because you matter

St Nicholas Hospice Care

A Registered Charity No. 287773

Safeguarding Policy

STNH607

Policy Information

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Equality & Diversity

This document has been assessed for equality impact. This policy is applicable to every member of staff within the organisation, irrespective of their age, caring responsibilities, disability, ethnic origin, gender, gender expression, gender identity, gender re-assignment, marital or civil partnership status, maternity or pregnancy status, race, religion or belief and sexual preference.

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Introduction

This policy draws together current inter-related safeguarding requirements for:

- Adult safeguarding
- Children's safeguarding
- The Government's Prevent Strategy
- Mental Capacity Act
- Deprivation of Liberty Safeguards
- Domestic Abuse Act

This policy must be read in conjunction with organisational guidelines.

St Nicholas Hospice Care (STNH) works closely with the Suffolk Safeguarding Partnership and Multi-Agency Safeguarding Hub (MASH) for Suffolk. The law protects people from maltreatment. Suffolk Safeguarding Partnership consists of Suffolk County Council, Suffolk Police, Suffolk Healthcare services and is responsible for carrying out statutory duty of care. Suffolk MASH receives and processes all safeguarding referrals of children and adults at risk of harm and abuse, they help people in the county who are at risk of harm, abuse and neglect. It consists of around 60 professionals from health, police, education, social care, probation, youth justice, mental health services and housing.

Scope

The policy is based upon the standards of safety and quality which are common requirements for all providers of health and social care. This demonstrates how St Nicholas Hospice Care complies with the Care Quality Commission (CQC) requirements on roles and responsibilities in safeguarding children and adults, recognising that this is work-in-progress for the CQC who will publish an update in due course.

Definitions

Colleagues – SNHC hospice staff and volunteers

Development - means physical, intellectual, emotional, social or behavioural development;

External colleagues –people on rotation or placement, consultants, people on temporary or part time contracts

Harm - means ill-treatment or the impairment of health or development, including, for example, impairment suffered from seeing or Hearing the ill-treatment of another

Health - means physical or mental health

Ill-treatment - includes sexual abuse and forms of ill-treatment, which are not physical.

Patients – a person receiving clinical care from SNHC

Family / Carers – people close to, or caring for a patient

MASH - Multi-Agency Safeguarding Hub

Parents / Guardians – use when describing the legal responsibility to a child

STNH – St Nicholas Hospice Care

Supporter – an individual or an organisation who makes a contribution to SNHC

Standards in Safeguarding - Fundamental Standards of safety and quality were published by the CQC in 2015, in which the 'vision for safeguarding' was clarified and the principles of safe, person-centred care and consent to treatment reinforced. These are set out in the CQC Statement on Roles and Responsibilities for Safeguarding Children and Adults. These standards are new in that they offer a comprehensive guide for policy and practice that applies both to adults and children.

The safeguarding standards state:

- Children and adults must be protected from abuse and improper treatment
- Allegations of abuse will be dealt with as soon as they are made
- Care or treatment must not discriminate on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion, belief, sex or sexual orientation
- Care must not include acts of control or restraint of an adult or child that are not a necessary and proportionate response to a risk of harm
- Care must not be degrading to an adult or child
- Needs for care or treatment of an adult or child must not be significantly disregarded
- No adult or child must be deprived of their liberty for the purposes of receiving treatment without lawful authority
- Regard must be paid to the vulnerability of anyone likely to be exploited, radicalised or drawn into terrorism

Child safeguarding and promoting welfare

- Protection from maltreatment
- Prevention of impaired health and development
- Ensuring children grow up in circumstances consistent with safe, effective care
- Taking action to promote best outcomes for all children
- Professionals working together and putting the child at the centre of their concerns.

Adult safeguarding

- Protecting adults' rights to live in safety, free from abuse and neglect
- Working together to prevent risks of abuse and neglect
- Promoting well-being, taking into account adults' views, wishes, feelings and beliefs.
- In balancing freedom and safety, the complexity of some adults' personal circumstances is recognised and the risks that might be inherent in choices people make are acknowledged.

Safeguarding is not

- A substitute for providers ensuring high quality care that promotes welfare
- A substitute for the core duties of lead agencies like the police or social services (CQC June 2015, section 13)

Vulnerability to Radicalisation (VTR) - Based on the Government's Prevent strategy, this deals with adults who may come into contact with the hospice and who are vulnerable to being influenced into supporting or committing acts of terrorism. Such individuals are regarded as Vulnerable to Radicalisation.

Mental Capacity Act (MCA) - The Mental Capacity Act provides the statutory framework for people who lack capacity to make decisions for themselves, or have capacity and want to make preparations for a time in the future when they may lack capacity. It sets out who can take decisions, in which situations' and how to undertake these.

Deprivation of Liberty Safeguards (DoLS) - The Deprivation of Liberty Safeguards are an addition to the original Mental Capacity Act. They provide legal protection for people who lack capacity to consent to their care or treatment when a deprivation of liberty is being invoked.

Domestic Abuse Act - The Domestic Abuse Act is being implemented in 2021-2022 to raise awareness and understanding about the devastating impact of domestic abuse on victims and their families. The Act aims to strengthen the support and legal protection for victims of abuse by statutory agencies. For more details relating to service users please see OCG 50 Domestic Abuse Guideline. A Domestic Abuse Policy is required by each organization and is in the process of being completed by Jan 2022.

Roles & Responsibilities

The Hospice

The general responsibilities of provider organisations are summarized by the CQC (2018) as follows:

- To put in place and operate effectively systems, processes, policies, procedures and training to help ensure children and adults who use services are safeguarded from the risk of or actual abuse and neglect
- To comply with accepted national guidance on paid colleague competencies in line with their role
- To be aware of the Mental Capacity Act (2005) and the meaning of consent
- To provide levels and a quality of service that meet all the requirements of the relevant safeguarding regulatory framework for the service they provide
- To remedy any shortcomings found in safeguarding practice in their service to help reduce risks to people who use the service
- To learn and apply learning from any safeguarding incident to help strengthen safeguarding in the future
- To refer incidences of abuse or potential abuse to local authority safeguarding teams
- To notify CQC of safeguarding incidents in accordance with regulations by completing a statutory notification at the time the abuse is identified
- To co-operate with safeguarding enquiries

Chief Executive Officer (CEO)

The Chief Executive has ultimate responsibility for implementation of this policy. The CEO will ensure that the Board of Trustees approves this policy. The Chief Executive will also ensure that Trustees are kept informed of any safeguarding allegations regarding service users that implicate the employer or volunteers of St Nicholas Hospice Care. There are 2 named Trustees as Safeguarding Leads and details are available from the staff Safeguarding Leads.

Safeguarding Leads

The following managers fulfil the role of "named professionals for protection of vulnerable adults" in the Hospice and will consult with social care managers as appropriate: Head of Psychological services and Head of Community Services

Managers

During new paid colleagues induction period the hospice managers will refer them to this policy and associated guidelines.

Managers have the responsibility to discuss concerns raised about the abuse of an adult or child or about individuals vulnerable to radicalisation. The Safeguarding Lead role is held by two key lead managers: the Head of Psychological Services and the Community Support Team Manager. Any concerns regarding safeguarding should be reported as soon as possible to one of the Safeguarding Leads (in hours where available) for initial review and to the On-Call Manager out of hours. In all instances the immediate safety of an individual is paramount, and therefore all staff should contact emergency services in the event of an immediate risk and/or notify the Multi Agency Safeguarding Hub (MASH) for advice where the Safeguarding Lead or On-Call Manager are not immediately available. A manager must always be informed if it has become necessary to take emergency action to protect 'life and limb'.

The Hospice Consultant in Palliative Medicine is the senior clinician responsible for assessment under the MCA and for ensuring that the DoLS safeguards are followed.

Colleagues

All paid colleagues and volunteers have the responsibility to safeguard the welfare of adults and children and to follow the guidelines if they receive or are made aware of concerns about abuse or radicalisation or in relation to MCA or DoLS. A manager must always be informed if it has become necessary to take emergency action to protect 'life and limb'.

Paid colleagues must make accurate and timely documentation within the individuals Healthcare Record where appropriate.

Reporting to the Care Quality Commission

The Care Quality Commission must be informed of any abuse or allegation of abuse concerning a person using the service, including both victims and perpetrators, implicating paid colleagues or volunteers. Cases of this nature will be notified to the Chief Executive and referred to the appropriate local agencies for investigation in the first instance, Police or the Local Authority, ensuring first and foremost that service users are safeguarded.

Modern Slavery Act 2015

The Modern Slavery Act 2015 provides a framework and descriptions for slavery, human trafficking servitude and 'forced' or 'compulsory labour'.

- Victims of modern slavery can be any age, gender, nationality and ethnicity
- Slavery is the commodification and exploitation of people for financial gain
- Human trafficking is a form of modern slavery, involving the movement of people by means such as force, fraud, coercion, abduction or deception with the aim of exploiting them
- Servitude is an obligation to provide one's services that are imposed by the use of coercion and is to be linked with the concept of 'slavery' described above
- Forced or compulsory labour is all work or service which is extracted from any person under the threat of a penalty and for which the person has not offered himself or herself voluntarily
- Organ harvesting is an illegal practice where people have their organs surgically removed for sale on the black market.

- It is our legal and moral duty at STNH to follow guidelines for use of suppliers and in volunteer, employee and patient / service user relationships

Other

STNH is fully committed to this policy and requires all paid colleagues and volunteers to comply with it. However, the policy is not intended to be contractual and maybe be changed subject to approval by the Board of Trustees in consultation with the representative for Staff forum.

Safeguarding Adults and Children

This Policy helps paid colleagues and volunteers identify concerns and play their part in alerting the appropriate services to instances of abuse by:

- raising the awareness of paid colleagues and volunteers
- setting out the procedures to follow if abuse is suspected or disclosed
- providing an information resource on definitions and recognition of abuse
- providing examples of best professional practice
- giving guidance on working within the multi-agency frameworks within Suffolk and South Norfolk.

Mental Capacity Act

The Policy helps (Mental Capacity and Deprivation of Liberty Policy STNH611) colleagues to work within the legal framework as they explore options whenever a person might lack the mental capacity to make their own decisions about care or treatment. Healthcare record documentation must demonstrate/evidence that the paid colleague's assessment and interventions up hold professional decision making in the individuals best interest.

When a patient, relative or other party discloses Lasting Power of Attorney (LPA) is in force under the MCA it is a paid colleague's responsibility to

- verify and record the type of LPA in the patient healthcare record
- verify and record the Deputy appointed by the Court of Protection.

Recent significant changes in safeguarding culture

Following the Care Act 2014 Local Authorities and their partners in the Statutory and Voluntary sector are encouraged to adopt an approach to adults that prioritises what makes safeguarding effective from the viewpoint of the individual who is safeguarded. This guidance aims to achieve:

- A personalised approach enabling safeguarding to be done with, not to, people
- Practice that seeks to achieve meaningful improvement in people's circumstances
- Utilising practitioner skill rather than just 'putting people through a process'
- Evaluating what difference has been made in service user's lives (Making Safeguarding Personal Guide, LGA, ADASS, 2014)

After widely publicised reports of sexual misconduct by a small number of colleagues in some major voluntary organisations, Charity Commission enquiries have been launched into several prominent national charities. These events are relevant to St Nicholas Hospice Care in that they emphasis the overriding need for all voluntary organisations to have robust internal processes, accountability and complete transparency with regard to any allegations that involve the integrity and behaviour of paid colleagues and volunteers (see 3.4 above). This is in keeping with the belief that 'charities that

report are probably the ones that are the best at dealing with problems' (Browning V. Association of Chief Executives of Voluntary Organisations, Charity Governance After Oxfam, 2018).

Deprivation of Liberty Safeguards

The MCA allows restraint and restrictions to be used against the patient only if they are in the person's best interests. DoLS can only be used for a person in a care home, hospice or hospital, in supported living or a domestic setting, where care and support effectively deprives them of their liberty. There are specific circumstances at the very end of life where DoLS is not considered appropriate and colleagues must pay attention to DoH guidance on how to apply these safeguards in the last few weeks of life (DoH 2015).

Duty of Care

If a person refuses protective action to safeguard their well-being, and has mental capacity, their wishes would normally be respected in keeping with the principles of the MCA. However this does not over-ride the responsibility of paid colleagues or volunteers to report abuse. Additionally, under Common Law, a charge of assault cannot be brought against anybody who has acted, in good faith, to save the life and limb of another person in an emergency.

Timescales

Safeguarding matters must be reported within one working day. Applications for authorisation to deprive a person of their liberty must be made to Suffolk or Norfolk County Council Supervising Bodies, according to the timescale set out in legislation, 7 days for an urgent application and 28 days for a standard authorisation.

Working together to safeguard children

The name of H.M. Government's official guidance to all statutory and voluntary agencies in matters of policy and practice to safeguard children is 'Working Together to Safeguard Children, 2015'

Working together enables agencies to ensure they can keep children safe. This means:

- Being prepared to share information
- Acting together
- Placing the well-being of the child at the centre of agency actions, whatever the remit of each particular organisation

What to do if you suspect child abuse

- If you have concerns about a child's safety or well-being you have a personal and professional responsibility to ensure that your concerns have been heard, understood and acted on
- Concerns about a child's safety or any allegations of abuse made by a child must be discussed at the earliest opportunity with your line manager and one of the Safeguarding Leads, who will listen to your concerns, ensure appropriate action is taken and report to the CEO
- In the unlikely event that none of these managers can be contacted or outside normal working hours, you should contact the Manager on Call
- In circumstances where no-one from the Hospice is available you should make a direct referral to social services or to the police

- As the 'named professionals' the Safeguarding Leads will ensure that a referral is made to social services in all cases where concerns persist
- As all professionals have a personal responsibility to ensure their concerns are acted on, they should satisfy themselves that a referral has been made. Equally, managers consulted should satisfy themselves that action has been taken

These procedures are summarised on the flowchart in **Appendix b**.

- A court will place reliance on information obtained from people involved particularly from the child/young person. The value of this may be reduced if it is known that someone has questioned or discussed the issues with the child or young person outside of the normal investigation process which will be undertaken by social services and the police (the lead agencies in safeguarding children)
- Passing on information (making a referral) to the right agency to investigate is likely, in the long run, to cause less harm
- Not passing on the information may allow any abuse to continue
- Healthcare Records and other clinical records or reports must be shared with your manager and kept in a secure place in case they are required in an investigation.

When talking to a child

- Be calm
- Reassure the child
- Listen carefully and convey to the child you are taking what they say seriously
- Do not ask leading question or begin to investigate
- Record what the child has said
- Time, date and sign the record
- Do not promise the child confidentiality
- Be clear you need to pass on information to others who can help
- Do not tell the child, "everything will be alright". Things may change for them
- Don't make promises you can't keep

Making a referral

When a referral must be made to social services best practice requires that this will normally be with the knowledge of the child's parents, though not necessarily with their consent. You should not consult with or seek the consent of parents if to do so would:

- Increase the risk of harm to a child, for example through physical punishment
- Prejudice a criminal investigation into an alleged offence or compromise formal enquiries under S:47 of the Children Act (the duty to investigate suspected child abuse)

Advice and guidance should be sought on these matters from the Safeguarding Leads. If a matter occurs outside normal office hours then the Director of Clinical Services should be informed.

After advice and guidance has been sought a referral should be made to Social Services, calls should be made initially to 'Customer First' in Suffolk or to the single number for South Norfolk (see Appendix 2 for this and details of surrounding counties).

Suffolk

- Telephone: 0808 800 4005 (free phone from landlines and some mobiles)
- Professionals' Telephone: 08456 023 023

- PO Box 771, Needham Market, Ipswich, IP6 8WB
- Email: customer.first@suffolk.gov.uk

South Norfolk

- Single point of access: 0344 800 8020

Following the telephone referral, current local procedures require the use of the Common Assessment Framework referral form to give complete and clear information. However, referrals made by any means will be acted on.

It may be appropriate for a preliminary discussion to take place between a staff member or manager at STNH and a social services manager or safeguarding manager to share initial concerns and to decide how best to proceed. Advice and consultation can be sought from the Multi Agency Safeguarding Hub (MASH).This can be especially useful in cases of suspected sexual abuse where investigations may have to be planned with extra care. Safeguarding Board procedures refer to these as 'what if' discussions. Such discussions will not automatically lead to a S.47 investigation, but if information shared is of sufficient gravity then formal inquiries must follow.

Multi Agency Safeguarding Hub (MASH)

- They have a professional advice line 0345 606 1499

Children's Information sharing & Disclosure

Many people may want to sort out any problems themselves or may be extremely cautious about referring to an agency such as the police or social services. However, unilateral action by staff or agencies is unlikely to be in the best interests of a child.

- Explain to children, young people and their parents what information should be shared and why, unless this would place a child at increased risk of harm or prejudice a police investigation
- A child's wishes about confidentiality should always be dealt with respectfully but, in deciding whether to share information, the child's safety must over-ride all other considerations
- Ensure information you share is as accurate and as up-to-date as possible
- If you have concerns about sharing information in a particular case, discuss them with one of the safeguarding leads
- There may be concerns about damaging trust between yourself and a patient or client; however, the best long-term outcome is likely to be achieved by explaining why you must act against a parent's wishes
- Unlike members of the public, professionals cannot remain anonymous in child protection referrals
- Helpful further guidance on making a referral to social services, information sharing and the steps taken in the safeguarding system are available in the HM Government document, 'What to do if you're worried a child is being abused'. This is available as a free download in summary or full document form

Once a referral has been made and an investigation concluded

You may be approached by social services and asked to provide information about a child or family or to contribute to an assessment. This may happen regardless of who makes the referral to social

services and you may be asked to attend a child safeguarding conference, in which case junior staff will be accompanied by a manager.

You may also be asked to provide help to a child or family, as a member of a core group, the role of which is to implement an agreed plan to promote a child's safety, welfare and offer family support. This is likely be a case of continuing the service the hospice is already providing.

As a member of staff or volunteer you will be given every means of support in fulfilling your duties by an experienced member of staff if you are involved in safeguarding procedures.

If you become aware of an allegation of ill treatment to a child by a member of staff or a volunteer

- Any allegations will be dealt with by Hospice managers in close liaison with the lead agencies for Safeguarding Children in Suffolk
- Your first duty is to report concerns to your manager or, if the allegation concerns your own manager, to a more senior manager. The CEO must be informed at the earliest opportunity
- The person subject to the allegation will be informed by a Hospice manager
- Following above, a referral to social services must be made and any necessary action will be taken to ensure the safety of the child. Records must be kept in the same way
- The Director of Corporate Services & Human Resources will also be informed as it is likely that disciplinary procedures will be followed in any such case. It is normal for staff or volunteers in any allegation to be suspended from duty, pending an investigation of the circumstances
- Allegations of this kind must be investigated by the formal safeguarding procedures in force in Suffolk, and if it is suspected that a crime has been committed, and a police investigation has been initiated, then this has to take precedence over all other inquiries
- This may affect the timescales within which other actions can be taken, for example disciplinary proceedings, as these must not obstruct any child protection or police investigation. Questions of this kind will be resolved by consultation between managers from the hospice and the lead safeguarding agencies

The Impact of Abuse and Neglect

This is reproduced from the Suffolk Safeguarding Children Board website to give a comprehensive background.

The Children Act 1989 introduced the concept of significant harm as the threshold that 'justifies compulsory intervention in family life, in the best interests of children'
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2 2015

Under Section 31(9) of the Children Act 1989 as amended by the Adoption and Children Act 2002 the following terms are defined:

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

Section 47 of The Children Act requires that if a local authority has 'reasonable cause to suspect that a child who lives or is found in their area is suffering or likely to suffer significant harm' the authority shall make, or cause to be made, such enquiries as they consider necessary….'

A section 47 enquiry should be carried out through a core assessment. The framework for the Assessment of Children in Need and their Families provides a structured framework for collecting and analysing information about a child and family, taking into consideration:

- The nature of harm, in terms of maltreatment or failure to provide adequate care;
- The impact on the child's health and development;
- The child's development within the context of their family and wider environment;
- Any special needs, such as a medical condition, communication impairment or disability that may affect the child's development and care within the family;
- The capacity of parents to meet adequately the child's needs; and
- The wider and environmental family context

The child's reactions, his or her perceptions, and wishes and feelings should be ascertained and taken account of according to the child's age and understanding.

To do this depends on effectively communicating with children and young people including those who find it difficult to do so because of their age, impairment or their particular psychological or social situation. It is essential that any accounts of adverse experiences coming from children are as accurate and complete as possible.

What is abuse and neglect?

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. Children may be abused in a family or in an institutional or community setting; by those known to them or, more rarely, by a stranger. A child may be abused by an adult or adults, or by another child or children. The primary responsibility for protecting all children from abuse lies with their parents and carers.

Categories of abuse often overlap and an abused child frequently suffers more than a single type of abuse. Therefore everyone who works or has contact with children (or pregnant women) should be able to recognise and know how to act upon evidence that the health or development of a child (or an unborn baby) is being or may be impaired, especially when s/he is suffering or at risk of suffering significant harm.

Physical abuse

Physical abuse 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.

The following may be indicators of concern:

- Parents/carers uninterested or unconcerned by an accident or injury
- Parents who are absent (without good reason) when a child is presented for treatment
- An explanation inconsistent with injury or several different explanations provided for an injury
- Reluctance to share information or mention previous injuries
- Unexplained delay in seeking treatment or use of different doctors, hospitals and other direct access health provisions

- Repeated presentation of minor injuries –may be a ‘cry for help’ (and if ignored could lead to a more serious injury) or may represent fabricated or induced illness

Bruises: children can have accidental bruising, but the following must be considered as highly suspicious of a non-accidental injury unless there is an adequate explanation provided:

- Any bruising or other soft tissue injury to a pre-crawling or pre-walking infant or non-mobile disabled child
- Bruising seen away from bony prominences
- Simultaneous bruising to both eyes without bruising to the forehead, (rarely accidental, though a single bruised eye can be accidental or abusive)
- Bruising on sites less commonly injured accidentally: the face, back, abdomen, buttocks, ears and hands
- Cluster of bruises may indicate defensive injuries on the upper arm, outside of thigh or the trunk and adjacent limb
- Multiple bruising of uniform shape.

Burns: it can be difficult to distinguish accidental and non-accidental burns and scalds, and to do so will always require experienced medical opinion. Any burn with a clear outline may be suspicious e.g.:

- Circular burns from cigarettes are usually 0.6 - 0.7 cm in diameter and healing usually leaves a scar
- Friction burns resulting from being dragged
- Signs of linear electrical fire elements or similar
- Burns of uniform depth over a large area
- Scalds that have a line indicating immersion or poured liquid, (A child getting into hot water of her/his own accord will struggle to get out and cause splash marks)
- Old scars indicating previous burns /scalds which did not have appropriate treatment or adequate explanation
- Scalds to the buttocks of a small child, particularly in the absence of burns to the feet. (Indicative of dipping into a hot liquid or bath.)

Fractures: fractures may cause pain, swelling and discolouration over a bone or joint. The possibility of abuse should be considered carefully for all fractures in non-mobile children. There are grounds for concern if:

- There is an unexplained fracture in the first 18 months of life
- History provided is vague, non-existent or inconsistent with the fracture type
- There are associated old and/or multiple fractures
- Medical attention is sought after a delay when the fracture has caused symptoms such as swelling, pain or loss of movement

Scars: a large number of scars, or scars of different sizes or ages, or on different parts of the body, may suggest abuse. Physical abuse can lead directly to neurological damage, physical injuries, disability or – at the extreme – death. Harm may be caused to children both by the abuse itself, and by the abuse taking place in a wider family or institutional context of conflict and aggression, including inappropriate or inexpert use of physical restraint. Physical abuse has been linked to aggressive behaviour in children, emotional and behavioural problems, and educational difficulties. Violence is pervasive and the physical abuse of children frequently coexists with domestic violence.

Emotional abuse

Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child's emotional development. It may involve conveying to children that they are worthless or unloved, inadequate, or valued only insofar as they meet the needs of another person. It may feature age or developmentally inappropriate expectations being imposed on children. These may include interactions that are beyond the child's developmental capability, as well as overprotection and limitation of exploration and learning, or preventing the child participating in normal social interaction.

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

Recognition of emotional abuse is usually based on observations over time. The following associated indicators may assist in assessing emotional abuse:

- Abnormal attachment between a child and parent / carer e.g. anxious, indiscriminate or no attachment
- Frequent complaints about / to the child and failure to provide attention or praise, (high criticism / low warmth environment)
- Conveying to a child s/he is worthless or unloved. e.g. persistent negative comments about the child or 'scape-goating' within the family
- Developmentally inappropriate or inconsistent expectations e.g. overprotection
- Limited exploration and learning, interactions beyond child's developmental capability, prevention of normal social interaction
- Causing a child to feel frightened or in danger e.g. through witnessing domestic violence/ violence against animals
- Failure to thrive and/ or faltering growth
- Delay in achieving developmental, cognitive and/or other educational milestones
- Behavioural concerns e.g. aggression, attention seeking.
- Frozen watchfulness, particularly in pre-school children.
- Low self-esteem, lack of confidence, fearful, distressed or anxious.
- Withdrawn or isolated behaviour and difficulties in peer relationships.

Parent/family related Issues:

- Dysfunctional family relationships including domestic violence
- Parental problems that may lead to lack of awareness of child's needs e.g. mental illness, substance misuse, learning difficulties.
- Parent or carer emotionally or psychologically distant from child
- There is increasing evidence of the adverse long-term consequences for children's development where they have been subject to sustained emotional abuse, including the impact of serious bullying. Emotional abuse has an important impact on a developing child's mental health, behaviour and self-esteem. It can be especially damaging in infancy
- Underlying emotional abuse may be as important, if not more so, than other more visible forms of abuse in terms of its impact on the child. Domestic violence is abusive in itself. Adult mental health problems and parental substance misuse may be features in families where children are exposed to such abuse

Sexual abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways. This may include the use of photographs, pictures, cartoons, literature or sound recordings etc., the internet, books, magazines, audio cassettes, tapes and CDs.

A child under 13 years is not legally capable of consenting to sexual activity. Working Together 2010 states 'Any offence under the Sexual Offences Act 2003 involving a child aged under 13 years is very serious and should be taken to indicate that the child in suffering or is likely to suffer significant harm'.

Sexual activity with a child aged less than 16 years is also an offence. Where it is consensual it may be less serious than if the child were aged less than 13 years, but may nevertheless have serious consequences for the welfare of the young person. Possible behavioural indicators may include:

- Inappropriate sexualised conduct
- Sexually explicit behaviour, play or conversation, inappropriate to child's age
- Self-harm (including eating disorder), self-mutilation ('cutting') and suicide attempts
- Involvement in prostitution or potential sexual exploitation
- An anxious unwillingness to remove clothes for sports events. (But this may be related to cultural norms or physical difficulties.)

Neglect

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to provide adequate food and clothing; shelter including exclusion from home or abandonment; failing to protect a child from physical and emotional harm or danger; failure to ensure adequate supervision, including the use of inadequate care-takers, or the failure to ensure access to appropriate medical care or treatment. It may also include neglect of, or unresponsiveness to, a child's basic emotional needs.

Evidence of neglect is built up over time and can cover different aspects of parenting as outlined above.

Child Related Indicators

- Failure to grow or develop within normal expected patterns
- Dirty, smelly, inadequately clothed, suffering recurrent or untreated infections or skin conditions. E.g. eczema, severe nappy rash or head lice
- Perceived to be frequently hungry
- Seen to be listless, apathetic and unresponsive with no apparent medical cause or displaying anxious attachment, aggression or indiscriminate friendliness
- Having unmanaged / untreated health /medical conditions including poor dental health
- Suffering frequent accidents / injuries
- Frequently absent or late at school
- Having poor self-esteem

- Thriving if away from home environment

Parental Related Indicators

- Failure to meet the basic needs of the child/children
- Failure to ensure the child/children attend health appointments with GP, Hospital, Health Visitor etc
- Dangerous / hazardous home including failure to use home safety equipment, risk from animals
- Poor state of home environment e.g. unhygienic facilities, lack of appropriate sleeping arrangements, inadequate ventilation (including passive smoking) and lack of adequate heating
- Lack of opportunities for child to play / learn
- Child/children left with adults who are intoxicated, misuse substances or are violent
- Child/children abandoned, or left alone for excessive periods.

Domestic abuse

Domestic Abuse can take the form of any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. This includes issues of concern such as so called 'honour based violence', female genital mutilation (FGM) and forced marriage.

Whatever form it takes, domestic abuse is rarely a one-off incident, and should instead be seen as a pattern of abusive and controlling behaviour through which the abuser seeks power over their victim. Typically the abuse involves a pattern of abusive and controlling behaviour, which tends to get worse over time. Domestic abuse occurs across society, regardless of age, gender, race, sexuality, wealth, and geography. The figures show, however, that it consists mainly of violence by men against women.

Children are affected not only by directly witnessing abuse, but also by living in an environment where a parent - usually the main caregiver - is being repeatedly victimised. They witness violence in the home in a number of different ways – even when parents believe children were unaware of what was happening the children can often give details accounts of the events.

Children living in families where they are exposed to domestic violence have been shown to be at risk of developing behavioural, emotional, physical and cognitive difficulties and long term developmental problems. Everyone working with families should be alert to the frequent inter relationship between domestic violence and the abuse and neglect of children.

Radicalisation

Summarised from Suffolk County Council Guidance on Managing Persons believed to be Vulnerable to Radicalisation or Influenced by Extremism, (May 2013).

Suffolk County Council guidance on VTR is based on the same cooperation between statutory agencies like police and social services and the community, including the voluntary sector, as the guidance in section 1 above. The guidance, referred to as ‘Channel Suffolk’, has been drawn up under the government PREVENT strategy, aiming to identify individuals at risk of being drawn into terrorism, to assess the nature and extent of risks and to provide appropriate support to the individuals concerned.

https://www.suffolk.gov.uk/care-and-support-for-adults/protecting-people-at-risk-of-abuse/supporting-people-at-risk-of-radicalisation/

Adult Safeguarding

Principles

Empowerment: the presumption that decisions will be person-led and that consent given to any actions taken will be informed consent

Protection: that those in greatest need will always receive support and representation.

Prevention: it is better to take action before harm occurs

Proportionality: responses to risks will be proportionate and the least intrusive, appropriate to the risk presented

Partnership: services should develop local solutions, working with their communities. Communities have an important role to play in preventing, detecting and reporting neglect and abuse

Accountability: safeguarding should be delivered in a transparent and accountable way

Dignity in Care

Dignity in care is a key principle that must underpin our practice in safeguarding vulnerable people. Derived from the Department of Health 2007 campaign our service aspires to:

- Have zero tolerance to abuse
- Support people with the same respect we would want ourselves or for members of our family
- Treat each person as an individual
- Enable people to retain maximum independence, choice and control
- Listen to and support people to express their needs and wants
- Respect the right to privacy
- Ensure people can complain without fear of retribution
- Engage with family members and carers as care partners
- Assist people to retain confidence and positive self-esteem
- Act to alleviate loneliness and isolation

Practice Points

In all cases, the prime concern will be the interests and safety of the abused person.

- Staff will aim to give a supportive service that minimises distress and risk to the abused person
- All vulnerable adults have the right to be protected and have their decisions respected – including decisions that may involve an element of risk
- A key requirement of the Mental Capacity Act is that a person's capacity (or lack of capacity) must be assessed and formally evidenced with regard to a particular decision at the time that decision needs to be made. Compliance with the provisions of the Act helps ensure a protective, approach to service users
- Services will be provided in a manner that respects an individual's rights, dignity, privacy, and beliefs, and will not discriminate on the basis of race, culture, gender, ability, age, or sexual orientation

- All witnesses, victims or those who disclose abuse should be treated with the same degree of sensitivity and offered support at all stages of an investigation
- To gain the best outcome for the individual, professionals must work in partnership with each other and the individual concerned
- The person who has the concern about the abuse to someone at risk also has the responsibility to alert others – victims should not be left with this responsibility once abuse is suspected
- All agencies receiving confidential information about abuse to a vulnerable adult must make decisions about how and when this information is appropriately shared
- Vulnerable adults have the right to an independent advocate if they wish. Where capacity is lacking, the Mental Capacity Act (s. 35-41) provides for the appointment of an Independent Mental Capacity Advocate (IMCA) on behalf of a vulnerable client. Compliance with these sections of the Act further safeguards vulnerable service users.

Patterns of abuse

May be identified as follows:

- Abuse may be long-term, in the context of ongoing family relationships such as domestic violence
- Abuse may be serial in nature, where a vulnerable person is targeted or 'groomed' by an abuser, as in sexual or financial abuse
- Opportunistic abuse may occur where money has been left lying around
- Situational abuse may occur where pressures have grown up within a relationship, exacerbated by challenging behaviour or the stress on a carer
- Neglect may occur because a carer becomes unwilling or unable to carry on caring
- Institutional abuse may occur through poor care standards, inadequate staffing, insufficient experience, lack of cultural sensitivity in staff, inflexible or unacceptable routines, punishing sanctions or use of controls and restraints

If an person discloses to you

Try to ensure that:

- They can speak to you in private
- They can communicate effectively with you
- You use an interpreter or translator where necessary
- You are aware of any cultural or gender issues
- You listen carefully
- You remain calm and non-judgmental
- You express regret for what has happened
- You will treat the information seriously
- The person has time to tell their story freely
- You don't ask leading questions
- You pay close attention to non-verbal or indirect communication
- The person understands you will have to share the information with your line manager

Summary of key guidance

- Duty of Care - dealing with immediate danger
- Police action - taken urgently if necessary
- Reporting - to managers within St Nicholas Hospice Care

- Confidentiality - information sharing
- Recording – factual, secure and accurate
- Referral - under Suffolk Adult Safeguarding Board Procedures
- Reporting to the Care Quality Commission - if allegations are about St Nicholas Hospice Care staff
- Strategy meeting - following safeguarding procedures, on an interagency basis
- Investigation - by the investigating officer, leading to a protection plan
- Decision making - points that will be considered

The Mental Capacity Act 2005 – relevant key provisions

Duty of care

The first step must be to take protective action to safeguard the person concerned e.g. calling an ambulance or a doctor for medical attention. When a person refuses protective action, and has mental capacity, their wishes would normally be respected, though this would not over-ride your responsibility to report abuse. At the same time, it is useful to remember that under Common Law, a charge of assault cannot be brought against anybody who has acted, in good faith, to save the life and limb of another person. Support and reassurance must be given throughout.

Police Action

If a person is in immediate danger you may have to call the police; this will also be necessary after you have reported to your manager, if it appears that a crime has been committed, and at all times it must be borne in mind that a vulnerable adult has a right to the full protection of the law. Where alleged abuse appears to constitute a criminal offence, then the responsibility for initiating action will rest with the police and the Crown Prosecution Service.

Examples of abuse that might constitute a criminal offence include: assault, physical or psychological, sexual assault and rape, theft, fraud and other types of financial exploitation, certain forms of discrimination, for example on racial or gender grounds. It is therefore a matter of urgency that the police are involved in such cases and if a criminal investigation is launched it will take precedence over other forms of enquiry.

If relevant managers are unavailable for discussion contact with the police should not be delayed. Normally however, managers would be involved in this step.

Reporting

Following a disclosure, you have a responsibility to take action with the information you have and you should make sure that the person themselves understands this responsibility. You must alert your line manager to the concerns at the earliest opportunity. If your own manager is unavailable, concerns must be reported to the. Head of Psychological services and Head of Community Services

In the unlikely event that none of these managers can be contacted, or outside normal working hours, please discuss any concerns with the On Call Manager. This MUST be done within one working day.

At this point, it may not be clear whether a decision will have to be made to intervene, and the decision about further action will not be yours alone. In all cases where a disclosure of abuse has taken place, whether or not immediate action to protect is necessary, the line manager with whom the information is shared will inform one of the designated managers: Head of Psychological services and Head of Community Services

In cases where there are possible implications for the Hospice, the Chief Executive Officer should be informed. Out of hours the Manager on Call must be informed; they in turn will notify the CSD and CEO. The unavailability of any of these staff should not delay decisions about intervention. Decisions about involving the police will invariably be considered at this stage if the need for this is not already apparent. Outcomes of any subsequent investigation must also be reported to the Clinical Services Director and where necessary, the Chief Executive Officer, who will inform Trustees of cases which are referred for interagency investigation.

Confidentiality

Under normal circumstances, patients and families have a right to expect confidentiality of information, that information will be shared with other agencies only with their consent and only on a 'need to know' basis. Where a person is in danger or abuse has taken place, information must be shared and it is important that the person understands your responsibility in this matter. Make sure you explain what steps you will take next and with whom any information will be shared. On no account must information be disclosed to the press / media (or to other lay individuals), without the client's consent.

Recording

The disclosure must be recorded, using the individual's own speech where possible - paying attention to times and dates - and taking care to distinguish between facts and opinions, recording any differences of opinion. It is important to record the views of the service user themselves and what they want to be done as well as any family members you may speak to at the same time. Do not attempt to establish blame or apportion responsibility for what may have happened, but record the facts as you can best ascertain them and include details of everyone else who knows that an allegation has been made. Record also the outcome of your discussion with your line manager. Your records must be securely kept.

Referral

A referral must be made under Suffolk's Adult Safeguarding Procedures, wherever possible by the person who made the first referral, with either Head of Psychological services and Head of Community Services

Along with your records, the referral must be kept safe in the event of any subsequent legal or disciplinary proceedings. See Appendix 2 or referral forms. Current practice is to make referrals by telephoning 'Customer First' and to follow this up on line using the on line portal to the Adult Safeguarding Referral Form which is available on the website of the Suffolk Adult Safeguarding Board, (http://www.suffolkas.org/). Adult Community Services, Customer First will forward the referral on line to the appropriate area team. Where St Nicholas Hospice Care is aware that a social care worker is already involved the team manager for the appropriate area should also be contacted direct. Out of hours and at weekends, referrals should be made to the County Council Emergency Duty Service. On receipt of a referral, the local team manager will get back in contact with St Nicholas Hospice Care. One of the following: Head of Psychological services and Head of Community Services (or referrer's line manager if they are not available) should be named on the referral as the contact at the Hospice.

For referrals in the South Norfolk area, a 'one-stop shop' telephone referral system may be used 24 hours a day. The telephone numbers are given at Appendix 2. Norfolk Social Services will request the

written information they consider necessary after a telephone referral has been made and we should be prepared to give them the same information that Suffolk require.

Reporting to the Care Quality Commission

The Care Quality Commission must be informed of any abuse or allegation of abuse concerning a person using the service including victims and perpetrators – see www.cqc.org.uk/publications.cfm?fde_id=16215.

Strategy Meeting

These can take place on the phone or face-to-face, and have the aim of ensuring effective communication and joint working. The meeting will:

- Ensure steps have been taken to protect the vulnerable adult
- Ensure effective multiagency work by deciding the roles of people from key agencies
- Reach a consensus about the nature and degree of the alleged incident
- Establish a common understanding about the overall plan for an investigation
- Agree and plan how the investigation should be carried out.

All referrals will warrant some kind of strategy discussion, even if the outcome is a decision not to proceed with a formal investigation. If a face-to-face strategy meeting is held, this will be attended from St Nicholas by the referring staff member or volunteer, and the designated manager or line manager as appropriate. The social care local team manager will normally contact the head of the police Adult Protection Unit.

The lead agency will be agreed, normally the police or social services, and a key worker will be appointed who will normally be a member of social care staff.

The Suffolk Adult Safeguarding Board Policy and Guidance may be consulted for further details of the strategy discussion and the following section on investigation and interviewing.

Adult Safeguarding Investigation

The purpose of the investigation is to:

- Decide on any further protective action that may be necessary
- Clarify the circumstances that led to the referral
- Establish whether abuse did in fact take place
- Gather evidence that may be used in formal proceedings
- Identify the levels of risk to this and other individuals
- Decide what action needs to be taken about the perpetrator.

This will include the following tasks:

- A comprehensive assessment
- Assessing the person's mental capacity
- Understanding their communication needs
- Deciding on the need for further medical intervention
- Deciding whether legal advice is needed
- Clarifying the needs for a case conference.

Following interviews by the investigating office a report and adult safeguarding plan will be made. The safeguarding plan may ascribe roles to particular St Nicholas staff and in general will state what actions need to be taken to ensure future safety, any changes to services, what support services are needed, how risks can be monitored in future and the arrangements for monitoring and review. All St Nicholas staff attending the case conference will receive a copy of the plan.

Decision making

All staff or managers receiving a report of abuse or involved in strategy discussions and case conferences are likely to pose the question, 'what degree of harm justifies intervention?' The following guidance is offered by 'No Secrets'.

The Law Commission uses the concept of 'significant harm', taken from children's legislation, stating that, 'harm should be taken to include not only ill treatment (including sexual abuse and forms of ill-treatment which are not physical) but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, emotional, social, or behavioural development.'

The seriousness or full extent of abuse may not be clear when anxieties are first expressed and incidents must be approached with an open mind. In assessing seriousness, the following factors must be considered:

- Nature and extent of abuse
- Length of time it has been occurring
- Risk of repeated or increasingly serious acts
- Risks posed to other individuals in the same or other settings.

'No Secrets' summarises this as a process of assessment, including:

- Whether the person suffering harm or exploitation
- Does the victim or the alleged perpetrator meet the eligibility criteria under the NHS and Community Care Act 1990?
- Is the intervention in the best interests of the individual and / or the public interest?
- Does the assessment of harm correspond to the depth of feeling and conviction of the person alleging the abuse?

The Mental Capacity Act

- The Mental Capacity Act 2005 (S.44) has introduced two new criminal offences, wilful neglect and Ill Treatment. These may apply to anyone caring for a person who lacks capacity, an attorney appointed under the act or a deputy appointed by the court
- The recent review of 'No Secrets' considered whether to make it a statutory responsibility of all registered professional staff (including social workers and nurses) and all licensed providers of care to report instances of adult abuse under their local procedures. St Nicholas' policy gives full weight to this duty to report, in advance of any future statutory requirements.

St Nicholas procedures regarding assessment of capacity must be followed and an Independent Mental Capacity Advocate appointed wherever appropriate, helping to ensure a comprehensive approach to safeguarding the best interests of a vulnerable adult.

Adults vulnerable to radicalisation

Summarised from Suffolk County Council Guidance on Managing Persons believed to be Vulnerable to Radicalisation or Influenced by Extremism, (May 2013).

Suffolk County Council guidance on VTR is based on the same cooperation between statutory agencies like police and social services and the community, including the voluntary sector, as the guidance in section 1 above. The guidance, referred to as 'Channel Suffolk', has been drawn up under the government PREVENT strategy, aiming to identify individuals at risk of being drawn into terrorism, to assess the nature and extent of risks and to provide appropriate support to the individuals concerned.

Indicators

On their own these characteristics do not necessarily indicate that a person is committed to violent extremism.

- Expressed opinions – may include support for violence and terrorist organisations and rejection of the concept of the rule of law
- Printed or digital material – extremist literature or imagery, material regarding weapons or explosives, military training or techniques, accessing extremist websites
- Behavioural changes – may include withdrawal from family, peers, social events, hostility towards former associates or family
- Personal history – claims or evidence of membership of organisations advocating violent extremism, military / terrorist training, or involvement in combat or violent activity either in the UK or overseas.

Government guidance to health organisations makes it clear that there is no single, reliable profile of an individual liable to be drawn into terrorism and that the pathways taken are variable and still subject to research inquiry (DoH 2011). There is neither any evidence to link palliative care nor the social and personal disruption bereavement can bring about with terrorism.

The process uses a single referral form, a single Point of Contact - the Channel Coordinator – and refers to a Multi Agency Panel to develop the most appropriate form of support based on an assessment of vulnerability. The VTR process is not a means of gathering intelligence but does require sharing information about individuals at risk on a case-by-case basis.

Information sharing

The principles for information sharing are set out in detail in the Suffolk Channel VTR Guidance. They include the legal background to decision making, protection about unfair disclosure and sharing information without consent.

Consent

The Channel process for sharing information in VTR cases is ultimately governed by the Human Rights Act, the Data Protection Act and the Common Law Duty of Confidentiality. However, consent to share information must not be sought until a case has been discussed at a Multi-Agency Panel where a decision will be made about who should seek consent and when. In some cases it may be undesirable to seek consent as this may prejudice the Channel process itself.

Proportionality, relevance and necessity

These principles will govern the way in which information is shared between agencies and this will only take place on a 'need to know' basis, based on professional judgement about the risks to an individual and the public.

Referral, investigation and support process

A staff member or volunteer may, as a result of observation or disclosure, become concerned that a family member, friend or patient is being drawn into violent extremism and should follow the same process within the hospice as in other safeguarding matters, detailed above.

Concerns should be discussed with your line manager at the earliest opportunity. If your own manager is unavailable, concerns must be reported to either the Head of Psychological services and Community Support Team Manager or the nearest available manager at St Nicholas Hospice Care.

- The Clinical Services Director and Chief Executive Officer will be kept informed as in the safeguarding referral process for other adults
- Head of Psychological Services, Head of Community Services or another available manager will ensure a VTR referral is made through Customer First to the Police Central Referral and Tasking Unit who will also alert the County Safeguarding Manager for VTR
- A triage process will weed out any malicious or misguided referrals and ensure that the referral process will not compromise any other investigations
- The Channel Coordinator will review and decide whether the referral information meets the threshold criteria for further action
- An information gathering process will ensure that only appropriate cases go through to the next stage of the process. Any individuals with vulnerabilities requiring support who 'fall out' of the process at this stage will be referred to the appropriate service for help
- A Channel Strategy Meeting will be convened, including the range of agencies involved. The Multi Agency Panel may decide that support is required and will assess who should provide this, as well as evaluating any potential risks to support providers themselves
- An action plan for support will be devised and it is possible that this could include ongoing support from Hospice staff. Hospice representation at a strategy meeting will be undertaken by either the Head of Psychological Services, Head of Community Services or another senior manager and ongoing Hospice involvement will be agreed at this level.
- The Hospice CEO will be kept informed of ongoing Hospice support in a VTR case and, at the CEO's discretion, Trustees will also be kept informed
- In appropriate cases, support may be provided by a Home Office Funded 'Intervention Provider', an approved service provider working with individuals around their personal ideologies
- The Channel Coordinator will liaise with support providers and together with the multi-agency panel will undertake a review of the process
- There is no fixed interval for review as the Channel process regards each intervention as different. The panel will decide whether risks have been reduced to the point where it can recommend that a case should exit the process.
- Advice about a particular case and whether it is appropriate to make a VTR referral can be sought from the Police Central Referral and Tasking Unit (CRTU).
- Customer First or the Police will supply a VTR referral form if a referral needs to be made.

Recognition of abuse of vulnerable adults

Summarised from: Suffolk Adult Safeguarding Board (Nov 2016), Suffolk County Council

Who are vulnerable adults?

The adults covered by the St Nicholas Hospice Care policy and procedures are over 18 years of age, and who are, or may be, in need of community care services. For example:

- People with a mental health problem or mental illness (including dementia)
- People with a physical disability
- People with drug and alcohol related problems
- People with sensory impairment
- People with a learning difficulty
- People who have a physical illness
- People with an acquired brain injury
- People who are frail
- Family carers providing assistance for a vulnerable person.

What is abuse?

Abuse will include all forms of harm and mistreatment. It is a violation of an individual's human or civil rights by any other person or persons.

It is a single or repeated act or omission, occurring within a personal or other close relationship where there is an expectation of trust, which causes harm to a vulnerable adult.

Abuse types and indicators

Physical abuse, including physical assault ranging from rough, inappropriate or careless handling to direct physical violence: hitting, slapping, pushing, kicking. It can include medical mistreatment such as the misuse of medication, withholding or inappropriately altering medication or treatment regimes. It is also the misuse of restraint, or inappropriate sanctions.

Abuse indicators and signs of abuse

The lists below are purely for guidance. The presence of one or more does not automatically confirm abuse. The existence of a number of the indicators may however suggest a potential for abuse and should therefore necessitate further assessment or scrutiny.

Indicators of Physical Abuse

- Unexplained bruising; some types of bruising are particularly characteristic of non-accidental injury
- Hand slap marks
- Marks made by an implement
- Pinch or grab marks
- Grip marks -this could indicate that the person has been shaken, inappropriately restrained, or forcibly moved
- Black eyes
- Bruising to buttocks, lower abdomen, thighs and genital or rectal area could be an indicator of sexual abuse
- Bruising may be faint or severe
- There may be a pattern to the bruising e.g. when the bruising occurs, where the bruising occurs

Other Physical Indicators

- Person flinches at physical contact
- Reluctance to undress or uncover part of the body
- A history of unexplained falls or minor injuries
- Prolonged interval between the onset of the injury or illness and subsequent presentation for medical care and attention.
- Evidence of improper use of medication e.g. excessive or repeat prescriptions, under-use of medication
- The general level of care is insufficient or deteriorating e.g. spectacles, dentures, hearing aid not in evidence; person is unwashed, unkempt or inappropriately dressed, clothing is dirty or soiled
- Unexplained ulcers or pressure sores
- Evidence of malnutrition
- Enforced social isolation

Other Types of Injury

- Burns inside the mouth, inside arms or on genitals
- Bite marks
- Cigarette burns
- Any injury, bleeding or soreness in the genital or rectal area which could also be and indicator of sexual abuse
- A bizarre or vague explanation is offered to explain an injury to a vulnerable adult

Sexual abuse

Sexual abuse, including rape and sexual assault, or sexual acts to which the vulnerable adult has not consented, or could not consent, or was pressured into consenting. Acts of a sexual nature where one of the participants is in a position of trust, power or authority. Sexual abuse occurs when someone is forced, or coerced into taking part in sexual activity to which they have not consented or do not fully understand.

There is an increasing understanding and respect for disabled people's human right to a sexually active life. It is important that sexual activity per se is not assumed to be abusive. It is also important to recognise that people who have neither received information about, nor exercised their sexual rights, can be more easily exploited.

Indicators of Sexual Abuse

- Disclosure by means of hints and veiled comments
- Uncharacteristic sexually explicit/seductive behaviour which may include promiscuity or use of sexually explicit language
- Urinary tract infections, vaginal infections or sexually transmitted diseases (STD's) that are not otherwise explained
- Continual open masturbation or aggressive sexual activity with peers
- A woman who lacks the mental capacity to consent to sexual intercourse becomes pregnant
- Fear of pregnancy that may be exaggerated
- Self-mutilation
- Difficulty in walking/sitting with no apparent explanation
- Torn, stained or bloody underclothes

- Bleeding, bruising, torn tissue or injury to the rectal and vaginal area

Psychological abuse

Psychological abuse, including verbal abuse, emotional abuse, threats, bullying, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, isolation or withdrawal from services or supportive networks.

The person who is neglected or abused may display uncharacteristic behaviour that may signal distress. The behavioural signs and symptoms may range from slight to severe. Onset may be sudden or gradual. One or several signs and symptoms may be displayed:

Indicators of psychological/emotional abuse

- Referred to in a disrespectful manner
- Humiliated in front of others
- Denied access to social activities
- Denied access to services
- Denied time alone with other people
- Is depressed, withdrawn, overly compliant or anxious to please
- Appears scared, anxious or withdrawn
- Appears to be frightened, fearful or has both low self-esteem and feelings of self-worth
- May be subdued in the presence of particular individuals.
- Displays acting out, aggressive, destructive, irritable behaviour at less powerful people, animals or objects
- Attempt to achieve a sense of control over their feelings through self-harm, refusing to eat, deliberate soiling, behaving in a way that elicits a predictable response.
- Sleep disturbances that cannot be explained
- Eating problems. Changes in appetite. Unusual weight gain/loss. Sudden withdrawal or absenteeism from activities or services
- A reluctance to accept medical attention

Financial or material abuse

- Financial or material abuse, including theft, fraud, exploitation, pressure, in connection with wills, property or inheritance. The misuse and misappropriation of money, property, possessions or benefits
- Indicators of financial abuse.
- Unexplained or sudden inability to pay bills
- Unexplained or sudden withdrawal of money from accounts with no known subsequent benefits
- Apparent lack of knowledge of income, financial resources and assets
- Disparity between income/assets and satisfactory living conditions
- Extraordinary interest by others in the person's finances
- Under pressure to make or alter a will.
- Unauthorised disposal of property, possessions
- Lack of receptivity by a person to any necessary assistance that requires expenditure, when finances are not a problem
- Extortionate demands for payments for services, e.g. building or repair work

In addition there are certain factors that may increase the risk of a person being financially abused:

- Person has a guaranteed high benefit income
- Person is unable to administer their own money due to a lack of capacity or numeric skills.
- Person is dependent on other people to administer money.
- Others become financially dependent on a person/service user.
- Person is isolated within their community
- Person has no independent advocate

Neglect or acts of omission

- Neglect and Acts of Omission, including ignoring medical, physical or social care needs, failure to provide access to appropriate health, social care or educational services, the withholding of daily living needs, such as medication, food and drink and heating.

Discriminatory abuse

Discriminatory abuse, including racist or sexist remarks or comments based upon a person's impairment, origin, colour, disability, age, illness, sexual orientation or gender, and other forms of harassment, slurs or similar treatment.

Institutional abuse

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

Indicators of institutional abuse

- Is unacceptable practice encouraged, tolerated or left unchallenged?
- Are people working in accordance with anti-racist, anti-sexist, anti-ageist, anti-homophobic practice, and do they promote the rights of individual service users?
- Are service users respected and treated with dignity?
- Does the organisation promote choice and an individual focus?
- Are staff well treated and do they enjoy their work?
- Do staff receive training?
- Is there a high staff turnover?
- Do staff, service users and family carers know how to make a complaint or voice a concern?
- Are visitors encouraged and made to feel relaxed and welcome?
- Does the organisation have an adult protection and whistle blowing policy?
- Does the organisation meet the quality standards laid down by regulatory bodies and contracting authorities?
- s there a culture of continuous improvement?

Remember

- Anyone can experience abuse
- Anyone may be a perpetrator of abuse

- Abuse may be a single or repeated act
- Abuse may be behaviour that deliberately or unknowingly causes harm, or endangers life or rights
- An individual, a group or an organisation may perpetrate abuse. Most often the perpetrator is someone who is known to the vulnerable person, such as a partner, a relative, a neighbour, care provider or another service user
- Abuse can take place in any setting and at any time
- An abused person may feel frightened, intimidated, embarrassed, isolated and have low self-esteem. To disclose abuse may therefore be traumatic and difficult. Your initial response is critical and will determine if the disclosure is made in full

Policy Supporting Documents & Laws

Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children 2010 - HM Government Department for Children and Families	What To Do If You're Worried A Child Is Being Abused 2003 – Department of Health
Suffolk Safeguarding Children Board Child Protection Policies and Procedures	The Children Act 1989
The Children Act 2004	The Framework for the Assessment of Children in Need and Their Families 2000 – Department of Health
The Common Assessment Framework 2007 – Department for Education	What to do if you're worried a child is being abused; Every Child Matters 2006
Information Sharing: Practitioner's Guide 2006	Mental Capacity Act (2005), Primary Legislation and Code of Practice
The Care Act 2014	Safeguarding Vulnerable Groups Act 2006 - Department for Education and Skills
The Health and Social Care Act 2008 – Department of Health	Suffolk Safeguarding Adults Framework which includes the Multi Agency Safeguarding Hub
'No Secrets: Guidance on developing & implementing multi-agency policies & procedures to protect vulnerable adults from abuse' 2000 – Department of Health	Protection of Vulnerable Adults (POVA) scheme in England & Wales for care homes & domiciliary agencies: a practice guide' 2004 – Department of Health
'Statement of Government Policy on Adult Safeguarding' 2011 – Department of Health	Guidance on Managing Persons believed to be Vulnerable to Radicalisation (VTR) or influenced by Extremism, Suffolk Safeguarding Boards and Suffolk Constabulary 2013 – Channel Suffolk
'Building Partnerships, Staying Safe: the health sector's contribution to HM Government's Prevent strategy for healthcare organisations' 2011 – Department of Health	Making Safeguarding Personal Guide 2014 – LGA & ADASS

Mental Capacity Act 2005 Annual Report 2013 2014 – Health and Social Care Information Centre	Care Quality Commission Regulations 2009 – Department of Health

Policy Communication

The policy has been shared with key stakeholders for review and comment.

Once completed the policy is sent to governance@stnh.org.uk for uploading to the Radar portal and final approval.

Once approved a notification will be sent to all staff and it is expected staff agree they have read, understood and comply with the policy.

Policy Training

Training is delivered by e-learning packages accredited by Suffolk County Council, backed up by in-house updates for operational colleagues and by access to the Suffolk Adult Safeguarding Manager – Mental Capacity Act / Deprivation of Liberty Safeguards

- Basic training is delivered at induction for new paid colleagues and volunteers will use Suffolk County Council CPD online programmes in Adult and Child safeguarding
- In-house updates will be delivered at 3 yearly intervals or more frequently at a manager's discretion
- The content of training, whether face to face or e-learning, will be vetted by the Safeguarding Lead Managers advising the Human Resource Department.

If incidents or new issues are presented a specific training plan may be arranged to ensure staff understand their obligations under this policy.

Depending on the outcome of any issues, further guidance and support may be provided.

Policy Audit

The policy will be checked on Radar to ensure staff have read and understood. Anyone not responding will be targeted to ensure they read and understand the policy.

As part of auditing the success of the policy, incidents will be checked regularly for any related trends that could be due to a non-understanding of policy. If this is the case the policy will be reviewed.

Policy Maintenance

The policy will be kept in a central location, on the Radar system with a review date set.

The policy will be reviewed yearly to ensure law change is acting upon as soon as possible.

APPENDIX A - Summary of contact numbers and brief details of services

Suffolk Police
The Police on 999
Main switchboard 01473 613500 or 101
Central Referral and Tasking Unit 01473 613500
Police can also be reached using 101
South Norfolk Police 0845 456 4567

The NSPCC child protection helpline: 0808 800 5000

Suffolk: concerns can be discussed with the Multi Agency Safeguarding Hub (MASH). They have a professional advice line 0345 606 1499

Adult Safeguarding Referral Forms can be down loaded from the Suffolk County Council Adult Safeguarding Board website: Complete the online form http://www.suffolkas.org/

Suffolk: all new requests for a Children's Social Care Service, including urgent child welfare concerns, should be made to Customer First

Suffolk Adult Community Services
Customer First 0808 800 4005
Emergency Duty Service 0808 800 4005 (diverted after hours)

Telephone: 0808 800 4005 (free phone from landlines and some mobiles)
Professionals' Telephone: 08456 023 023
PO Box 771, Needham Market, Ipswich, IP6 8WB
Email: customer.first@suffolk.gov.uk

Sending secure emails

If you have a Government Secure Intranet (GSI) email domain you can email our secure email: customer.first@suffolk.gcsx.gov.uk.

GSI domains include: .nhs.net For urgent requests out of office hours which cannot wait until the next working day, please contact the Emergency Duty Service: 0808 800 4005.

https://www.suffolk.gov.uk/children-families-and-learning/keeping-children-safe/reporting-a-child-at-risk-of-harm-abuse-or-neglect-safeguarding/

South Norfolk: single point of access: 0344 800 8020

Norfolk Adult Social Services
Customer Service Centre (24 hrs) 0344 800 8020

Cambridgeshire: Referrals to the Local Authority - In office hours (8am - 8pm Mon - Fri) 0345 045 5203. Children's Social Care Services at Cambridgeshire Direct. Referrals to the Local Authority - Outside office hours 01733 234724. Cambridgeshire Children and Young People's Service

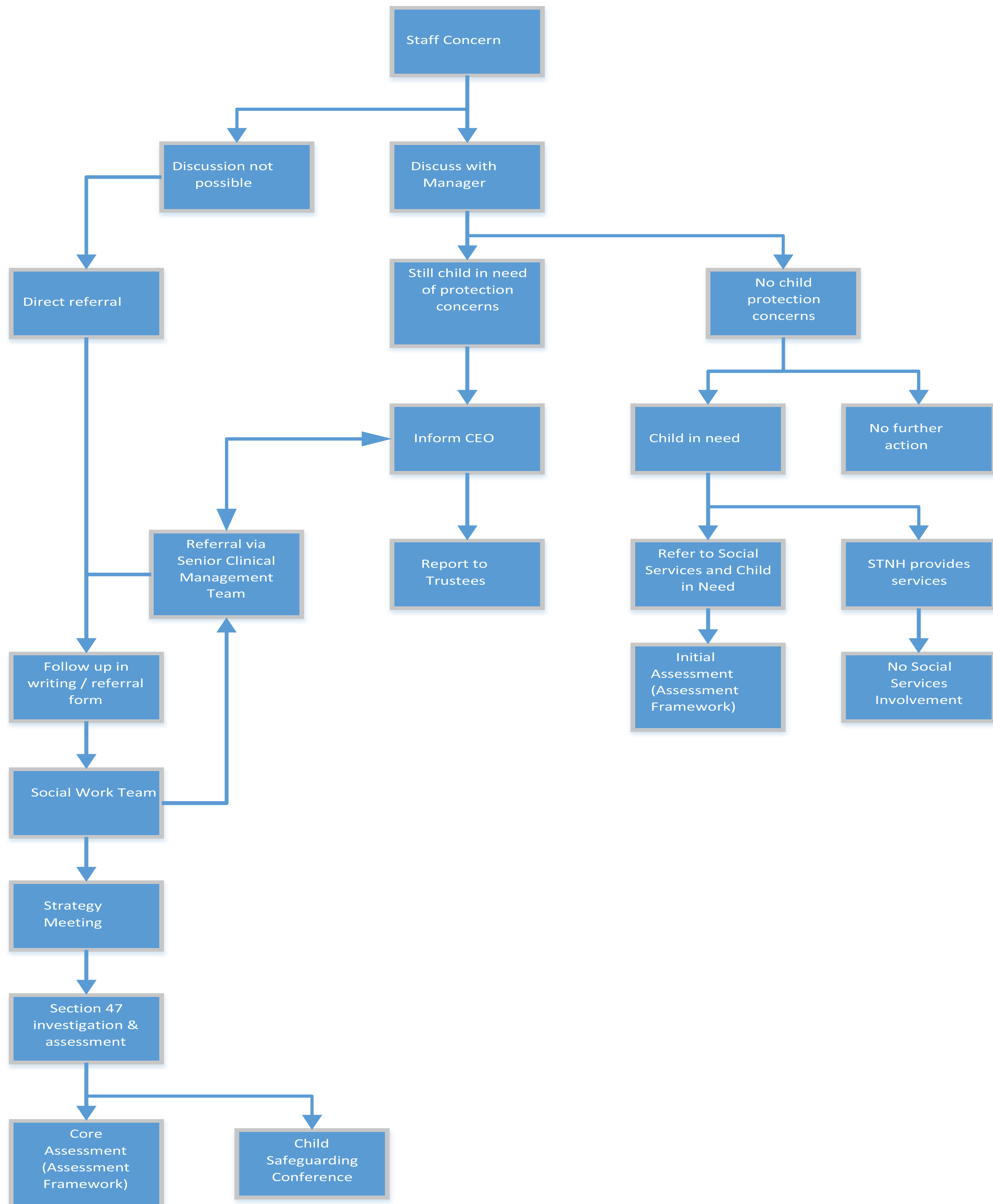
Essex: where there are concerns about the immediate welfare or safety of a child/young person:

Working hours: 0345 603 7634

Out of hours - 5.30pm - 9.00am Monday - Thursday, 4.30pm Friday - 9.00am Monday and Bank holidays): tel: 0345 606 1212 or

Please contact us through the online portal.

APPENDIX B – Safeguarding Children Flowchart



APPENDIX C – Adult Safeguarding Guidance Flow