



ELITE: THE KINGDOM ORGANIZATION

REHABILITATION CENTER

CHILD PROTECTION & SAFEGUARDING POLICY

Internationally aligned | Disability-inclusive | Sindh and Pakistan compliant

ZERO TOLERANCE: The Organization will not tolerate abuse, neglect, exploitation, grooming, bullying, humiliation, corporal punishment, unsafe restraint, retaliation, concealment, or interference with a safeguarding report.

Policy Owner	President & CEO / Board-approved Safeguarding Governance
Operational Lead	Designated Safeguarding Lead (DSL): _____
Deputy DSL	_____
Version	1.0
Approved By	Executive Committee / Governing Body
Approval Date	_____
Effective Date	_____
Next Review	Within 12 months, after a serious incident, or after legal/regulatory change

House # L-2382, Block 4/2, Metroville III, Gulzar-e-Hijri (Scheme-33), Karachi

WhatsApp: 03208317530 | EliteTheKingdomorganization@gmail.com | www.elitethekingdom.com



Executive Approval and Commitment

Elite: The Kingdom Organization recognizes every child as a rights-holder and accepts a non-delegable duty of care to prevent foreseeable harm arising from its staff, volunteers, consultants, therapists, transporters, visitors, contractors, partners, premises, services, communications, digital systems, fundraising, events, and decisions. Child safety takes priority over reputation, hierarchy, convenience, financial interest, or informal settlement.

This policy is approved by the governing body and applies without exception to the President & CEO, Executive Committee, management, employees, interns, volunteers, board/advisory members, consultants, vendors, drivers, security staff, domestic staff, donors, media personnel, and any person acting for or representing the Organization.

Leaders must model compliance, allocate adequate safeguarding resources, ensure independent handling of conflicts of interest, and never delay or suppress a report. No person - regardless of title, influence, relationship, donor status, or professional standing - is exempt.

President & CEO

**Executive Committee
Representative**

Designated Safeguarding Lead

LEGAL EFFECT: This policy is an internal governance and risk-control instrument. It does not replace Pakistani law, professional licensing, SHCC requirements, police reporting, child-protection referral, insurance, or advice from a Pakistan-qualified lawyer. No consent form or waiver can excuse negligence, abuse, unlawful conduct, or failure to act.



Contents

Part I - Policy Foundation

1. Purpose and Objectives
2. Scope and Application
3. Legal and International Framework
4. Definitions
5. Guiding Principles

Part II - Governance and Prevention

6. Governance and Accountability
7. Safeguarding Risk Management
8. Safer Recruitment and Vetting
9. Code of Conduct
10. Safe Service Delivery and Environment
11. Disability-Inclusive Safeguarding

Part III - Recognizing and Responding

12. Forms and Indicators of Harm
13. Receiving a Disclosure
14. Mandatory Internal Reporting
15. External Referral and Emergency Response
16. Allegations Against Staff or Leaders
17. Case Management, Confidentiality and Records

Part IV - Organizational Assurance

18. Child-Friendly Complaints and Participation
19. Whistleblowing and Non-Retaliation
20. Training and Competency
21. Partners, Contractors and Visitors
22. Monitoring, Audit and Review
23. Breaches and Disciplinary Action

Annexes

- A. Adult Code of Conduct
- B. Reporting and Response Flowchart
- C. Safeguarding Concern / Incident Report
- D. Safer Recruitment Checklist
- E. Program Risk Assessment
- F. Intimate Care Plan
- G. Positive Behaviour Support and Restrictive Intervention Protocol
- H. Missing Child / Elopement Protocol
- I. Media, Photography and Digital Safeguarding
- J. Parent / Guardian Partnership Rules
- K. Child-Friendly Safety Message (English and Urdu)
- L. Staff Declaration
- M. Emergency and Referral Contact Schedule
- N. Research and Legal References



PART I - POLICY FOUNDATION

1. Purpose and Objectives

The purpose of this policy is to create a safe, respectful, accessible, transparent, and accountable rehabilitation environment for children, especially children with developmental, intellectual, physical, sensory, communication, behavioural, psychosocial, or multiple disabilities.

- Prevent harm through safer recruitment, risk assessment, supervision, professional boundaries, accessible reporting, and competent service delivery.
- Identify abuse, neglect, exploitation, grooming, unsafe practice, medical risk, bullying, and organizational misconduct at the earliest possible stage.
- Provide a clear response system that protects the child, preserves evidence, supports fair process, and activates competent authorities without avoidable delay.
- Protect the Organization and its administration through lawful due diligence, accurate documentation, independent review, insurance notification, and continuous improvement - not through concealment or overbroad waivers.
- Ensure children with limited speech, AAC use, sensory differences, high support needs, or behavioural communication can report concerns and be believed.

2. Scope and Application

This policy applies to every child under 18 who is enrolled, assessed, referred, transported, visited, photographed, recorded, supported online, involved in an event, or otherwise affected by the Organization. Where services continue after age 18, adult safeguarding and disability rights requirements also apply; this child policy remains applicable to any service involving minors.

2.1 Persons covered

- Governing body, President & CEO, Executive Committee, advisory members and senior management.
- Therapists, teachers, psychologists, counsellors, doctors, nurses, aides, administrative staff, reception, security, drivers, cleaners, interns and volunteers.
- Consultants, contractors, vendors, transport providers, photographers, donors, media teams, researchers and partner organizations.
- Parents, guardians, authorized pick-up persons and visitors while on Organization premises or activities.

2.2 Settings covered

- The Rehabilitation Center, therapy rooms, classrooms, sensory spaces, play areas, roof/playground, toilets, waiting areas, offices, entrances and parking areas.
- Organization vehicles and third-party transport arranged, approved or promoted by the Organization.
- Home visits, camps, trips, hospitals, community events, outreach, fundraising, media work and online sessions.
- Official and unofficial digital contact connected to Organization work, including WhatsApp, email, social media, CCTV, cloud storage and personal devices used for work.

3. Legal and International Framework

The policy is designed around the four Keeping Children Safe standards - Policy, People, Procedures and Accountability - and a risk-based, survivor-centred approach reflected in UNICEF safeguarding guidance. It also applies disability-inclusive practice consistent with the UN Convention on the Rights of the Child (UNCRC), the UN Convention on the Rights of Persons with Disabilities (CRPD), UNICEF disability-inclusive child-protection resources, and WHO INSPIRE violence-prevention strategies. [1-7]



3.1 Pakistan and Sindh framework

- Constitution of the Islamic Republic of Pakistan, including life, dignity, equality and education protections, as applicable.
- Sindh Child Protection Authority Act, 2011, as amended in 2021, and Sindh Child Protection Authority Rules, 2016. The framework recognizes abuse broadly, supports case management and referral, enables protective action, protects child identity, and addresses missing or abducted children. [8-10]
- Sindh Prohibition of Corporal Punishment Act, 2016. No corporal punishment or humiliating treatment is permitted. [11]
- Sindh Empowerment of Persons with Disabilities Act, 2018 and applicable disability rights rules, regulations and professional standards. [12]
- Sindh Healthcare Commission Act/Ordinance, 2013, licensing regulations and Sindh/Minimum Service Delivery Standards for healthcare establishments. SHCC identifies physiotherapy clinics and other healthcare premises as healthcare establishments requiring registration and licensing. [13-16]
- National Commission on the Rights of Child Act, 2017. [17]
- Zainab Alert, Response and Recovery Act, 2020 and the Ministry of Human Rights AWAZ/ZARRA reporting system for missing and abducted children. [18-20]
- Pakistan Penal Code, Code of Criminal Procedure, Anti-Rape (Investigation and Trial) Act, 2021, Prevention of Electronic Crimes Act, 2016, employment, labour, health, education, evidence and other applicable laws as amended.

HIGHER STANDARD RULE: Where this policy sets a safer standard than the minimum law, personnel must follow the safer standard unless it conflicts with law or a competent authority directs otherwise.

4. Definitions

Term	Meaning
Abuse	Any act or omission causing or risking physical, sexual, emotional or psychological harm, exploitation, neglect, degrading treatment, trafficking, child labour, grooming, online harm, or unlawful punishment.
Child	Any person under 18 years of age.
Child safeguarding	The Organization-wide responsibility to prevent and reduce harm caused by personnel, operations, programmes, partners, premises, communications or decisions, and to respond appropriately when concerns arise.
Child protection concern	Information, observation, disclosure, allegation, pattern, unsafe practice, or incident indicating that a child may be harmed or at risk.
Consent	Informed permission from the legally authorized parent/guardian, subject to law. Consent must be specific, voluntary, understood, documented and capable of withdrawal.
Assent	The child's affirmative agreement expressed verbally, behaviourally, through gesture, sign, AAC or another accessible method. Silence or lack of resistance is not assent.
Designated Safeguarding Lead (DSL)	The trained senior person responsible for receiving reports, risk triage, referral coordination, records, training and policy monitoring.
Grooming	A process of building trust, secrecy, dependency, access or compliance in order to abuse, exploit or cross boundaries with a child, family, staff member or institution.



Term	Meaning
Neglect	Persistent or serious failure to meet a child's basic physical, emotional, medical, educational, supervision or accessibility needs, including failure to act on known risk.
Reasonable suspicion	A concern based on facts, behaviour, disclosure, injury, pattern or professional judgment. Proof is not required to report.
Restrictive intervention	Any physical action that limits a child's movement to prevent imminent serious harm. It is not ordinary clinical positioning, safe guidance, or consensual therapeutic handling.
Survivor-centred / child-centred response	A response prioritizing safety, dignity, wishes, privacy, accessibility, non-discrimination, trauma awareness and best interests while following law.

5. Guiding Principles

- Best interests: the child's safety, dignity, rights, development and recovery are primary considerations.
- Do no harm: services, therapy, publicity, fundraising and investigation must not expose a child to added risk.
- Equal protection: disability, gender, religion, language, ethnicity, socioeconomic status, behaviour, communication method or family background never reduces protection.
- Participation: children are listened to directly and supported to express views in accessible ways.
- Prevention first: risk is designed out of programmes, buildings, staffing, transport and digital communication.
- Need-to-know confidentiality: information is restricted, but secrecy is never promised where safety or law requires sharing.
- Prompt action: reasonable concern is reported; staff do not wait for proof, conduct private investigations, or seek informal permission from alleged offenders.
- Fair process: protective action is taken without prejudging guilt; accused persons receive lawful and impartial process.
- No retaliation: good-faith reporting is protected even when an allegation is not substantiated.
- Accountability and learning: incidents, near misses and complaints lead to documented corrective action.



PART II - GOVERNANCE AND PREVENTION

6. Governance and Accountability

Role	Core accountability
Governing Body / Executive Committee	Approves the policy; appoints an independent safeguarding oversight member; receives quarterly anonymized reports; ensures resources, insurance and external audit; handles allegations involving the President & CEO.
President & CEO	Accountable for implementation, culture, resources and compliance. Must not suppress, privately settle or interfere with reports. Ensures regulator, insurer, legal counsel and authorities are notified when required.
Designated Safeguarding Lead	Receives concerns; secures immediate safety; records and triages; coordinates external referral; protects confidentiality; monitors plans; reports trends; maintains contact mapping and training records.
Deputy DSL	Acts when the DSL is absent or conflicted. Receives allegations involving the DSL.
Clinical / Program Manager	Ensures competent practice, supervision, care plans, risk assessments, staffing, consent/assent, incident review, medical and behaviour protocols.
HR / Administration	Applies safer recruitment, police verification, reference and qualification checks, induction, contracts, disciplinary procedures, visitor control and secure files.
All Personnel	Prevent harm, follow boundaries, report immediately, preserve evidence, cooperate with lawful processes and complete training.
Parents / Guardians	Provide accurate medical, behavioural, custody and safety information; respect policies; use authorized channels; update changes promptly; avoid abusive or threatening conduct.

6.1 Conflict-of-interest escalation

- Concern about the DSL -> report to Deputy DSL and President & CEO.
- Concern about the President & CEO -> report directly to the independent Executive Committee safeguarding member, external legal adviser, and relevant authority; the President & CEO has no control over the case.
- Concern about an Executive Committee member -> report to the Chair/remaining independent members and relevant authority.
- Concern involving relatives, donors, political figures or senior professionals -> use the same process; no privileged treatment.
- Any person may bypass internal channels and contact police, SCPA, MoHR/ZARRA, SHCC or another competent authority where delay, conflict or interference creates risk.

7. Safeguarding Risk Management

Safeguarding risk assessment is mandatory before a new programme, therapy, room, trip, vehicle, digital platform, partnership, publicity activity, building change or service expansion begins. A written assessment identifies the child group, hazards, likelihood, impact, current controls, additional controls, responsible person and review date.

7.1 High-risk situations requiring enhanced controls

- One-to-one therapy, closed rooms, personal care, toileting, changing, feeding and medical procedures.



- Children with limited communication, intellectual disability, seizure risk, elopement, self-injury, aggression, trauma or dependency on adults.
- Transport, home visits, off-site events, overnight activities, roof/play areas, stairs, kitchens, water, electricity and crowded events.
- Photography, video, case stories, social media, livestreams, fundraising and access to personal records.
- New, temporary, unvetted or poorly supervised staff; volunteers and donors seeking direct child contact.
- Allegations, family disputes, custody orders, threats, staff conflict, media interest or law-enforcement involvement.

7.2 Opening and annual safeguarding audit

- ☐ DSL and Deputy DSL appointed in writing with direct access to the governing body.
- ☐ SCPA, police, hospital, ambulance, SHCC, legal adviser and insurer contacts verified and displayed confidentially for staff.
- ☐ SHCC registration/licensing status and relevant professional registrations verified.
- ☐ Building, fire, electrical, accessibility, first-aid, medicine storage, CCTV and emergency evacuation checks completed.
- ☐ All staff vetted, contracted, inducted and trained before unsupervised contact.
- ☐ Child-friendly complaint options available in speech, picture, gesture and AAC-friendly formats.
- ☐ Incident, visitor, transport, medication, restraint, injury, pickup and training registers operational.

8. Safer Recruitment and Vetting

No person may have unsupervised child contact until required checks are complete and documented. Urgency, personal recommendation, volunteer status, donor influence, political connection or seniority does not waive safeguards.

- Child-safeguarding statement and role-specific risk level in every job description and advertisement.
- Identity and CNIC verification; current address and contact details; signed declaration of criminal, disciplinary, safeguarding and employment history.
- Police character verification/background check to the extent available and lawful; repeat checks at a risk-based interval and after material concerns.
- At least two independent references, including the most recent relevant employer, with direct safeguarding questions and identity verification of referees.
- Qualification, experience, licence, registration and membership verification directly from issuing institutions/professional bodies where possible.
- Structured interview with safeguarding scenarios, gaps in employment explored, and risk-based second interview.
- Probation with close supervision, observation and documented performance review.
- Written contract containing code of conduct, reporting duty, confidentiality, digital/media rules, disciplinary consequences and cooperation with investigations.
- No deployment of an employee under investigation for child-related misconduct to another child-facing role without formal risk assessment and legal advice.

REFERENCE RULE: A missing or vague reference is a risk signal, not an administrative inconvenience. HR records the verification method, date, person contacted and outcome.

9. Code of Conduct

Every covered person signs the Code of Conduct in Annex A before child contact. The following rules are mandatory and apply on-site, off-site and online.



9.1 Required conduct

- Treat every child with dignity, patience, respect and age/disability-appropriate communication.
- Explain activities, seek consent and child assent, observe distress signals, and stop or modify non-emergency activity when assent is withdrawn.
- Use clinically necessary touch only, explain it in advance, document it in the care plan, and provide a chaperone or visible setting where risk is higher.
- Maintain professional boundaries; use official communication channels; promptly report boundary crossings by self or others.
- Use positive behaviour support, de-escalation, environmental adjustments and communication support before any protective intervention.
- Protect privacy while maintaining safe visibility and supervision.

9.2 Prohibited conduct

- Hitting, slapping, shaking, pinching, pushing, dragging, hair pulling, painful exercise, forced posture, food deprivation, threats, insults, shouting, ridicule, humiliation or any corporal punishment.
- Sexual contact, sexualized comments, grooming, sharing pornography, asking a child to keep secrets, or unnecessary exposure/touching of private areas.
- Being alone with a child in a locked, concealed or unobservable space; unnecessary transport alone; taking a child home; unauthorized meetings outside services.
- Personal social-media contact, private messaging, disappearing messages, personal gifts, favoritism, financial dealings, asking for personal photos or sharing personal problems with a child.
- Photographing, recording or posting a child on a personal device/account, even with informal parental permission.
- Using restraint or seclusion for punishment, convenience, coercion, compliance, staff shortage or routine behaviour management.
- Concealing, deleting, changing, backdating or pressuring anyone to withdraw a concern or incident record.
- Retaliating against a child, parent, employee, volunteer or witness for reporting in good faith.

10. Safe Service Delivery and Environment

10.1 Supervision and one-to-one work

- Staffing is based on individual risk and support needs, not only room capacity. High-risk children receive a written supervision plan.
- One-to-one sessions occur in scheduled rooms with visibility panels, unlocked doors where clinically and safely appropriate, attendance records, supervisor access and periodic observation.
- Where visibility is limited for privacy or sensory reasons, equivalent controls are documented: door-open protocol, chaperone, CCTV outside the room, timed checks or parent observation.
- No child is left unsupervised in a vehicle, toilet area, stairwell, roof, playground, therapy room or waiting area beyond their assessed independence level.

10.2 Therapeutic touch, positioning and examination

- Touch must be clinically relevant, proportionate, explained and consistent with the therapist's competence and plan.
- Sensitive areas are avoided unless essential to authorized care. Where essential, explicit parental consent, child assent, privacy, chaperoning and detailed documentation are required.
- A child's distress, freezing, avoidance, behavioural change or AAC refusal is treated as communication and reviewed before continuing.
- No invasive procedure, sedation or medical treatment is provided outside legal scope, professional competence, licence and written consent/emergency authority.



10.3 Intimate care and toileting

- A written intimate-care plan identifies tasks, preferred communication, privacy, gender/cultural needs, equipment, staff, consent, distress signs and emergency action.
- Two-person support is preferred for higher-risk or newly introduced intimate care; where one person is appropriate, the environment must remain safely observable without compromising dignity.
- Staff wear appropriate gloves/PPE, explain each step, encourage independence, record unusual injuries or behaviour and never take personal photographs.
- Parents are informed of significant incidents, unless they are implicated or authorities advise otherwise.

10.4 Medication, feeding and health

- Medication is accepted only in original labelled packaging with written authorization, dose, timing, route, prescriber and emergency instructions.
- Administration is recorded immediately; controlled/high-risk medication uses double-checking and secure storage.
- Allergy, seizure, choking, diabetes, asthma, mobility, infection, dietary and emergency plans are current and accessible to relevant staff.
- Feeding therapy and swallowing support are provided only within professional competence and risk plan; choking response equipment and trained staff are available.
- The Center is not a substitute for emergency hospital care. Serious symptoms trigger emergency services and parent/guardian notification without delay.

10.5 Positive behaviour support and protective intervention

- Behaviour is understood as communication. Plans identify triggers, sensory needs, communication methods, preventive strategies, calming supports and recovery steps.
- No restraint or seclusion is used as punishment, therapy, behaviour modification, convenience or staff response to non-compliance.
- Protective physical intervention is permitted only to prevent imminent serious harm, by trained staff, using the least restrictive method for the shortest time.
- Prohibited methods include prone restraint, pressure to neck/chest/abdomen, airway restriction, pain compliance, joint locks, mechanical restraint not medically prescribed, forced feeding, or isolation in a locked room.
- Every intervention requires immediate health check, incident record, parent notification, DSL/management review, child and staff debrief, plan revision and regulator/authority notification where required.

10.6 Transport and authorized release

- Written manifest, child count at every transition, verified driver/attendant, seat belts/appropriate restraints, emergency contacts, route control and end-of-route vehicle sweep.
- A child is released only to a verified parent/guardian or authorized person using identity verification and current written authorization.
- Custody orders, restricted persons and pickup disputes are recorded; staff do not physically negotiate family disputes and contact police when needed.
- Transport incidents, delays, route changes and unauthorized requests are documented and escalated.

10.7 Visitors, donors, media and VIPs

- All visitors sign in, wear identification, receive boundaries, remain escorted and have no unsupervised child access.
- Donations, influence or status never create a right to touch, interview, photograph, give gifts to or privately meet children.
- Media access requires prior risk assessment, specific consent, child assent and a staff escort; children are never pressured to perform personal stories.



10.8 Digital, photography and CCTV

- Only Organization-approved devices/accounts and secure storage may be used for child information. Personal devices are prohibited unless an emergency exception is approved and files are transferred/deleted under supervision.
- Consent for service is separate from consent for publicity. Refusal of media consent does not affect admission or care.
- No nude, semi-nude, toileting, distress, restraint, medical-procedure or humiliating image is created for publicity. Clinical images require strict necessity, consent, secure storage and limited access.
- CCTV is for safety, not surveillance of intimate care. Cameras are prohibited in toilets/changing areas and positioned to respect privacy. Access and retention are controlled and logged.
- Online sessions use official links, parent/guardian arrangements appropriate to age and risk, neutral backgrounds, no recording by default, and the same conduct rules as in-person services.

10.9 Premises, emergency and disaster safety

- Restricted access, safe stairs/railings, window guards where necessary, locked hazardous substances, electrical protection, fire extinguishers, evacuation plans, first-aid supplies and accessible exits.
- Emergency drills include children with mobility, sensory, communication and behavioural support needs; individual evacuation assistance is documented.
- Roof/play areas require barriers, controlled access, staffing, equipment inspection, heat/weather controls and a written opening/closing checklist.

11. Disability-Inclusive Safeguarding

Children with disabilities may face increased dependency, communication barriers, disbelief, inaccessible reporting, stigma, institutional power imbalance and exposure to intimate care. Safeguarding measures must therefore be individualized, accessible and proactive. UNICEF guidance emphasizes obtaining information directly from the child where possible, using patience, accessible communication and appropriate facilitators. [5-6]

- Record each child's preferred communication, yes/no signals, pain indicators, fear signs, trusted adults, AAC access and interpretation needs.
- Never assume that a non-speaking child cannot understand, consent, refuse, remember or report.
- Do not treat sudden behaviour, regression, self-injury, toileting change, sleep change, fear of a person/place, sexualized behaviour or unexplained injury as "just the disability."
- Provide accessible information using simple language, symbols, pictures, sign language, AAC, demonstration, social stories or repetition.
- Avoid diagnostic overshadowing. Medical, emotional and safeguarding causes must be considered when a child's presentation changes.
- Support child participation in care planning and complaint review, with reasonable accommodation and without requiring eye contact, speech or conventional behaviour.
- Do not use therapy goals to justify coercion, forced compliance, suppression of harmless self-regulation or denial of dignity.



PART III - RECOGNIZING AND RESPONDING

12. Forms and Indicators of Harm

Form	Examples
Physical abuse	Hitting, shaking, burning, poisoning, suffocation, harmful restraint, fabricated/induced illness or unexplained/inconsistent injury.
Sexual abuse/exploitation	Contact or non-contact sexual acts, grooming, exposure to pornography, sexual images, trafficking, commercial exploitation, sexualized communication or abuse by another child.
Emotional/psychological abuse	Threats, terrorizing, rejection, humiliation, scapegoating, coercive control, degrading language, isolation, persistent invalidation or exposure to violence.
Neglect	Failure in supervision, nutrition, hygiene, medical care, medication, education, accessibility, emotional care, safe transport or protection from known risk.
Organizational abuse	Unsafe systems, normalized harsh treatment, understaffing, unqualified care, concealed incidents, retaliation, falsified records, privacy violations or leadership interference.
Online/digital harm	Cyberbullying, sexual messaging, image-based abuse, doxxing, live-stream exploitation, unauthorized recording, privacy breach or grooming.
Child-on-child harm	Bullying, physical assault, coercion, sexual behaviour that is harmful or non-consensual, exploitation, extortion, humiliation or discriminatory harassment.

Indicators are not proof and may have non-abusive explanations. Staff record observations factually and report patterns; they do not diagnose abuse or interrogate the child.

13. Receiving a Disclosure

1. Stay calm. Ensure immediate safety and move to a suitable visible/private setting.
2. Listen without shock, blame, judgment or repeated questioning. Let the child use their own words, gesture, AAC, drawing or communication method.
3. Say: "You did the right thing by telling me. This is not your fault. I will share this only with people who need to help keep you safe."
4. Do not promise secrecy, confront the alleged person, arrange mediation, seek a confession, ask leading questions, or contact the family if doing so may increase risk.
5. Record the child's exact words and observable behaviour as soon as possible; separate fact, direct quote and professional concern.
6. Report immediately to the DSL/Deputy DSL and activate emergency/external response where needed.
7. Preserve messages, clothing, CCTV, attendance, access logs and other potential evidence; do not copy or circulate sexual images of a child.

DO NOT INVESTIGATE: The Center's role is immediate safety, accurate recording, limited risk clarification and referral. Formal criminal or statutory investigation belongs to competent authorities or a properly appointed independent investigator.



14. Mandatory Internal Reporting

Every covered person has an internal contractual duty to report any safeguarding concern, disclosure, allegation, unsafe practice, boundary crossing, injury pattern, missing child, near miss, retaliation or suspected concealment. Failure to report is a serious disciplinary matter.

14.1 Timelines

- Immediate danger, serious injury, sexual assault, missing child, weapon or medical emergency: call emergency services/police and notify the DSL immediately.
- All other safeguarding concerns: verbal report to DSL/Deputy DSL immediately and normally within two hours of awareness; written report before end of shift and within 24 hours at the latest.
- If the DSL is unavailable, implicated or does not act: report to Deputy DSL, President & CEO or independent Executive Committee safeguarding member, and external authority as necessary.

14.2 Reporting threshold

Report on reasonable suspicion. Staff are not required to prove abuse. An explanation by a child, parent or colleague does not close the matter unless the DSL completes and records a risk-based decision.

15. External Referral and Emergency Response

The DSL decides external referral in consultation with senior management/legal counsel where time permits, but consultation must not delay emergency protection. Any person may report directly when required by law, immediate safety, conflict of interest or organizational inaction.

15.1 Referral options

- Sindh Police emergency helpline 15 and the relevant police station.
- Sindh Child Protection Authority helpline 1121 and District Child Protection Unit, including Karachi East contacts maintained in Annex M.
- Ministry of Human Rights helpline 1099 and AWAZ/ZARRA for missing or abducted children.
- Emergency medical/ambulance service and an identified child-appropriate hospital.
- Sindh Healthcare Commission where the matter concerns unsafe healthcare practice, licensing, clinical negligence or a healthcare establishment complaint.
- National Commission on the Rights of Child, legal aid, court, professional council or another authority as applicable.

15.2 Missing child / elopement

The Center does not wait four hours. Once a child cannot be immediately located, the missing-child protocol begins at once: secure other children, search assigned zones, review exits/CCTV, call the parent/guardian and police based on risk, and activate SCPA/ZARRA as appropriate. The 2021 Sindh amendment's missing-child definition and FIR mechanism do not justify operational delay. [9,18-20]

15.3 Parent/guardian notification

Parents are normally informed promptly. Notification may be delayed or managed through authorities when a parent/guardian is alleged to be involved, the child objects and risk requires assessment, contact may lead to retaliation/evidence loss, custody is disputed, or police/child-protection authorities direct otherwise.

16. Allegations Against Staff, Volunteers or Leaders

8. Secure the child's immediate safety and medical/psychological needs.
9. Notify the DSL, or the conflict escalation route if the DSL/leader is implicated.



10. Remove the accused person from child contact through neutral administrative leave, reassignment or access restriction, without treating protective action as a finding of guilt.
11. Preserve evidence and restrict records on a strict need-to-know basis.
12. Make external reports/referrals as required; do not condition reporting on internal interviews or parental compromise.
13. Appoint an independent investigator only for employment/organizational questions that do not interfere with police/statutory processes.
14. Provide fair notice and opportunity to respond at the appropriate stage, support persons as lawful, and prohibit retaliation or witness contact outside the process.
15. Document outcome categories: substantiated, unsubstantiated, unfounded, malicious, or unable to determine - each with reasons and required risk controls.
16. Notify regulator, professional body, insurer, donor/partner or future employer where law, contract, safeguarding duty or legal advice requires.

16.1 Communication and liability control

- Only an authorized spokesperson communicates with media or external parties.
- Staff show empathy, provide factual safety information, and do not speculate, blame, alter records, admit legal liability, negotiate compensation or make unofficial settlements.
- No non-disclosure agreement, family pressure, resignation or apology may be used to block a lawful safeguarding report.
- The Organization's image is never prioritized over the child's safety or lawful process.

17. Case Management, Confidentiality and Records

- Each case has a unique reference number, chronology, risk assessment, actions, referrals, decisions, reasons, safety plan, communications and closure/review record.
- Safeguarding records are separate from routine HR and general student files, encrypted/password controlled, access logged and limited to authorized persons.
- Child identity is not disclosed in public reports, social media or general staff groups. The Sindh amendment protects identifying information and images in child-protection reporting. [9]
- Information is shared on a lawful need-to-know basis for safety, treatment, investigation, regulation or court process. Consent is sought where appropriate, but lack of consent does not prevent necessary protective reporting.
- Serious case records are placed under legal hold and not destroyed under routine schedules. The governing body adopts a retention schedule on counsel, insurer, SHCC and professional advice.
- CCTV and digital evidence are promptly preserved when relevant; staff do not download or circulate material unnecessarily.
- Closure requires confirmation of safety, referrals, support, employment action, corrective actions and review date. Reopening occurs if new information appears.



PART IV - ORGANIZATIONAL ASSURANCE

18. Child-Friendly Complaints and Participation

- Children are told, in accessible formats, what safe and unsafe adult behaviour looks like and who they can tell.
- Reporting options include speaking, writing, picture cards, a safety/complaint box, AAC, trusted-person support, parent report, phone/WhatsApp and direct DSL contact.
- A child may choose a trusted staff member; the staff member must pass the concern to the DSL and cannot keep it private.
- No child is punished, removed from services, labelled difficult, deprived of therapy or pressured to withdraw a complaint.
- Children and parents receive age/ability-appropriate feedback unless disclosure would create risk or violate lawful confidentiality.
- At least annually, children and families are consulted about safety, privacy, touch, communication, transport, bullying and complaint accessibility.

19. Whistleblowing and Non-Retaliation

Personnel may raise concerns outside line management and directly to the DSL, Deputy DSL, independent governing-body member, regulator or authority. Good-faith reporters and witnesses are protected from dismissal, demotion, harassment, threats, poor appraisal, schedule punishment, social exclusion or pressure to change evidence.

Knowingly false and malicious allegations may lead to disciplinary action, but an allegation that is unsubstantiated or mistaken is not automatically malicious. Honest error remains protected.

20. Training and Competency

Training stage	Minimum content
Before child contact	Policy, code of conduct, boundaries, disability-inclusive communication, recognizing harm, reporting routes, emergency action, confidentiality, digital/media rules.
Role-specific	DSL case management; HR safer recruitment; therapists touch/consent; intimate-care staff; behaviour/de-escalation; drivers/attendants; reception/security; media/fundraising.
Refresher	At least annually and after policy change, incident trend, role change or identified gap.
Drills	Missing child, medical emergency, fire/evacuation, child disclosure and allegation against a senior person.
Competency assurance	Knowledge checks, scenarios, observed practice, supervision and signed acknowledgement - attendance alone is insufficient.

21. Partners, Contractors and Visitors

- Due diligence includes legal status, reputation, safeguarding policy, staff vetting, references, insurance, qualifications, complaint history and capacity.
- Contracts include safeguarding standards, reporting timelines, audit access, data protection, staff removal, incident cooperation, notification and termination rights.
- A partner's weaker policy does not reduce the Organization's standards.



- Third-party transport, security, cleaning, therapy, catering, IT, photography and construction personnel follow equivalent controls.
- Serious breach permits immediate suspension or termination while preserving child support and lawful process.

22. Monitoring, Audit and Review

- DSL maintains anonymized data on incidents, near misses, allegations, injuries, restraints, elopement, complaints, staff checks, training and overdue actions.
- Management reviews safeguarding monthly; the governing body receives a quarterly dashboard and immediate notice of critical incidents.
- Annual self-assessment against Policy, People, Procedures and Accountability standards; independent external evaluation at least every three years or sooner after a major case. [3]
- Unannounced spot checks cover one-to-one rooms, transport, visitor control, medicine, files, CCTV access, bathrooms and roof/play areas.
- Every serious incident has a learning review that asks what system allowed or failed to prevent harm, without replacing accountability for misconduct.
- Policy is reviewed at least annually, after legal/regulatory change, new service, serious incident, audit finding or child/parent feedback.

23. Breaches and Disciplinary Action

Breach may lead to retraining, supervision, warning, removal from child contact, suspension, termination, contract cancellation, professional-body referral, regulator notification, police report or civil action, depending on seriousness and law. Resignation does not end an investigation or reporting duty.

- Immediate gross-misconduct concerns include abuse, sexualized conduct, corporal punishment, unauthorized intimate contact, dangerous restraint, retaliation, evidence tampering, deliberate concealment, private child contact, unauthorized media use, or knowingly allowing an unsafe person access.
- Managers who ignore, delay, suppress or informally settle safeguarding concerns are subject to the same accountability as direct perpetrators where applicable.
- Disciplinary process is documented, impartial and coordinated with external authorities to avoid compromising criminal or statutory proceedings.



ANNEXES - IMPLEMENTATION TOOLS

Annex A - Adult Code of Conduct

I understand that my duty is to protect children, maintain professional boundaries, and report concerns. I will:

- ☐ Treat children with dignity and use accessible, respectful communication.
- ☐ Seek consent and assent; explain therapeutic touch and respect distress/refusal.
- ☐ Work in observable, authorized settings and follow one-to-one controls.
- ☐ Use positive behaviour support and only lawful, trained emergency protection.
- ☐ Use official communication, devices and accounts; protect records and images.
- ☐ Report any concern, boundary crossing, injury, disclosure or retaliation immediately.

I will never:

- ☐ Use corporal punishment, humiliation, threats, degrading language or harmful restraint.
- ☐ Engage in sexualized behaviour, grooming, secrets, favoritism, personal gifts or financial dealings.
- ☐ Meet, transport, message, photograph or record a child privately or without authorization.
- ☐ Enter a sexual/romantic relationship with any child; consent is legally and ethically irrelevant.
- ☐ Conceal, alter, delete or pressure anyone about a safeguarding concern.

Name and Role

Signature

Date

Annex B - Reporting and Response Flowchart

Step	Required action
1. Concern arises	Disclosure, observation, injury, behaviour change, boundary breach, missing child, digital concern, near miss or allegation.
2. Immediate safety	Separate from danger; urgent medical care; call Police 15 / emergency service when needed.
3. Listen and record	No investigation; exact words; facts, time, location, witnesses and immediate action.
4. Internal report	DSL immediately / within 2 hours; written form before end of shift and within 24 hours.
5. Conflict route	If DSL/leader implicated or inactive -> Deputy DSL / independent governing member / direct external report.
6. Triage and referral	SCPA 1121, Police, ZARRA/AWAZ, hospital, SHCC, regulator or legal advice as appropriate.
7. Protective management	Safety plan; remove alleged person from contact; preserve evidence; parent notification unless unsafe.
8. Case management	Chronology, support, investigation coordination, outcome, corrective action and learning review.

Annex C - Safeguarding Concern / Incident Report

Case reference	_____
Date/time of report	_____
Reporter name/role/contact	_____
Child name/ID/age	_____
Date/time/location of concern	_____



Type of concern	☐ Disclosure ☐ Injury ☐ Abuse ☐ Neglect ☐ Boundary ☐ Missing ☐ Digital ☐ Other
Immediate danger/medical need	_____
Exact words of child/person	_____ _____
Objective observations	_____ _____
Alleged person(s)	_____
Witnesses/evidence/CCTV	_____
Immediate actions taken	_____
Parent informed? Why/why not?	_____
External referral	☐ Police ☐ SCPA ☐ Medical ☐ ZARRA ☐ SHCC ☐ Other: _____
DSL decision and reasons	_____ _____
Safety plan / follow-up	_____

Reporter Signature

DSL Signature

Date/Time

Annex D - Safer Recruitment Checklist

- ☐ Role risk-rated and child-safeguarding duties included in job description.
- ☐ CNIC/identity, address and employment history verified; gaps explained.
- ☐ Police character verification/background check completed or documented risk controls approved.
- ☐ Two references directly verified, including latest relevant employer.
- ☐ Qualifications, licences and registrations verified from issuing source.
- ☐ Safeguarding interview questions and scenario assessment completed.
- ☐ Conflict of interest, relatives and prior work with children declared.
- ☐ Signed code of conduct, confidentiality, reporting and digital/media rules.
- ☐ Induction completed before contact; probation supervision plan approved.
- ☐ Vetting recheck date entered and HR file access restricted.

Annex E - Program / Activity Safeguarding Risk Assessment

Hazard / scenario	Who may be harmed	Likelihood	Impact	Existing controls	Additional action / owner / date

Risk decision: ☐ Approved ☐ Approved with controls ☐ Not approved Reviewer: _____ Date: _____



Annex F - Intimate Care Plan

Child and communication method	_____
Care tasks required	_____
Independence goals	_____
Consent/assent signals	_____
Distress/refusal signals	_____
Preferred staff / gender / cultural needs	_____
Location and privacy controls	_____
PPE/equipment and infection control	_____
Two-person/chaperone requirement	_____
What must be recorded	_____
Parent notification thresholds	_____
Emergency action	_____

Parent/Guardian

Clinical Lead

DSL Review

Annex G - Positive Behaviour Support and Restrictive Intervention Protocol

Prevention plan

- ☐ Triggers, sensory needs, pain/medical causes and communication barriers identified.
- ☐ Child's calming strategies, AAC, break request, preferred people and safe space documented.
- ☐ Staff response roles, environment changes and emergency thresholds agreed.
- ☐ Family and child participation documented; plan reviewed after incidents.

Emergency intervention requirements

- ☐ Imminent serious harm present; alternatives attempted or unsafe/impossible.
- ☐ Only trained staff; least restrictive; shortest duration; continuous breathing/circulation monitoring.
- ☐ No prone restraint, airway/chest/neck pressure, pain compliance or locked seclusion.
- ☐ Immediate health check and first aid/medical referral where needed.
- ☐ Incident form, parent notification, DSL/clinical review, child/staff debrief and plan update.

Annex H - Missing Child / Elopement Protocol

17. Raise immediate internal alert with child description, risk information and last known location.
18. Assign one person to command, one to contact parent/police, and search teams to defined zones; do not leave other children unsafe.
19. Check toilets, stairs, roof, exits, vehicles, nearby roads, usual preferred places and CCTV/access logs.
20. Call Police 15 immediately for high-risk child, suspected abduction, dangerous environment, or unsuccessful rapid search. Do not wait four hours.
21. Notify parent/guardian and SCPA 1121; activate AWAZ/ZARRA as appropriate.
22. Preserve CCTV, visitor and attendance records; document exact timeline and actions.
23. On return, conduct medical/emotional check, non-punitive debrief, parent meeting, incident review and revised elopement plan.

Annex I - Media, Photography and Digital Safeguarding

- ☐ Separate written consent for photography/video and separate assent from child where possible.



- ☐ Purpose, platform, audience, duration and withdrawal limits explained.
- ☐ Use minimum identifying information; no full name plus location/schedule/diagnosis unless exceptional lawful purpose.
- ☐ No humiliating, intimate, distressed, restrained, medically exposed or stereotyped images.
- ☐ Official equipment/account; file transfer and access control; no personal gallery/cloud backup.
- ☐ No direct donor/media contact with child without risk assessment and escort.
- ☐ Withdrawal request actioned for future use; already published material addressed transparently within practical/legal limits.

Annex J - Parent / Guardian Partnership Rules

- Provide complete and accurate medical, medication, allergy, seizure, feeding, behavioural, trauma, custody, pickup and safety information and update changes immediately.
- Use respectful communication; no threats, abuse, violence, weapons, harassment, unauthorized recording or social-media attacks involving children/staff.
- Follow attendance, arrival/release, medication, transport, media and complaint procedures.
- Do not ask staff to conceal incidents, bypass authorization, use punishment, provide treatment outside competence or communicate privately.
- Report concerns promptly. Good-faith complaints will not affect the child's services; urgent safety concerns may be referred externally.
- The Center may temporarily suspend attendance where an immediate unmanaged risk exists, while arranging review and reasonable support; decisions are documented and non-discriminatory.

Parent/Guardian Name

Signature

Date

Annex K - Child-Friendly Safety Message

Simple English

- You have the right to feel safe and be treated kindly.
- No one may hit, hurt, frighten, shame or touch you in a way that is unsafe or unwanted.
- Adults should explain what they are doing. You can say stop, no, break, or use your sign/picture/device.
- You will not be in trouble for telling us. It is not your fault.
- Tell a trusted adult, your parent, the Safeguarding Lead, or use the complaint box/card.

آسان اردو

- آپ کو محفوظ رہنے اور عزت کے ساتھ پیش آنے کا حق ہے۔
- کسی کو اجازت نہیں کہ وہ آپ کو مارے، ڈرائے، شرمندہ کرے یا غلط طریقے سے چھوئے۔
- بڑے افراد کو ہر کام پہلے سمجھانا چاہیے۔ آپ "نہیں"، "رکیں" یا "وقفہ" کہہ سکتے ہیں، یا اشارہ/تصویر/ڈیوائس استعمال کر سکتے ہیں۔
- شکایت کرنے پر آپ کو سزا نہیں ملے گی۔ یہ آپ کی غلطی نہیں ہے۔
- اپنے والدین، کسی قابلِ اعتماد بڑے، یا چائلڈ سیف گارڈنگ افسر کو بتائیں۔

Annex L - Staff Safeguarding Declaration

I confirm that I have read, understood and will comply with the Child Protection & Safeguarding Policy, Code of Conduct, reporting procedures and lawful instructions. I disclose below any criminal charge, conviction,



disciplinary finding, complaint, investigation, dismissal, resignation during investigation, professional restriction, or conflict relevant to work with children:

I understand that withholding or falsifying relevant information may result in withdrawal of offer, dismissal, referral or legal action. I authorize lawful verification of information and undertake to report future relevant changes immediately.

Employee / Associate

Witness / HR

Date

Annex M - Emergency and Referral Contact Schedule

Agency / role	Contact	Use
Police emergency	15	Immediate danger, offence, abduction, high-risk missing child
Sindh Child Protection Authority	1121 (24/7)	Child abuse, neglect, exploitation, protection and referral
SCPA / DCPU Karachi East	0333-7163669 (verify quarterly)	District child-protection coordination
Ministry of Human Rights	1099 / AWAZ-ZARRA	Human-rights advice; missing/abducted child reporting
Ambulance / emergency medical	_____	Center to nominate and verify primary/backup services
Nearest child-appropriate hospital	_____	Emergency assessment and treatment
Sindh Healthcare Commission	0800-07422 (verify)	Healthcare-establishment/licensing/ clinical complaint
Organization DSL	_____	Internal safeguarding lead
Deputy DSL	_____	Conflict/absence route
Independent Executive Committee member	_____	Allegation against senior leadership
Legal adviser	_____	Urgent safeguarding/legal advice
Insurer	_____	Incident notification and claims guidance

CONTACT CONTROL: Administration verifies this schedule at least quarterly and after any failed contact. Current official sources should be printed behind this page. Do not rely on memory during an emergency.

Annex N - Research and Legal References

- [1] United Nations, Convention on the Rights of the Child (UNCRC), particularly Articles 2, 3, 12, 19, 23, 34 and 36.
- [2] United Nations, Convention on the Rights of Persons with Disabilities (CRPD), particularly Articles 7 and 16.
- [3] Keeping Children Safe, International Child Safeguarding Standards: Policy, People, Procedures and Accountability.
- [4] UNICEF, Policy on Safeguarding, June 2025.
- [5] UNICEF, Disability Inclusive Child Protection Competency Framework for the Social Service Workforce.
- [6] UNICEF, Disability Inclusive Child Protection Systems Strengthening Resource; and Tips on Communicating with Children with Disabilities.
- [7] World Health Organization and partners, INSPIRE: Seven Strategies for Ending Violence Against Children; INSPIRE Handbook.



-
- [8] Government of Sindh, Sindh Child Protection Authority Act, 2011.
[9] Government of Sindh, Sindh Child Protection Authority (Amendment) Act, 2021.
[10] Government of Sindh, Sindh Child Protection Authority Rules, 2016.
[11] Government of Sindh, Sindh Prohibition of Corporal Punishment Act, 2016.
[12] Government of Sindh, Empowerment of Persons with Disabilities Act, 2018.
[13] Government of Sindh, Sindh Healthcare Commission Act/Ordinance, 2013 and applicable regulations.
[14] Sindh Healthcare Commission, Registration and Licensing requirements for Healthcare Establishments.
[15] Sindh Healthcare Commission, Minimum/Sindh Service Delivery Standards and clinical governance guidance.
[16] Sindh Healthcare Commission, Risk management guidance for healthcare establishments.
[17] Government of Pakistan, National Commission on the Rights of Child Act, 2017.
[18] Government of Pakistan, Zainab Alert, Response and Recovery Act, 2020.
[19] Ministry of Human Rights, AWAZ/ZARRA missing and abducted child reporting system and Helpline 1099.
[20] Government of Sindh, official emergency contacts and Sindh Child Protection Authority Helpline 1121.

Legal review note

This policy is a research-based organizational draft, not a legal opinion. Before adoption, Elite: The Kingdom Organization should obtain review from a Pakistan-qualified lawyer familiar with Sindh child-protection, disability, healthcare, employment, criminal, privacy and NGO law; confirm SHCC and professional licensing; obtain appropriate public liability/professional indemnity insurance; and align the policy with actual staffing, building, transport and clinical services.

Policy Adoption Record

The governing body confirms that it has reviewed this policy, approved the implementation plan, appointed responsible persons, allocated resources and required all covered persons to comply.

President & CEO

Executive Committee / Board

Safeguarding Lead

Policy distribution: ☐ Staff ☐ Parents ☐ Volunteers ☐ Contractors ☐ Website/public version ☐ Child-friendly version