / relationship difficulties between the parent and infant. These include, but are not limited to:

- **Attachment patterns:** Extreme 'frozen watchfulness', lack of eye contact, or an absence of seeking comfort from a primary caregiver when distressed.
- **Developmental regression:** A sudden loss of previously acquired milestones (e.g., stopping babbling, loss of motor skills).
- **Physiological indicators:** Inconsolable crying that does not respond to usual soothing, or conversely, a 'passive' or overly quiet infant who has 'given up' on signaling their needs.
- **Physical markers:** Unexplained bruising (particularly in non-mobile infants), poor hygiene, or persistent untreated rashes/infections.
- **Relational cues:** Intense flinching or fearful reactions to sudden movements or specific tones of voice from a caregiver.

The "Think Family" Context for Disclosures is required when a parent or caregiver discloses information about their own circumstances that directly impacts the infant's safety (e.g., domestic abuse, substance misuse, or suicidal ideation). Since infants are seen within the context of their primary relationships, a disclosure may also be **indirect** through a parent or caregiver disclosing information.

When an infant "discloses" through behaviour or other physical signs:

- **Be descriptive, not evaluative:** Record exactly what was seen (e.g., *"Infant turned head away and stiffened body when parent attempted to scoop them up"*) rather than interpretations (e.g., *"Infant doesn't like the mother"*).
- **Immediate Action:** If a practitioner observes a physical injury on a non-mobile infant (a "still" baby), this must be reported immediately to the DSL, as the risk of significant harm is statistically highest in this age group.

2.7 Managing disclosures from adults

If an adult chooses to share information about abuse they have experienced or makes a disclosure about their actions towards a child that may be abusive:

(a) Real Group staff should aim to:

- **Be calm and remain focussed**: Appearing calm and relaxed will encourage the child or adult to trust you.
- **Reassure the person**: let them know they were right to tell you, tell them that they are not to blame and thank them for being brave.
- **Listen well and don't rush**: give the child or adult the chance to speak, don't rush them and listen carefully to everything they say. This is vital as you will need to record their disclosure later on if not possible at the time.

(b) Real Group staff should **avoid**:

- **Making promises or agreeing to keep information secret**. Do not promise that you will keep their disclosure to yourself. Do not make promises you will not be able to keep. Say that you will get help from someone else as it is your responsibility to keep them safe.
- **Making assumptions** about what the person is experiencing, or implying disbelief.
- **Asking leading questions** and 'putting words into their mouth'. Listen well and don't rush. This is vital as you will need to record their disclosure later on if not possible at the time.
- **Using negative language** since describing the potential abuser using negative words can reduce trust in your professional support because the abuser may be someone the person disclosing information loves.
- **Posing many questions in an interview approach.** It is the responsibility of social care or the police to find out more information.

2.7 Managing allegations about staff

Any safeguarding allegations (or potential allegations) about a member of Real Group staff, should be passed straight to the Real Group DSL and / or Real Group Head of People and / or Directors. This procedure includes managing situations where the actions of an individual

in their personal life may indicate that their behaviour could be a risk of harm to infants or vulnerable adults they work with (transferable risk).
If an allegation is made about a Real Group employee, freelancer, or volunteer, it must be reported to the DSL immediately. The DSL will report the matter to the **Local Authority Designated Officer (LADO)** in Kent. If the concern involves the DSL, it must be reported to the Managing Director, Dr Mark Turner, who will contact the LADO.

2.8 Good Practice regarding record keeping

All safeguarding concerns must be recorded as soon as possible after the event. Records must be clear, factual, objective, and stored securely on the PAIRS digital Case Management System in compliance with GDPR.

2.9 Staff support for effective safeguarding

2.9.1 Safer Recruitment

Real Group enforces rigorous Safer Recruitment procedures for the PAIRS workforce. All employed and freelance staff coming into direct contact with infants, will be subject to safer recruitment procedures appropriate for the role, including an Enhanced DBS with barred list check. Staff in roles which grant access to the data generated by other staff working in direct contact with infants and vulnerable adults will be required to have a basic DBS check.

Staff working in roles involving direct work with infants and adult clients receiving psychological therapies will follow statutory requirements for safer recruitment:

(a) During the interview, the candidate's understanding of safeguarding issues and procedures, and their motivation for working with infants and young people, will be tested in an interview.
(b) Any gaps in employment will be questioned and explored.
(c) References will always be taken up and the most recent employer will be contacted by phone for a 'safer recruitment' discussion about the candidate's suitability for working with infants and vulnerable adults.
(d) Qualifications will be checked, including registration checks for Educational Psychologists (Health Care Professions Council - HCPC) and Psychotherapists (Association of Child Psychotherapists - ACP).
(e) It is the responsibility of each PAIRS clinical team member, and also the Real Group Head of People, to ensure that personal DBS checks are carried out in line with RG39 Real Group DBS policy.
(f) Online Searches / social media check will be undertaken.
(g) Enhanced DBS and Barred List Check. It is our policy that an Enhanced DBS with barred list check is required for all staff coming into direct contact with infants and

vulnerable adults. The DSL must ensure that an accurate, up-to-date DBS database is maintained. As PAIRS clinical team members are unable to practise without a valid and up-to-date DBS. Real Group will fund such checks for directly employed staff as a legitimate business expense.

(h) Overseas applicants and those who have worked abroad, will be checked following Home Office guidance. A letter of professional standing will be obtained from the professional regulating authority where appropriate. Advice about which regulatory or professional body should be contacted is available from the National Recognition Information Centre for the United Kingdom, UK NARIC.

2.9.2 Training and supervision

a. Real Group will ensure that all staff undertake, and are given the opportunity to attend or access, face to face or on-line, role appropriate, training in Child Protection and wider safeguarding issues, in order to ensure that they have the necessary skills and knowledge to deal appropriately with any issues that may arise in their particular roles. Safeguarding training is mandatory for all PAIRS personnel. Level 1/2 Safeguarding training must be completed during the mobilisation induction period. The DSL and Deputy DSL must attend regular advanced multi-agency training.

b. During induction, all new workers and freelancers will be made aware of this policy and must sign a declaration confirming they have read and understood its contents.

c. Safeguarding is a standing item in PAIRS team meetings, including discussion of casework, policy and internal systems.

d. PAIRS team members delivering clinical work will also be provided with regular supervision from a suitably qualified lead clinician and will also have a clear line management relationship within Real Group. Supervision records should be kept in line with general BPS or other relevant professional body good practice guidance.

e. All safeguarding concerns should be discussed in supervision, as well as any issues of a more general nature that the psychologist has encountered in their work relating to child protection or safeguarding.

f. Whenever a Real Group Clinical team member (whether directly employed or working as a freelance team member) has safeguarding questions or concerns, they must seek supervision as soon as possible after the event (and within 2 working days), with a note of the discussion recorded in the Real Group Safeguarding Log (see appendix 1 for information about the information held in the safeguarding log).

g. The Real Group Safeguarding Log will be filled in by the DSL / DDSL for all situations when a PAIRS clinical team member has referred a safeguarding concern. Cases will only be closed in the log when the concern has been followed up with other

professionals and there is evidence that actions relating to the safeguarding concerns are underway from other agencies. A record that the safeguarding concern has been communicated to other agencies will be maintained for the time that data records for the PAIRS service are held.

h. The DSL will keep accurate and up-to-date records of Safeguarding training undertaken by each member of clinical staff.

2.9.3 Wellbeing

Real Group recognises that working with traumatised infants and complex families carries a risk of vicarious trauma. Real Group mandates monthly clinical supervision and reflective practice groups for all PAIRS clinicians to safely process the emotional impact of the work. Additional support is available via Sanctus coaching and the Simply Health scheme.

2.9.4 Photography, Mobile Phones, and Video Interventions

Staff will not use personal mobile phones during service delivery. As the PAIRS offers Video Interaction Guidance (VIG) as a Level 2 intervention, only specific, designated Real Group devices/iPads may be used to record sessions. **Parents must provide signed consent** before any photographic or video images are taken of their infants. Further information about how data from the VIG interventions is managed, is available in the PAIRS Privacy Notice.

2.9.5 Mitigating risk

Real Group staff working in one-to-one situations with infants and vulnerable adults in quiet, private spaces in Family Hubs, therapeutic settings and homes may be vulnerable to allegations made against them. Real Group staff should recognise this possibility and plan and conduct sessions / meetings accordingly. Every attempt should be made to ensure the safety and security needs of both staff and clients are met.

Clinicians conducting home visits or community appointments will adhere to Real Group's RG92 Lone Working Policy which involves staff having contact with another team member when lone working. When working 1:1, staff must avoid remote or secluded areas to ensure safety and transparency. Real Group staff do not provide intimate care (e.g., nappy changing or bottle feeding) for infants in the service.

Methods to mitigate risk include: carefully considering the needs and circumstances of the infant and vulnerable adult involved and weighing this against risk; considering whether another member of PAIRS staff should be present or close by for the work; always reporting any situation where a parent or infant becomes dysregulated / upset to a senior colleague as soon as is practical.

Extra caution may be required where it is known that safeguarding concerns have previously been reported about an infant or vulnerable adults, since staff may be more vulnerable to

allegations of abuse. It is recognised that some infants or vulnerable adults may initiate inappropriate physical contact. Should this occur, Real Group staff should ensure personal physical boundaries are maintained, and if necessary remove themselves from the situation as soon as is feasible and alert other members of staff or other responsible adults in the vicinity. The general culture of 'no / minimal touch' should be adopted in all interactions with infants and vulnerable adults.

2.9.6 Whistleblowing

Real Group maintains a clear 'Whistleblowing' procedure. All Real Group staff have a duty to raise legitimate concerns about the conduct of colleagues in the company or other settings, especially in relation to poor or unsafe practice, and should expect that managers will deal with these issues sensitively, appropriately and in line with the process set out in section 2.7 ‘Managing allegations about staff’. Staff are encouraged and supported to raise safeguarding concerns against colleagues or managers if they believe practice is unsafe or unethical. These procedures are clearly understood and must be followed without fear of reprisal.

2.10 Safeguarding issues within supervision

2.10.1 Managing risk during supervision

If a supervisor identifies a safeguarding risk during a supervision session, the following protocol must be observed:

- **Consultation and agreement:** Supervisors must transparently explore any risk concerns with the supervisee(s) during the session. The goal is to reach a mutual agreement on the necessary next steps and who will undertake them.
- **Documentation and notification:** When a safeguarding risk has been identified, the supervisor must record the specific details discussed with the supervisee(s) and the agreed action plan. All discussions and decisions regarding the risk must be clearly recorded in the notes and shared with the Real Group DSL who will record this in the Safeguarding log.
- **Escalation:** If it is agreed between the supervisor and supervisee that the risk requires escalation to the supervisee’s service manager, this must be recorded in the action plan with allocated named responsibilities and agreed timescales for each action.
- **Verification of action:** The supervisor will require the supervisee to confirm via email once the agreed actions and communications with their manager have been completed. This email must be copied to the Real Group DSL. The supervisor and Real Group DSL will ensure that all safeguarding and supervision records are updated.

- **Non-Compliance:** If the supervisor does not receive assurance that the agreed actions have been taken within the set timeframe, they must contact the Local Authority (LA) safeguarding manager directly, copying in the Real Group DSL.
- **Information Sharing:** Personal information regarding supervisees is only shared with third parties when there is a serious risk of harm to themselves or others. Such decisions are only made following careful consideration and consultation with DSLs.

2.10.2 Managing Mental Health and risk crises during supervision

In the event of an immediate threat to a supervisee's safety due to mental health difficulties or another risk to physical well-being:

- **Online Sessions:** The supervisor should stay on the call with the supervisee while a safety plan is initiated to locate support in the vicinity of the supervisee and that plan is implemented
- **In-person sessions where there is risk of self-harm/suicide):** If it is unsafe for the supervisee to leave the premises, the supervisor must:
    - Contact the **DSL** to co-assess the situation and determine a safe path forward.
    - Identify and contact a member of the individual's employer / immediate support system to help escort them to a place of safety.
    - If no support person is available, arrange for the individual to be safely accompanied to the nearest A&E department.
    - File a detailed incident report and notify the PAIRS lead.

2.10.3 Fitness to attend supervision

Supervisors have a duty to maintain a safe and professional environment.

- **Substance use or general fitness to practice concerns:** If a supervisee appears under the influence of alcohol/drugs or is otherwise unfit for the session (online or in-person), the supervisor must terminate the session immediately with reasons given. This must be reported as an incident to the DSL and the PAIRS lead, with written description of the behaviours observed completed.
- **Acute medical or psychiatric crisis (online):** If a supervisee displays signs of physical illness or an active psychiatric/psychotic episode during a remote session, the supervisor must remain with the supervisee whilst also contacting professionals in the supervisees place of work for assistance or assess if an emergency service intervention (phoning 999) is required.
- **Acute Crisis (In-Person):**
    - The supervisor must immediately contact the DSL, DDSL and / or PAIRS Clinical lead to manage the situation and discuss an urgent transfer to A&E.

- Seek assistance from a senior staff member within the supervisee's organisation.
- If necessary, call **999** for an ambulance. When reporting a mental health crisis to emergency services, provide relevant context leading up to the incident, the supervisee's basic details, and whether next of kin have been informed.
- Ensure the incident is recorded by the DSL and the PAIRS Lead is notified as soon as possible.

2.11 Review

The procedures contained within this policy will be monitored through:

- supervision / line management of each clinical staff member working directly with infants and young people.
- monthly review of the safeguarding log by both the DSL and DDSL. Discussions are recorded, actions are logged and reviewed to ensure they are carried out in a timely way. Where deemed necessary, Real Group Executive Board members are made aware of safeguarding issues and risks affecting the organisation.
- Annual review of this policy by both the DSL and DDSL.

Real Group Executive Board members demonstrate a commitment to safeguarding and hold the organisation and staff to account regarding these responsibilities.

2.12 Related Documents

- Kent Safeguarding Children multiagency Partnership
  https://www.kscmp.org.uk/about-kscmp
- Kent Safeguarding Children Escalation Procedure March 2026
  https://www.kscmp.org.uk/__data/assets/pdf_file/0007/233737/Kent-Safeguarding-Children-Escalation-Procedure-March-2026.pdf
- Kent and Medway Safeguarding Children Partnership Procedures Manual
  https://kentandmedway.trixonline.co.uk/
- Early Help District team by email or phone
  https://www.kelsi.org.uk/special-education-needs/integrated-childrens-services/early-help-contacts
- Support Level Guidance
  https://www.kscmp.org.uk/__data/assets/pdf_file/0007/238318/Support-level-guidance.pdf

Real Group policies

- RG88 Whistleblowing policy
- IP16 Customer Complaints Handling Process
- RG39 DBS Policy
- RG70 Training / Workplace training record procedure

2.13 Appendices

Appendix 1: Real Group Safeguarding Log - data collected.

1. Reference Number;
2. Date of incident;
3. Category of Abuse;
4. Short narrative of what took place;
5. Name/initials of person reporting the concern;
6. Action taken;
7. Any referrals made to outside agencies such as LADO, police, social services;
8. Outcomes;
9. Case open or closed.