South East Coast Ambulance Service NHS
NHS Foundation Trust

Safeguarding Policy and Procedures for Children, Young People and Adults.

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Be Proud Show Respect Have Integrity Be Innovative Take Responsibility

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1 Safeguarding Policy Principles and Scope

1.1 The primary purpose of this document is to assist all staff, volunteers and visitors within South East Coast Ambulance Service NHS Foundation Trust (SECAmb) to be aware of their role and responsibilities in safeguarding and promoting the safeguarding of adults, children and young people. The associated procedures within this Policy document will enable the Trust to fulfil its relevant legislative duties as determined by The Children Act 1989/2004 and The Care Act 2014.

1.2 The Trust commits to working in partnership with other agencies including Local Authorities, Police and other Health Care Partners.

1.3 The Trust is committed to the principles and activities which monitor, review, learn from, support and promote safeguarding.

1.4 This policy sets out the key arrangements for safeguarding and promoting the welfare of children and adults. Given the nature of safeguarding children, young people and adults this is not a definitive document and should be read in conjunction with Working Together to Safeguard Children (DCSF, 2015) and Local Safeguarding Children and Adults Board's (LSCB & LSAB) guidelines and procedures in line with recent changes in law and policy.

1.5 Staff must always adhere to SECAmb policy and procedure. The safeguarding team, who manage all referrals and provide support to SECAmb staff are aware of the relevant local multi-agency safeguarding policies and procedures, and any strategies specific to safeguarding or in respect of relevant services.

1.6 In line with central government guidance the Trust has appointed The Director of Quality & Safety and Chief Nurse as the Board level named individual to oversee safeguarding children and adult matters.

1.7 The Trust will seek to increase staff awareness of matters appertaining to safeguarding children and adults through the provision of information, education and training programmes.

1.8 The Trust has implemented the following safeguarding children and adult's policy and guidance notes to aid staff in the management of incidents where there is an identified or perceived risk to a child or adult.

1.9 The Trust will monitor the effectiveness of the policy via audit and reporting to the Trust Board via the Safeguarding Sub Group (SSG), on the successes of its organisational and operational expectations described within this policy. The SSG meets 6 times per year and has representatives from operations, learning and development and external support in the form of local designated nurses.

1.10 This policy applies to all staff working for the Trust regardless of their role or place within the organisation, and must be brought to their attention and read by them. The policy is also applicable to contractors and volunteers working within, or on behalf of the organisation.

1.11 This policy is Trust specific, but is not a replacement for the local multi agency Safeguarding Policy & Procedures, nor is it a replacement for one to one discussion, support or supervision with the safeguarding service.

1.12 The Trust believes that all children and adults have a right to be safeguarded from harm and exploitation regardless of their:

- Race, religion, first language or ethnicity
- Gender or sexuality
- Age
- Health or disability
- Location or placement
- Any criminal behaviour
- Political or migration status

1.13 The Trust is committed to promoting a culture where employees are able to raise concerns about safeguarding issues and will be supported in doing so. Raising concerns at work (Whistle Blowing) procedures are available via the Trust intranet site.

1.14 Failure to comply to the policy will leave the organisation exposed to challenge by Local Safeguarding Boards who have a statutory duty to monitor compliance of organisations in discharging their duties under section 11 of the Children Act 2004, Care Act 2014 and challenge from other inspectorial and regulatory bodies, such as the Care Quality Commission (CQC), Clinical Commissioning Groups (CCGs), NHS England, Healthwatch, and NHS Improvement – the independent regulator of NHS Foundation trusts.

1.15 Staff have a duty to report in a timely way any concerns or suspicions that a child or adult is at risk of being abused.

2 Definitions

2.1 Children are defined as anyone who has not yet reached their 18th birthday (Children Act 2004) and for the purpose of this policy in line with local Child Protection and Safeguarding Policies include the unborn child. ‘Children’ therefore means ‘children and young people’ throughout. The fact that a child has reached 16 years of age, is living independently or is in further education, is a member of the armed forces, is in hospital or in custody in the secure estate for children and young people, does not change their status or entitlement to services or protection under the Children Act 1989” (Working Together 2010). An adult is classed as anyone aged 18 or older.

2.2 Safeguarding and promoting the welfare of children is defined in Working Together (2015) as:

- Protecting children from maltreatment;
- Preventing impairment of children’s health or development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care; and

- Taking action to enable all children to have the best outcomes.

2.3 The Care Act 2014, is the first statutory framework for safeguarding adults, and replaces the ‘No Secrets’ guidance 2000 and ‘Safeguarding Adults – A national framework of standards for good practice and outcomes’ 2005. With the new legislation, the term ‘vulnerable person/adult’ is no longer used.

2.4 As defined in the Care Act (2014) the safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs)
- is experiencing, or at risk of, abuse or neglect
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

2.5 Under section 31(9) of The Children Act 1989 as amended by the Adoption and Children Act 2002:
’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.

3 Roles and Responsibilities.

3.1 Accountability for Safeguarding Children and Adults ultimately sits with the Trusts Chief Executive; however, this can be devolved within the Trust Board to a clinical director, and within SECAmb this responsibility has been devolved to the Director of Quality and Safety.

3.2 **Director of Quality and Safety/Chief Nurse**

The Director of Quality and Safety/Chief Nurse has Board level responsibility for Safeguarding Children and Adults. The Director chairs the Safeguarding Sub Group and sits on local Safeguarding Boards

3.3 **Safeguarding Lead**

3.3.1 The Trust has a Safeguarding Lead, who reports to the Chief Nurse. They have senior responsibility for Safeguarding Children and Adults across the Trusts region and safeguarding roles and responsibilities are clearly identified within the job description with reference to the competencies identified in the intercollegiate documents for children (2014) and adults (draft - 2016). The Trust’s Safeguarding Lead will be supported and supervised by a Designated Nurse from one of the local CCG’s. They will maintain links with the wider Safeguarding networks in all localities and ensure that relevant information is disseminated as required to all staff within South East Coast Ambulance Service.

3.3.2 The Safeguarding Lead will have a key role in promoting good professional practice within their organisation, and provide advice and expertise for fellow professionals.

3.3.3 The Safeguarding Lead should support the organisation in its clinical governance role, by ensuring that regular audits on safeguarding are undertaken and that safeguarding issues are part of the Trust's clinical governance system.

3.4 Safeguarding Team

3.4.1 The safeguarding team have an integral role in safeguarding children and adults across the Trust. The Safeguarding Coordinators will ensure prompt management of internal referrals and be a point of contact for external stakeholders. They are supported by the Safeguarding Support Officer who will manage more complex queries and identify issues which may require escalation to the Safeguarding Lead/Chief Nurse.

3.4.2 All staff should utilise these individuals for advice and support with regard to any safeguarding queries, as well as following the Trust's policy and procedures at all times.

3.5 **Caldicott Guardian**

The Trust's Caldicott Guardian (Trust Medical Director) has overall responsibility for ensuring that all patient information relating to safeguarding referrals remains securely stored and confidential. Day to day responsibility for safeguarding records is held by the Trust's safeguarding team.

3.6 **All Staff**

All staff have a responsibility to read and understand this policy and adhere to the Trust current procedure for safeguarding children and adults. Effective communication systems must exist between all levels of staff and external agencies as required.

3.7 **Safeguarding Sub Group (SSG)**

The Safeguarding Sub group will monitor the effectiveness of the policy and staff training and co-ordinate the production of gap analysis and action plans for the Quality and Safety group to monitor. Regular reports should be bought to the SSG to update and inform the sub group members.

3.8 **Local Safeguarding Boards**

The lead professionals are responsible for identifying suitable representation at Child Death Overview Panels (CDOP) and other Local Safeguarding Children Board (LSCB) and Local Safeguarding Adult Board (LSAB) sub groups as required.

3.9 **Overview of the Safeguarding Role of the Ambulance Service**

3.9.1 All Health and Social Services professionals play an essential part in ensuring that children, adults, their families and carers receive the care, support and services they need in order to promote their health and development. The “front-line” nature of the Ambulance Service and 111 within the NHS means that staff may be the first to be aware that families or carers are experiencing difficulties in looking after their children or adults. The emergency and urgent care elements of the service give a unique position to note pre-disposing factors in the home and the history of events in each case.

3.9.2 Over recent years there have been a number of high profile cases such as the Victoria Climbié inquiry (2000), Baby P (2009), Daniel Pelka (2013), Winterbourne View (2012), the Mid Staffordshire enquiry (2013) and the Lampard enquiry (2016) which have highlighted major failings by multiple agencies to act on evidence of abuse and neglect. Such incidents are the extreme, however there are undoubtedly many others where there is doubt over a person’s welfare, where there is a need to refer concerns to the Local Authority, or other Health organisation, thus ensuring that the person and his / her family receive the necessary care, support and services they require.

3.9.3 SECAmb has a duty to conform to the legislation, as do their staff. As the emergency and urgent care arm of the Health Service, Ambulance Services and 111 providers come into contact with children and adults in a wide variety of situations, directly and indirectly.

3.9.4 As a professional service and a provider of Pre-Hospital and urgent care the Trust is in a unique position to note important pre-disposing factors such as The Home (The environment from which the child or adult comes) and the Initial Story (History of Events). Such information should be recorded and shared as part of the referral process.

3.9.5 The Trust has a duty of care to protect any child or adult and as such have clear guidelines and a reporting mechanism that records and notifies incidents. The notification of a child or adult perceived to be at risk does not immediately label the child/ adult and / or their parents / carers; notification raises the need to investigate matters further. At the other end of the spectrum, some children and adults are clearly at great risk and immediate action is required to provide protection. The Trust’s responsibility is to ensure the appropriate professionals are made aware of the concerns.

4 Monitoring

4.1 The Policy will be monitored for its effectiveness by the Safeguarding Sub-Group (SSG) through the following mechanisms:

- Responsibilities of staff will be monitored through attendance at relevant safeguarding meetings (i.e. Safeguarding Boards, Sub-groups etc.), management of systems, development of reports and the appraisal process;
- Number and percentage of staff completing mandatory and induction training in year;
- Production of reports showing trend analysis

• Monitoring of actions arising from Serious Case Reviews (SCRs), Safeguarding Adult Reviews (SARs) and Domestic Homicide Reviews (DHRs).

- Monitoring of actions resulting from self-assessment requirements i.e. Assurance & Accountability (CCG), Section 11 (Children Act), Lampard enquiry etc.

4.2 These will be monitored as agenda items at the bi monthly SSG meetings and reported on as part of the annual safeguarding report presented to the Board.

5 Sharing Information

5.1 In accordance with legislative guidelines the Trust will share information with other Health, Social Care and other Safeguarding Children or Adult partners, where such information will be in the best interest of the child or adult.

5.2 All requests for information sharing will be coordinated by the Safeguarding Lead and Safeguarding Team, under delegated authority of the Trusts Caldicott Guardian.

5.3 All LSAB and LSCBs have information sharing protocols, which as a partner of the Board the Trust must adhere to.

5.4 SECAmb staff will adhere to the principles of the Caldicott Committee’s report on the review of patient-identifiable information sharing by recognising that confidential patient information may need to be disclosed in the best interests of the patient on the basis that;
• Information can only be shared on a ‘need to know’ basis when it is in the best interest of the patient.
• Confidentiality must not be confused with secrecy.
• Informed consent must be obtained if referring an adult at risk but, if this is not possible and others are at risk, it may be necessary to override the requirement.
• Pregnancy in a person who is unable to consent to sexual relations (i.e. under 13 years of age – statutory rape)

6 Guidance for Frontline staff

The following is guidance for frontline staff, however, full information can be found in the Trust Safeguarding Procedures.

6.1.1 Any Trust staff, including those having telephone contact will often be the first professional contact following an incident and their actions and recording of information may be crucial to subsequent enquiries. Trust staff are ideally placed to identify safeguarding.

6.1.2 Trust staff with safeguarding concerns about a child or adult should follow the normal history-taking routine, taking particular note of any inconsistency in history and any delay in calling for assistance. They should limit any questions to those of

routine history-taking, asking questions only in relation to the presentation or for clarification. They should document exactly what they have been told.

If Trust staff attend an incident where they are have a safeguarding concern they should ensure that:-

- The presenting clinical condition is assessed and treated;
- The patient is transported to the appropriate medical facility if clinically indicated;
- Concerns and actions are fully recorded, dated and signed;
- Safeguarding concern form is completed and sent to the safeguarding team;
- Any assault is notified to the police;
- Advice and support is sought where necessary, from members of the safeguarding team.

6.1.3 If Trust staff believe an individual - adult or child to be at immediate risk, an urgent verbal referral should be made to the appropriate local authority and/or the police. Immediate safeguards must be put in place to protect that individual. Information shared should include:-

- The identity of referrer and professional role;
- The clinical presentation and clinical outcome for the patient;
- As much demographic information as is possible to obtain about the individual concerned (where known);
- The name and relationship to the patient of anyone else present (where known);
- The patients' GP (where known);
- A brief summary of the concerns and any immediate action taken.
- Any verbal referral must be followed up in writing using a standard referral form, containing the above information.

For non-urgent referrals, the above information must be included on a safeguarding referral form and sent to the safeguarding team. Referrals must be made even when another agency such as the Police are in attendance. Staff must take responsibility for acting on their concerns and cannot delegate this to a third party.

6.1.4 Concerns for the child should normally be shared with the parent or carer responsible for the child, unless this is likely to jeopardise the clinical outcome or place the child at increasing risk. There should also be a consideration of risk to the staff if concerns are shared.

6.1.5 Any observations of injuries and verbal abuse must be carefully documented. The Patient Clinical Record and Referral Form may form a vital evidence base for safeguarding enquiries, investigations or prosecutions. Staff may be required, following a referral, to attend a case conference or for their evidence to be called to court. Staff will be supported in these processes by their line manager or a member of the safeguarding team.

7 Related SECAmb policies

7.1 Frequent Callers SECAmb takes its responsibility for patient care very seriously and is committed to achieving the best outcomes for individual patients and the community it serves. The proactive management of individuals who call the service frequently aims to achieve both these ends. Callers who call frequently may indicate a level of unmet need either social or medical or may indicate an inappropriate use of resources. Please refer to the frequent callers policy for further information.

7.2 Mental Capacity Act. The Act provides a framework for decision making for those aged 16yrs and over who lack the capacity to make decisions on their own. The overriding principle of the Act is that there is a presumption that a person has capacity unless it is proved (by undertaking a capacity assessment) otherwise. Any decisions made on behalf of those lacking capacity, must be made in their Best Interests. Capacity to consent may be affected by many factors, including learning disability, drug or alcohol ingestion or emotional state, this is not an exhaustive list and the Trust MCA policy should be consulted for further information.

7.3 Managing Safeguarding Allegations Against Staff. Children and adults can be subjected to abuse by those who work with them in any and every setting. All safeguarding allegations of abuse or maltreatment of children and adults by a professional, staff member, volunteer or contractor, must therefore be taken seriously and treated in accordance with consistent procedures. If there is a concern raised in relation to a member of SECAmb staff, the Managing Allegation policy and procedure must be followed

7.4 Managing Death or life threatening incidents in the under 18 years. When there is a child who has died or who has life threatening injuries, the procedure must be followed ensuring the police and the safeguarding team are notified. Every unexpected, unexplained child death is reviewed by the local Child Death Overview Panel (CDOP) where the child was normally resident. Any areas identified as part of the CDOP review process will be escalated and considered internally under the Learning from Deaths Policy (Draft).

7.4.1 All staff identified as having been involved in an incident where a child dies will be offered support via their line manager, Traumatic Risk Management (TRiM) coordinator or local and national support services available to all staff. The safeguarding team will email all staff involved to make sure they have access to this information with immediate de-brief/support arranged via the Emergency Operations Centre (EOC) at the time of any incident.

8 Education, Training and Awareness

8.1 The Trust has a Safeguarding Training Strategy which outlines all of the training requirements for SECAmb staff, and at which level.

8.2 Safeguarding training is offered to staff in both face to face ‘classroom’ sessions and via e-learning, dependent on the level of training.

8.3 In addition to the Safeguarding training packages available, there are other courses available to staff including MCA and Prevent.

Appendix 1 - Safeguarding Guidance Notes (Relevant to All)

Safeguarding Guidance which relates to both Children and Young People and Adults.

All types of abuse may be inflicted deliberately; some may be as the result of negligence, ignorance or lack of understanding. The person responsible for the abuse is often known to the person being abused, however abuse or neglect can be caused by anyone.
Abuse can take place anywhere, in homes, in the community, in hospitals, day care, residential homes, nursing homes, hostels and sheltered housing. People living in their own homes may also be abused by staff employed to provide support to them. Abusive behaviour may be part of the accepted custom within an organisation, or it may be carried out by an individual member of staff or a particular staff group.

Domestic Abuse

Domestic abuse is a serious crime that has a major impact on the primary victim as well as members of the extended family. It costs society and the health service billions of pounds and has long lasting effects on the mental and physical health of all victims.
The Home Office have defined domestic abuse as “any incident of threatening behaviour, violence or abuse, (psychological, physical, financial or emotional) and coercive control between anyone aged 16 and over, who are or have been intimate partners or family members, regardless of gender and sexuality” Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family (ACPO).
Extent of the problem:-

- 25% of women report having been physically assaulted by a partner at some point; (Walby and Allen, 2004).
- Domestic violence is the largest cause of morbidity in women aged 19-44, greater than war, cancer, and motor vehicle accidents (Krug et al, 2002).
- Although 90% of reported domestic abuse is perpetrated by men on women, it is recognised that there is an under reporting of abuse, particularly by men who are victims of abuse by women, and by those in same sex relationships;
- Victims of domestic abuse are assaulted on average 35 times before reporting it to the police;
- 30% of cases of domestic abuse start during pregnancy;
- 52% of child protection cases involve domestic abuse.
- These figures relate to reported cases of domestic abuse and therefore are an underestimate of the problem.

Forced Marriage

A marriage conducted without the freely given consent of both parties where duress is a factor. Duress includes emotional pressure and the use of violence. (Foreign and Commonwealth Office)

There is a difference between an arranged marriage and a forced marriage. In arranged marriages, families arrange the match but the choice of whether or not to accept the arrangement remains with the individual. Arranged marriage is a valuable, long established tradition based on compatibility, consent and retaining choice. In forced marriages, there is no choice. No culture or religion sanctions forced marriage.
Planned or actual forced marriage places children and young people at risk of significant harm, which may include sexual, physical and emotional abuse, and is contrary to the United Nations Convention on the Rights of the Child.
Whilst it is unlikely, it is possible that Ambulance personnel may become aware of such cases, as there is an increased risk of self-harm, attempted suicide, eating disorders and depression. It is imperative that any concerns are referred as a Child Protection and Safeguarding matter and that normal procedures are followed.
In the interests of the child/young person's safety, staff making a referral should not inform the young person's family. The decision regarding contact with parents/carers will be taken by Social Services at the strategy discussion stage, based on a risk assessment regarding likelihood of immediate harm to that young person.

Female Genital Mutilation (FGM)

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. However, more than 18% of all FGM is performed by health care providers, and the trend towards medicalisation is increasing
Female Genital Mutilation (FGM) mandatory reporting duty is a legal duty provided for in the FGM Act 2003 (as amended by the Serious Crime Act 2015). The legislation requires regulated health and social care professionals and teachers in England and Wales to make a report to the police where, in the course of their professional duties, they either:

- are informed by a girl under 18 that an act of FGM has been carried out on her; or
- observe physical signs which appear to show that an act of FGM has been carried out on a girl under 18 and they have no reason to believe that the act was necessary for the girl's physical or mental health or for purposes connected with labour or birth.

For the purposes of the duty, the relevant age is the girl's age at the time of the disclosure/identification of FGM (i.e. it does not apply where a woman aged 18 or over discloses she had FGM when she was under 18).
However, Health professionals have a duty to consider the risk to any female child associated with an adult who has undergone FGM.
Key facts

- Female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.
- The procedure has no health benefits for girls and women.
- The procedure has no religious foundation
- Procedures can cause severe bleeding and problems urinating, and later cysts, infections, infertility as well as complications in childbirth and increased risk of new born deaths.

• More than 125 million girls and women alive today have been cut in the 29 countries in Africa and Middle East where FGM is concentrated.
• FGM is mostly carried out on young girls sometime between infancy and age 15.
• FGM is a violation of the human rights of girls and women.
• It is illegal in the UK under the Female Genital Mutilation Act 2003
For more information, please go to:
http://www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx

Prevent

Prevent is the Government's national counter terrorism strategy, aims to reduce the risk to the United Kingdom and its interests overseas from national and international terrorism, so that people can go about their lives freely and with confidence.
The *Prevent* Strategy seeks to stop people becoming terrorists or supporting terrorism. It is the preventative strand of the Government's counter-terrorism strategy and is the area which requires local authorities and other statutory agencies, and voluntary and community organisations, to work together.

The revised *Prevent* strategy was published by the Home Office in June 2011. The principles are aligned to the safeguarding process. *Prevent* highlights the importance for healthcare staff to work in partnership with other agencies.

There are 3 key objectives:

- Respond to the ideological challenge of terrorism and the threat from those who promote it.
- Prevent individuals from being drawn into terrorism and ensure that they are given appropriate advice and support.
- Work with sectors and institutions where there are risks of radicalisation that we need to address.

The Trust has an identified PREVENT lead who acts as a single point of contact for the Trust, and is responsible for implementing *Prevent* within SECAmb.

Any staff that come into contact with a patient or any persons displaying any of the indicators listed above while on duty they must complete a safeguarding form for that person capturing all the relevant details.
If any staff member has concerns of a Prevent nature with regard to any individual working for SECAmb then these concerns must be emailed to safeguarding@secamb.nhs.uk in confidence. These concerns will then be passed to the relevant authority so the individual can be supported.
It is very important to remember that by reporting any individual through the Prevent process is not making them a criminal. There are teams with in the local authorities and police across the SECAmb area that are in place to support these individuals outside of the criminal processes.
For further information on Prevent please go to:
http://www.homeoffice.gov.uk/counter-terrorism/review-of-prevent-strategy/

Appendix 2 - Safeguarding Children Guidance Notes

Safeguarding Children Guidance Notes

The current guidance is outlined in the document “Working Together to Safeguard Children” 2015 and it is from this document that much of the following advice and information is taken. A full copy of the document can be accessed at https://www.gov.uk/government/pubications/working-together-to-safeguard-children--2
The Children Act 1989 places two specific duties on agencies to co-operate in the interests of vulnerable children:
Section 27 provides that a local authority may request help from: any health authority, Special Health Authority or National Health Service Trust;
In exercising the local authority's functions under Part III of the Act. This part of the Act places a duty on local authorities to provide support and services for children in need, including children looked after by the local authority and those in secure accommodation.
The authority whose help is requested in these circumstances has a duty to comply with the request, provided it is compatible with its other duties and functions.
Section 47 places a duty on: any health authority, Special Health Authority or National Health Service Trust; to help a local authority with its enquiries in cases where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, **significant harm**.

The Concept of Significant Harm

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.
The local authority is under a duty to make enquiries, or cause enquiries to be made, where it has reasonable cause to suspect that a child is suffering, or likely to suffer significant harm (s.47).
A court may only make a care order (committing the child to the care of the local authority) or supervision order (putting the child under the supervision of a social worker, or a probation officer) in respect of a child if it is satisfied that:
• the child is suffering, or is likely to suffer, significant harm; *and*
• the harm or likelihood of harm is attributable to a lack of adequate parental care or control (s.31).

There are no absolute criteria on which to rely when judging what constitutes significant harm. Consideration of the severity of ill-treatment may include the degree and the extent of physical harm, the duration and frequency of abuse and neglect, and the extent of premeditation, etc.

Additional triggers which can impact on safeguarding children

Many families although under great stress nonetheless manage to bring up their children in a warm, loving and supportive environment in which the children’s needs are met and they are safe from harm. Sources of stress within families may, however, have a negative impact on a child’s health, development and well-being, either directly, or because they affect the capacity of parents to respond to their

child's needs. This is particularly the case when there is no other significant adult who is able to respond to the child's needs.

The Mental Illness of a Parent or Carer

Mental illness in a parent or carer does not necessarily have an adverse impact on a child, but it is essential always to assess its implications for any children involved in the family. Parental illness may markedly restrict children's social and recreational activities. With both mental and physical illness in a parent, children may have caring responsibilities placed upon them inappropriate to their years, leading them to be worried and anxious. If they are depressed, parents may neglect their own and their children's physical and emotional needs.

In some circumstances, some forms of mental illness may blunt parents' emotions and feelings, or cause them to behave towards their children in bizarre or violent ways. Unusually, but at the extreme, a child may be at risk of severe injury, profound neglect, or even death.

A study of 100 reviews of child deaths where abuse and neglect had been a factor in the death, showed clear evidence of parental mental illness in one-third of cases. In addition, postnatal depression can also be linked to both behavioural and physiological problems in the infants of such mothers.

Drug and Alcohol Misuse

As with mental illness in a parent, it is important not to generalise, or make assumptions about the impact on a child of parental drug and alcohol misuse. It is, however, important that the implications for the child are properly assessed.

Maternal substance misuse in pregnancy may impair the development of an unborn child. A parent's practical caring skills may be diminished by misuse of drugs and/or alcohol.

Some substance misuse may give rise to mental states or behaviour that put children at risk of injury, psychological distress or neglect. Children are particularly vulnerable when parents are withdrawing from drugs. The risk will be greater when the adult's substance misuse is chaotic or otherwise out of control. Some substance-misusing parents may find it difficult to give priority to the needs of their children, and finding money for drugs and/or alcohol may reduce the money available to the household to meet basic needs, or may draw families into criminal activities. Children may be at risk of physical harm if drugs and paraphernalia (e.g. needles) are not kept safely out of reach. Some children have been killed through inadvertent access to drugs (e.g. methadone stored in a fridge).

Role of Social Services

Local authorities, acting in order to fulfil their social services functions, have specific legal duties in respect of children under the Children Act 1989. They have a general duty to safeguard and promote the welfare of children in their area who are in need. Social services departments also have a duty to make enquiries if they have reason to suspect that a child in their area is suffering, or likely to suffer significant harm, to enable them to decide whether they should take any action to safeguard or promote the child's welfare (s.47). They need the help of other agencies in order to do this effectively.

A child who is at risk of significant harm will invariably be a child in need. The social services department is responsible for co-ordinating an assessment of the child's needs, the parents' capacity to keep the child safe and promote his or her welfare, and of the wider family circumstances.
In the great majority of cases, children are safeguarded from harm by working with parents, family members and other significant adults in the child's life to make the child safe, and to promote his or her development, within the family setting. Where a child is at continuing risk of significant harm, social services are responsible for coordinating an inter-agency plan to safeguard the child, which sets out and draws upon the contributions of family members, professionals and other agencies.
In a few cases, the social services department, in consultation with other involved agencies and professionals, may judge that a child's welfare cannot be sufficiently safeguarded if he or she remains at home. In these circumstances, the social services department may apply to the courts for a Care Order, which commits the child to the care of the local authority. Where the child is thought to be in immediate danger, the social services department may apply to the courts for an Emergency Protection Order, which places the child under the protection of the local authority for a maximum of eight days, alternatively the police may be called to take out a Police Protection Order (PPO) which allows the child to be removed to a place of safety for a period of up to 72 hours.
Because of their responsibilities, duties and powers in relation to vulnerable children, social services departments act as the principal point of contact for children about whom there are child welfare concerns. Social Services may be contacted directly by parents or family members seeking help, concerned friends and neighbours, or by professionals and others from statutory and voluntary agencies.

Classification of Child Abuse

- Neglect
- Physical injury
- Sexual abuse
- Emotional abuse

In summary, a child is considered to be at risk of significant harm if he or she is treated by another person in a way that is unacceptable. This can be by an act or omission (failure to protect).
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.

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 feigns the symptoms of, or deliberately causes ill health to a child whom they are looking after.

Emotional Abuse

Emotional abuse is the persistent emotional ill-treatment 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 develop-mentally inappropriate expectations being imposed on children. It may involve 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 ill-treatment of a child, though it may occur alone.

Sexual Abuse

Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape or buggery) 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. Child Sexual Abuse CSE) is a form of Sexual Abuse. Children in exploitative situations and relationships receive something such as gifts, money or affection as a result of performing sexual activities or others performing sexual activities on them. Children or young people may be tricked into believing they're in a loving, consensual relationship. They might be invited to parties and given drugs and alcohol. They may also be groomed online.

Some children and young people are trafficked into or within the UK for the purpose of sexual exploitation. Sexual exploitation can also happen to young people in gangs.

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. It may involve a parent or carer failing to provide adequate food, shelter and clothing, failing to protect a child from physical harm or danger, 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.

Recognition of Non-Accidental Injuries within Children:

Bruises:

To the soft part of the ear which could be caused by slaps to the side of the head. For further information regarding bruises in non-mobile children see NICE guideline 89 (https://www.nice.org.uk/guidance/cg89)

Black Eye:

Bruising around one or both eyes could be caused by a fist or blow or, in the case of both eyes, possibly a blow across the bridge of the nose with something like a feeding bottle.

Suspicious Patterns of Bruising

For example finger marks which could be caused by hard slaps to the body or the child being forcibly gripped and shaken.

Abnormal Bruising

Over areas of the body not normally injured for example, abdomen, chest, back and perineum.

Different Stages of Bruising:

Could mean repeated assaults over a period of time.

Torn Frenulum:
(The tissue attaching the inside of the top lip to the inner upper jaw). Not a common injury but may be caused by a feeding bottle being rammed into a child's mouth, this would also cause dark red spots of blood beneath the membrane (petechial spotting) on the inside of the top lip.

Frozen Awareness
Where a child's eyes have a frozen look but follow your every move. The child's fears that you will abuse them if you approach.

Burn Marks:
Caused by hot objects placed on the child's body for example keys, poker ends, hot iron, etc.

Cigarette Burns:
In various stages of healing. A combination of fresh, raw burns or healed pink circles. These are normally deep burns.

Scalds with Inconsistent History:
"The child stepped into a bath of hot water". If only the tops of the child's feet are scalded, is this history plausible?

Bite Patterns:
Bruising and abrasions in bite patterns on the child's limbs.

Looked After Children & Care Leavers
Most children become looked after as a result of abuse and neglect. Although they have many of the same health issues as their peers, the extent of these is often greater because of their past experiences. For example, almost half of children in care have a diagnosable mental health disorder and two-thirds have special educational needs. Delays in identifying and meeting their emotional well-being and mental health needs can have far reaching effects on all aspects of their lives, including their chances of reaching their potential and leading happy and healthy lives as adults. (DfE DH 2015)

In accordance with The Statutory Guidance for Promoting the Health & Wellbeing of Looked After Children (DfE DH 2015) The NHS has a major role in ensuring the timely and effective delivery of health services to looked-after children. The Mandate to NHS England, Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies and The NHS Constitution for England make clear the responsibilities of CCGs and NHS England to looked-after children (and, by extension, to care leavers).

In fulfilling those responsibilities the NHS contributes to meeting the health needs of looked-after children in three ways: commissioning effective services, delivering through provider organisations, and through individual practitioners providing coordinated care for each child.

The Government's Mandate to NHS England includes an explicit expectation that the NHS, working together with schools and children's social services, will support and safeguard looked-after children (and other vulnerable groups) through a more joined-up approach to addressing their emotional, mental and physical health needs.

Every local authority should have agreed local mechanisms with CCGs to ensure that they comply with NHS England's guidance on establishing the responsible commissioner in relation to secondary health care when making placement decisions for looked-after children and to resolve any funding issues that arise.

Looked After Children and Care Leavers – Definition

In England and Wales the term 'looked after children' is defined in law under the Children Act 1989. A child is looked after by a local authority if he or she is in their care or is provided with accommodation for more than 24 hours by the authority.

Looked after children fall into four main groups:

- Children who are accommodated under voluntary agreement with their parents (section 20);
- Children who are the subject of a care order (section 31) or interim care order (section 38);
- Children who are the subject of emergency orders for their protection (section 44 and 46);
- Children who are compulsorily accommodated. This includes children remanded to the local authority or subject to a criminal justice supervision order with a residence requirement (section 21).

The term 'looked after children' includes unaccompanied asylum seeking children, children in friends and family placements, and those children where the agency has authority to place the child for adoption.

It does not include those children who have been permanently adopted or who are on a special guardianship order.

The Children (Leaving Care) Act 2000 states that a Care Leaver is someone who has been in the care of the Local Authority for a period of 13 weeks or more spanning their 16th birthday. CCG's should ensure that there are effective plans in place to enable Looked After Children aged 16 – 17 to make a smooth transition into adult hood. (Dfe DH 2015)

Appendix 3 - Safeguarding Adults Guidance Notes

Guidance Notes specific to Safeguarding Adults

The safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting those needs
- is experiencing, or at risk of, abuse or neglect
- as a result of these care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect.

The safeguarding duties have a legal effect in relation to all organisations including SECAmb.
Where someone is 18 or over but is still receiving children's services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. For example, this could occur when a young person with substantial and complex needs continues to be supported in a residential educational setting until the age of 25. Where appropriate, adult safeguarding services should involve the local authority's children's safeguarding colleagues as well as any relevant partners (for example, the Police or NHS) or other persons relevant to the case. However, the level of needs is not relevant, and the young adult does not need to have eligible needs for care and support under the Care Act, or be receiving any particular service from the local authority, in order for the safeguarding duties to apply.

Local authority statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting, other than prisons and approved premises where prison governors and National Offender Management Service (NOMS) respectively have responsibility. However, senior representatives of those services may sit on the Safeguarding Adults Board and play an important role in the strategic development of adult safeguarding locally. Additionally, they may ask for advice from the local authority when faced with a safeguarding issue that they are finding particularly challenging.

<u>Adult safeguarding – what it is and why it matters</u>

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted including, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. This must recognise that adults sometimes have complex interpersonal relationships and may be ambivalent, unclear or unrealistic about their personal circumstances. Organisations should always promote the adult's wellbeing in their safeguarding arrangements. People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and

other staff should not be advocating ‘safety’ measures that do not take account of individual well-being, as defined in Section 1 of the Care Act.

Safeguarding is not a substitute for:
- SECAmb’ responsibilities to provide safe and high quality care and support
- commissioners regularly assuring themselves of the safety and effectiveness of commissioned services
- the Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action
- the core duties of the police to prevent and detect crime and protect life and property

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

In order to achieve these aims, it is necessary to:
- ensure that everyone, both individuals and organisations, are clear about their roles and responsibilities
- create strong multi-agency partnerships that provide timely and effective prevention of and responses to abuse or neglect
- support the development of a positive learning environment across these partnerships and at all levels within them to help break down cultures that are risk-averse and seek to scapegoat or blame practitioners
- enable access to mainstream community resources such as accessible leisure facilities, safe town centres and community groups that can reduce the social and physical isolation which in itself may increase the risk of abuse or neglect
- clarify how responses to safeguarding concerns deriving from the poor quality and inadequacy of service provision, including patient safety in the health sector, should be responded to.

The following six principles apply to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider local authority functions and the criminal justice system. The

principles should inform the ways in which professionals and other staff work with adults. The principles can also help SABs, and organisations more widely, by using them to examine and improve their local arrangements.

Six key principles underpin all adult safeguarding work

Empowerment
People being supported and encouraged to make their own decisions and informed consent.
I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.

Prevention
It is better to take action before harm occurs.
I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.

Proportionality
The least intrusive response appropriate to the risk presented.
I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.

Protection
Support and representation for those in greatest need.
I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.

Partnership
Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.

Accountability
Accountability and transparency in delivering safeguarding.
I understand the role of everyone involved in my life and so do they.

Making safeguarding personal
In addition to these principles, it is also important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised.
Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as

well as improving quality of life, wellbeing and safety. Nevertheless, there are key issues that local authorities and their partners should consider.

What constitutes abuse and neglect?
This section considers the different types and patterns of abuse and neglect and the different circumstances in which they may take place. This is not intended to be an exhaustive list but an illustrative guide as to the sort of behaviour which could give rise to a safeguarding concern. This chapter also contains a number of illustrative case studies showing the action that was taken to help the adult stay or become safe.
Local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered; although the criteria above will need to be met before the issue is considered as a safeguarding concern. Exploitation, in particular, is a common theme in the following list of the types of abuse and neglect.

Physical abuse including:

- assault
- hitting
- slapping
- pushing
- misuse of medication
- restraint
- inappropriate physical sanctions

Domestic violence including:

- psychological
- physical
- sexual
- financial
- emotional abuse
- so called ‘honour’ based violence

Sexual abuse including:

- rape
- indecent exposure
- sexual harassment
- inappropriate looking or touching
- sexual teasing or innuendo
- sexual photography
- subjection to pornography or witnessing sexual acts
- indecent exposure
- sexual assault
- sexual acts to which the adult has not consented or was pressured into consenting

Psychological abuse including:

- emotional abuse
- threats of harm or abandonment
- deprivation of contact

- humiliation
- blaming
- controlling
- intimidation
- coercion
- harassment
- verbal abuse
- cyber bullying
- isolation
- unreasonable and unjustified withdrawal of services or supportive networks

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

Modern slavery encompasses:
- slavery
- human trafficking
- forced labour and domestic servitude.
- traffickers and slave masters using whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment

Read Modern slavery: how the UK is leading the fight for further information.

Discriminatory abuse including forms of:
- harassment
- slurs or similar treatment:
  - because of race
  - gender and gender identity
  - age
  - disability
  - sexual orientation
  - religion

Read Discrimination: your rights for further information.

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

Neglect and acts of omission including:
- ignoring medical
- emotional or physical care needs

- failure to provide access to appropriate health, care and support or educational services
- the withholding of the necessities of life, such as medication, adequate nutrition and heating

Self-neglect
This covers a wide range of behaviours including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.
Incidents of abuse may be one-off or multiple, and affect one person or more. Professionals and others should look beyond single incidents or individuals to identify patterns of harm, just as the CCG, as the regulator of service quality, does when it looks at the quality of care in health and care services. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organisational abuse. In order to see these patterns it is important that information is recorded and appropriately shared.

Patterns of abuse vary and include:
- serial abuse, in which the perpetrator seeks out and 'grooms' individuals Sexual abuse sometimes falls into this pattern as do some forms of financial abuse
- long-term abuse, in the context of an ongoing family relationship such as domestic violence between spouses or generations or persistent psychological abuse
- opportunistic abuse, such as theft occurring because money or jewellery has been left lying around

Domestic abuse
The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to:
- psychological
- sexual
- financial
- emotional

A new offence of coercive and controlling behaviour in intimate and familial relationships was introduced into the Serious Crime Act 2015. The offence will impose a maximum 5 years imprisonment, a fine or both.

The offence closes a gap in the law around patterns of coercive and controlling behaviour during a relationship between intimate partners, former partners who still live together, or family members, sending a clear message that it is wrong to violate the trust of those closest to you, providing better protection to victims experiencing continuous abuse and allowing for earlier identification, intervention and prevention.

The offence criminalising coercive or controlling behaviour was commenced on 29 December 2015. Read the accompanying statutory guidance for further information.

Financial abuse

Financial abuse is the main form of abuse investigated by the Office of the Public Guardian both amongst adults and children at risk. Financial recorded abuse can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring. Although this is not always the case, everyone should also be aware of this possibility.

Potential indicators of financial abuse include:

- change in living conditions
- lack of heating, clothing or food
- inability to pay bills/unexplained shortage of money
- unexplained withdrawals from an account
- unexplained loss/misplacement of financial documents
- the recent addition of authorised signers on a client or donor's signature card
- sudden or unexpected changes in a will or other financial documents

This is not an exhaustive list, nor do these examples prove that there is actual abuse occurring. However, they do indicate that a closer look and possible investigation may be needed. Read report on The Financial Abuse of Older People

Most financial abuse is also capable of amounting to theft or fraud and would be a matter for the police to investigate. It may also require attention and collaboration from a wider group of organisations, including shops and financial institutions such as banks.

Internet scams, postal scams and doorstep crime are more often than not, targeted at adults at risk and all are forms of financial abuse. These scams are becoming ever more sophisticated and elaborate. For example:

- internet scammers can build very convincing websites
- people can be referred to a website to check the caller's legitimacy but this may be a copy of a legitimate website
- postal scams are massed-produced letters which are made to look like personal letters or important documents
- doorstep criminals call unannounced at the adult's home under the guise of legitimate business and offering to fix an often non-existent problem with their property. sometimes they pose as police officers or someone in a position of authority

In all cases this is financial abuse and the adult at risk can be persuaded to part with large sums of money and in some cases their life savings. These instances should always be reported to the local police service and local authority Trading Standards Services for investigation. The SAB will need to consider how to involve local Trading Standards in its work.

These scams and crimes can seriously affect the health, including mental health, of an adult at risk. Agencies working together can better protect adults at risk. Failure to do so can result in an increased cost to the state, especially if the adult at risk loses their income and independence.

Where the abuse is perpetrated by someone who has the authority to manage an adult's money, the relevant body should be informed - for example, the Office of the

Public Guardian for deputies or attorneys (see para 14.61) and Department for Work and Pensions (DWP) in relation to appointees.
If anyone has concerns that a DWP appointee is acting incorrectly, they should contact the DWP immediately. Note that the DWP can get things done more quickly if it also has a National Insurance number in addition to a name and address. However, people should not delay acting because they do not know an adult's National Insurance number. The important thing is to alert DWP to their concerns. If DWP knows that the person is also known to the local authority, then it should also inform the relevant authority.
While a lot of attention is paid, for example, to targeted fraud or internet scams perpetrated by complete strangers, it is far more likely that the person responsible for abuse is known to the adult and is in a position of trust and power. Read the report on Abuse of Vulnerable Adults in England for more information.

Spotting signs of abuse and neglect
Workers across a wide range of organisations need to be vigilant about adult safeguarding concerns in all walks of life including, amongst others in health and social care, welfare, policing, banking, fire and rescue services and trading standards; leisure services, faith groups, and housing. GPs, in particular, are often well-placed to notice changes in an adult that may indicate they are being abused or neglected. Findings from serious case reviews have sometimes stated that if professionals or other staff had acted upon their concerns or sought more information, then death or serious harm might have been prevented.

Deprivation of Liberties Safeguards (DoLs)
The **Deprivation of Liberty** Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. Sometimes we have to place restrictions on people for their own safety. There are different levels of restriction ranging for example from a locked door to physical restraint. At some point the degree and intensity of these restrictions become what is legally known as a deprivation of liberty.
Deprivation of Liberty safeguards applies to persons over the age of 18 only. There are separate safeguards with regard to persons under 18
Background
Deprivation of liberty legislation arises from the "Bournewood" case which was heard by the European Court of Human Rights. The case decided that where a person is deprived of their liberty without any legal authority then it is a breach of Article 5 of the European Convention of Human Rights:
"No one should be deprived on their liberty unless it is prescribed by law"
Therefore, when a person needs to be deprived of their liberty there must be safeguards in place that will ensure that:
• it is in the person's best interests;
• they have representatives and rights of appeal;
• the deprivation of liberty is regularly reviewed and monitored

The Safeguards cover people in both hospitals and care homes registered under the Care Standards Act 2000. They became a statutory obligation on 1st April 2009.
Some examples that are likely to be a deprivation of liberty:
• Force being used to convey (transport) a resisting person to hospital

• Force being used to prevent a person leaving hospital where they persistently try to leave
• Severely restricting access to the patient by relatives & carers
• Decision to admit being opposed by relatives / carers who live with the patient
• Denying a request by relatives to have the person discharged to their care
• Severely restricting movement within the setting or access to the wider community

Transporting a person who lacks capacity from their home, or another location, to a hospital or care home will not usually amount to a deprivation of liberty (for example, to take them to hospital by ambulance in an emergency.) Even where there is an expectation that the person will be deprived of liberty within the care home or hospital, it is unlikely that the journey itself will constitute a deprivation of liberty so that an authorisation is needed before the journey commences. In almost all cases, it is likely that a person can be lawfully taken to a hospital or a care home under the wider provisions of the Act, as long as it is considered that being in the hospital or care home will be in their best interests.
The following examples are unlikely to be a deprivation of liberty by themselves:
• Locked ward
• Keypad / double door handles
• Bringing back the patient who has wandered
• Reasonable persuasion being used to take a confused person to hospital
• Placing reasonable limitations on visitation rights
• Refusing to let the patient leave without an escort whose job is to support them
• Force being used to convey (transport) a resisting person to hospital this isn't a deprivation of liberty, ref para 2.14 MCA DoLS Code of Practice 2009

Remember a person must lack capacity as defined in the Mental Capacity Act 2005 and be considered in need of a deprivation of liberty before any person can have their liberty deprived, even in an emergency situation. All staff depriving a person's liberty in any form **MUST** ensure that a full Mental Capacity assessment has been completed and this assessment is fully documented unless they are lawfully detained under the Mental Health act 1983.
When attending a patient that has a Deprivation of Liberty order in place the attending staff must ensure that the order is valid and request to see a copy of the order to confirm this. If you are transporting the patient then a request to take a copy of the order with the patient to hospital must be made to the senior manager responsible for ensuring the compliance of the order. If this is refused then the refusal must be documented and the name of the refusing manager recorded.
While carrying out your duties if you come across a patient that has their liberty deprived and there has been no formal assessment completed you must report this via a safeguarding alert and in some extreme cases report this to the police immediately.
For further information please go to:
http://www.scie.org.uk/publications/ataglance/ataglance43.asp.

Appendix 4 – Training Strategy

training strategy
Final.docx