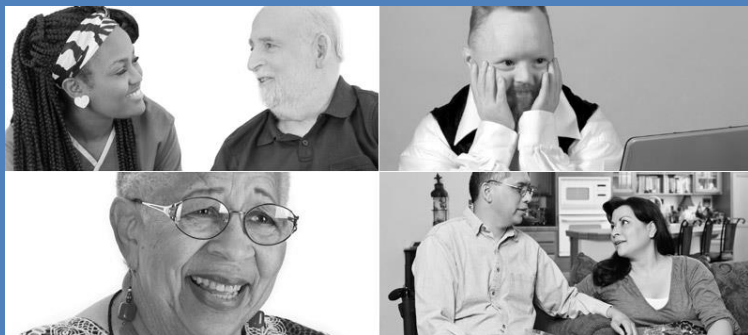




Southend, Essex and Thurrock CCG's

Safeguarding Adults Handbook

(Incorporating MCA/DoLS, Prevent and FGM)



April 2015

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Adult Safeguarding Boards

Your Responsibilities

Safeguarding Adults

All staff within health services have a responsibility for the safety and wellbeing of patients and colleagues.

Living a life that is free from harm and abuse is a fundamental human right of every person and an essential requirement for health and well-being.

Safeguarding adults is about the safety and well-being of all patients by providing additional measures for those least able to protect themselves from harm or abuse.

Safeguarding adults is a fundamental part of patient safety and wellbeing and the outcomes expected of the NHS. Safeguarding adults is also integral to complying with legislation, regulations and delivering cost effective care.

These cards should be used by you as a guide should you have a safeguarding concern and should always be used alongside your organisations safeguarding policy and procedures.

The Care Act does not give a definition of a “vulnerable adult” but instead states that Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) 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 or neglect.

NB: Throughout this publication we have used the term ‘patient’ to refer to patients and clients.

Your Responsibilities

Your responsibilities when you have safeguarding concerns:

- Assess the situation i.e. are emergency services required?
 - Ensure the safety and wellbeing of the individual
 - Establish what the individual's views and wishes are about the safeguarding issue and procedure
 - Maintain any evidence
 - Follow internal procedures for reporting incidents/risks
 - Remain calm and try not to show any shock or disbelief
 - Listen carefully and demonstrate understanding by acknowledging regret and concern that this has happened
- Inform the person that you are required to share the information, explaining what information will be shared and why
 - Make a written record of what the person has told you, using their words or what you have seen as well as your actions

Your Responsibilities

Duty of care:

You have a duty of care to your patients/service users, your colleagues, your employer, yourself and the public interest. Everyone has a duty of care – it is not something that you can opt out of.

All professional bodies, such as the GMC, NMC and HPC have guidance on duty of care. As an example, the Health Professions Council standards state:

‘...a person who is capable of giving their consent has the right to refuse treatment. You must respect this right. You must also make sure they are fully aware of the risk of refusing treatment, particularly if you think there is a significant or immediate risk to life.’

Duty of care can be said to have reasonably been met where an objective group of professional considers.¹⁰

- All reasonable steps have been taken
- Reliable assessment methods have been used
- Information has been collated and thoroughly evaluated

- Decisions are recorded, communicated and thoroughly evaluated
- Policies and procedures have been followed
- Practitioners and managers should seek to ascertain the facts and are proactive

You should always treat every individual with dignity and respect to ensure that they feel safe in services and empowered to make choices and decisions.

Ensure that significant others, i.e. family member, friend or advocate, are involved to support the individual where appropriate.

However it is important to recognise that though an individual with capacity has the right to refuse care for themselves, the duty of care extends to considering where others may be at risk and action is needed to protect them.

Your Responsibilities

You have a responsibility to follow the six key principles that underpin all adult safeguarding work:

Empowerment - People being supported and encouraged to make their own decisions and informed consent.

"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

Prevention – It is better to take action before harm occurs.

"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

Proportionality – The least intrusive response appropriate to the risk presented.

"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

Protection – Support and representation for those in greatest need.

"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

Partnership – Local solutions through services working with their communities.

"I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

Accountability – Accountability and transparency in delivering safeguarding.

"I understand the role of everyone involved in my life and so do they."

(Ref: The Care Act 2014)

Categories of Abuse

1. Categories of abuse

This section considers the different types and patterns of abuse and neglect and the different circumstances in which they may take place. This is not intended to be an exhaustive list but an illustrative guide as to the sort of behaviour which could give rise to a safeguarding concern.

Physical Abuse – including assault, hitting, slapping, pushing, misuse of medication, restraint or inappropriate physical sanctions.

Domestic Violence – including psychological, physical, sexual, financial, emotional abuse; so called ‘honour’ based violence.

Sexual Abuse – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Psychological Abuse – including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

Financial or Material Abuse – including theft, fraud, internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

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

Discriminatory Abuse – including forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.

Categories of Abuse

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

Neglect and Acts of Omission – including ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

Self-Neglect – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

(Ref: The Care Act 2014)

2. Frequency

Incidents of abuse may be one-off or multiple, and affect one person or more. Professionals and others should look beyond single incidents or individuals to identify patterns of harm, just as the Care Quality Commission, as the regulator of service quality, does when it looks at the quality of care in health and care services. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organizational abuse. In order to see these patterns it is important that information is recorded and appropriately shared.

3. Significant Harm

“Harm should be taken to include not only ill treatment but also the impairment of, or avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social, or behavioural development”
Law Commission 1995.

Categories of Abuse

4. Patterns of Abuse

Patterns of abuse can vary and may include:

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

(Ref: The Care Act 2014)

5. Whistle Blowing

Always act whenever abuse is suspected including when your legitimate concern is not acted upon. Whistle blowers are given protection under the Public Interest Disclosure Act 1998.

The **National Whistleblowing Helpline** provides free confidential advice to staff within the NHS and Social Care who are unsure whether they have a whistleblowing concern, or how to raise a concern internally or escalate this externally. The helpline will also explain their rights to protection under the Public Interest Disclosure Act (PIDA) when they raise a concern.
National Whistleblowing Helpline:
08000 724725

If in doubt refer to your own organisations' policy, contact your nominated Lead for Adult Safeguarding or your Line Manager, who will be able to offer advice and support.

Your Role as Alerter

Your role as 'Alerter' in the Safeguarding Process

- The 'alerter' raises a safeguarding concern within their own agency following own policy and procedures
- This concern may result from something that you have seen, been told or heard
- Make a referral to Safeguarding Adults where this is necessary

Assessment

Your assessment should be holistic and thorough considering the patient's emotional, social, psychological and physical presentation as well as the identified clinical need. You need to be alert to:

- Inconsistencies in the history or explanation
- Skin integrity
- Hydration
- Personal presentation e.g. is the person unkempt
- Delays or evidence of obstacles in seeking or receiving treatment
- Evidence of frequent attendances to health services or repeated failure to attend (DNA)
- Environmental factors eg. signs of neglect, the reactions and responses of other people with the patient
- Does the patient have capacity for the decision required?
- Are they able to give informed consent or is action needed in their best interests?
- Are there others at risk e.g. children or other vulnerable adults?
- Is immediate protection required?
- Has a crime been committed and should the Police be informed?
- Preserving any evidence
- Is any action that is being considered proportionate to the risk identified?
- What are the patient's views/wishes?
- Cultural differences or religious beliefs
- Are there valid reasons to act even without the patient's consent? E.g. where others are at risk; need to address a service failure that may affect others

Your Role as Alerter

Golden Rules: Holistic Assessment

These rules are focused on patients in an inpatient setting, but could easily apply in principle to patients being seen in General Practice, Out Patient Clinic, Day Service or in the Community/Patients Home.

On admission:

- Does this fall under adult safeguarding duties as defined by the 'Care Act'?
- Are there any existing alerts relating to the patient?
- Is there any current agency involvement? Consider both statutory and private providers
- What are the home circumstances?
- Is the patient likely to require more input on discharge?
- Who else lives in the household?
- Skin integrity
- Nutritional state including hydration
- Personal presentation
- Person's communication and behaviour
- Are any reasonable adjustments required
- Treat the person with dignity and respect

Before discharge:

- Where is the patient being discharged to?
- Don't transfer problems
- Is there any previous involvement/support (consider statutory and private providers and informal carers) that needs re-engaging?
- Think about information sharing when transferring patient
- Will they be safe on discharge?
- Is this the patient's choice?
- Does there need to be a referral to Adult Social Care?
- Have community nurse referrals been made?
- Has the care package been restarted?
- Check for outcomes of any Safeguarding referrals
- Does an alert need adding to patient notes?

Communication

- Consider use of communication aids/language line if required to involve the patient
- Take account of individual differences
- Listen carefully, remain calm and try not to show shock or disbelief

Continued over...

Your Role as Alerter

- Acknowledge what is being said
- Do not ask probing or leading questions which may affect credibility of evidence
- Be open and honest and do not promise to keep a secret
- Seek consent to share information if patient has capacity and if this does not place you or them at increased risk
- You may share information without consent if it is in the public interest in order to prevent a crime or protect others from harm (follow own organisation's policy and procedures)

Reporting

- Report concern following your safeguarding adult policy and procedures
- Make clear and concise referral so that person reading the form understands the key issues
- Do not delay unnecessarily
- Concern about a colleague should be raised through your organisations Managing Allegations against staff or Whistle blowing policy

Remember that you are accountable for what you do or choose not to do.

Recording

- You are accountable for your actions or omissions
- Make a legible, factual, timely and accurate record of what you did and why, to demonstrate transparent, defensible decision making e.g. capacity assessment made, best interest decision, any restraint which was required which must be proportionate to the situation

Information Sharing

Information sharing

Where there are safeguarding concerns staff has a duty to share information.

It is important to remember that in most serious case reviews, lack of information sharing can be a significant contributor when things go wrong.

Information should be shared with consent wherever possible. A person's right to confidentiality is not absolute and may be overridden where there is evidence that sharing information is necessary to support an investigation or in best interests e.g. in the interests of public safety, police investigation, implications for regulated service.

1. **Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately
2. **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe, or inappropriate to do so

3. **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible
4. **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You may still share information without consent if, in your judgment, that lack of consent can be overridden in the public interest. You will need to base your judgment on the facts of the case
5. **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions
6. **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely

Continued over...

Information Sharing

7. **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose

Any information disclosed should be:

- clear regarding the nature of the problem and purpose of sharing information
- based on fact, not assumption
- restricted to those with a legitimate need to know
- relevant to specific incident
- strictly limited to the needs of the situation at that time
- recorded in writing with reasons stated

Sharing data when someone lacks mental capacity

- Can the patient give consent to disclosure of information?
- You have a responsibility to explore approaches to help them understand
- In some instances the individual will not have the capacity to consent to disclosure of personal information relating to them. Where this is the case any disclosure of information needs to be considered against the conditions set out in the Data Protection Act and Best interests

The Mental Capacity Act

The Mental Capacity Act (MCA) 2005

Five Principles Which Underpin The Mental Capacity Act:

In order to protect those who lack capacity and to enable them to take part, as much as possible in decisions that affect them, the following statutory principles apply:

- You must always assume a person has capacity unless it is proved otherwise
- You must take all practicable steps to enable people to make their own decisions
- You must not assume incapacity simply because someone makes an unwise decision
- Always act, or decide, for a person without capacity in their best interests
- Carefully consider actions to ensure the least restrictive option is taken

Assessment of Capacity:

Follow the 2 stage test for capacity:

- **Stage 1:** Does the person have an impairment of the mind or brain (temporary or permanent)?

If Yes:

- **Stage 2:** Is the person able to:
 - Understand the decision they need to make and why they need to make it?
 - Understand, retain, use and weigh information relevant to the decision?
 - Understand the consequences of making, or not making, this decision?
 - Communicate their decision by any means (i.e. speech, sign language)?
 - Failure on one point will determine lack of capacity

How to Act In Someone's Best Interests:

- Do not make assumptions about capacity based on age, appearance, condition or diagnosis
- Encourage the person to participate as fully as possible
- Consider whether the person will in the future have capacity in relation to the matter in question
- Consider the person's past and present beliefs, values, wishes and feelings

Continued over...

The Mental Capacity Act

- Take into account the views of others – i.e. carers, relatives, friends, advocates
- Consider the least restrictive options
- Best Interests checklist will be available as part of local policy and procedure

What Else Do You Need To Consider?

MCA Code of Practice: Professionals and carers must have regard to the Code and record reasons for assessing capacity or best interests. If anyone decides to depart from the Code they must record their reasons for doing so.

LPAs & ADs: Is there a valid/current Lasting Power of Attorney **or** an Advance Decision in place?

IMCAs: The Mental Capacity Act sets up a new service, the Independent Mental Capacity Advocate (IMCA), to help vulnerable people who lack capacity and are facing important decisions including serious healthcare treatment decisions and who have no one else to speak for them.

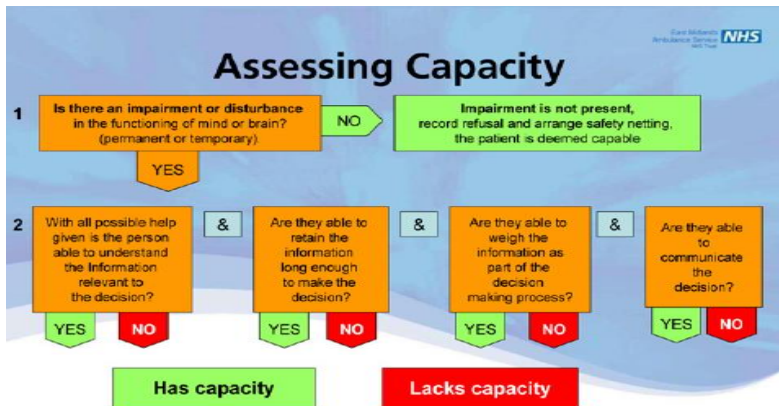
The full text of the act and the code of practice is available at:

Where to Find Guidance

The full text of the act and the code of practice is available at:- <https://www.gov.uk/government/collections/mental-capacity-act-making-decisions>

NB There may not always be time in emergency situations for all investigation and consultation, and there should be no liability for acting in the reasonable belief that someone lacks capacity, and what you do is reasonably believed to be in their best interests (MCA s5). This can include restraint if need be, if it is proportionate and necessary to prevent harm (MCA s6), and even “a deprivation of liberty”, if this is necessary for “life sustaining treatment or a vital act”, while a Court Order is sought if need be (MCA s4B).

How to Assess Capacity



If the answer to 1. is YES and the answer to any of 2. is NO then the person lacks capacity under the Mental Capacity Act 2005.

Consent and Best Interests Decisions

Consent

Consent is the principle that a person must give their permission before they receive any type of care intervention.

For consent to be valid, it must be **voluntary** and **informed**, and the person consenting must have the **capacity** to make the decision. These terms are explained below:

- **Voluntary** – the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from medical staff, friends or family.
- **Informed** – the person must be given all of the information in terms of what the intervention involves, including the benefits and risks, whether there are reasonable alternatives and what will happen if the intervention does not go ahead.
- **Capacity** – the person must be capable of giving consent, which means they understand the information given to them, and they can use it to make an informed decision. (see Two Stage Test)

Best Interests

If the patient is not able to consent to or refuse an intervention, there is a duty to make a best interest decision about whether to treat the patient.

You must:

- involve the person who lacks capacity
- have regard for past and present wishes and feelings, especially written statements
- consult with others who are involved in the person's care
- there can be no discrimination

Deprivation of Liberty

Deprivation of Liberty Safeguards

What are they?

The Deprivation of Liberty Safeguards 2009 (DoLS) are an amendment to the Mental Capacity Act 2005. They provide a legal framework to protect those (over 18 years) who lack the capacity to consent to the arrangements for their treatment or care, for example by reason of Dementia, Learning disability or Brain Injury and where levels of restriction or restraint used in delivering that care for the purpose of protection from risk/harm are so extensive as to potentially be depriving the person of their liberty. Deprivation of Liberty Safeguards goes beyond the actions permitted under section 5 of the Mental Capacity Act (MCA) 2005

Who does it apply to?

Community

If a person is being deprived of their liberty and they are not in a care home or hospital, their care can only be authorised through the Court of Protection.

Please refer to your local policy to determine how to make an application to the Court of Protection

Hospital or Care Home

The safeguards ONLY apply to people who lack capacity to consent to care/treatment they receive: AND are over 18 years of age AND receive care in a hospital or a care home setting AND the care they receive deprives them of their liberty AND they are not detained under the Mental Health Act.

Supreme Court Ruling 2014

The Supreme Court ruling in March 2014 significantly lowered the threshold regarding what could be considered a Deprivation of Liberty.

It is no longer relevant whether the person is compliant or whether there is a lack of objection. The focus is not on the person's ability to express a desire to leave, but on what those with control over their care arrangements would do if they sought to leave. The purpose of the placement is not relevant and the person should no longer be compared only with another person who has the same level of disability. The concept of "relative normality" as expressed by the Court of Appeal in the Cheshire West case is no longer good law.

Deprivation of Liberty

Defining a Deprivation of Liberty

The test of Deprivation of Liberty has now been revised into a so-called “acid test” by the Supreme Court as follows

The person is under continuous supervision and control AND is not free to leave

Every element of this must be satisfied i.e.

- Continuous
- Supervision
- Control
- Not free to leave

If you are unsure if an individual is being deprived of their liberty, in a care home, hospital or a community setting, please contact your Safeguarding Adults Lead or the local authority DoLS Team for advice.

What you need to know

- Sometimes deprivation of liberty (DoL) is required to provide care/ treatment and protect people from harm, BUT every effort should be made to prevent DoL by making provision to avoid placing restrictions, if DoL cannot be avoided it should be for no longer than is necessary

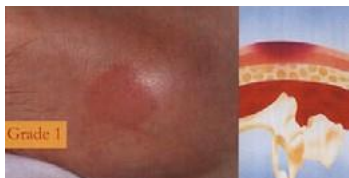
- There is a legal duty on the hospital or care home, if the Safeguards apply, to request the local authority to authorise to deprive someone of their liberty for a limited period of time
- A major part of preventing DoL is minimising any restraint. Restraint must be appropriate, proportionate and in the patient's best interests

What to do

- If you are worried about a patient in your care who you think might be being deprived of their liberty, consider ways in which you can minimise restrictions. Please refer to your local DoLS procedures
- Discuss the case with your Adult Safeguarding Lead
- In a community setting you can contact your Local Authority DoLS team who will be able to assist

It is important to act quickly to comply with legislation.

Pressure Ulcer Staging



Stage 1:

Non-blanching erythema of intact skin.



Stage 2:

Partial thickness skin loss involving epidermis, dermis or both. Superficial and presents as blister or abrasion.



Stage 3:

Full thickness skin loss involving damage / necrosis of subcutaneous tissue may extend to underlying fascia.



Stage 4:

Extensive destruction, tissue necrosis, damage to muscle, bone, supporting structures +/- full thickness skin loss.

If patient has pressure ulcers ask yourself – could this be neglect?

NB: Some areas of health use a slightly different categorisation based on European Guidelines

PREVENT

The Governments counter-terrorism strategy is called CONTEST and it is divided up into four priority objectives:

Pursue – stop terrorist attacks

Prepare – where we cannot stop an attack, mitigate its impact

Protect – strengthen overall protection against terrorist attacks

PREVENT – stop people becoming terrorists and supporting violent extremism

PREVENT is a strategy that seeks to stop people becoming terrorists and supporting violent extremism. There are numerous government departments and local partners involved in the strategy, and one of the main organisations involved are health care services.

The specific PREVENT objectives that relate to healthcare services are to:

- Support individuals who are vulnerable to recruitment, or have already been recruited by violent extremists
- Disrupt those who promote violent terrorism and support the places where they operate

- Address the grievances which radicalisers are exploiting

The health service has been identified as a key partner in preventing vulnerable people being radicalised.

The key message is that all staff must escalate a concern and have confidence that each issue will be taken seriously, handled appropriately and that, where necessary, specialist advice will be available.

Contracts of employment, professional codes of conduct and safeguarding frameworks such as the Care Act require all healthcare staff to exercise a duty of care to patients and, where necessary, take action for safeguarding and crime prevention.

If you have a concern discuss it with your safeguarding lead and they will advise and identify local referral pathways.

Domestic Violence and Abuse.

Domestic Violence /Abuse

One woman in three (and one man in five) in the UK will be a victim of domestic violence during their lifetime, according to research estimates. Two women a week are killed by a current or former male partner.

Domestic violence and abuse is officially classified as "any incident of threatening behaviour, violence or abuse between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality".

We think of domestic violence as hitting, slapping and beating, but it can also include emotional abuse as well as forced marriage and so-called "honour crimes". It's abuse if a partner, ex-partner or a family member:

- threatens/frightens an individual
- shoves or pushes an individual
- makes an individual fear for their physical safety
- puts an individual down, or attempts to undermine their self-esteem
- controls an individual, for example by stopping them seeing friends and family
- is jealous and possessive, such as being suspicious of friendships and conversations

Key Principles

The following are some key principles to remember when encountering service users that may have been victims of Domestic Violence or Sexual Abuse.

- **Act** - Never assume someone else is addressing the domestic violence and abuse issues
- **Respect** - Remember it is not the professional's role to comment on or encourage a person experiencing abuse to leave their partner
- **Revisit** - If a patient does not disclose but you suspect otherwise, accept what is being said but offer other opportunities to talk and consider giving information (e.g. 'for a friend')
- **Share** - Share information appropriately subject to policy and local guidance

The following page is guidance on "Asking the Question" taken from:

<https://www.gov.uk/government/publications/guidance-for-health-professionals-on-domestic-violence>

Domestic Violence and Abuse.

Asking the question – A Guide

Ensure it is safe to ask

1. Consider the environment
 - Is it conducive to ask?
 - Is it safe to ask?
 - Never ask in the presence of another family member, friend, or child over the age of 2 years (or any other persons including a partner)
2. Create the opportunity to ask the question
3. Use an appropriate professional interpreter (never a family member).

Ask

Frame the topic first then ask a direct question.

Framing: *“As violence and abuse in the home are so common we now ask contacts about it routinely”*

Direct Question: *“Are you in a relationship with someone who hurts, threatens or abuses you?” Did someone cause these injuries to you?”*

Validate

Validate what's happening to the individual and send important messages to the contact:

- *“You are not alone”*
- *“You are not to blame for what is happening to you”*
- *“You do not deserve to be treated in this way.”*

Assess

Assess contacts safety:

- *“Is your partner here with you?”*
- *“Where are the children?”*
- *“Do you have any immediate concerns?”*
- *“Do you have a place of safety?”*

Action

Be aware of your local domestic violence agency, how to contact local independent domestic violence advisor (IDVA), offer leaflet and suggest referral.

Action any local safeguarding procedures.

Document

Consider safety and confidentiality when recording information in patient notes. (not in service user held record).

Medical records can be used by survivors in future criminal justice proceedings.

Domestic Violence and Abuse.

FGM (Female Genital Mutilation)

Female genital mutilation (sometimes referred to as female circumcision or cutting) refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. It has no medical benefits and causes severe pain and has several immediate and long term health consequences.

Seven Key Facts about FGM

1. It's illegal in the UK as is taking anyone out of the UK for the procedure.
2. It is prevalent in 28 African countries as well as in parts of the Middle East and Asia.
3. Approximately 137,000 women and children resident in England and Wales are living with the consequences of FGM.
4. Over 60,000 girls under the age of 15 are at risk of FGM in the UK each year.

5. It constitutes a form of child abuse and violence against women and girls, and has severe short-term and long-term physical and psychological consequences.
6. The procedure may be carried out when the girl is newborn, 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 5 and 8 and therefore girls within that age bracket are at a higher risk.
7. It's practiced by families for a variety of complex reasons but often in the belief that it is beneficial for the girl or woman.

In all cases: If you are worried about a child under 18 who is at risk of FGM or has had FGM, you have a legal obligation to share this information with social care and/or the police. Professionals must also consider the risks to other girls and women who may be related to or living with an individual with FGM as it is an inter-generational practice, their girls and young women may also be at significant risk of harm.

If you are concerned about an individual, please contact Safeguarding Lead (Child or Adult)

Domestic Violence and Abuse.

Forced Marriage

A forced marriage is where one or both people do not (or in cases of people with learning disabilities, cannot) consent to the marriage and pressure or abuse is used. It is an appalling and indefensible practice and is illegal in Great Britain. It is recognised as a form of violence against women and men, domestic/child abuse and a serious abuse of human rights.

A marriage must be entered into with the free and full consent of both parties; you should feel you have a choice. The pressure put on people to marry against their will can be physical (including threats, actual physical violence and sexual violence) or emotional and psychological (for example, when someone is made to feel like they're bringing shame on their family). Financial abuse (taking your wages or not giving you any money) can also be a factor.

In some case people may be taken abroad without knowing that they are to be married. When they arrive in that country, their passport(s)/travel documents may be taken to try to stop them from returning to the UK.

There are many different ways individuals may come to the attention of health professionals. For example, they may present to:

- Accident and emergency (A&E) departments, rape crisis centres or genito-urinary clinics with injuries consistent with rape or other forms of violence.
- Dental surgeries with facial injuries consistent with domestic abuse.
- Mental health services, counselling services, school nurses, health visitors, or to their GP, with depression as a result of forced marriage. They may display self-harming behaviour such as anorexia, cutting, substance misuse or attempted suicide.
- Family planning clinics or GP for advice on contraception or a termination as many women do not want to have a baby within a forced marriage.
- Midwifery services if a woman becomes pregnant.

If you have concerns, contact your local Safeguarding Lead for advice

Domestic Violence and Abuse.

National Domestic Abuse/ Violence Helplines

National Domestic Violence Helpline

This free-phone 24- hour helpline is a national service for women experiencing domestic violence, their family, friends, colleagues and others calling on their behalf.

Telephone: **0808 2000 247**

www.nationaldomesticviolencehelpline.org.uk

Women's Aid

This is a national charity working to end domestic violence against women and children.

Telephone: **0808 2000 247**

www.womensaid.org.uk

Men's Advice Line

Advice and support for men experiencing Domestic abuse.

Telephone: **0808 801 0327**

www.mensadvice.org.uk

Broken Rainbow

For support with domestic abuse involving lesbian, gay, bisexual and transgender people.

Telephone: **0300 999 5428**

www.brokenrainbow.org.uk

Forced Marriage Unit

If you are worried you might be forced into marriage or are worried about a friend or relative, contact the Forced Marriage Unit.

Telephone: **020 7008 0151**

FGM Helpline

Telephone: 0800 028 3550

Sexual Assault Referral Centres (SARC)

Sexual assault referral centres offer medical, practical and emotional support to anyone who has been sexually assaulted or raped. They have specially trained doctors and counsellors to care for individuals. If an individual is considering reporting the assault to the police, they can arrange for individuals to have an informal talk with a specially trained police officer who can explain what's involved.

Your Local SARC can be located using the following web link:

www.nhs.uk/Service-Search/Rape-and-sexual-assault-referral-centres/LocationSearch/364

My Notes & Contacts:

Local Authority Referral Lines	

Organisations Safeguarding Lead	

<u>Notes</u>

**It is your responsibility to make sure
you know how to contact your
local Safeguarding Adults Lead**

Resources

Adult Safeguarding Boards

The following are links to the Adult Safeguarding Boards in your area.

These websites provide information and resources that may be helpful to you, if you are either a service user, or a professional working with adults at risk of harm.

Essex

www.essexsab.org.uk

Southend

<http://www.southend.gov.uk/safeguardingboard>

Thurrock

<https://www.thurrock.gov.uk/keepin-g-safe-from-abuse/how-we-safeguard-vulnerable-adults>

Legislation

Care Act 2014

<https://www.gov.uk/search?q=care+act>

Mental Capacity Act 2005

<https://www.gov.uk/government/collections/mental-capacity-act-making-decisions>

Prevent

<https://www.gov.uk/government/publications/prevent-strategy-2011>

More Resources

Association of Directors of Adult Social Services – Safeguarding Adults Key Documents
www.adass.org.uk

Adult Safeguarding Resources and Reports from Social Care Institute for Excellence:
<http://www.scie.org.uk/adults/safeguarding/index.asp>

Adult Safeguarding Community of Practice:
<http://www.communities.idea.gov.uk/comm/landing-home.do?id=2962596>

This guidance document was originally developed by Midland and East SHA in 2012. It was updated in 2015 by the CCG safeguarding leads across Essex and East Anglia including:

Basildon & Brentwood CCG
Castle Point & Rochford CCG
Mid Essex CCG
North East Essex CCG
Southend CCG
Thurrock CCG
West Essex CCG