Safeguarding Adults in Stockport

Safeguarding Adults at Risk

The Multi Agency Policy for Safeguarding Adults at Risk

Version Control

	Date	Author
1	August 2019	Nuala O'Rourke
2	October 2019	Nuala O'Rourke after multi-agency meeting
3	September 2019	Updating - Nuala O'Rourke
4	October 2019	Updated - Nuala O'Rourke
5	**November 2020**	**Updated – Lee Woolfe**

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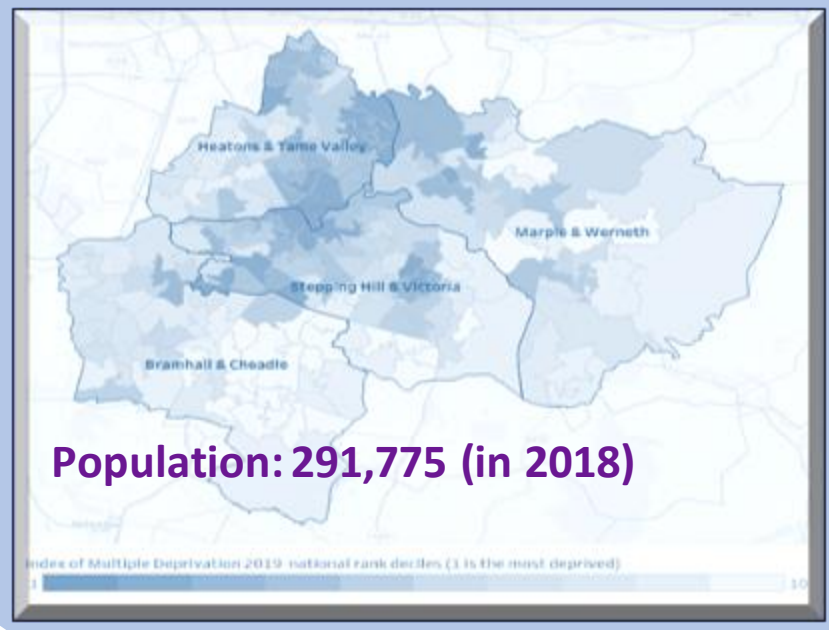
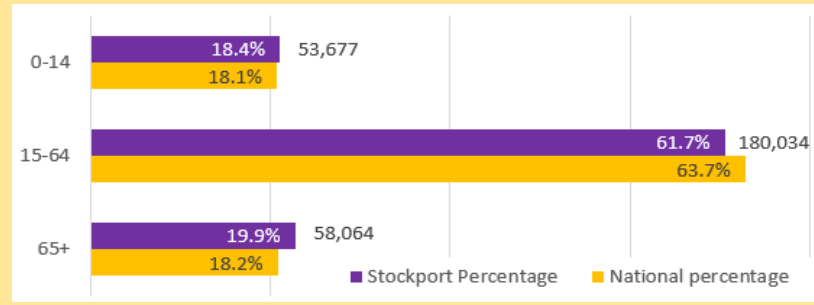
Part 1 - Stockport Context

Stockport Demographics



Population: 291,775 (in 2018)

AGE



DIVERSITY

Stockport is less diverse than the National Average, with most identifying as White British – but this is changing.

HEALTH

44% of the GP registered population have a long-term health condition.

22% of life of the average person will be spent in ill-health.

There is an ageing population with increasing complex needs.

POVERTY

Small areas rank within the 2% most and 2% least deprived in the UK. 38% of the population live in areas of higher than average deprivation. The 65+ group is more represented in less deprived areas.

LIFE EXPECTANCY

Males are expected to live to 79.9 years and females to 83.3 years, rates similar to the national average.

EFFECTS

The increase in the dependency ratio increases the burden on expenditure and services. People who live on their own are at higher risk of social isolation.

GROWTH

The 65+ group has grown by 18% in the last 10 years.

38,535 people live in one person households, 21,657 of whom are aged 65+.


If Stockport were 100 people...
Services
4 known to adult social care
18 admitted to hospital
22 visit A&E
£2,025 spend per head
The people
Age
6 aged 0 to 4
17 aged 5 to 19
57 aged 20 to 64
14 aged 65 to 79
6 aged 80+
Social
4 are unemployed
14 live alone
14 live in 20% most deprived areas
Health
Lifestyles
25 drink unhealthily
22 are obese
16 smoke
23 are inactive
Long term conditions
15 have hypertension
7 have asthma
5 have diabetes
4 have heart disease
30 have at least 1 long term condition
1 has dementia
1 has a serious mental illness
2 have had a stroke
3 have cancer
9 have 2 or more key long term conditions

Vision, Aims and Values

Our vision is 'working in partnership to support and safeguard the people of Stockport to enable them to live safe, healthy and, where possible, independent lives'.

Our values that underpin the vision

- Be excellent
- Be of service and accountable
- Be honest and open
- Learn from experience
- Respect and value everyone
- Be kind and work together

Aims of the safeguarding board

The Safeguarding Board has extended the definition of safeguarding to include prevention and promotion of welfare, and has a remit to promote the safety and welfare of all children in Stockport, in addition to continuing to lead in the well-established area of child protection for those who are vulnerable. The aims to:

- To develop and agree local policies and procedures for inter-agency work to protect children, within the national framework;
- To audit and evaluate how well local services work together to protect children;
- To put in place objectives and performance indicators;
- To encourage effective working relationships between services and professional groups, based on trust and mutual understanding;
- To ensure agreement across agencies about operational definitions and thresholds;
- To improve local ways of working based on knowledge from national and local experience and research, and to ensure lessons learned are acted upon;
- To undertake case reviews where a child has died or in certain circumstances has been seriously harmed;
- To help improve the quality of child protection work through inter agency training and development;
- To raise awareness within the wider community of the need to safeguard children and promote their welfare.

Values – How we work together

Part 2 – Safeguarding Policy

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What is Safeguarding Adults?

Partners in Stockport believe it is a fundamental human right for our residents to live in safety, free from abuse and the fear of abuse.

Safeguarding adults is everyone's responsibility and our wish is to develop a town where all organisations, communities, families and individuals understand how to support and safeguard adults in our Town to live their lives free from abuse and neglect.

Safeguarding adults involves taking positive action to protect the rights of adults with care and support needs to live in safety within Stockport.

Safeguarding is a term with a broad meaning. It encompasses a range of responsibilities including:

- Supporting people to manage risk in their lives, so as to minimise the risk of abuse or neglect
- Continuously improving services within Stockport, learning from our practice, in a way that limits opportunities for abuse and neglect to occur
- Supporting people to end abuse that they are experiencing.

The **Care Act 2014** guidance describes safeguarding adults as:

'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.'

The Aim of the Policy and Procedures

This policy, in line with the Care Act 2014, recognises that adults at risk can suffer abuse, ill treatment and discrimination, and that this is an infringement of their human and civil rights. This policy aims to make sure that:

- **Practice is person led and outcome focused; ensuring** the adult at risk is supported to maintain choice and control.
- The needs and interests of adults at risk are always respected and upheld.
- The human rights of adults at risk are respected and upheld.
- The dignity of adults at risk is respected and upheld.
- The prevention of abuse where possible is a key priority for all services.
- A proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse.
- All relevant decisions and actions comply with the Mental Capacity Act 2005.
- The health and safety of the adult at risk is paramount.

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What are Stockport's Multi-Agency Policy and Procedures?

The Stockport Multi-Agency Safeguarding Adults Policy and Procedures is the local code of practice that has been formulated and agreed in by the Safeguarding Adults Board in accordance with the Care Act 2014. This is the updated 2019, 4th edition and replaces all previous guidance on adult protection and safeguarding in Stockport.

This document reflects the recognition that adults at risk (see below for definition) can suffer abuse, ill treatment and discrimination and that these represent an infringement of their human and civil rights. The policy recognises that all people have the right to live their life free from abuse and free from the fear of abuse.

The policy is concerned with adults at risk in Stockport who are unable without assistance to protect themselves from abuse. This policy and procedures makes a clear distinction between the broader safeguarding agenda for all Adults at Risk, and the Adult Protection operational procedures that should be invoked in individual cases of suspected or actual abuse of an adult at risk.

All activity undertaken within the policy and procedure will be carried out in a way that is appropriate to the level of understanding, degree of disability, means of communication, ethnic and cultural background, gender or sexual orientation of the person concerned.

Definitions of Adult at Risk, Abuse, Harm, Significant Harm and Dignity

Adult at Risk

The term 'Adult at Risk' is used throughout this policy but is interchangeable with term 'Vulnerable Adult.

Care Act 2014 section 42 (1) states Safeguarding duties apply to an adult who:

- **Has needs for care and support (whether or not the Local Authority is meeting any of these needs) *and;***
- **Is experiencing, or at risk of abuse or neglect*; and***
- **As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse and neglect.**

The Care Act defines an Adult at Risk as a person aged 18 or over whom:

- Is aged 18 or over but stills receives children's services *(the level of care and support is not relevant, and the young adult does not have 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- as long as the conditions set out above are met).
- Is eligible for or receives any adult social care service* (including carers services) provided or arranged by the local authority or

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Adult at Risk (continued)

- receives Direct Payments in lieu of Adult Social Care services, or
- funds their own care and has social care needs, or
- otherwise has social care and/or health needs that are low, moderate, substantial or critical.
- Falls within any other category prescribed by the secretary of state
- Is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse by the cared for person.
- Is unable to demonstrate the capacity to make a decision and is in need of care and support.

This does not mean that just because a person is old or frail or has a disability that they are inevitably 'at risk'. For example, a person with a disability who has mental capacity to make decisions about their own safety would be perfectly able to make informed choices and protect themselves from harm. In the context of Safeguarding Adults, the vulnerability of the adult at risk is related to their care needs and how able they are to make and exercise their own informed choices, free from duress, pressure or undue influence of any sort, and to protect themselves from abuse, neglect and exploitation.

It is important to note that people with capacity can also be vulnerable.

Abuse, Harm, Significant Harm and Dignity

For the purpose of this policy the term abuse is defined as:

'An act or omission, a violation of an individual's **dignity**, human or civil rights, by any other person or persons which results in **significant harm** to the physical, emotional or social wellbeing of an adult at risk'.

Key concepts in adult safeguarding work are 'Harm' and 'Significant Harm'. They help to determine the seriousness and extent of abuse and assist in determining the level of intervention. However the distinction between harm and significant harm should not be the sole means in determining whether or not abuse has occurred.

Harm (regardless of whether the impact of this is a significant or not) is defined as:

- Ill treatment (including sexual abuse and forms of ill-treatment that are not physical).
- The impairment of development and/ or an avoidable deterioration in, physical or mental health.
- The impairment of physical, emotional, social or behavioural development or the impairment of health.
- Unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion).

(Taken from: Who Decides? - Lord Chancellor's Department 1997; and the Law Commission Review of Adults Social Care Law

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Significant Harm

The impact of harm upon a person will be individual and depend upon each person's circumstances and the severity, degree and impact or effect of this upon that person. The concept of 'significant harm' is therefore relative to each individual concerned.

The difference between harm and significant harm is not always clear at the point of the alert or referral. All reports of suspicions or concerns should be approached with an open mind and could give rise to action under the policy and procedures.

Dignity

Being treated with dignity and respect is a human right. The opening sentence of the United Nations Universal Declaration of human rights declares that;

'Recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world'.

Dignity, quality and safeguarding are inextricably linked in the provision of services to adults at risk. Treating people with respect and therefore helping them retain their dignity and self-respect is an important aspect of the quality of services provided by both health and care providers. Corporate neglect is often the result of not putting dignity at the core of service provision. For further information regarding harm, please see the Harm Level Guidance.

Who is expected to Comply with this Policy and Procedures?

- All statutory organisations delivering Health and Social Care in Stockport (see 3.1.1)
- All organisations from which services are commissioned by the statutory Health and Social Care organisations.
- Any other organisation working with adults at risk in Stockport.

Additionally each organisation should have its own internal procedures and guidelines informing their staff of their responsibilities to protect adults at risk and specifying how these relate to Stockport's multi agency policy and procedures.

These multi-agency procedures should also be used in conjunction with individual organisations procedures on related issues such as domestic violence, fraud, disciplinary procedures and health and safety.

In complying with the policy and procedures all organisations and individuals confirm their commitment to:

- Work together on the prevention, identification and investigation of abuse and the protection and support of people who may be at risk.
- Maintain a dialogue at both strategic and operational levels to ensure multi-agency co- operation.
- Share information within legal and professional constraints.
- Ensure that staff – both in commissioned and directly provided services - understands the policy and procedures and implement it consistently.
- Contribute to the monitoring and evaluation of the implementation of the policy and procedures.
- Identify the resources required, within acknowledged constraints, to meet these commitments.

Recognise that the right of self-determination can involve risk and ensure that such risk is acknowledged and understood and appropriate steps taken to minimise the risk once it has been identified.

Relevant Training

The Care Act 2014, requires that all those involved in the provision of health and social care will undergo appropriate training to ensure all staff meet the relevant level of competency in relation to safeguarding adults at risk.

Details of available training can be found here

Guiding Principles underpinning this Policy

By implementing this policy and procedures to safeguard the basic human rights of individuals in our society, we have agreed the following principles as set out in the care act 2014

- **Empowerment -** Presumption of person led decisions and informed consent.
- **Prevention -** It is better to take action before harm occurs.
- **Proportionality -** Proportionate and least intrusive response appropriate to the risk presented.
- **Protection -** Support and representation for those in greatest need.
- **Partnership -** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability -** Accountability and transparency in delivering safeguarding.

In order to effectively implement these guiding principles it is of paramount importance that at all times, the adult at risk and/or their representatives are fully supported to engage in the adult protection process.

Making Safeguarding personal

Making Safeguarding Personal is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Making Safeguarding Personal is about seeing people as experts in their own lives and working alongside them. It is about collecting information about the extent to which this shift has a positive impact on people's lives. It is a shift from a process supported by conversations to a series of conversations supported by a process.

Why do we need this Policy and Procedures?

This policy lays out locally agreed multi-agency procedures so that NHS Services, Adult Social Care, the Police, local Independent, Statutory and Voluntary organisations can work together to safeguard and protect adults at risk from abuse.

There are many advantages to a multi-agency approach including:

- Having an overview of a person at risk's vulnerability through sharing information between organisations.
- A reduction in the number of interviews conducted.
- A clearer understanding of agency roles in dealing with abuse.
- Co-ordinated service delivery to the abused person and carer.
- Shared responsibility for working with people who have experienced abuse.
- An assurance that procedures for protection and care of vulnerable adults are consistently implemented and understood.
- The process being monitored.

The Rights of the Individual

The policy and procedure is a practical expression of the commitment of all partners in Stockport to ensure that individual rights are recognised and upheld. All people have the right to:

- Be treated with dignity at all times.
- Respect from their families and carers, and professionals and volunteers providing services for them.
- The freedom to express their thoughts and feelings providing this does not break the law or infringe other people's rights.
- Be meaningfully involved in making decisions that affect their lives.
- Personal privacy, including not having personal letters opened or phone calls listened to unless the law allows this.
- Be included in the activities and opportunities of ordinary living.
- Information, especially concerning things that would make life better for them.
- Adequate standards of living, good food, access to health care and freedom from neglect.
- Opportunities and support to become as independent and active as possible and to develop their full potential.
- Safety, adequate care and protection from all forms of violence, including physical punishment, intimidation, harassment, belittling, and sexual assault.
- To access the criminal justice system if a crime is believed to have been committed.
- Leisure time activities of their choice, including those with an element of risk.
- Retain money and property that is legally theirs.
- To be free from discrimination on the grounds of ethnic origin, culture, religion, gender, sexuality, age or disability.

All adults should be enabled to take control of their lives. The challenge for the implementation of this policy and procedure is to achieve the right balance between protecting individuals and enabling them to manage their own risks. In doing this individuals need to be at the centre of making any decisions that affect them.

This policy and procedures will be implemented with due regard to equality of opportunity and where appropriate will take into account the statutory rights of carers. This will include work undertaken in partnership with carers wherever it is in the interests of the adult at risk.

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The remit of the Safeguarding Adults Board

The Care Act 2014 puts Adult Safeguarding on a legal footing. From April 2015, the Stockport Safeguarding Adults Board (SSAB) became a legal entity with core membership from the local authority, the Police and the NHS (specifically the local Clinical Commissioning Groups).

The (SSAB) must lead adult safeguarding arrangements across Stockport and oversee and coordinate the effectiveness of the safeguarding work of its members and partner agencies. The Board will work to promote the wellbeing, security and the safety of vulnerable people, recognising their rights, mental capacity and personal responsibility in order to help prevent abuse wherever possible.

Under the Care Act 2014, SSAB has three core duties. It **must:**

- develop and publish a strategic plan setting out how it will meet its objectives and how its members and partner agencies will contribute
- publish an annual report detailing how effective its work has been
- commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these (please see supporting documents for criteria and how to make a SAR referral)

In addition the SSAB should evidence its arrangements for peer review and self-audit and evidence how SSAB members have challenged one another and held each other account.

Complaints and Appeal Process

Any complaints relating to investigations of abuse under this policy and procedures will be dealt with through the existing complaints processes within Stockport Councils Adult Social Care or Pennine Care NHS Foundation Trust.

However the Safeguarding Adults Board will maintain an overview of all complaints made and the responses given.

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Who could be supported with these multi-agency safeguarding policy and procedures?

These multi-agency safeguarding adults policy and procedures apply:

Where the local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

a) has needs for care and support (whether or not the authority is meeting any of those needs),
b) is experiencing, or is at risk of, abuse or neglect, and
c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

In these circumstances, the local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

These procedures may therefore be relevant to: a person with age related frailty (Care Act 2014, Section 42)

- a person with a physical disability, a learning disability or a sensory impairment
- someone with mental health needs, including dementia or a personality disorder
- a person with a long-term health condition
- someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living.

When deciding whether or not these policy and procedures apply, it is not relevant whether the person is ordinarily resident in the area or not; nor is it relevant whether the person meets the eligibility criteria for local authority services.

Part 3 - Key issues

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What is Abuse? – Categories and Indicators

Abuse may be:

- A single act or repeated acts
- An act of neglect or a failure to act
- Multiple acts, for example, an adult at risk may be neglected and also being financially abused.

Abuse is about the misuse of power and control that one person has over another. Where there is dependency, there is a possibility of abuse or neglect unless adequate safeguards are put in place. Intent is not an issue at the point of deciding whether an act or a failure to act is abuse; it is the impact of the act on the person and the harm or risk of harm to that individual.

Abuse can take place in settings such as the person's own home, day or residential centres, supported housing, educational establishments, or in nursing homes, clinics or hospitals.
What constitutes abuse or neglect should not be considered in isolation. Abuse and neglect can take many forms and the circumstances of each individual must always be considered.
A number of abusive acts are crimes and informing the police must be a key consideration.

Categories and indicators of Abuse

There are ten categories of abuse in the policy which are listed below with possible indicators for each type of abuse.

The presence of one or more indicators does not necessarily mean that a vulnerable person is being abused; however, they may reflect the potential for abuse in a given situation and suggest the need for further investigation.

Different indicators of abuse are not mutually exclusive to one category and the same indicators may present across the various categories of abuse.

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Physical Abuse

Physical abuse is any abuse which has a physical impact on that individual, this includes:

- Hitting, slapping, kicking, shaking, pinching, dragging, pulling or pushing
- Burning or scalding.
- Force feeding or tampering with food.
- Misuse or mal-administration of medication.
- Inappropriate restraint*.
- Inappropriate moving and handling/rough handling.
- Inappropriate isolation or confinement.
- Withdrawal of sensory or mobility aids.
- Honour based violence.
- Making someone purposefully uncomfortable (e.g. opening a window and removing blankets).
- Forcible feeding or withholding food.
- Unauthorised restraint, restricting movement (e.g. tying someone to a chair).
- Neglect leading to pressure ulcers.

Possible Indicators

- Injuries inconsistent with or not fully explained by the account given and / or differing accounts given.
- Injuries inconsistent with the person's lifestyle.
- History of unexplained injuries or falls.
- Bruising on the torso, back, buttocks or thighs or in well protected areas such as the inside of the leg or upper arm or on each side on soft parts of the body.
- Bruising clustered from repeated striking.
- Injuries or bruising at different stages of healing.
- Marks on the body in the shape of an object.
- Finger mark bruising.
- Fractures, especially if these are in different stages of healing.
- Multiple or spinal injuries.
- Burns, including scald marks, rope burns, carpet burns, electrical appliance burns.
- Unexplained hair loss in clumps.
- Cuts or abrasions to the mouth, lips, gums, eyes or external genitalia.
- History of changes of GP or social care agencies.
- Signs of misuse of medication such as over or under medication.
- Lack of personal care, inadequate or inappropriate clothing, inadequate heating, left in wet clothing.
- Subdued behaviour in presence of the carer.
- Urinary or faecal incontinence.
- Malnutrition – rapid or continuous weight loss, complaints of hunger.
- Use of furniture and other equipment to restrict movement.

Further Information

Physical abuse can also be associated with other forms of abuse, such as psychological abuse.

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Use of Restraint

Inappropriate use of restraint or physical interventions and/or unlawful deprivation of liberty is physical abuse. In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence. Someone is using restraint if they use force, or threaten to use force, to make someone do something they are resisting, or where a person's freedom of movement is restricted, whether they are resisting or not. Restraint covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned does something, or does not do something they want to do. Appropriate use of restraint can be justified to prevent harm to a person who lacks capacity as long as it is a proportionate response to the likelihood and seriousness of the harm. Providers of health and social care must have in place internal operational procedures covering the use of physical interventions and restraint incorporating best practice guidance and the Mental Capacity Act, Mental Capacity Act *Code* and the Deprivation of Liberty Safeguards (DoLs) (see below).

Please note appropriate use of restraint can be justified to prevent harm to a person who lacks capacity as long as it is a proportionate response to the likelihood and seriousness of the harm. Such practice should be clearly documented, stating who the decision maker is and how the less restrictive option was determined.

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Deprivation of Liberty Safeguards (DoLS)

These safeguards provide protection to people in hospitals and care homes who do not have the capacity to consent to their care and treatment and the manner in which it is provide.

In March 2014, the Supreme Court handed down judgment in two cases: *P v Cheshire West and Chester Council and P & Q v Surrey County Council*.1 That judgment, commonly known as *Cheshire West* has led to a considerable increase in the numbers of people in England and Wales who are considered to be deprived of their liberty for the purposes of receiving care and treatment. The Supreme Court decided that when an individual lacking capacity was under continuous or complete supervision and control **and** was not free to leave, they were being deprived of their liberty. This is now commonly called the "**acid test**."

Any Adult at Risk who is detained without consent for the purpose of care or treatment should be deprived of their liberty via a legal means. The legal means available for such actions are a DOLS authorisation, detention under the Mental Health Act 1983, or an order by the Court of Protection.

Care Homes and hospitals must make requests to the Supervisory Body for authorisation to legally deprive someone of their liberty if they believe it is in their best interests. All decisions on care and treatment must comply with the Mental Capacity Act.

Stockport's Supervisory Body is managed by the Adults Safeguarding and can be contacted on 0161 474 3696. Referral forms must be sent to DoLSreferrals@stockport.gov.uk for new Deprivation of Liberty Safeguard authorisations.

Liberty Protection Safeguards

New legislation amending the Mental Capacity Act are making changes and DoLS will now be Liberty Protection Safeguards. The main changes are around completion of assessments and authorisation.

Deprivations of liberty have to be authorised in advance by the 'responsible body'.

- For NHS hospitals, the responsible body will be the 'hospital manager'.
- For arrangements under Continuing Health Care outside of a hospital, the 'responsible body' will be their local CCG (or Health Board in Wales).
- In all other cases – such as in care homes, supported living schemes etc. (including for self-funders), and private hospitals, the responsible body will be the local authority.

For the responsible body to authorise any deprivation of liberty, it needs to be clear that:

- The person lacks the capacity to consent to the care arrangements
- The person has a mental disorder
- The arrangements are necessary to prevent harm to the cared-for person, and proportionate to the likelihood and seriousness of that harm.

Further Information

https://www.scie.org.uk/mca/dols/practice/lps

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Domestic Abuse

Domestic abuse includes psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence; Female Genital Mutilation; forced marriage. Domestic abuse is not only between intimate partners, other family members can be considered perpetrators of domestic abuse.

The Home Office 2013 defines domestic abuse as:

- Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse…. By someone who is or has been an intimate partner or family member regardless of gender or sexuality, who is 16 years old and above.

Domestic abuse is multifaceted in its presentation please see all other categories of abuse for possible indicators of Domestic abuse.

The abuse may take many forms, including physical, psychological, sexual, financial or emotional abuse. It also includes so called 'honour-based violence', female genital mutilation and forced marriage.

Learning from research:

- Women with a disability are twice as likely, to experience domestic abuse than non-disabled women1
- Women with a disability can, due to their circumstances, often be at higher risk than women in the general population[1].
- Older victims are less likely to attempt to leave partner in the year before accessing help[2].
- Victims aged 61+ are much more likely to experience abuse from a current intimate partner than those 60 and under 2.

There is advice and guidance available on the following websites – both for practitioners and members of the public.

Our Domestic Abuse Strategy and Domestic Abuse Pathway can be found here:
https://www.stockport.gov.uk/groups/domestic-abuse-services-in-stockport

www.stockportwithoutabuse.org.uk

www.safelives.org.uk

www.womensaid.org.uk

1 Public Health England: Disability and Domestic Abuse: Risks, Impact and Response
2 Safe Lives: Safe Later Lives: Older people and domestic abuse

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Domestic Abuse in the elderly population

Older victims additional risk indicators

Perception of Aging and age discrimination is one of the most significant contributory factors in assessing and managing the risk of Domestic Abuse in older victims. According to BMA's briefing paper on Ageism (Dr Swift H. and Professor Abrams, D.) 95% of Nursing staff and ED professionals have implicit discriminatory views on Older patients

Implications for health and social care

At the individual level, health care professionals and organisations should be aware that older individuals are potentially vulnerable to age prejudice and stereotyping processes; patients might self-stereotype or be at risk of stereotype threat effects, which have implications for how well they respond to cognitive and physical performance tasks, as well as for their decision making, preventative health behaviours and rehabilitation. It is particularly important, therefore, that health care professions should be careful not to stereotype, use demeaning or patronising language, or use age as a justification for health treatments.

Warning signs an older adult

- Living in an unhealthy relationship (Professional observation and direct questions)
- Controlling behaviour
- Speaking for a family member, at medical visits for example, answering questions and not letting the older adult talk
- Making all the decisions without asking
- Preventing visits with family and friends
- Threatening to leave, neglect or hurt
- Often being short-tempered or angry with the older adult
- Not respecting privacy
- Putting locks in the house, such as bedroom doors, to keep the older adult in or out
- Reading or withholding mail
- Controlling finances without permission or legal authority
- Blaming the older adult
- Treating the older adult like a child
- Belittling and name calling
- Leaving a dependent person alone for long periods of time

Additional adversities that contributes to risk:

- Older adult may feel dependent on the person who is the abuser, so they feel there are no other options.
- Older adults is unable to talk about their unhappy feelings with the abuser, or they don't speak in the same language as the person causing harm.
- Older adult does not feel they can tell anyone because they feel ashamed of embarrassed that someone they loved such as a spouse or family member, has harmed them.
- Older adult does not know about any support services that can help, and is unaware of their options.

Warning Signs – Abusive Behaviour Unique factors or circumstances

- It is importance to consider the power dynamics within the relationship dynamics. All the warning signs in context of power imbalance needs to be explored thoroughly and routinely .
- Refuses or interferes heavily and dominantly, with older adult to have medication, food, water or personal care items.
- Limits use of assistive devices (walker, cane, glasses, hearing aids).
- Hits, pushes, slaps, kicks, burns, pinches and/or restrains or locks older adult in a room.
- Makes older adult fearful or nervous when they are present.
- Takes money, property or belongings without agreement or consent, lives with them and refuses to pay their share of the rent/ mortgage.
- Puts limits on their using the phone or having contact with other people.
- Forces older adult to take part in sexual activity, makes unwanted comments of a sexual nature, shows unwanted images of a sexual nature or forces you to watch other engage in sexual activities
- Yells, threatens, and makes fun of them.
- Convinces the older adult to sign over the legal control of their property or health when they are capable of looking after these things themselves; forced to change their will, or to sign over the ownership of their home, or add them to their bank / credit card accounts.
- The substitute decision maker or power of attorney for property and/or personal care is not acting in older adult's best interest, has not paid their bills or provided enough money for food and necessary items.
- Demeans older adult verbally or with gestures and discredits their views or version of events in name of illness or confusion

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Self Neglect

The Care Act 2014 formally recognises self-neglect as a category of abuse. Adults who self-neglect can now be supported through intervention under safeguarding adults procedures.

The term 'self-neglect' refers to an unwillingness or inability to care for oneself and/or one's environment. It encompasses a wide range of behaviours, including hoarding, living in squalor, and neglecting self-care and hygiene.

Self- neglect is a difficult issue to address in practice, not least because people who self-neglect may not see that they are living with self-neglect. There are questions of personal choice and how to provide help and support to someone who may not want it. In addressing self-neglect under this policy and procedure the response must be proportionate to the risk of harm to the mentally capacitated individual.

Possible indicators

Factors that may indicate neglect include:

- Malnutrition, rapid or continuous weight loss, complaints of hunger or thirst.
- Dehydration.
- Poor personal hygiene.
- Untreated pressure sores.
- Indications of untreated medical problems.
- Signs of mal-administration of medication.
- Failure to provide hearing aids, mobility aids, glasses and dentures.
- Clothing and bedding dirty, wet, soiled, inadequate or inappropriate.
- Accommodation in poor state, inadequate heating or lighting.
- Failure to adhere to agreed care plans and risk assessments.
- Failure to ensure appropriate privacy and dignity.
- Person is exposed to unacceptable risk.

Further Information

Our Self Neglect policy can be found here.

SCIE: Social Care Institute for Excellence provides the following useful reports:

- Self-neglect and adult safeguarding: findings from research
- Self-neglect policy and practice key research messages
- Self-neglect policy and practice: research messages for practitioners

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Neglect and acts of omission

Neglect and acts of omission occur when a person is harmed, as a result of the failure of a person with responsibility to provide the amount and type of care that a reasonable person would be expect to be provided. This might include:

- Failure to provide essential nutrition, clothing, medication and heating.
- Ignoring physical or medical care needs.
- Ignoring emotional care needs
- Denying access to medical, psychiatric, psychological or social care.
- Failure to assess risk or to intervene to avert or reduce danger.
- Failure to access assessments or technical aids (e.g. hearing test/aids).
- Failure to access to educational services
- Failure to give privacy and dignity in delivery of care.

This could be either intentional, such as:

- Wilfully failing to provide care
- Wilfully preventing the person at risk from getting the care they need
- Being reckless about the consequences of the person not getting the care they need

It could also be unintentional, as may occur when:

- An unpaid carer does not fully understand the needs of the person they are caring for, or the consequences of their decisions
- An unpaid carer becomes unable to continue providing for the person's care needs due to their own ill health.

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Hoarding

Hoarding behaviour is typically manifested in three ways:

Acquisition - Compulsive buying and/or the accumulation of items. The motivations for this can be complex and need time to understand. Often reasons for hoarding are deeply entrenched and connected to personal loss or trauma, often going back to childhood. It is important for professionals not to form judgements and to take time to try to identify why the person hoards.

Saving - There are three common reasons for saving: 'sentimental' which can be motivated by grief and refers to the emotional attachment a person feels toward an object i.e. it may become linked to a happy memory or someone they love and miss; 'instrumental' which can often stem from a history of having experienced deprivation, or of having had possessions forcibly taken from them in the past and so items are saved 'just in case I need them' or to guard against 'being without' again in the future; 'intrinsic' or 'aesthetic' where items are saved because they are seen as too beautiful to be discarded.

Disorganisation - Items of value are mixed in with rubbish and items of no apparent value. People who hoard often have difficulty with information processing, categorisation, sequencing tasks and decision making. They may also believe that they have a poor memory which leads to items being stored where they are visible instead of put away in cupboards i.e. 'if I put them away, I won't be able to see them and if I can't see them I won't remember I have them and they will be lost to me'.

Simply working to clear the hoarding is known not to have lasting impact and can cause and exacerbate the long term situation by reinforcing mistrust. Agreed standard practice must be to work with the individual and to agree a strategy which reduces risk and works to minimise future problems. The types of things hoarded vary just as much as the reasons why, and the level of personal acceptance that this is a problem.

The emotions stirred up when attempting to discard hoarded items can be too distressing and/or leave the person feeling vulnerable and insecure. In addition, difficulty with decision making and not being able to break a task down into smaller steps could mean that the process of clearing hoarded items is overwhelming for the person and so avoided.

Clutter images
The help for hoarder's charity gives additional best practice on hoarding. It references clutter images to support an impartial assessment of scales of clutter and hoarding.

Please refer to Help for Hoarders

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Sexual Abuse

Sexual abuse is involving people in sexual activity without their voluntary and informed consent and may also include sexual activity where one party is in a position of trust, power or authority. Sexual abuse includes:

- Vaginal or anal rape
- Inappropriate looking or touching
- Denial of a sexual life
- Incest
- Indecent assault
- Gross indecency
- Sexual harassment
- Coercion or undue influence to engage in sexual activity.
- Sexual teasing or innuendo
- Sexual harassment
- Sexual photography
- Exposure to sexual explicit materials or situations
- Forced marriage
- Sexual activity with a person who lacks the mental capacity to consent.

Professional Relationships

All sexual activity involving staff with individuals for whom they care, or know to be vulnerable is contrary to professional standards. It is abusive and will result in disciplinary proceedings.

Possible indicators

- Factors that may indicate sexual abuse include:
- Full or partial disclosure or hints of sexual abuse.
- Bruising, bleeding or pain in genital, vaginal or anal area.
- Bruising of upper thighs or upper arms.
- Unexplained difficulty in sitting and walking.
- Love bites.
- Sexually transmitted diseases.
- Urinary tract infection or vaginal infection.
- Pregnancy in a person who is unable to consent to sexual relations.
- Persistent unexplained removal of urinary catheters.
- Wetting or soiling when no history of incontinence.
- Torn, stained or bloody underclothing or bedding.
- Overt sexual behaviour or language.
- Unexplained behaviour or mood change.
- Obsession with washing.
- Reluctance to be alone with an individual known to them.
- Fear of caregiver offering help with personal care.
- Signs of depression or stress.

Further Information

https://rapecrisis.org.uk

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Psychological or emotional abuse

Psychological or emotional abuse is behaviour that has an adverse effect on an individual's mental well-being. It includes:

- Bullying and aggression.
- Inappropriate befriending
- Threats and intimidation of harm and or abandonment
- Derivation of contact
- Isolation
- Unreasonable and unjustified withdrawal of services or supportive networks
- The denial of basic human and civil rights such as self-expression, privacy and dignity.
- Humiliation, ridicule and name calling.
- Exclusion from group or marginalisation.
- Denial of access to social contact, cultural or religious observance or possessions.
- Disregard of choice and consent.
- Verbal abuse.
- Cyber bullying
- Grooming, recruiting and encouraging participation in acts of violence or violent extremism – **(The Channel Process - see section 2.10 for more information)**
- Forced Marriage – this is a violation of internationally recognised human rights and contrary to Matrimonial Causes Act 1973. – comes under Domestic Abuse

Possible indicators

Factors that may indicate psychological or emotional abuse may include:

- Fear, watchfulness or agitation
- Deference, resignation and passivity
- Excessive loyalty and over-anxious to please
- Oppressive atmosphere or tension in the presence of certain others
- Low self-esteem
- Loss of interest, emotional withdrawal or symptoms of depression
- Sleep disturbance
- Significant weight loss or gain
- Over controlling behaviour by third party
- Self-harm
- Denial of access to the vulnerable adult
- Social isolation
- Lack of consideration for the vulnerable adult
- Denial of privacy, choice, freedom of movement
- Denial of religious or cultural needs
- Restricting access to sensory, mobility or continence aids or equipment
- Decisions always made by others
- Person not allowed visitors/phone calls.

Further Information

Often psychological does not occur in isolation and is linked to financial and other forms of abuse or harm.

https://www.elderabuse.org.uk/psychological

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Financial or material abuse

In many instance financial abuse is a crime and the police should be involved at an early stage if appropriate. Financial abuse is the misuse of a person's property, assets, income, funds or any resources it includes:

- Theft, misappropriation or withholding of money, possessions or property.
- Mismanagement of finance and property.
- Pressure, by threat or persuasion, to influence wills, inheritance, property or financial transactions.
- The misuse of an enduring power of attorney, a lasting power of attorney, benefits agency appointeeship or court appointed deputyship.
- Denying access to care or accommodation for financial reasons.
- Manipulating or grooming an adult at risk in receipt of a personal budget direct payment.

Professional relationships

It is contrary to professional standards for staff to enter into any kind of financial arrangements with an individual for whom they provide care. This includes knowingly being named as a beneficiary in a will.

Possible indicators

- Factors that may indicate financial or material abuse include:
- Unexplained or sudden debts or inability to pay bills.
- Unusual or inappropriate bank account activity.
- Unexplained disappearance of financial documents.
- Disparity between assets and living conditions.
- Extraordinary interest by certain others in person's assets.
- Financial dependency of others on the vulnerable adult.
- Person managing financial affairs is evasive or uncooperative.
- Enduring Power of Attorney or Lasting Power of Attorney obtained or wills signed when the person lacks mental capacity.
- Unexplained arrival of bills, credit card bills.
- Denial of access to funds or documentation.
- Changes to wills or deeds of title.
- Responsible person(s) fail(s) to account for expenses incurred on behalf of other(s).

Further Information

Avoiding Scams
https://www.ageuk.org.uk/globalassets/age-uk/documents/information-guides/ageukig05_avoiding_scams_inf.pdf

Action Fraud
https://www.actionfraud.police.uk

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Discriminatory Abuse

Discriminatory abuse exists when values, beliefs and culture result in a misuse of power that denies opportunity to individuals or groups.

A person may be exploited or targeted by others who have a negative view of the individual based on the following factors:

- Gender and gender identity
- Sexuality
  Culture
- Ethnicity
- Sexual orientation i.e. lesbian, gay, bi-sexual, transgender
- Age
- Disability as a result of physical condition or cognitive impairment
- Religious observance
- Political affiliation.
- Race

Possible indicators

- A failure to support the adult at risk to communicate in the language or medium most appropriate to them
- Loss of weight through lack of provision of culturally appropriate diet
- Anxiety/depression through lack of opportunities for religious observance
- Excluded from decision making
- Poor health as a consequence of poor care standards
- Failure to protect or provide redress through the criminal or civil justice system
- Denial of sexual expression
- Inappropriate use of language
- Delivery of personal care without reference to gender
- Harassment

Further Information

The Equality Act

https://www.equalityhumanrights.com/en/equality-act-2010/what-equality-act

Stop Hate UK – Stockport

https://www.stophateuk.org/stockport/

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Organisational / Institutional Abuse

Organisational/Institutional abuse can be defined, as abuse or mistreatment by a regime as well as by individuals within any health or care setting or persons own home.

Organisational/ Institutional abuse violates the person's dignity, which results in lack of respect for their human rights.

Organisational/Institutional abuse may range from a one off incident to ongoing ill treatment. It can be neglect or poor professional practice as a result of the structure, policies, process and practices within an organisation; which result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of adults at risk.

The risk of organisational/ institutional abuse increases in services:

- With poor management.
- With too few staff.
- Which use rigid routines and inflexible practices.
- Where there is a closed culture.
- Where there is poor training of staff.
- Where there is poor supervision of staff and inadequate guidance.
- Where there is a culture of failing to promote people's rights.
- Where is there is a lack of or poor response to complaints.
- Where there is poor communication between staff, residents, managers, visitors and carers.
- Where there is an inflexible services based on the convenience of the provider rather than the person receiving the services.
- Where there is a lack of adherence to confidentiality.
- Where there is a lack of understanding regarding the importance of person centred planning.
- Where there are out of date/poor care plans, risk assessment and care reviews.

Indicators of institutional abuse:

- Lack of dignity, privacy or respect.
- Lack of opportunity for drinks or snacks outside of main meal times.
- Lack of choice regarding meals.
- Lack of flexibility and choice, excessively rigid routines.
- Lack of opportunity to personalise environment, lack of personal possessions.
- Use of restraint except where there has been clear multi agency risk assessment and planning.
- Lack of choice of same sex staff to undertake intimate personal care.
- Treating adults as children.
- Lack of choice in everyday activities.
- Changes in accommodation (within or between homes) without agreement.
- Denial of individual identity.
- Lack of privacy and personal care.
- Lack of personal clothing or possessions.
- Being left on toilet/commode for long periods.

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Modern Slavery

Encompasses slavery, human trafficking, and forced labour and domestic servitude.

Signs of slavery in the UK and elsewhere are often hidden, making it even harder to recognise victims around us.

Possible indicators

- Physical Appearance–victims may show signs of physical or psychological abuse, look malnourished or unkempt, or appear withdrawn.
- Isolation-victims may rarely be allowed to travel on their own, seem under the control, influence of others, rarely interact or appear unfamiliar with their neighborhood or where they work.
- Poor living conditions- victims may be living in dirty, cramped or overcrowded accommodation, and/or living and working at the same address.
- Few or no personal effects-victims may have no identification documents, have few personal possessions and always wear the same clothes day in day out. What clothes they do wear may not be suitable of the season or their type of work.
- Restricted freedom of movement- victims have little opportunity to move freely and may have their travel documents retained e.g. passports
- Unusual travel times- may be dropped off and collected for work on a regular basis either very early of late at night.
- Reluctant to seek help- victims may avoid eye contact, appear frightened or hesitant to talk to strangers and fear law enforcers for many reasons, such as not knowing who to trust or where to get help, fear of deportation , fear of violence to them or their family.

Further Information

Lived experience
https://www.youtube.com/watch?v=KMtaUjsB6h0&feature=youtu.be

Spot the signs
https://www.salvationarmy.org.uk/spot-signs

Government information
https://www.gov.uk/government/collections/modern-slavery

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Safeguarding and those at risk of homelessness

From April 2018, organisations have had a duty to help those at risk of becoming homeless and refer them to a housing authority.

Prisons, probation services, Jobcentres and NHS Trusts are among the organisations that have a duty to help those at risk of becoming homeless and refer them to a housing authority.

The public authorities which are subject to the duty to refer are specified in the Homelessness (Review Procedure etc.) Regulations 2018. The public services included in the duty are as follows:
(a) prisons;
(b) youth offender institutions;
(c) secure training centres;
(d) secure colleges;
(e) youth offending teams;
(f) probation services (including community rehabilitation companies);
(g) Jobcentre Plus;
(h) social service authorities;
(i) emergency departments;
(j) urgent treatment centres; and,(k) hospitals in their function of providing inpatient care.

In new guidance published 22/02/18, the government has outlined how councils and public bodies must support the homeless or those at risk of losing their home under their new duties introduced by the Homelessness Reduction Act. The Act places new legal duties on English councils to intervene at an earlier stage to prevent homelessness.

Councils are required to ensure the advice and information they provide is designed to meet the needs of particular at risk groups including care leavers, people leaving prison, people who have left the armed forces, survivors of domestic abuse and those suffering from a mental illness.

In addition to new duties to refer those at risk of homelessness, the reforms will include:

- providing free information and advice on preventing homelessness and the rights of homeless people, to all residents, including information tailored to the needs of particularly vulnerable groups
- a new duty for those who are already homeless so that that local authorities will work with them for 56 days to help secure accommodation

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Part 4 - Causes of Abuse

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Factors contributing to the occurrence of abuse

The following paragraphs identify some possible causes of abuse. The presence of one or more of these will not necessarily lead to abuse and abuse may occur when none are present. They do reflect, however, some of the stresses that may affect the relationship between people who are dependent on others for their care and those who provide that care and which may, therefore, be predisposing factors for abuse to occur.

Possible causes of abuse within personal relationships (Carer Stress)

A carer is someone who provides care for a relative, friend or neighbour at home. It is recognised that providing care can be very stressful and can occasionally lead to either deliberate acts of harm or an inability to provide appropriate care (omission).

There is no evidence from research that the stress of caring *in itself* is a cause of abuse. In addition carers may find themselves being abused by the person that they care for and some adults at risk are themselves carers for others.

Section 1 of the Care Act 2014 includes protection from abuse and neglect this includes both the cared for and the carer.

In situations where the abuse occurs within a caring relationship (the victim being either the carer or cared for) the aim of the safeguarding adults protection plan will be to provide support to eliminate abuse to either party and decrease the risk of further harm.

A carer's assessment should be offered.

Stress may occur within the relationship between an adult at risk and a carer when:

- The nature of the previous relationship has changed from one of equality to one of dependency and care giver.
- The quality of the previous relationship between the adult at risk and the carer was poor or abusive.
- A previous power-abusive relationship is reversed, as when an abusive husband/father becomes dependent on a partner or adult child.
- The carer has a number of other significant dependants.
- The carer or the adult at risk has a mental illness, misuses drugs or alcohol or has a history of violence or sexual offences.
- Living conditions are poor or there are financial difficulties.
- The adult at risk and the carer have different values and standards.
- The carer has had to change their lifestyle unwillingly.
- Incontinence or difficult behaviour is perceived as deliberate.
- The demands of physical and emotional care are considerable.
- The carer feels isolated and unsupported and has no respite.
- Sleep patterns are disturbed.
- Support services are unavailable or are rejected by the adult at risk or the carer.
- Sudden, significant changes such as loss or bereavement affect normal coping mechanisms.
- Where a carer causes deliberate harm to an adult at risk the same principles and responsibility for reporting to the police apply as described throughout this policy.

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Possible causes of abuse in service settings

Poor quality care in service settings may be a result of inadequate management, poor performance, low staff morale or breakdown in communication whereby:

- Policy and practice guidance, quality standards and monitoring are lacking.
- Staffing levels are inadequate.
- Staff are untrained or unsupported.
- Staff turnover and sickness levels are high.
- Communication between managers and staff is poor.
- Teamwork among staff is poor.
- There is a culture of control between staff and managers or between staff and adult at risk.
- Adult at risk have little opportunity to express their views and wishes.
- Adults at risk are critical about their placement or service delivery.
- Adults at risk are abusive to staff and other service users.

Organisational/institutional abuse may range from one off incidents leading to ongoing ill treatment.

For Adult safeguarding under the Care Act 2014 the responsibility to act first lies with the employing organisation as a provider of the service.

When an employer is aware of abuse or neglect they are under a duty to correct this and protect the adult at risk as soon as possible and inform Stockport Local Authority, CCG and CQC. Transparency, open-mindedness and timeliness are important features of fair and effective safeguarding enquires. In Stockport partners should be aware of the local agreement regarding who needs to notified or involved in safeguarding alerts.

Safeguarding procedure should be used in a proportionate way that reflect the principles of the care act and the significance of the harm and risk identified**.**

For further information in relation to responding to abuse in a service setting please see Harm Levels Guidance.

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Responding to Disclosures

Staff working with adults a risk in any setting may find themselves in a situation in which a person discloses information alleging or suggesting that they have been abused. It is most important that the adult risk is given the fullest opportunity to say what they want to say and that the staff member's response to the disclosure provides the foundation for appropriate action to be taken within the Safeguarding Adults Policy and Procedures.

Do:

- Remain calm and try not to show any shock or disbelief.
- Listen very carefully to what you are being told.
- Demonstrate a sympathetic approach by acknowledging regret and concern about what has happened.
- Reassure the person that:
- They have done the right thing in sharing the information with you
- You are treating the information seriously
- The abuse is not their fault.
- Be aware that in cases of physical or sexual abuse, medical or criminal evidence may exist and it is important to preserve this.
- Explain that you are required to share the information with your line manager.
- Reassure the person that:
- Any further investigation will be conducted sensitively and, wherever possible, with their full involvement;
- Steps will be taken to support and, where appropriate, protect them in the future.
- Report the information to your line manager at the earliest opportunity.
- Record what the person has told you as soon as possible, including the actual words used by the person and precise factual information such as dates and times.
- Sign and date the record, including a note of when and to whom you reported the information.

Do not:

- Stop someone who is freely recalling significant events but allow them to share whatever is important to them.
- Ask the person for more details as this may be done during any subsequent inquiry and it is important to avoid unnecessary repetition for the person concerned.
- Ask questions about the person's own behaviour or reaction to the abuse.
- Promise to keep secrets.
- Make promises you are unable to keep.
- Contact the alleged abuser.
- Talk to other staff or service users about the information that has been shared with you.

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Part 5 – Mental Capacity and Consent

The Mental Capacity Act 2005

The assumption is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. However, issues of mental capacity and the ability to give informed consent are central to decisions and actions in Safeguarding Adults. All interventions need to take into account the mental capacity of individual to make informed choices about the way they want to live and the risks they want to take.

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for them and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the Safeguarding Adults process must comply with the Act. The Act says that:

"… a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or brain"

Further, a person is not able to make a decision if they are unable to:

- **understand** the information relevant to the decision or
- **retain** that information long enough for them to make the decision or
- **use or weigh** that information as part of the process of making the decision or
- **communicate** their decision (whether by talking, using sign language or by any other means such as muscle movements, blinking an eye or squeezing a hand).

Mental capacity is **time and decision specific**. This means that a person may be able to make some decisions but not others at a particular point in time. For example, a person may have the capacity to consent to simple medical examination but not to major surgery. Their ability to make a decision may also fluctuate over time.

The five Principles of the Mental Capacity Act 2005

- An adult at risk has the right to make their own decisions and must be assumed to have capacity to make decisions about their own safety unless it is assessed otherwise.
- Adults at risk must receive all appropriate help and support to make decisions before anyone concludes that they cannot make their own decisions.
- Adults at risk have the right to make decisions that others might regard as being unwise or eccentric and a person cannot be treated as lacking capacity for these reasons.
- Decisions made on behalf of a person who lacks mental capacity must be done in their best interests.
- The decision should be the less restrictive of their basic rights and freedoms.

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The Mental Capacity Act 2005

Informed Consent

Informed Consent is the process by which a individual learns about and understands the purpose, benefits, and potential consequences of a medical or surgical or social intervention and then agrees to receive the treatment or engage in the intervention.

When a practitioner seeks informed consent from an individual, they should consider the following three areas.

- **Voluntary** – an individuals' decision must be made freely without any kind of influence or pressure from professionals, friends or family.
- **Informed** – individuals must be given all the information in terms of what the treatment / intervention / service involves including the benefits, the possible consequences and the risks.
- **Capacity** – individuals must be capable of giving consent which means they need to understand the information they are being given and are able to use that information in order to reach an informed decision.

When can you override consent

There are times when it will be appropriate to override an individuals' decision to withhold consent. For example:

- If other people appear to be at risk of harm (adults or children).
- If there is a 'legal restriction' or an overriding public interest.
- If the person is exposed to life threatening risk and they are unreasonably withholding their consent.
- If the person has impaired capacity or decision making in relation to the safeguarding issues and the withholding of consent.

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Ill treatment and willful neglect

An allegation of abuse or neglect of an adult at risk who does not have mental capacity will always give rise to action under the Safeguarding Adults process and subsequent decisions made in their best interests in line with the Mental Capacity Act and Mental Capacity Act *Code* as outlined above.

Section 44 of the Mental Capacity Act makes it a specific criminal offence to willfully ill-treat or neglect a person who lacks capacity.

The Criminal Justice and Courts Act 2015 section 20 and 21 introduces the specific offences of ill- treatment or neglect by care-workers (s 20) or care providers (s 21) which is applicable regardless of the person's mental capacity.

Consent

It is always essential in safeguarding to consider whether the adult at risk is capable of giving informed consent.

An Adult with Mental Capacity

Points to consider:

- The adult consents to the abusive activity (if consent is believed to have been given under duress, for example, as a result of exploitation, pressure, fear, intimidation or family loyalty, consideration should be given to the need to disregard adult at risks wishes).

- The adult at risk does not consent to a Safeguarding Adults investigation going ahead and there are no public interest issues, risk to others and criminal activity considerations, then their wishes must be respected. However the person must be given the relevant information and have the opportunity to consider all the risks and fully understand the likely consequences of that decision over the short and long term.

Consent will be required for each of the following:

- The recommendations of an individual protection plan being put in place
- A medical examination
- An interview
- Sharing of information with others.

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Part 6 – Prevention of Abuse

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Prevention of Abuse

All organisations working with vulnerable adults should ensure they have systems in place to proactively prevent abuse. Section 6 (7) of the Care Act requires Local authorities and their relevant partners to cooperate with each other in the exercise of their functions relevant to care and support inclusive of the protection adults.

The Care Act 2014 requires providers of care and support to prevent abuse wherever possible. Positive early intervention can make a huge difference to people's lives and the safeguarding outcome.

The following list out lines good practice guidelines which will contribute to the prevention of abuse:

- Rigorous recruitment practices (including volunteers)
- Internal guidelines for employees
- Training
- Information for users, carers and the general public
- Attention to issues relating to protection of vulnerable adults in Direct Payments arrangements Commissioning of services

The Care Act requires all parties to have robust risk management processes in order to prevent concerns escalating to a crisis point and requiring intervention under the Safeguarding adult's procedures

For further information in relation to responding to abuse in a service setting please see Harm Levels Guidance.
https://www.stockport.gov.uk/harm-levels-guidance

Recruitment and Selection

It is essential all employees are carefully selected and recruited in order to ensure a high quality of service is offered to vulnerable adults and the following addressed.

- Convictions - The Rehabilitation of Offenders Act 1974 (ROA Exceptions) Order 1975 as amended by ROA 1974 (exceptions) (Amendment) Order 1986 allows convictions that are ordinarily spent (under the ROA 1974) to be disclosed for the purpose of working with vulnerable people and to be taken into account in deciding whether to recruit an applicant. All applicants should therefore be asked to list all convictions and cautions.
- A past conviction should not in itself preclude employment but consideration must be given as to whether past behaviour of the individual may put the vulnerable adult at risk.
- References - All employers should take up references from a minimum of two referees, with one being from the last employer. This should be undertaken before offers of appointment and these should be provided in writing. Prospective employers should make all efforts to ensure references can be checked and are in writing.
- Disclosure and Barring Service (DBS) - All prospective staff in regulated activity must have an enhanced DBS disclosure which includes a check whether a person's name is on either of the Barred Lists maintained by the DBS.
- Volunteers - Where volunteers in regulated activity with adults at risk the employing organisation should ensure the same checks are undertaken as with a paid employee. Employers should ensure that volunteers are fully aware of agency polices including those relating to adult protection

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The Disclosure and Barring Service (DBS)

The DBS role is to help prevent unsuitable people from working with children and vulnerable adults. It assesses those individuals working or wishing to work in regulated activity that are referred to the DBS on the grounds that they pose a possible risk of harm to vulnerable groups. Referral is required where an employer or an organisation, for example, a regulatory body, has concerns that a person has caused harm or poses a future risk of harm to children or vulnerable adults. In these circumstances the employer or regulatory body must make a referral to the DBS. The range of organisations that have this duty to make referrals include:

Regulated activity providers
- Personnel suppliers
- Local authorities
- Education and Library Boards
- Health and Social Care (HSC) bodies
- Keepers of Registers named in the legislation
- Supervisory authorities named in the legislation.

The DBS replaces all previous vetting and barring schemes including the ISA, POVA list, the POCA List and List 99.

Any inquiry which is considering an allegation of abuse against a paid or voluntary worker must determine whether a referral to the DBS needs to be made and who is to make the referral.

Comprehensive guidance on the scheme in general, the referral process and the referral form can be downloaded from www.gov.uk/government/organisations/disclosure-and-barring-service

In addition, Skills for Care has produced a recruitment and retention toolkit for the adult care and support sector. 'Finders Keepers' is designed to help care providers, particularly smaller organisations, to improve the ways they recruit staff and retain them.

Please see http://www.skillsforcare.org.uk/Document-library/ Finding-and-keeping-workers/Practical- toolkits/

Health and Care Professions Council (HCPC)

All professionals registered with the HCPC should be familiar with codes of practice and proficiency standards relevant to their role. Compliance with these is expected at all times.

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Frameworks / Codes of Practice

Stockport Safeguarding Adults Competency Framework

A competency framework based on the National Occupational Standards for Health and Social Care and the National Competence Framework produced by Bournemouth University has been adopted by the Stockport Safeguarding Board. The framework identifies the knowledge and skills required by staff to carry out their specific roles identified within this policy and procedures. All training is delivered base do this framework.

For detail of available training go to:
www.stockport.gov.uk/staffdevelopment

Nursing and Midwifery Council Code of Practice

The code is the foundation of good nursing and midwifery practice, and a key tool in safeguarding the health and wellbeing of the public. Please see the NMC website for info on safeguarding and training resources

http://www.nmc-uk.org/Nurses-and-midwives/safeguarding/Introduction-to-safeguarding-adults/

Whistleblowing

Whistleblowing encourages and enables employees to raise serious concerns **within** their service rather than overlooking a problem or 'blowing the whistle' outside.

Employees are often the first to realise that there is something seriously wrong with the service. However, they may not express their concerns as they feel that speaking up would be disloyal to their colleagues or to their employer.

In order to encourage the raising of such concerns it is expected that all health and social care organisations have internal formal whistle blowing policies which are understood by all employees and volunteers.

Staff reporting concerns at work (whistle Blowing) are entitled to protection under the Public Interest Disclosures Act 1998**.**

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Risk Assessment

The Care Act 2014 requires all partners to implement robust risk management processes in order to prevent concerns escalating to a crisis point and requiring intervention under this policy and procedure.

Adults at risk have a right to take risks about their own lives. Where intervention is required under this policy and procedure, in considering any interventions practitioners should note adults at risk who are in receipt of services under the Care Act 2014 or who are receiving services under the 'Care Programme Approach' will already have been assessed for services and any risk will have been taken into account as part of this assessment. Additional risk assessments will also have been undertaken by provider services. The adult protection process however may identify the need for further risk assessments and management plans to protect.

Disagreements about risk assessments and refusals of propose interventions should be noted. Risk evaluation may change during the course of an intervention as risk levels reduce or increase. This may result in the need for further review to evaluate the concerns or changes.

A risk assessment (where appropriate) should be completed categorising the risk(s) presented and establishing the severity of possible injury, ill health or loss. The inquiry should consider the following categories:

- High Risk – The adult at risk is in immediate danger or at continuing risk of abuse which would include neglect.
- Medium Risk – The adult at risk is at risk because the potential harm is significant **or** the likelihood of abuse happening is high or both.
- Low Risk – The adult at risk may be at some risk of harm but it requires little or no action.

In the first instance practitioners should utilise their existing risk assessment procedures.

(For risk assessment as part of adult protection procedures see section 4.15.3)

Abuse by another Adult at Risk (sometimes known as service user on servicer user abuse)

Service user on service user abuse is still abuse irrespective of the intention and/or the mental capacity of the service users involved. Early intervention with service users who abuse others may be important in the protection of other adults at risk, preventing the continuation or escalation of abusive behaviour.

For further information in relation to responding to abuse in a service setting please see Levels of Harm Guidance and section 4.10.

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Abuse of Trust

A relationship of trust is one in which one person is in a position of *power or influence* over the other person because of their work or the nature of their activity. There is a particular concern when abuse is caused by the actions or omissions of someone who is in a position of power or authority and who uses their position to the detriment of the health and well-being of a person at risk, who in many cases could be dependent on their care. There is always a power imbalance in a relationship of trust. Where the person who is alleged to have caused harm is in a position of trust with the adult at risk, they may be deterred from making a complaint or taking action out of a sense of loyalty, fear, of abandonment or other repercussions.

Where the person who is alleged to have caused the abuse or neglect has a relationship of trust with the adult at risk because they are a member of staff, a paid employee, a paid carer, a volunteer or a manager or proprietor of an establishment, the organisation will invoke its disciplinary procedures as well as taking action under the Safeguarding Adults policy and procedures. If a crime is suspected, reporting to the police should always be considered, and referral must be made to the Disclosure and Barring service (DBS) if they have been found to have harmed or put at risk of harm an adult at risk.

If the person who is alleged to have caused the abuse is a member of a recognised professional group the organisation will act under the relevant code of conduct for the profession as well as taking action under this policy and procedures. Where the person alleged to have caused the abuse or neglect is a volunteer or a member of a community group, adult social care services will work with the relevant group to take action under this policy and procedures.

Where the person alleged to have caused the abuse is a neighbour, a member of the public, a stranger or a person who deliberately targets vulnerable people, in many cases the policy and procedures will be used to ensure that the adult at risk receives the services and support that they may need. In all cases regard should be given to issues of consent, confidentiality and information sharing.

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Part 7 – Partners in Safeguarding Adults

Stockport Adult Social Care

Stockport Adult Social Care shares the lead responsibility with Pennine Care NHS Foundation Trust for the coordination of all investigations related to the alleged abuse of an adult at risk where the abuse occurs within the boundaries of Stockport.

Social work team managers, assistant team managers, senior practitioners, qualified social workers and nurses within the Learning Disability Partnership all have designated responsibilities under this policy and procedures.

Adult Safeguarding and Quality Service (within Adult Social Care)

The primary function of **Adult Safeguarding and Quality Service** is to ensure that the Local Authority fulfils its responsibilities under Care Act 2014 and the Mental Capacity Act 2005. In the first instance this is to oversee the appropriate implementation of this policy and procedures across the Borough of Stockport both by Local Authority staff and all the partner agencies and services who are expected to comply by dint of their statutory, contractual or regulatory requirements.

The **Adult Safeguarding and Quality Service** has responsibility for the supporting the implementation of the Mental Capacity Act 2005 including the Deprivation of Liberty Safeguards and acts as the Supervisory Body for both Local Authority and NHS.

The Adult Safeguarding and Quality Service has the responsibility for the Investigation and co- ordination of complaints/contract compliance issues. It works closely with external regulators and has a pro-active role in quality monitoring of contracted providers. The Quality Assurance Officers make a significant contribution to the safeguarding process and should be kept informed of all investigations related to contracted providers.

The **Adult Safeguarding and Quality Service** provides advice and guidance on all operational matters where required as well as supporting the Workforce Development Service with the development and delivery of all relevant training. SAMCAS can be contacted at: ASQS@stockport.gov.uk

Pennine Care NHS Foundation Trust staff

Pennine Care NHS Foundation Trust shares the lead responsibility with Stockport Adult Social Care for the coordination of all investigations related to the alleged abuse of an adult at risk where the abuse occurs within the boundaries of Stockport. Team managers, deputy team mangers, qualified social workers and community mental health nurses and community occupational therapists all have designated responsibilities under this policy and procedure.

The Coroner

Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause, and deaths in custody, which must be reported to them.

With regard to the Mental Capacity Act 2005 Deprivation of Liberty Safeguarding 2009 the Managing Authority should inform the coroner's office of the death of any person subject to authorised Deprivation of Liberty Safeguards.

Where the coroner is involved or is likely to become involved in a case which is subject to this policy and procedures please refer to sections 4.8.7 and 4.12.8.

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Stockport Police

The Police service in Stockport has been a co-signatory to the policy and procedures since its inception in 2002.

The MASSH team based at Fred Perry House will triage all matters relating to Child Protection, Domestic Violence and Vulnerable Adults. Investigations will be managed by the divisional CID, NBO's or NPO's

The Case Management Team (CMT) deals with all Police Checks and Case Conference work.
The MASSH can be contacted on the secure email: stockport.cmt@gmp.pnn.police.uk

In circumstances where immediate police involvement is required ring:
999 in an emergency
101 or livechat in a non-emergency

Further details and information is available at:
Go to: http://www.gmp.police.uk/ for further information.

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The NHS Stockport Clinical Commissioning Group (CCG)

From 1st April 2013, NHS Stockport Clinical Commissioning Group formally took over the responsibility for local health services from Stockport Primary Care Trust (NHS Stockport).

The Clinical Commissioning Group is one of the three statutory partners within the Safeguarding Adults Board. The CCG designated nurse for adult safeguarding is required to have the oversight on safeguarding across the health economy. This includes service areas with health or nursing provision, regardless of commissioning arrangements and in a coordinated and collaborative framework across lead commissioner organisations (e.g. local authority, NHSE specialist commissioning, primary care commissioning, host CCG etc.)

The CCG designated nurse for adult safeguarding will seek assurance from GP practices and CCG commissioned services (e.g. SFT, St Annes Hospice etc.) within the safeguarding assurance framework and the forum of regular, planned, safeguarding assurance meetings.

These meetings will take place to include both adult and child safeguarding assurance.

The CCG has in place a designated GP for safeguarding, who maintains the relationships between safeguarding and GP practices, providing expert advice and direction as required within that role.

The CCG exec nurse will be the executive lead for safeguarding adults and be the CCG representative on the SSAB, supported by the designated nurse for safeguarding adults.

The CCG has an important role in ensuring that the services they commission from are compliant with their own internal safeguarding responsibilities as the Designated Nurse may attend strategy meetings, case conferences and may have an investigatory role in certain aspect of any adult protection inquiry.

Go to: http://stockportccg.org/ for further information

North West Ambulance Service NHS Trust (NWAS)

NWAS has its own system for raising safeguarding alerts where it is believed an adult has been harmed or is at risk of harm.

NWAS are often the first professionals on the scene and their actions and information recording can be crucial to subsequent inquiries and investigations and where appropriate the service should be requested to provide all relevant information.

Where concerns are raised that about the actions of the ambulance service, contact should be made with the Safeguarding lead for NWAS based in Bolton.

Go to: http://www.nwas.nhs.uk/ for further information

Housing Providers

Staff employed within housing are in a position to identify tenants and other customers who are adults at risk of abuse, neglect and exploitation. Housing providers employ a range of staff who deliver services and provide accommodation to customers who may be vulnerable, including supported and specialist housing.

Many housing staff have privileged access to people's homes and communities and therefore are able to identify safeguarding concerns. Staff employed by housing organisations have an important part to play in identifying issues, escalating concerns, sharing information and contributing to protection plans.

Crown Prosecution Service (CPS)

The CPS is the principal public prosecuting authority for England and Wales and is headed by the Director of Public Prosecutions. The CPS has produced a policy on prosecuting crimes against older people which is equally applicable to adults at risk, who may also be vulnerable witnesses. Support is available within the judicial system to support adults at risk to enable them to bring cases to court and to give best evidence. If a person has been the victim of abuse that is also a crime, their support needs can be identified by the police, the CPS and others who have contact with the adult at risk. Witness Care Units exist in all judicial areas and are run jointly by the CPS and the police.

The CPS has a key role to play in making sure that special measures are put in place to support vulnerable or intimidated witnesses to give their best evidence.

The Probation Service

The Probation Service protects the public by working with offenders to reduce re-offending and harm. The Probation Service share information and work in partnership with other agencies including local authorities and health services, and contribute to local Multi Agency Public Protection Arrangements (MAPPA) to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public and previous victims from serious harm.

Although the focus of the Probation Service is on those who cause harm, they are also in a position to identify offenders who themselves are at risk from abuse and to take steps to reduce the risk to those offenders in line with the principals of this policy and procedures.

NHS Services in Stockport

The policy and procedures apply to all health services within Stockport. The NHS is accountable to patients for their safety and well-being through delivering high-quality care. This duty is underpinned by the NHS constitution that all providers of NHS services are legally obliged to take account of. Quality is defined as providing care that is effective and safe and which results in a positive patient experience. Some patients may be unable to uphold their rights and protect themselves from harm or abuse. They may have the greatest dependency and yet be unable to hold the service to account for the quality of care they receive. The NHS has particular responsibilities to ensure that those patients receive high-quality care and that their rights are upheld, including their right to be safe.

General Practitioners, Optometrists, Dentists and Pharmacists

All independent practitioners have a significant role in Safeguarding Adults.

This includes:

- Making a referral to a Safeguarding Adults referral point should they suspect or know of abuse, in line with these procedures.
- Playing an active role in strategy discussions or meetings, case conferences and protection planning.

NHS England and the CCG should make sure that effective training and reporting systems are in place to support practitioners in this work.

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The Care Quality Commission (CQC)

The CQC regulates and inspects health and social care services including domiciliary services and protects the rights of people detained under the Mental Health Act 1983. It has a role in identifying situations that give rise to concern that a person using a regulated service is or has been at risk of harm, or may receive an allegation or a complaint about a service that could indicate potential risk of harm to an individual or individuals.

Where the CQC receives information about a possible Safeguarding Adults situation or issue, then that information must be immediately brought to the attention of the lead regulatory inspector for the service, or the duty inspector. If, on a review of the information, there appears to be a Safeguarding Adults concern, the CQC should pass the information to the local authority through the locally determined referral point.

Following referral, the CQC may participate in any strategy discussions to consider on-going risk factors and the implications for the well-being for the people who use the service and contribute to the agreement of a protection plan.

The CQC must always be made aware of a Safeguarding Adults concern within a regulated service. If the concern is reported to the local authority, the local authority must notify the CQC even though the regulated service also has a duty to do so.

The CQC will be directly involved with a Safeguarding Adults process where:

- One or more registered people are directly implicated
- Urgent or complex regulatory action is indicated
- A form of enforcement action has been commenced or is under consideration in relation to the service involved.

The CQC would expect that registered providers and managers who are not implicated in the alleged abuse, people who use the service and/or their representatives are invited to attend meetings or to participate in the discussions.

Whether relevant CQC staff attend or not they must be sent copies of minutes of the agreed strategy. The regulatory inspector is responsible for ensuring that communication is established. If they have any concern about the proposed protection plan, they will discuss this with the responsible manager in the first instance.

Where the allegation suggests breaches of regulation and standards, the CQC may conduct enquires or initiate a random inspection, in which case they will inform the relevant responsible manager.

This activity may take place as well as other investigations being undertaken by another organisation. If the police are investigating, the CQC will coordinate their action with them.

The outcome of any assessment or investigation must also be shared with the CQC if it is related to a regulated service. The CQC have a role in ensuring adherence to any part of a Safeguarding Adults plan that relates to service compliance with regulation and standards.

Where the CQC have not undertaken any activity in relation to the initial concern, they should be notified of the outcome of the Safeguarding Adults process. If the allegation is substantiated and indicates a breach of regulation or standards, the CQC will consider whether any further regulatory activity is required and will inform the relevant responsible manager of their decision

Go to: http://www.cqc.org.uk/ for further information

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Court of Protection

The Court of Protection deals with decisions and orders affecting people who lack capacity. The court can make major decisions about health and welfare, as well as property and financial affairs. The court has powers to:

- Decide whether a person has capacity to make a particular decision for themselves make declarations, decisions or orders on financial and welfare matters affecting people who lack capacity to make such decisions.
- Appoint deputies to make decisions for people lacking capacity to make those decisions.
- Decide whether a lasting power of attorney or an enduring power of attorney is valid.
- Remove deputies or attorneys who fail to carry out their duties.

In most cases decisions about personal welfare will be able to be made legally by the appropriate decision maker without making an application to the court, as long as the decisions are made in accordance with the core principles set out in the Mental Capacity Act 2005. Any disagreements should be resolved informally. However, it may be necessary and desirable to make an application to the court in a safeguarding situation where there are:

- Particularly difficult decisions to be made.
- Disagreements that cannot be resolved by any other means.
- On-going decisions needed about the personal welfare of a person who lacks capacity to make such decisions for them self.
- Matters relating to property and/or financial issues to be resolved.
- Serious healthcare and treatment decisions, for example, withdrawal of artificial nutrition or hydration.
- Concerns that a person should be moved from a place where they are believed to be at risk.
- Concerns or a desire to place restrictions on contact with named individuals because of risk or where proposed Safeguarding Adults actions may amount to a deprivation of liberty.

Go to:
http://www.justice.gov.uk/courts/rcj-rolls-building/court-of-protection

Court appointed deputies

In a situation where a person does not have mental capacity and does not have anyone to act for them, the court can appoint a deputy to take decisions on welfare, healthcare and financial matters.

Personal Assistants

The introduction and development of Personal Budgets is increasingly leading to the establishment of a workforce which is independent of traditional services. This workforce should be familiar with the policy and procedures. All staff and volunteers from any service or setting who have contact with adults at risk have a responsibility to be aware of issues of abuse, neglect or exploitation. This includes personal assistants paid from direct payments or personal budgets or from the private funds of individuals.

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Office of the Public Guardian (OPG)

The OPG was established under the Mental Capacity Act to support the Public Guardian and to protect people lacking capacity by:

- Setting up and managing separate registers of lasting powers of attorney, of enduring powers of attorney and of court-appointed deputies.
- Supervising deputies.
- Sending Court of Protection visitors to visit people who lack capacity and also those for whom it has formal powers to act on their behalf.
- Receiving reports from attorneys acting under lasting powers of attorney and deputies.
- Providing reports to the Court of Protection.
- Dealing with complaints about the way in which attorneys or deputies carry out their duties.

Go to www.justice.gov.uk/about/opg for further information.

Independent, Voluntary and Private Health and Social Care Providers

Employees in these organisations are in a unique position to identify adults at risk who are or may be experiencing abuse, neglect and exploitation. The majority of these services are regulated by the Care Quality Commission and are expected to comply with the Essential Standards for Quality and Safety which includes specific compliance with Safeguarding. For those providers not subject to regulation there is an equal expectation that they will cooperate fully with all measures developed to protect adults from abuse. This includes contributing to and implementing risk assessments and adult protection plans.

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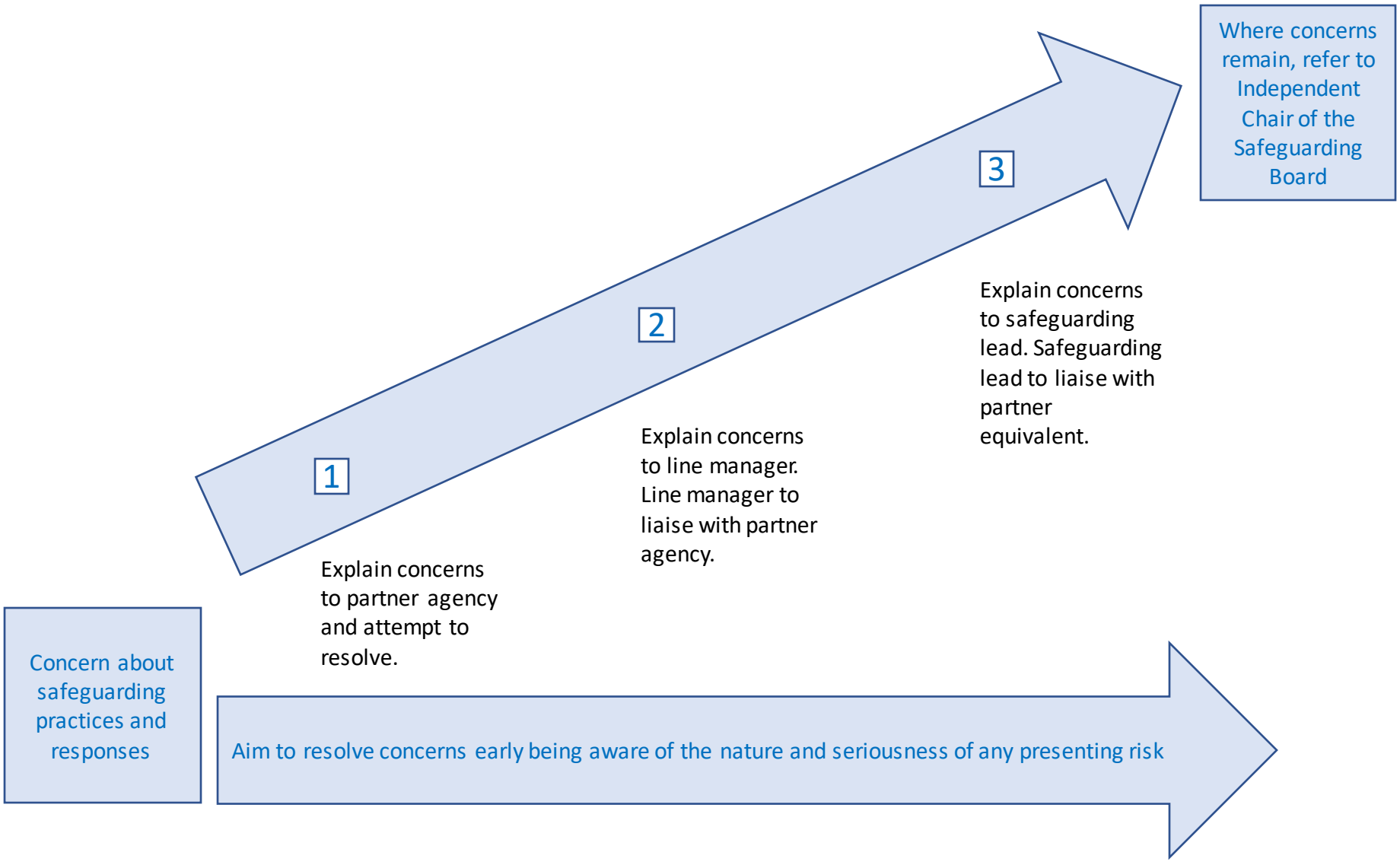
Working together to resolve disagreements



Part 8 – Transitional Arrangements between Children and Adult Services

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Transitional Arrangements between Children and Adult Services

Whilst this policy and procedures relates to adults from the age of eighteen onward there will be many circumstances where the care needs of younger adults will continue beyond their eighteenth birthday.

Additionally for some there will the continuation of the need for ongoing protection from abuse and risk of abuse.

Assessments of eligible needs at this stage should include issues of safeguarding and risk whilst maintaining their independence, well-being and choice. Care planning needs to ensure that the young adult's safety is not put at risk through delays in providing the services they need as they make the transition to adult services.

Where somebody is eighteen or over and still receiving support from children services and a safeguarding issue is raised the matter should be dealt with via adult safeguarding arrangements irrespective of the young adult's level of need.

Good practice includes:

- Having policies and procedures which support effective transition processes
- Acknowledging that the view of risk as a potential danger for a child is not necessarily the same for adult.
- Managing family expectations (being clear about the level of support and resources available).
- Taking time to get to know the young person and their family, especially if they have communication difficulties.
- Acknowledging the rights of adults to take more responsibility for their decisions.

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Part 9 – Information Sharing

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Information Sharing

Early sharing of information is the key to an effective response where there are emerging concerns. The Care Act 2014 requires organisations to share information about individuals who may be at risk from abuse. It is important to identify an abusive situation as early as possible so that the individual can be protected.

Withholding information may lead to abuse not being dealt with early enough.

Confidentiality must never be confused with secrecy, nor should any professional assume someone else will pass on information which they think maybe critical to the safety and welling of the adult at risk. This policy and procedure requires all suspicions of abuse to be reported. Information given to an individual member of staff, or organisation representative, belongs to the organisation not that member of staff.

Personal information shared with a worker in the course of their employment is:

- Confidential to the employing organisation and can be shared within that organisation.
- Should only be used for the purposes for which it was intended.

Can be shared with another organisation either when:

- Permission is given by the person about whom the information is held.
- There is an overriding justification, statutory power or duty to share information without the person's consent.

Investigating and responding to suspected abuse or neglect requires close cooperation between a range of disciplines and organisations. Safeguarding Adults work is concerned with sharing 'personal information', both about someone who is alleged to have experienced abuse and an alleged perpetrator.

This policy and procedures relies upon appropriate information sharing between partner agencies in relation to situations involving adults at risk who meet the criteria for Safeguarding Adults interventions.

Non-partner organisations are not precluded from involvement in the information sharing process. The contact person within a non-partner organisation should be a senior member of staff and the information shared would be specifically relevant to that organisation's function and statutory powers.

Purpose of information sharing

The information exchanged will only be used for safeguarding adult purposes and where it meets these conditions:

- A criminal offence has taken place
- It may prevent crime
- The alleged victim is at risk of harm
- Staff, other service users, or the general public may be at risk of harm
- For early intervention and identification of abuse
- For investigations under safeguarding adult procedures.

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Consent to the sharing of Information

Informed consent is a freely given specific and informed indication of a person's agreement to a course of action where information is given to that person about the proposed course of action. It may be expressed verbally or in writing (except where an individual cannot write or speak when other forms of communication may be sufficient).

Workers need to make sure that the adult at risk understands what will be recorded, what the information will be used for and with whom it might be shared. If the worker does not explain this, they will not be able to give valid informed consent for information sharing to take place.

The following information should be recorded clearly within their own organisation's record:

- When consent to share information has been freely given.
- Why the information needs to be shared.
- What information the service user has consented to be shared.
- Who the service user has consented for the information to be passed to, and any limitations to this.
- That this has been explained to the service user and they understand the implications of giving consent to share their information.
- Any comments made by the service user in relation to the disclosure.

Overriding a refusal to share Information

Individuals have the right to refuse, or withhold consent for your organisation to share information in relation to the suspected abuse. Wherever possible the views and wishes of the vulnerable adult will be respected. However, if it is thought that they are in a situation that results in their abuse or if they may be abusing another person(s), the duty of care overrides the individual's refusal.

The need to protect the individual or the wider public outweighs their rights to confidentiality. Decisions to share information about the adult at risk must be made by the organisation and not that member of staff acting on their own. This, however, should not cause unnecessary delay in the disclosure process. The worker must explain to the person why the disclosure needs to take place and to whom the information will be passed. This should generally be done unless it would increase the risks of harm.

The person's decision to withhold consent to share information must be recorded, along with any further decisions to sharing information. Decisions to share without consent must make sure that it does not interfere with that person's human rights.

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Adult at Risk without the Mental Capacity to Consent

Where an adult at risk lacks the mental capacity to consent to sharing information, professionals are required to make 'best interests' decision which comply with the Mental Capacity Act Code of Practice. **(See section 4.5. for more information)**

Sharing information with carers, parents, family, partners etc.

When the adult at risk has the 'mental capacity' to make the decision, it is for them to decide what information is disclosed to their carers/ parents/family/partners, and records should reflect this.

When the adult does not have the mental capacity, consideration should be given to when to share information with carers/parents of vulnerable adults. In addition, consideration must be given to the relationship between the carers/parents and the alleged abuser.

Clear decisions should be recorded about when and what to share, and about who is the most appropriate person to talk to the parent/carer etc. Generally some assessment should be made as to whether the sharing of certain information with a particular person or organisation is in the adult's be adult's best interests.

Sharing Information with third parties about the (alleged) abuser

Under the Data Protection Act (1998), organisations and workers must 'honestly and reasonably believe' that the sharing of information is necessary to protect a vulnerable adult or the wider public and should consider the following issues:

- How strong is the belief in the truth of the particular allegation? The greater the conviction that the allegation is true, the more compelling the need for disclosure.
- What is the interest of the third party in receiving the information? The greater the legitimacy of the interest in the third party in having the information, the more important need to disclose.
- What is the degree of risk posed by the individual if disclosure is not made?
- Decisions about who needs to know and what needs to be known should be taken on a case- by-case basis. It is vital there is a balancing exercise undertaken weighing the serious consequences of disclosure against risks to vulnerable adult.
- This decision will be made as part of the safeguarding process, where it will be determined who will contact and speak to the alleged abuser and how this will be managed.

Confidentiality

All organisations and staff involved in the commissioning or provision of health or social cares have a duty to maintain the confidentiality of personal information. **(See section 4.6. for further information)**

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Disclosures to other organisations outside of the Safeguarding Process

There may be some cases where the risk posed by an alleged perpetrator in the community cannot be managed without the disclosure of some information to a third party outside statutory organisations. Such an example would be where an employer, voluntary group organiser or church leader has a position of responsibility/control over the individual and other persons who may be at serious risk.

Caution should be exercised before making any such disclosure: it should be seen as an exceptional measure. The following check list may be of assistance:

- The alleged perpetrator presents a risk of serious harm to the adult at risk, or to those for whom the recipient of the information has responsibility.
- There is no other practical, less intrusive means of protecting the adult at risk, and failure to disclose would put them in danger. Information which is necessary to prevent harm should be disclosed, this will rarely be all the information available.
- The risk to the alleged perpetrator should be considered however it should not outweigh the potential risk to others if a disclosure was not made. The alleged perpetrator retains his rights and consideration must be given to whether those rights are endangered as a consequence of the disclosure.
- The disclosure is to the right person and that they understand the confidential and sensitive nature of the information they have received. The information should not be disclosed by the recipient third party without the express permission of the original disclosing organisation.
- Consider consulting the alleged perpetrator about the proposed disclosure. This should be done in all cases, unless to do so would not be safe or appropriate. If it is possible and appropriate to obtain the individual's consent, then a number of potential objections to the disclosure are overcome.

Access and Security

Access to personal information must be adequately protected from unauthorised or inappropriate access. Parties to this policy and procedure must implement and maintain appropriate security measures to protect confidentiality, integrity and availability of personal information. Adopted security measures must be effectively communicated to all staff and system users, detailing individual roles and responsibilities.

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Part 10 – Complex Safeguarding

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Referrals to the Multi-agency Risk Assessment Conference (MARAC)

The MARAC is a multi-agency process where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, children and adults safeguarding, housing practitioners, substance misuse services, independent domestic violence advisers (IDVAs) and other specialists from statutory and voluntary sectors.

- The aims of the MARAC are:
- To share information to increase the safety, health and wellbeing of victims – adults and their children;
- To determine whether the perpetrator poses a significant risk to any particular individual or to the general community;
- To construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;
- To reduce repeat victimisation;
- To improve agency accountability;
- To improve support for staff involved in high-risk DV cases.

After sharing all relevant information that they have about an adult at risk, the representatives discuss options for increasing the safety of the adult at risk and form a coordinated action plan.

The MARAC will also discuss the risks posed to children and how to manage the person alleged to be causing the harm. At the heart of a MARAC is a working assumption that no single agency or individual can see the complete picture of the life of a person at risk, but all may have insights that are crucial to their safety, as part of the coordinated community response to domestic violence.

Relevant forms, agency tool kits and further information about the MARAC can be obtained through: http://www.stockportdaf.org.uk/marac.html
If a Safeguarding referral indicates there could be concerns that the adult at risk is a victim of domestic violence, stalking or so called honour based violence and this is confirmed by subsequent information, a decision must be taken at the strategy meeting or case conference whether or not to refer to the MARAC. In most cases this would be decided by the responsible manager.

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Channel Process – (Prevention of Violent Extremism)

The governments counter terrorism strategy (CONTEST), has four strands to it:
Pursue – Prevent – Protect – Prepare

The Prevent Agenda includes the Channel Project, which is a pan Greater Manchester initiative which sets out to identify and support through a multi-agency process, those adults at risk as defined under this policy, who may be susceptible to exploitation into violent extremism by radicalisers across the political spectrum. Additionally, adults at risk may be spontaneously drawn towards the messages of radicalism as a result their personal circumstances.

For further information including how to refer see 'Related Documents'.

Honour Based Violence

Honour-based violence is a crime, and referring to the police should always be considered. It has or may have been committed when families feel that dishonour has been brought to the family.
Women are predominantly (but not exclusively) the victims and the violence is often committed with a degree of collusion from family members and/or the community. Some victims will contact the police or other organisations themselves, but some may be so isolated and controlled that they are unable to do this.

Alerts that may indicate honour-based violence may include issues of domestic violence, concerns about forced marriage, enforced house arrest and missing persons. If a concern is raised through a Safeguarding Adults referral, and there is a suspicion that the adult is the victim of honour-based violence, there should be early consultation with the specialist police officers in the Public Protection Investigation Unit (PPIU).
For further information go to:
http://www.cps.gov.uk/legal/h_to_k/honour_based_violence_and_forced_marriage/

Forced Marriage

Forced marriage is a term used to describe a marriage in which one or both of the parties are married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties consent to the assistance of their parents or a third party in identifying a spouse.

If a concern is raised through a Safeguarding Adults referral, and there is a suspicion that the adult is the victim of forced marriage, there should be early consultation with the specialist police officers in the Public Protection Investigation Unit (PPIU)
HM Government guidelines can be found at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/35530/forced-_marriage-guidelines09.pdf

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Female Genital Mutilation (FGM)

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life.

The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is new-born, during childhood or adolescence, just before marriage or during the first pregnancy. However, the majority of cases of FGM are thought to take place between the ages of five and eight and therefore girls within that age bracket are at a higher risk.

FGM is illegal in the UK.

Serious Crimes Act 2015 section 72 introduces the new offence of failing to protect a girl from FGM. This will mean that if an offence of FGM is committed against a girl under the age of 16, each person who has responsibility for the girl at the time FGM occurred will be liable under this new offence.
The maximum penalty for the new offence is seven years' imprisonment or a fine or both.

Section 74. Duty to notify police of female genital mutilation

(1)A person who works in a regulated profession in England and Wales must make a notification under this section (an "FGM notification") if, in the course of his or her work in the profession, the person discovers that an act of female genital mutilation appears to have been carried out on a girl who is aged under 18.
HM Government multi agency guidelines can be found at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97857/FGM.pdf

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Appendix 1

Useful Links

Useful Links

Issue	Organisation	Web Link	Telephone number
Hate Crime	Stop Hate UK	http://www.stophateuk.org/	0800 138 1625
Criminal Investigations	Greater Manchester Police		
Misuse of appointeeship	Department of Work and Pensions (DWP)	https://www.gov.uk/government/publications/procedures-for-dealing-with-agents-appointees-attorneys-deputies-and-third-parties/part-5-appointee	
Forced Marriage / Honour Based Violance	Karma Nirvana	https://karmanirvana.org.uk/	0800 5999 247
Anti Social Behaviour	GM Police Public Protection Team	https://www.gmp.police.uk/	Call 101 for non-emergency enquiries. Call 999 in an emergency
Quality and Safety	Care Quality Commission	https://cqc.org.uk/	03000 616161
Fraud and Scams	Greater Manchester Police Stockport Trading Standards	https://www.gmvictims.org.uk/find-information/ive-been-affected-by/fraud-and-scams	0161 200 1950
Serious Incidents	NHS Serious Incident Framework	https://www.england.nhs.uk/patient-safety/serious-incident-framework/	0300 311 22 33
Domestic Abuse Services	Stockport without Abuse Positive Relationships Team	http://www.stockportwithoutabuse.org.uk/	0161 477 4294

Useful Links

Issue	Organisation	Web Link
Breach of Code of Conduct	**Nursing and Midwifery Council**	https://www.nmc.org.uk/
	Health Professions' Council	https://www.hcpc-uk.org/
	General Medical Council	https://www.gmc-uk.org/
	General Optical Society	https://www.optical.org/
	General Dental Society	https://www.gdc-uk.org/
	General Chiropractic Council	https://www.gcc-uk.org/
	Royal Pharmaceutical Society of Great Britain	https://www.rpharms.com/
	General Osteopathic Council	https://www.osteopathy.org.uk/home/
Modern Slavery and Human Trafficking	National Crime Agency Modern Slavery	www.modernslavery.co.uk
Multi Agency Public Protection Arrangements (MAPPA	Multi Agency Public Protection Arrangements (MAPPA	https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

Useful Links

Issue	Organisation	Web Link	Telephone number
Multi Agency Public Protection Arrangements (MAPPA)	Multi Agency Public Protection Arrangements (MAPPA)	https://mappa.justice.gov.uk/connect.ti/MAPPA/view?objectId=5682416	
Criminal Investigations	Greater Manchester Police	https://www.gmp.police.uk/	Call 999 If you're deaf or hard of hearing, use textphone service 18000.
Misuse of appointeeship	Department of Work and Pensions	https://www.gov.uk/government/publications/procedures-for-dealing-with-agents-appointees-attorneys-deputies-and-third-parties/part-5-appointee#revoking-an-appointment	
Forced Marriage / Honour Based Violance	Karma Nirvana	https://karmanirvana.org.uk/	https://karmanirvana.org.uk/contact/
Anti Social Behaviour	Greater Manchester Police Public Protection Team	https://www.gmp.police.uk/advice/advice-and-information/asb/asb/antisocial-behaviour/	Call 999 If you're deaf or hard of hearing, use textphone service 18000.
Quality and Safety	Care Quality Commision	https://cqc.org.uk/	03000 616161
Fraud and Scams	Greater Manchester Police Stockport Trading Standards	https://www.gmp.police.uk/ro/report/fo/fraud/	Call 999 If you're deaf or hard of hearing, use textphone service 18000.
Serious Incidents	NHS Serious Incident Framework	https://www.england.nhs.uk/patient-safety/serious-incident-framework/	
Domestic Abuse Services	Stockport without Abuse Positive Relationships Team	http://www.stockportwithoutabuse.org.uk/	0161 477 4294 0800 2000 247

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Appendix 2

Multi Agency Processes

Multi Agency Public Protection Arrangements MAPPA

MAPPA is the process through which the police, probation and prison services work together with other agencies to assess and manage violent and sexual offenders in order to protect the public from harm. It is a system of sharing information and combining resources to maximise the risk management in place for each individual offender.

It is the responsibility of the National Probation Service to manage all offenders that are classed as high risk or managed by MAPPA. The Community Rehabilitation Company has a statutory responsibility to co-operate with these arrangements as required.

There are **three levels of management** which are based upon the level of multi-agency co-operation required to implement the risk management plan effectively. Higher risk cases tend to be managed at the higher levels and offenders will be moved up and down levels as appropriate.

Level 1 - Ordinary management

These offenders are subject to the usual management arrangements applied by whichever agency is supervising them.

Level 2 - Active multi agency management

The risk management plans for these offenders require the active involvement of several agencies via regular MAPP meetings.

Level 3 - Active multi agency management

Same as Level 2 but these cases additionally require the involvement of senior officers to authorise the use of special resources, such as police surveillance or specialised accommodation and/or to provide ongoing senior management oversight.

Offenders Managed Through MAPPA

There are three categories of offenders managed through MAPPA:

Category 1 - Registered sex offenders

Category 2 - Violent offenders sentenced to imprisonment for 12 months or more, or those detained under hospital orders. This category also includes a small number of sexual offenders who do not qualify for registration and offenders disqualified from working with children; and

Category 3 - Other dangerous offenders who do not qualify under categories 1 or 2 but who currently pose a risk of serious harm, there is a link between the offending and the risk posed, and they require active multi-agency management.

Violent and Sexual Offenders' Register (ViSOR)

ViSOR is a database holding details of sexual and violent offenders, and other dangerous persons. Police, prisons and probation all work on the same IT system enabling the sharing of risk assessments and risk management information on individual violent and sex offenders.

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Multi Agency Risk Assessment Conference – MARAC

The role of the MARAC is to facilitate, monitor and evaluate effective information sharing around Domestic Abuse to enable appropriate actions to be taken to increase public safety

The risk assessment process, MARAC procedures (including referral) and standards for operating MARAC meetings have been developed by Safe Lives, a national organisation supported by the Home Office.

In a single meeting the MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic violence case: – victim, children perpetrator and agency workers.

At a MARAC meeting high risk cases are discussed with a very brief and focused information sharing process. This is followed by the creation of an individualised multi-agency action plan which is put into place to support the victim and to make links with other public protection procedures, particularly those that manage perpetrators and safeguard children and vulnerable adults. Issues relating to children such as conflict over child contact, pregnancy and perception of harm to children are key indicators of risk in the CAADA risk assessment process. Thus a substantial number of victims who become MARAC cases have children (although many do not).

The aim of the MARAC is to:

- Share information to increase the safety, health and well-being of victims and their children.
- Determine whether the perpetrator poses a significant risk to any particular individual or the general community.
- Construct and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm.
- Reduce repeat victimisation.
- Improve agency accountability.
- Improve support for staff involved in high risk domestic violence cases.

Stockport has signed up to the Greater Manchester Safeguarding Procedures and details for MARAC can be found here.

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Multi Agency Adults at Risk Panel - MAARS

The multi-agency adults at risk system (MAARS) was developed to address the needs of adults who are known to agencies but do not engage effectively with them. It is a platform to help address the complex needs of adults who present with a range of multi-layered issues that means providing support to meet their needs in a multi-agency approach.

Such issues include physical and mental ill health, domestic violence and abuse, trafficking, anti-social behaviour, organised crime, low level criminality and drugs and alcohol misuse.

These adults are also likely to have experienced adverse childhood experiences such as child sexual exploitation, sexual abuse, living in a violent and or criminal household, living with parents with mental and physical ill health and living with parents with substance misuse issues.

MAARS panel meetings take place on a monthly basis and all new referrals, or old cases being referred back, are considered at the meeting

The panel will;

- make specific recommendations or
- signpost the case to the most appropriate services or
- agree that the case be included on the agenda for a full panel discussion, within the confidentiality agreement that MAARS participants sign up to, this is otherwise known as the Team around the Adult process (TAA).

The TAA brings together a range of different practitioners from across the wider public-sector workforce to support an individual and their family. The members of the TAA develop and deliver a package of solution-focused support to meet the needs identified through Assessment.

The meeting should be attended by all agencies who are/or could offer a service to the adult.

The purpose of the strategy meeting is to develop a Team around the Adult, where all partners know what activity is underway and who is responsible for it. The meeting should result in a plan that is shared with the adult by the identified lead practitioner and review meetings should be held on a regular basis to assess progress against the plan and what changes might be needed.

https://www.stockport.gov.uk/maars/overview-maars

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Guidance on Taking Photographs

Appendix 3

Guidance for Taking Photographs as Evidence in Adult Safeguarding Cases

Introduction

The use of photographs can be a very effective way to record evidence in safeguarding cases where there is an observable physical injury e.g. bruising lacerations etc. They are particularly useful in securing (a permanent record of) evidence that would otherwise be temporary in nature as a result of the healing process, medical attention or in some other way lost, (if not quickly collected or recorded). However there are important things to consider. The physical and mental well-being of the adult at risk will always take priority over the need to gather evidence. The agreed actions related to a safeguarding enquiry will always ensure that any plans to take photographs take account of the likely consequences that this will have on an adult at risk.

The purpose of this this Guidance relates to the taking of photographs in the context of concerns relating to abuse and neglect and the use of photographic evidence in relation to safeguarding. Other photographs are not covered in this guidance which will be subject to the individual agency's own policy and procedures. As part of their normal daily duties, most staff should not need to take photographs of individuals or of any injuries they may have received. Where this might be part of their usual duties they should refer to their own agency guidance governing the taking/storing of photographic images of service users

Points to Consider

i) Rape or Sexual Assault

Photographs of genitals should **never** be taken. Any suspicion of rape or sexual assault should be treated as requiring an urgent call to the police. The police will advise on how to preserve evidence and if required a specially trained police doctor will collect evidence for any subsequent criminal or safeguarding investigations.

ii) Consent

If a photograph is going to be taken it is essential under usual circumstances, you ensure consent is obtained. Consent must be valid and given freely and appropriately recorded.

You should be mindful that consent is more than just a signature on a form. Consent should be unambiguous and explicit.

Therefore a two stage approach is required in seeking appropriate consent-:

- Consent to take the photograph (ensuring the adult understands the purpose for which it is being taken)
- Its use as evidence (ensuring the adult understanding who it will be shared with and what will happen to it after the investigation)

The latter consent should be sought after the individual has had a chance to view the photograph in question.

iii) Lack of Mental Capacity to consent

Where capacitated informed consent cannot be given for photographs to be taken a best interest decision should be made.
Whoever is taking or asking for the photograph to be taken will be the d*ecision maker* and will need to record they have made a best interest decision in line with the Mental Capacity Act 2005 Code of Practice. The decision should be recorded in the appropriate records.
To assist a safeguarding adult investigation where abuse is suspected, it is likely to be in the person's best interest to preserve evidence by taking an appropriate photograph.

iv) Taking the Photograph:

The person taking a photograph of a service user's body should ensure the individual's dignity and modesty is preserved at all time.

The person taking the photographs should sign and date them if possible and or write and sign a paragraph or two describing who they are, and the circumstances, time, and place of taking the photograph.
If a photograph is being taken of a particular space within a room or location (to assist in the understanding of an event) it is important to establish context by taking the first picture as an overview of the physical surroundings and context of the evidence.

For example, in photographing the corner of a table, that someone cut their head on, start by stepping back and taking a picture of the whole of the room. Then step in a little closer and take another picture, and in a little closer still, and take another picture, until you arrive at a close-up of the edge of the table. In this way, there is no question that the final picture of the edge of the table was taken at the exact location where it is claimed to have been taken.

In the case of photographing injuries, always step back and take a full body, face-front picture of the person with the injuries. Then, as you move in and methodically take pictures of the injuries, try to keep the picture coverage big enough to include at least a little of the clothing. This way, it can be reasonably concluded that the person in the first picture is the same as the person in the close-up of the injury.

If one is available, put a ruler or tape measure in the picture alongside the injuries, damage, handprint, or other physical evidence, so as to give an accurate measure of the size of the subject of your pictures.

Bruises can be technically difficult to capture in a photograph. The way to be sure the bruises show up is to take two or three pictures of each bruise under different lighting conditions. For example, take one picture of a bruised arm near the window, and take the same picture with the arm turned away from the window, and perhaps another with the flash on. Of course this should only be with the person's agreement (if obtainable) and where such movement does not compromise the comfort, safety and dignity of the person.

In some cases (e.g. pressure areas) photography will be required for clinical care reasons and such photographs may also be admissible as evidence where they indicate neglect or ill treatment. In such cases it will be necessary to obtain a medical opinion to provide expert interpretation of the images.

v) Retention of Photographs

Photographs should be regarded as confidential personal data in accordance with GDPR and only used accordingly and stored securely. They should be retained in accordance with your agency's retention guidelines.

3. Whistle Blowing and Covert Camera Use

In some circumstances covert imagines and/or recordings are justifiable. The law offers some protection to people who blow the whistle under the Public Interest Disclosure Act 1998. The Act offers protection, from victimisation in employment following a disclosure, to public, private and voluntary sector workers. The parameters of 'protected disclosure' are set out in the Employment Rights Act 1996 (ERA). The person making the disclosure should not commit an offence in doing so (e.g. breach the Official Secrets Act 1989) and must reasonably believe one or more of the following:

- that a criminal offence has been committed, is being committed or is likely to be committed
- that a person has failed, is failing or is likely to fail to comply with any legal obligation to which he is subject
- that a miscarriage of justice has occurred, is occurring or is likely to occur
- that the health or safety of any individual has been, is being or is likely to be endangered
- that the environment has been, is being or is likely to be damaged
- that information tending to show any matter falling within any one of the preceding paragraphs has been, is being or is likely to be deliberately concealed. (ERA,1996)

The Whistleblowing Helpline[link 4] is a free-phone service (08000 724 725) for employees, and organisations working within the NHS and social care sector. It is not a disclosure line; it provides advice and guidance to staff, employers, contractors, unions and professional bodies.

Link to CQC using cameras or recording equipment

https://www.cqc.org.uk/contact-us/report-concern/using-cameras-or-other-recording-equipment-check-somebodys-care

An interpreting service is available, if you need help with this information.

Please telephone Stockport Interpreting Unit on 0161 477 9000. Email: eds.admin@stockport.gov.uk

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如果你需要他人為你解釋這份資料的內容，我們可提供傳譯服務，

請致電 0161 477 9000 史托波特傳譯部。電郵 eds.admin@stockport.gov.uk

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