**O R G A N I S A T I O N A L**

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**Executive Summary**

* This policy applies to all staff in all roles paid and unpaid working on behalf of FFT. The full policy must be read and understood.
* Action is taken when adults who have care needs and *are unable to protect themselves* are at risk of suspected abuse or neglect. Consideration must be given to any children who might be at risk.
* It is good practice, where the service user has the capacity to do so, to seek consent, but remember that it may be necessary to override the client’s consent in order to prevent significant harm. If you are in any doubt about the service user’s capacity to consent, or if they withhold consent, you must consult your line manager.
* Safeguarding Adults is not the same as Child Protection. Different legislation applies, and adults may have care needs but *have capacity to protect themselves* and should be empowered to make their own decisions. In this case, it is good practice to inform a service user of your concerns and gain consent to share information outside of the organisation if this is required.

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# 1. Introduction

1.1 Protecting people from abuse, harm and neglect is a fundamental purpose of any human rights organisation and of safe clinical practice.

1.2 Freedom from Torture believes that no person should ever experience abuse of any kind. We have a responsibility to help promote the welfare and wellbeing of adults at risk and keep them safe. We are all committed to working in ways that protect them.

# 2. Scope

* 1. In line with our “whole organisation” approach to safeguarding, this policy applies to all staff and volunteers including trustees, employees, self-employed staff, pro bono or unpaid staff, interpreters, agency staff or anyone working on behalf of Freedom from Torture (FfT) (hereafter “staff”).

***Safeguarding is “everybody’s business” at Freedom from Torture – it is not just for clinicians. Many colleagues – including reception staff, interpreters, the service user engagement and survivor activism teams, legal and welfare advisors, researchers, staff dealing with clinical records, quality assurance and recruitment processes – come into contact with survivors of torture and their families and/or play a role in ensuring that our organisation is a safe place and that we take all the necessary steps to ensure that vulnerable people we work with or are aware of are kept safe.***

# 3. Purpose:

3.1 The purpose of this policy is to:

* + Ensure clients of from Freedom from Torture are protected from harm, abuse and neglect.
  + Ensure staff are able to recognise, prevent, intervene and protect in cases of suspected abuse in line with the Care Act 2014, and Adult Support and Protection (Scotland) Act 2007.
  + Ensure staff are able to follow the necessary procedures in the event it is suspected an adult with care needs may be experiencing or be at risk of abuse.
  + To ensure that when safeguarding risks are identified for any adult, consideration is given to any children who might be living in the home or otherwise at risk.

# 4. The importance of exemplary safeguarding practice

4.1 It is imperative that everyone working for Freedom from Torture is actively seeking to prevent adults from experiencing abuse or neglect.

4.2 The local authority that covers the area where the abuse has occurred takes the lead in investigating safeguarding concerns. However, we have a mandatory duty to report concerns and to cooperate with any investigations under the Act.

4.3 Aside from the fact we have a legal obligation, there are wider implications for failing in our duty of care to safeguard adults and children. A failure to identify and appropriately respond to safeguarding concerns can have significant ramifications for the client and their family, and members of society. There are a number of serious case reviews that show the dangers of not acting on concerns, leading to the serious harm, abuse, or even death of an individual or others. Our primary focus and concern must be the wellbeing and safety of our clients and their families, and the public.

4.4 Individual staff members who do not identify or respond appropriately to safeguarding concerns may also put themselves at risk. When it comes to safeguarding, you are accountable for both the actions you take and the actions you do not take. Failure to act could result in disciplinary action or investigation by Freedom from Torture and/or any relevant governing body that regulates you professionally.

4.5 There are also serious reputational risk concerns for Freedom from Torture if we fail to safeguard adults at risk against abuse or neglect. There is rightfully increased scrutiny on charities to fulfil their safeguarding obligations and failure to do this could result in negative press coverage, significant reduction in donors, and potentially even closure.

# 5. Legal framework

There are statutory requirements to ensure robust procedures for responding to the suspicion or evidence of abuse and neglect in order to ensure the protection of adults at risk. These include a wide range of laws including general community care legislation and guidance including:

* Human Rights Act 1998<http://www.legislation.gov.uk/ukpga/1998/42/contents>
* Mental Health Act 1983 & 2007<http://www.legislation.gov.uk/ukpga/2007/12/contents>
* Disability Discrimination Act 1995<http://www.legislation.gov.uk/ukpga/1995/50/contents>
* Mental Capacity Act 2005<http://www.legislation.gov.uk/ukpga/2005/9/contents>
* Safeguarding Vulnerable Groups Act 2006<http://www.legislation.gov.uk/ukpga/2006/47/contents>
* Health and Social Care Act 2008<http://www.legislation.gov.uk/ukpga/2008/14/contents>
* Care Act 2014<http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>Further guidance on the new Care Act can be found here: [https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-forimplementation](https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation)
* Guidance on forced marriage[: https://www.gov.uk/guidance/forced-marriage](https://www.gov.uk/guidance/forced-marriage)
* Guidance on FGM [https://www.gov.uk/government/publications/safeguarding-women-and-girlsathttps://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgmrisk-of-fgm](https://www.gov.uk/government/publications/safeguarding-women-and-girls-at-risk-of-fgm)
* Modern Slavery Act 2015 http://www.legislation.gov.uk/ukpga/2015/30/contents/enacted

**Scotland specific legislation**

* Adults with Incapacity (Scotland) Act 200[0 http://www.legislation.gov.uk/asp/2000/4/contents](http://www.legislation.gov.uk/asp/2000/4/contents) Mental Health (Care and Treatment) (Scotland) Act 2003 [http://www.legislation.gov.uk/asp/2003/13/contents A](http://www.legislation.gov.uk/asp/2003/13/contents)dult Support and Protection (Scotland) Act 2007 <https://www.legislation.gov.uk/asp/2007/10/contents>

**Guidance and web links can also be found on the following websites:**

* [http://www.islington.gov.uk/services/socialhttp://www.islington.gov.uk/services/social-care-health/adultprotection/Pages/policiesandprocedures.aspxcarehealth/adultprotection/Pages/policiesandprocedures.aspx](http://www.islington.gov.uk/services/social-care-health/adultprotection/Pages/policiesandprocedures.aspx)
* <http://www.glasgowadultprotection.org.uk/>
* [http://www.manchester.gov.uk/info/100010/social\_care\_and\_support/4093/manchester \_safeguarding\_adults\_board](http://www.manchester.gov.uk/info/100010/social_care_and_support/4093/manchester_safeguarding_adults_board)
* <http://www.bsab.org/>
* [http://www.newcastle.gov.uk/health-and-social-care/adult-social-care/safeguardingadultshttp://www.newcastle.gov.uk/health-and-social-care/adult-social-care/safeguarding-adults-information-for-professionals/safeguarding-adults-unitinformation-for-professionals/safeguarding-adults-unit](http://www.newcastle.gov.uk/health-and-social-care/adult-social-care/safeguarding-adults-information-for-professionals/safeguarding-adults-unit)

**Cultural competencies in safeguarding:**

* [https://www.newcastle.gov.uk/sites/default/files/Final%20Cultural%20Competence%20M arch%202019%20(1).pdf](https://www.newcastle.gov.uk/sites/default/files/Final%20Cultural%20Competence%20March%202019%20(1).pdf)

**Modern Slavery Guidance**

* <https://www.newcastle.gov.uk/sites/default/files/Modern%20Day%20Slavery%20Guidanc>

[e%20Nof%20Tyne.pdf](https://www.newcastle.gov.uk/sites/default/files/Modern%20Day%20Slavery%20Guidance%20Nof%20Tyne.pdf)

# 6. Definition of Safeguarding

6.1 The Care Act (2014) guidance describes safeguarding as ‘*protecting an adult’s right to live safely, free from harm 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*.’ Living a life that is free from harm and abuse is fundamental to the human rights framework and an essential requirement for health and wellbeing.

6.2 ‘Organisations should always promote the adult’s wellbeing in their safeguarding arrangements. People have complex lives and being safe is only one of many things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and other staff should not be advocating “safety” measures that do not take account of individual wellbeing, as defined in Section 1 of The Care Act.’

6.3 Safeguarding Adults is not the same as Child Protection. Different legislation applies, and adults with capacity to do so should be empowered to make their own decisions. It is good practice to inform a service user of your concerns and gain consent to share information outside of the organisation if this is required. While careful explanation of safeguarding procedures with clients can help them to understand the benefits of safeguarding referrals, there will be times where a client does not give consent, possibly through fear of reprisals, fear that it will reduce already limited support structures, or cause unwanted attention towards them and their situation. While negotiating consent is best practice, there will still be situations where information will need to be shared without consent, for example, if sharing concerns will increase risk or, if it is in the public interest to breach confidentiality, e.g. to prevent a serious crime being committed. Examples of where we would share concerns without consent can be found listed below in Table 1, and in the information sharing section of this policy.

6.4 The participation/representation of people who lack capacity is also important. Their rights are protected by the Mental Capacity Act (2005) or Adults with Incapacity (Scotland) Act 2000. The principles embodied in these Acts should be followed.

6.5 It is common for there to be overlap between clinical risk management and adult safeguarding. While there is overlap, it is important to be clear about the differences so the correct legislation can be applied.

6.6 Clinical risk management is largely associated with assessing and mitigating risk of harm to self through self-harm, suicidal behaviours, or risk to others in the forms of violence or aggression. Our duty of care regarding these matters is covered within Freedom from Torture’s Clinical Risk Management policy and applies to every service user in our care who is assessed as being at risk to self or others. To be considered under safeguarding legislation, an individual must meet the definition of an adult at risk (See 6.1). However, clinical risk issues will often also raise safeguarding concerns; for example, the impact of parental health on parenting would warrant consideration of child protection needs.

6.7 There are times where a chaperone within appointments may be appropriate. Please see The Chaperone Procedure in [Appendix 6](#_Appendix_6:_Use) for further information. If a client requests a chaperone, or you feel a chaperone may be indicated, please liaise with your line manager in the first instance.

# 7. Who is an Adult at Risk?

* 1. The Care Act 2014 replaced the term ‘Vulnerable Adult’ with the term ‘Adult at risk.’ Under the Care Act 2014, an adult at risk is one who is:
     + Over 18
     + Has needs for care and/or support (whether or not the authority is meeting any of those needs)
     + Is experiencing or is at risk of abuse or neglect, and
     + As a result of those needs is unable to protect themselves against the abuse or neglect

* 1. Under the Adult Support and Protection Act 2007 (Scotland), an adult at risk is defined as one who is:
     + Over 16
     + unable to safeguard their own well-being, property, rights or other interests
     + experiencing or at risk of harm, abuse or neglect, and
     + affected by disability, mental disorder, illness or physical or mental infirmity, and are more vulnerable to being harmed than adults who are not so affected
  2. It is recognised that a 16- or 17-year-old young person at risk of or experiencing harm, abuse or neglect will have additional vulnerabilities due to age, development, and other contextual factors. These factors, which may include the young person’s position in the family, experience as an unaccompanied young person, and relationships or pressure from peers, may leave a young person at increased risk.

* 1. Factors to consider which may make FfT service users vulnerable to abuse or neglect:

**Being a survivor of torture is not in itself a reason to be considered vulnerable for safeguarding purposes.** It is however recognised that our client group present with a broad range of needs and challenges that increases the risk factors of being open to abuse or neglect, as detailed below:

* + - Language – e.g. not speaking or understanding English
    - Unfamiliarity with cultural norms, which may include lack of knowledge that certain practices are illegal in the UK, such as FGM, physical chastisement, domestic abuse and forced marriage.
    - Lack of knowledge of their right to protection from abuse
    - Immigration status, e.g. fear of being deported
    - Socio-economic marginalisation
    - Fear or mistrust in authority
    - Psychological factors

However, for adult safeguarding duties to be triggered, it must be clear that an individual’s care needs mean that the person is unable to protect him or herself from abuse. While all of FfT’s clients have care needs, these care needs will not necessarily prevent a person from being able to safeguard themselves. In line with our core value of empowerment, it is important to recognise and value the fact that many people are fully capable of protecting themselves.

**Table 1:** **Decision making checklist when making referrals**

(Taken from Newcastle Safeguarding Board Multi-Agency safeguarding adults procedures:[https://www.newcastle.gov.uk/sites/default/files/FINAL%20NSAB%20Procedure s%202018.pdf)](https://www.newcastle.gov.uk/sites/default/files/FINAL%20NSAB%20Procedures%202018.pdf)

|  |  |
| --- | --- |
|  | The alleged victim is an adult who is:  Aged 18 or over in England / Aged 16 or over in Scotland    Has needs for care and support (whether or not those needs are being met)    As a result of those needs is unable to protect him or herself against the abuse, neglect or the risk of it. |
|  | **AND** |
|  | The alleged victim is experiencing, or at risk of experiencing, abuse or neglect |
|  | **AND** |

|  |  |
| --- | --- |
|  | The alleged victim has mental capacity to make decisions about their own safety and wants this referral to happen  **OR**  The alleged victim has been assessed as not having mental capacity to make a decision about their own safety, but a decision has been made in their best interest to make a referral.  **OR**  A crime has been, or may have been, committed against an adult at risk without mental capacity and a best interest decision is made  **OR**  The abuse or neglect is a serious crime and not proceeding would prejudice the detection or prevention of the crime  **OR**  The abuse or neglect has been caused by a member of staff or a volunteer and other adults or children are at risk from the person causing the harm OR The concern is about institutional or systemic abuse  **OR**  There is a concern that the abuse or neglect may cause serious harm to the adult or others  **OR**  There is a concern that a person is not able to freely consent because they have been threatened or coerced  **OR**  Seeing consent would be too dangerous, putting either the adult or others at further risk of harm. |

# 8. Identifying concerns

8.1 In our professional capacity, we will not always be in a position where a formal disclosure of neglect or abuse is made to us. While this may occur, it is more likely that we will notice signs of abuse and neglect and it is of vital importance that we are alert to these signs.

8.2 Abuse can happen in a range of settings, in a variety of relationships and can take a number of forms. Abuse may be more likely to happen in the following situations:

* Environmental Factors - overcrowding/poor housing conditions/lack of facilities;
* Financial Factors - low income and a dependent adult may add to financial difficulties, inability to work due to caring role, debt arrears, full benefits not claimed;
* Psychological and Emotional Factors - family relationships over the years have been poor and there is a history of abuse in the family or where family violence is the norm;
* Communication Factors - this may include people for whom English is a second language, the adult at risk or their [Carer h](https://www.proceduresonline.com/jersey/adults/chapters/pr_local_keywords.html#carer)as difficulty communicating due to sensory impairments, loss or difficulty with speech and understanding, poor memory or other conditions resulting in diminished menta[l Capacity;](https://www.proceduresonline.com/jersey/adults/chapters/pr_local_keywords.html#capacity)
* Dependency Factors - Increased dependency of the person, major changes in personality and behaviour, carers are not receiving practical and/or emotional support;
* Organisational culture - services which are inward looking, where there is little staff training/knowledge of best practice and where contact with external professionals is resisted can put service users at greater risk. High staff turnover or shortages may also increase the risk of abuse.

8.3 The most common forms of abuse are:

**Physical** **abuse** – physical force or violence that results in bodily injury, pain, or impairment such as pinching, hitting, forced feeding, excessive restraint. Possible factors:

* No explanation for injuries, or inconsistent with the account of what happened
* Injuries are inconsistent with the person’s lifestyle
* Loss of hair in clumps
* Frequent injuries
* Subdued or changed behaviour in the presence of a particular person
* Signs of malnutrition
* Failure to seek medical treatment or frequent changes of GP.

**Sexual abuse** – any form of sexual activity (including being forced to look at pornographic materials) to which a person has not consented or cannot consent. Possible factors:

* Bruising to the upper arms, neck, thighs
* Unusual difficulty sitting or walking
* Repeated infections or sexually transmitted diseases
* Pregnancy in a woman who cannot consent to intercourse
* Self-harming
* Withdrawal
* Fear of receiving help with personal care
* Reluctance to be alone with a particular person.

**Psychological** **or emotional abuse** – characterised by a person subjecting or exposing another to behaviour that may result in psychological trauma - such as threats, racial abuse, humiliation, shouting, swearing, ignoring. Possible factors:

* An air of silence when a particular person is present
* Withdrawal or change in the psychological state of the person
* Insomnia
* Low self-esteem
* A marked change in usual behaviour
* A change of appetite, weight loss/gain
* Signs of distress: tearfulness, anger

**Domestic abuse** – abuse whether physical, psychological or sexual perpetrated within a domestic setting. This would include ‘honour’-based violence and acts of coercive control within the home.

Please see [Appendix 5](#_Appendix_5:_Considerations) for specific guidance on managing risk of domestic violence and abuse. Coercive control is now recognised as the behaviour that underpins domestic abuse. It is a pattern of behaviour which seeks to take away the victim’s sense of self, minimising their freedom of action and violating their human rights. It is also used in other types of abuse such as modern day slavery.

The [Serious Crime Act 2015 c](https://www.cps.gov.uk/legal-guidance/controlling-or-coercive-behaviour-intimate-or-family-relationship)reates a new offence of controlling or coercive behaviour in intimate or familial relationships (section 76). Possible factors:

* Low self-esteem
* Feeling that the abuse is their fault when it is not
* Physical evidence of violence such as bruising, cuts, broken bones
* Verbal abuse and humiliation in front of others
* Fear of outside intervention
* Damage to home or property
* Isolation – not seeing friends and family
* Limited access to money

The factors below are research based and known to be indicative of increased risk to the victim. They themselves are not a measure of the likelihood of, or indeed the type of violence that may be carried out. They can be used to guide the professional understanding about the probability of abuse and it happening again:

* Alcohol and Drug misuse
* Mental Health Problems
* Men with PTSD
* Women with anxiety
* Disabled people
* Older people
* Pregnancy
* Child Abuse
* Animal Abuse
* LGBT+
* Adolescent to Parent violence and Abuse

‘Think Family’ is the approach used by local authorities to encourage services to deal with families as a whole, rather than responding to each problem, or person, separately. It was introduced by the Department of Children, Schools and Families to help families struggling with factors such as debt, homelessness, mental health issues, domestic violence, poor parenting, illness or substance abuse.

Children living in a home where there is domestic abuse will always be impacted. A safeguarding children’s referral should be made alongside any action taken to address concerns regarding an adult at risk.

**Financial** **and material abuse** – theft or misuse of money or personal possessions, which involves an individual’s resources being used to the advantage of another person - such as depriving someone of benefits or other income, fraud, taking possessions without consent, pressuring someone into a financial transaction, obtaining rights to property or money through coercion.

Possible factors:

* Missing personal possessions
* Un-explained lack of money
* The family or others show unusual interest in the assets of the person
* Rent arrears and eviction notices
* Disparity between the person’s living conditions and their financial resources, e.g. insufficient food in the house

**Organisational/Institutional abuse** – where residents or users of an institution or service are denied choice about daily routine, are unnecessarily physically restrained, denied privacy, failure to protect personal property. Possible factors:

* Lack of flexibility and choice for people using the service
* Inadequate staffing levels
* People being hungry or dehydrated
* Poor standards of care
* Lack of personal clothing and possessions and communal use of personal items
* Lack of adequate procedures
* Poor record-keeping and missing documents
  + Absence of visitors
* Few social, recreational and educational activities
* Absence of individual care plans
* Lack of management overview and support

**Discriminatory** abuse – including racist or sexist language, insults or harassment on account of disability, denial of services on account of race, gender, disability, or any other protected characteristic. Possible factors:

* The person appears withdrawn and isolated
* Expressions of anger, frustration, fear or anxiety
* The support on offer does not take account of the person’s individual needs in terms of a protected characteristic

**Neglect** or acts of omission – not providing reasonable, appropriate or agreed care or a failure to act in a way that any reasonable person would act - behaviour which results in basic needs not being met e.g. for food, hygiene, healthcare, safe environment. Possible factors:

* Poor environment – dirty or unhygienic
* Poor physical condition and/or personal hygiene
* Pressure sores or ulcers
* Malnutrition or unexplained weight loss
* Untreated injuries and medical problems
* Inconsistent or reluctant contact with medical and social care organisations
* Accumulation of untaken medication
* Uncharacteristic failure to engage in social interaction
* Inappropriate or inadequate clothing

**Self-neglect** – neglect for one’s personal hygiene, health or surroundings, e.g. hoarding. Possible factors:

* Very poor personal hygiene
* Unkempt appearance
* Lack of essential food, clothing or shelter
* Malnutrition and/or dehydration
* Living in squalid or unsanitary conditions
* Neglecting household maintenance
* Hoarding
* Collecting a large number of animals in inappropriate conditions
* Non-compliance with health or care services
* Inability or unwillingness to take medication or treat illness or injury

**Modern slavery** - any situation where a person is under the control of another person who applies violence, psychological entrapment or force to maintain that control, with the goal of that control being exploitation.

**Human trafficking** is a type of modern slavery that is defined in article 3 of the Palermo Protocol as: 1. The act (what is done) 'Recruitment, transportation, transfer, harbouring, or receipt of persons'.

2. The means (how it is done) 'Threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person';

3. The purpose (why it is done) 'For the purpose of exploitation’. (NB it does not matter if the aim is achieved).

The National Referral Mechanism (NRM) for Human Trafficking exists as a formal mechanism to identify victims of human trafficking. Only designated first responder organisations are able to refer directly into the NRM. One of the biggest first responders is The Salvation Army who have a designated referral helpline: 0300 3038151.

It is important that we are alert to Human Trafficking so that appropriate safeguards can be put into place. However, from an asylum law perspective it is not always in a person’s best interests to be referred in to the NRM. When considering an NRM referral, please make a referral to our Legal Advice and Welfare Service (LAWS) who will explore whether it is in the client’s best interests to make a referral and support the client to make an informed decision. LAWS will also liaise with the client’s legal representative. Please note this does not mean you should not take immediate action to respond to any identified risks of harm to the client through the usual channels of police intervention, or safeguarding processes.

Other types of Modern-Day Slavery:

* **Forced/bonded labour -** victims (often legitimate migrant workers) reach a destination country having been promised work and a chance for a better life. Often they are found legitimate work (factories, takeaways, food packaging, recycling) and given accommodation but are forced to forfeit their wages as payment for expenses. Essential documents and access to information is often withheld and verbal and physical violence can be used or threatened.
* **Sexual exploitation -** victims are forced to perform non-consensual or abusive sexual acts against their will. Whilst women and children make up the majority of victims, men can also be affected. Adults are coerced often under the threat of force, or another penalty.
* **Criminal exploitation -** victims are often controlled, maltreated, and forced into crimes such as cannabis cultivation or pick pocketing against their will.
* **Domestic servitude -** once their employment transfers into a situation whereby they cannot move around freely or leave, it is enslavement. Victims are forced to carry out housework and domestic chores in private households with little or no pay, restricted movement, very little or no free time and minimal privacy often sleeping where they work.

Possible factors:

* Physical appearance including any of those listed above
* Isolation
* Poor living conditions
* Few or no personal possessions (to include documentation such as passports, bank details, visas).
* Restricted freedom of movement
* Unusual travel times
* Reluctance to seek help
* Signs of physical or emotional abuse
* Appearing to be malnourished, unkempt or withdrawn
* Isolation from the community, seeming under the control or influence of others
* Fear of law enforcers

**Ritualistic abuse -** repeated, extreme, and on occasion sadistic abuse, within a group setting. Ritualistic abuse is usually highly organised and often perpetrated by a group of people as opposed to an individual. It can take a range of forms including physical, psychological and sexual abuse. The abuse is usually ritualised in some way and perpetrated by those within a common ideology. Victims of some forms of ritualistic abuse have been compelled to swear an oath that they will not disclose the nature of these rituals and may believe that if they do so they will die because of this oath.

Signs of ritualistic abuse will vary widely according to the ideology under which the abuse is carried out. Possible factors:

* Physical appearance including all of those listed in the categories above
* Scars / tattoos
* Fear of disclosure (especially in relation to rituals)
* Beliefs in an omnipresent abuser (for example believing that the abuser is able to hear their thoughts / knows what they are doing).

Victims of trafficking modern slavery may still be under control in the UK and may present to services. An indicator that someone is still under control is the presence of an accompanying person who insists on attending the session with the client. It is therefore important that all clients be seen alone for at least a part of the session (once trust is established with the clinician) in order that the nature of the relationship can be explored. As noted above, please refer to LAWS who will then consider whether referral to NRM has been made and whether it is in the client’s best interests to make such a referral. LAWS can also consider referral to immigration solicitors or liaising with the existing legal representative.

**Forced marriage** – Physical or psychological coercion to enter into marriage. The victim could be our client or, could be the partner of our client. Possible factors:

* The victim or her family come from a community where Forced Marriage and ‘Honour’ is culturally embedded
* An announcement of engagement to a stranger not previously mentioned
* There may feel like an element of ‘surveillance’ and control by the family or community members
* The victim may appear depressed, withdrawn, anxious or suicidal. There may be noticeable deterioration in the victim’s self-esteem and appearance
* Reports of self-harm or suicide attempts, particularly in the early stages of marriage
* Domestic incidents or crimes at the family home. The fact that a victim was forced to marry may only reveal itself years after the marriage has taken place

**Female genital mutilation** - partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. This is something that is most frequently perpetrated against children as opposed to adults. Possible factors:

* Referencing FGM
* Discussions about a ceremony
* A family preparing to take a child abroad.
* An individual suddenly has difficulties walking or sitting.

**Radicalisation** – being pressured into or otherwise psychologically manipulated into joining or supporting a /terrorist group. See section 9 for further details. Possible factors:

* Use of inappropriate language
* Possession of violent extremist literature
* Behavioural changes
* The expression of extremist views
* Advocating violent actions and means
* Association with known extremists
* Seeking to recruit others to an extremist ideology.

* 1. Abuse may occur anywhere – in an individual’s home, in someone else’s home, in a care home or other residential provision, in a day centre, in a public place.

* 1. Anyone may be an abuser, but it is more likely to be someone well known to the individual, such as a friend or family member, a carer, a professional worker, or even another service user.
  2. Exploitation, in particular, is a common theme in abuse and neglect.

# 9. PREVENT

PREVENT is part of the Government’s broader CONTEST strategy. PREVENT focuses on safeguarding interventions to stop people (adults and children) from being drawn into extremism through radicalisation and places specific duties on ‘specified authorities’ to have ‘due regard to the need to prevent people from being drawn into terrorism’ (Section 26, Counter-Terrorism and Security Act 2015).

Freedom from Torture, as a charity, is not a ‘specified authority’ (Schedule 6, Counter-Terrorism and Security Act 2015).However, our staff are required to consider risks of radicalisation and extremism as a safeguarding issue in relation to our clients, staff and public safety.

Freedom from Torture will support staff through training and information in seeking to recognise when individuals are at risk of being exploited and/or radicalised as part of a broader safeguarding structure and will make safeguarding referrals to statutory services regarding these concerns in the usual way. Statutory services will then be obliged to decide whether to treat a referral as a PREVENT matter or not.

Where a member of staff has a concern about risks relating to radicalisation and/or extremism, they should raise it in the same way as other safeguarding concerns and according to this policy. PREVENT do share information with the Home Office and on this basis, when considering a safeguarding referral in relation to risk of radicalisation, please ensure LAWS are involved in the safeguarding discussion.

# 10. Where you have concerns that an adult is at risk

10.1 **Duty of care**

Safeguarding is everybody’s business. You have a responsibility to follow the six safeguarding principles covered within the Care Act 2014:

Principle 1: Empowerment: Safeguarding individuals in a way that supports them in making choices and having control in how they chose to live their lives. Actions must be person led and ensure informed consent.

Principle 2: Prevention: It is better to take action before harm occurs

Principle 3: Proportionality: Any action taken is proportionate to the risk identified

Principle 4: Protection: Acting to support those in the greatest need

Principle 5: Partnership: working together with the service user and other agencies to identify and respond to safeguarding concerns

Principle 6: Accountability and transparency: **We are all accountable for the actions we take, or choose not to take when dealing with safeguarding concerns.**

10.2 **If you do receive a formal disclosure of abuse or neglect**

**DO**

* Listen carefully and take all allegations of abuse seriously. Acknowledge regret and concern that this has happened.
* Remain calm and try not to show disbelief or shock
* Assess the situation i.e. is there an immediate risk and are emergency services required?
* Establish what the individual's views are about the safeguarding issue and procedure
* Maintain any evidence
* Inform the individual that you need to share this information and the reasons why
* Explain what will happen next, explaining as clearly as possible why, what, how and with whom information will be shared, and seek their agreement unless it is unsafe or inappropriate to do so.
* Seek advice from the Caldicott Guardian (National Director of Clinical Services) if you are in any doubt about disclosing personal information.
* Make a written record of what you have heard; using the person's words, what you have seen and what actions you have taken.

**DO NOT**

* Make assurances that you are able to keep this information to yourself.
* Confront a suspected abuser; you may put yourself or your client at further risk
* Destroy any evidence of abuse
* Initiate an investigation. **Your duty is to report, not to investigate. The local authority have the lead responsibility for investigating concerns.**
* Delay acting – you are accountable for what action you take, and equally for what action you do not take.

**10.3 Considerations (including in relation to information-sharing)**

* Is it a safeguarding issue or simply poor practice? If you are not sure, treat it as a safeguarding issue
* Never assume someone else in another agency knows about the alleged abuse and is dealing with it – you should always report in all cases of suspected abuse
* Your duty to safeguard overrides your therapeutic relationship with the client, and in these circumstances, you are entitled to breach confidentiality. Data protection legislation (including the General Data Protection Regulation or ‘GDPR’) is not a barrier to sharing information but it does provide a framework for ensuring that personal information is shared appropriately.
* It is good practice, where the service user has the capacity to do so, to seek consent, but remember that it may be necessary to override the client’s consent in order to prevent significant harm. If you are in any doubt about the service user’s capacity to consent, or if they withhold consent, you must consult your line manager.
* Many abusive behaviours may constitute a criminal offence and therefore all suspected abuse must be reported.
* Leaflets on Adult Protection can be found in several languages on the Islington website [http://www.islington.gov.uk/services/social-carehealth/adultprotection/Pages/default.aspx](http://www.islington.gov.uk/services/social-care-health/adultprotection/Pages/default.aspx)

10.4 It is a duty of all employees and volunteers, in whatever capacity, to report any concerns that a service user is being abused, regardless of whether it is related to a colleague. Failure to report concerns is in itself an abusive act and may lead to disciplinary action.

10.5 The immediate line manager, Clinical Services Manager, Designated Safeguarding Lead and the National Director of Clinical Services should be informed of any allegations of safeguarding incidents against FFT staff (as defined in section 2 above).

10.6 The Home Office also has internal safeguarding protocols. Home Office safeguarding incorporates a broader range of concerns than local authority safeguarding definitions. For example, we would not need to meet the same definition of an adult at risk under The Care Act to raise a concern via Home Office safeguarding, and a concern could be raised based on a lower threshold of vulnerability. It can be particularly helpful to consider Home Office safeguarding where there is an identified vulnerability, particularly when this relates to a Home Office provision e.g. when there is an issue with abusive behaviour within Home Office accommodation. If you think there may be a role for Home Office safeguarding to support a client, liaise with your line manager and the LAWS team.

# 11. Procedure for reporting Safeguarding concerns (please also see flow chart in Appendix 3)

11.1 Basic procedure:

* Incident of abuse suspected – gather as much information as possible, following the do’s and don’ts. (For LAWS responsibilities, see appendix 8.)
* Report suspected incident(s) to immediate line manager using the Safeguarding Concerns Report form (See [Appendix 7](#_Appendix_7:_Safeguarding)). Line manager and reporter ensure that issues of client safety are addressed.If the line manager is not clinical, the support of a Clinical Services Manager should be sought. *TIME* *SCALE: SAME DAY* If neither the line manager nor the Heads of Clinical Services (HoCS) is available, then the Associate Director of Clinical Services (ADCS) or National Director of Clinical Services (NDCS) should be notified. In the event that there is no manager available from Clinical Services, then the CEO should be notified.
* Line manager and reporter to decide together whether issue should be reported to local Safeguarding authorities – if in any doubt, the incident should still reported.
* A decision-making checklist can be found in [Appendix 4](#_Appendix_4_Decision) to support this process. **The decision-making process should be recorded on Daylight including the specific considerations that have been given to whether the safeguarding adult concern raises any further concerns relating to child protection, in which case a safeguarding children’s report must be made.**
* If there is a requirement to make a safeguarding adult’s referral, the Safeguarding report form for the local authority should be completed and sent to the relevant safeguarding board. The manager should update the safeguarding adult’s tracker and notify the Designated Safeguarding Adults lead.

11.2 Please note, if a decision is made **not** to report under safeguarding procedures, then consideration should be given to other action that should be taken to address the perceived risk. For example:

* Referral into another multiagency system
* Health and/or social care assessments
* Safety planning with the adult
* Signposting to other services
  1. The manager should consider whether the incident is notifiable to the Care Quality Commission/Healthcare Improvement Scotland (in which case our Quality Assurance Manager should also be informed).

* 1. Obtain an outcome from the local safeguarding board. *TIME SCALE: WITHIN ONE WEEK OF INITIAL REPORT.* **It is important that if you disagree with the action taken by the safeguarding board that you raise these concerns directly with the safeguarding board and make a record of this action. There is extensive learning from serious case reviews that highlights the importance of this.**

* 1. Regarding incidents where the alleged abuser is member of Freedom from Torture staff, the Whistleblowing, Disciplinary & Capability, Professional Boundaries and Behaviour at Work policies apply.Concerns involving a person in a Position of Trust (POT) must be reported to the Local authority safeguarding board, making it clear the concern is being raised in relation to someone who is in a Position of Trust, or via Social Care Direct (SCD) in Scotland. The concern can arise in connection with:
* The POTs own work or voluntary activity
* The POTS life outside work.
* Concerns can be current or historical.

* 1. The safeguarding lead will decide and advise on whether the relevant Safeguarding team will investigate the allegation or if the organisation should conduct an internal investigation. In Scotland, the case may be referred to the area social work team for assessment. TIME SCALE SAME DAY.

* 1. After the report to the POTS/SCD has been made, the line manager of the member of staff, the National Director of Clinical Services and Human Resources should be informed immediately TIME SCALE SAME DAY

* 1. Where the line manager is the National Director of Clinical Services, then the Chief Executive should be informed.
  2. Once a decision has be received from the POTS/SCD, SMT, in conjunction with Human Resources, may consider whether the relevant member of staff should be suspended pending an investigation.

# 12. Management of ongoing risk

12.1 Where a safeguarding concern has been raised about the behaviour of a service user, (e.g., where a service user may be committing domestic abuse) the Clinical Services Manager of the relevant service should conduct a risk assessment regarding their continued access to the service and any appropriate risk management measure which may need to be put in place. This risk assessment should be forwarded to the DNCS. TIME SCALE: WITHIN ONE WEEK

12.2 If your line manager decides not to treat the incident as a safeguarding issue and yet you remain concerned, you MUST report the matter to your line manager’s manager and the CEO. Where the line manager is the CEO, you must make the report to the Chair of the Board of Trustees. Contact details are included at the end of this document

# 13. Monitoring

13.1 The Designated Adult Safeguarding Lead will maintain overall oversight over safeguarding reports via our internal safeguarding adult’s tracker. The Clinical Services Manager will enter the initial alert on to the tracker and is responsible for ensuring that any updates are also entered here, and the Designated Adult Safeguarding Lead notified. Where safeguarding concerns relate to an individual who is not in receipt of clinical services, for example, where the individual is a former service user involved in survivor activism activities, the Designated Adult Safeguarding lead should be contacted and the nature of the concerns shared. In these cases, the Designated Adult Safeguarding Lead will update the tracker.

13.2 Any ongoing safeguarding concerns should be shared within the Multi Disciplinary Team meetings, to enable these needs to be fully supported by the team.

13.3 In some cases, a safeguarding matter may also warrant an incident form to be completed. Copies of all incident forms related to Safeguarding must be sent to the National Director of Clinical Services (NDCS) and to the Quality Assurance and Information Governance Team

13.4 The NDCS will review any comments made by the Safeguarding Adults Panels, joint working meetings, Health Authorities, the Police and/or the CQC to assess whether the procedure has been followed in all cases.

13.5 The NDCS will ensure that the procedure is reviewed using both data provided by the QA Team and their own findings. Where appropriate, a revised procedure will be circulated for comment and then published.

13.6 If a safeguarding concern relates to an internal practice issue then services/staff teams are required to review each Safeguarding Adults incident, identifying practice issues that need to be changed/introduced and how this is going to be achieved. The outcome of the review will be recorded as a ‘post-incident’ follow up report. A copy of this post incident follow up must be sent to the NDCS and the QA Team.

13.7 Where an incident started out being considered as a Safeguarding one, and upon further investigation it transpires not to be, the notifying manager will inform all those previously notified stating that the incident is no longer in the safeguarding adult category. The manager will record the actions they have taken and the names of all those contacted on the post incident report.

# 14. Information sharing

14.1 Effective sharing of information between our staff and external agencies is essential for early identification of need, assessment and service provision to keep adults safe from abuse and neglect.

14.2 Staff should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns.

14.3 Staff should aim to gain consent to share information but should be mindful of situations where to do so would place an individual at increased risk of harm. Information may be shared without consent if a staff member has reason to believe that there is good reason to do so in

order to prevent risk of harm and ensure thorough safeguarding practices. (This is expressly provided for in the Data Protection Act 2018).

14.4 When decisions are made to share or withhold information, staff must record who has been given the information and why.

|  |
| --- |
| **Myth-busting guide to information sharing** |
| Sharing information enables practitioners and agencies to identify and provide appropriate services that safeguard and promote the welfare of children. Below are common myths that may hinder effective information sharing. |
| **Myth 1: Data protection legislation is a barrier to sharing information** |
| No – the Data Protection Act 2018 and GDPR do not prohibit the collection and sharing of personal information, but rather provide a framework to ensure that personal information be shared appropriately. In particular, the Data Protection Act 2018 balances the rights of the information subject (the individual whom the information is about) and the possible need to share information about them. |
| **Myth 2: Consent is always needed to share personal information** |
| No – you do not necessarily need consent to share personal information. Wherever possible, you should seek consent and be open and honest with the individual from the outset as to why, what, how and with whom, their information will be shared. You should seek consent where an individual may not expect their information to be passed on. When you gain consent to share information, it must be explicit, and freely given. There may be some circumstances where it is not appropriate to seek consent, because the individual cannot give consent, or it is not reasonable to obtain consent, or because to gain consent would put an individual’s safety at risk. |
| **Myth 3: Personal information collected by one organisation/agency cannot be disclosed to another** |
| No – this is not the case, unless the information is to be used for a purpose incompatible with the purpose for which it was originally collected. In the case of safeguarding adults, it is difficult to foresee circumstances where information law would be a barrier to sharing personal information. |
| **Myth 4: The common law duty of confidence and the Human Rights Act 1998 prevent the sharing of personal information** |
| No – this is not the case. In addition to the Data Protection Act 2018 and GDPR, practitioners need to balance the common law duty of confidence and the Human Rights Act 1998 against the effect on individuals or others of not sharing the information. |
|  |

# 15. Responsibilities for safeguarding

(See also [Appendix 1](#_Appendix_1:_Scheme) setting out the scheme of delegation).

15.1 **Trustees** have overall responsibility for ensuring that:

* Freedom from Torture has adequate safeguarding policies and procedures in place and that these are well understood and complied with across the charity
* Safeguarding policies are reviewed and updated annually to ensure continuing effectiveness and compliance with legislation and guidance
* We have a strong safeguarding culture at Freedom from Torture including collective reflection on learning from incidents
* There are clear whistleblowing and complaints procedures in place, to protect staff/volunteers and service users in line with the principles in Sir Robert Francis’[s Freedom to Speak Up review,](http://freedomtospeakup.org.uk/the-report/) that are referenced in staff training and codes of conduct
* Any serious incidents involving harm to our beneficiaries are reported to the Charity Commission or Office of the Scottish Charity Regulator

15.2 The **Senior Management Team** must ensure that:

* Freedom from Torture has effective safeguarding policies and procedures in place
* All managers and staff are aware of these policies and procedures and discharge their safeguarding responsibilities – including by ensuring we have in place: (i) a framework to ensure staff are effectively/suitably/appropriately skilled and supported to discharge these responsibilities (ii) delegation to managers of operational management responsibility for safeguarding
* Freedom from Torture is abreast of the most up-to-date relevant legal, policy, best practice and other developments relating to safeguarding
* Safeguarding risks are identified and managed at a corporate level including via our risk register and collective reflection on incidents
* Reporting procedures are in place and complied with – including in relation to our regulators and “safeguarding partners” (local authorities, clinical commissioning group and police) and the Children’s Reporter in Scotland

15.3 **National Director of Clinical Services** must ensure that:

* Services are delivered in accordance with this policy
* A Designated Adult Safeguarding Lead is in place at all times, with clear deputising arrangements in the event of absence, so that staff have a lead to liaise with at all times.
  + Compliance with the monitoring arrangements set out in section 13 above

15.4 **People managers** must ensure that:

* All staff in their team are familiar with this policy and their safeguarding responsibilities and are implementing and complying with the policy
* All staff in their team know what to do if they are worried about a child or adult at risk and have the necessary management support to act accordingly
* Safeguarding incidents are monitored and reported appropriately – internally and externally
* Team members are supervised in relation to compliance with this policy
* Team members have the relevant training (in line with the national guidance set out in section 5 above) and refresher training and that this is recorded on People HR
* Team members contribute to the audit programme / clinical incident review process which will inform the continual process to improve practice
* Act as the first port of call for any safeguarding concerns

15.5 **All staff who work with children and adults at risk** must be able to evidence that they:

* Understand their responsibilities in relation to safeguarding
* Understand risk factors and recognise children and adults in need of support and/or safeguarding
* Pay attention to any verbal or non-verbal indicators of abuse
* Respond quickly and appropriately to all suspicions or allegations of abuse
* Empower adults to voice any concerns they have
* Liaise closely with other agencies and share information as appropriate
* Generally safeguard adults from abuse and neglect, including through preventative and proactive work

* 1. **All members of staff who are regulated health and social care professionals are now under a mandatory duty to report to the police any case of FGM in girls under 18 which they identify in the course of their professional work** (a helpful flowchart on this legal duty is available [here).](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/525405/FGM_mandatory_reporting_map_A.pdf) This includes all doctors, social workers and physiotherapists. Whilst this is legally mandatory only for certain roles, we require all Freedom from Torture staff to report in this way.

* 1. **All staff** at Freedom from Torture must be able to demonstrate that they:
* Understand their responsibilities in relation to safeguarding
* Identify development and training needs in relation to safeguarding through mid- and end of year review processes
* Know how to report and document all concerns and subsequent actions in accordance with the procedures in this policy and any related policies.

15.8 Designated Adult Safeguarding Lead

Every organisation working with children has to have a person who takes a lead on safeguarding. We call this this role our Designated Adult Safeguarding Lead (or “Adult’s Safeguarding Lead”).

Key Aspects of the Designated Adult’s Safeguarding Lead role include:

* Keeping up to date with developments in safeguarding legislation, guidance, reports and learning from major safeguarding incidents in the sector and beyond and ensure these are shared with the Senior Management Team
* Updating policies and procedures
* Making sure all staff are aware of how to raise safeguarding concerns
* Ensuring all staff understand the symptoms of abuse and neglect
* Implementing any appropriate procedures and sharing concerns and information with relevant agencies.
* Gathering and collating all information relating to safeguarding incidents, concerns and referrals in all cases across the organisation – updating this at least once a month or more often as a case progresses
* Preparing and submitting a quarterly report to the Clinical Secretariat and Clinical and Legal Governance Committee
* Reporting to the Board on all matters pertaining to safeguarding as required
* Maintaining accurate and secure records. Storage of these records will be in line with GDPR legislation.

See [Appendix 2](#_Appendix_2_-) for the contact information for our Designated Adult Safeguarding Lead

15.9 The **Head of Human Resources** must ensure that:

* Safe recruitment practices are in place including for ensuring that all our staff and volunteers, including interpreters, temporary, locum and agency staff (and contractors where appropriate), are carefully selected and vetted through DBS (England) and PVG (Scotland) and have the relevant qualifications, accreditation and experience, and accept responsibility for helping to prevent the abuse of adults and children in their care
* Compliance with our DBS (PVG) Check Policy, including in relation to renewals of these checks
* All interview letters inviting applicants to interview request specific identification documents (ID) to enable the DBS and PVG checks to be undertaken at the right level
* All relevant staff receive a mandatory induction, which includes familiarisation with their safeguarding responsibilities and the policies and procedures to be followed if they have concerns about an adult.

# 16. Equality & Diversity

* 1. Freedom from Torture is committed to equality in both employment and the provision of services. No job applicant, employee, service referrer or service user shall be subjected to any discrimination, as defined in UK law. Any practice that may result in the provision of substandard service due to unfair or unlawful discrimination will not be tolerated.
  2. An equality & diversity Impact assessment has not been completed in the development and review of this policy. Following the issuing of an organisational procedure on Impact Assessments, an impact assessment will be completed at next review

# 17. Supporting Resources / references

* Care and support statutory guidance (Department of Health) [https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/366104/43380\_2 3902777\_Care\_Act\_Book.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf)
* The Care Act 2014: easy read version (Department of Health) [https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/365345/Making \_Sure\_the\_Care\_Act\_Works\_EASY\_READ.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365345/Making_Sure_the_Care_Act_Works_EASY_READ.pdf)
* Adult Support and Protection (Scotland) Act 2007 [http://www.legislation.gov.uk/asp/2007/10/contents P](http://www.legislation.gov.uk/asp/2007/10/contents)revent guidance Scotland:
* [https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/445978/3799\_R evised\_Prevent\_Duty\_Guidance\_\_Scotland\_V2.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445978/3799_Revised_Prevent_Duty_Guidance__Scotland_V2.pdf)
* England& Wales: [https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/445977/3799\_R evised\_Prevent\_Duty\_Guidance\_\_England\_Wales\_V2-Interactive.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/445977/3799_Revised_Prevent_Duty_Guidance__England_Wales_V2-Interactive.pdf)
* Domestic abuse: How to Get Hel[p https://www.gov.uk/guidance/domestic-abuse-how-to-get-help](https://www.gov.uk/guidance/domestic-abuse-how-to-get-help)
* Gov e-learning training:<https://www.elearning.prevent.homeoffice.gov.uk/>

**18. Policies/procedures that strongly impact:**

* Safeguarding Children
* Chaperone
* Professional Boundaries
* Managing Incidents
* Clinical Risk Management
* Clinical Supervision Policy
* Working with Perpetrators
* Whistleblowing
* Health & Safety
* Process for Investigating Fitness to Practice of Doctors
* Recruitment and Selection Policy
* Disciplinary and Capability Policy
* DBS (PVG) Check Policy
* Grievance Policy
* Behaviour at Work
* Comments, Suggestions & Complaints
* Confidentiality
* Data Protection
* Diversity, Equality & Inclusion

# 19. Policy Review

This policy is subject to revision at any time when considered necessary by Freedom from Torture. It also forms part of the regular review cycle and will be reviewed every 6 months.

# 20. Supporting documents

A1 – Scheme of delegation

A2 – Key contacts

A3 - Safeguarding Adult Procedure

A4 - Decision making checklist when making referrals

A5 - Considerations for domestic abuse concerns

A6 – Chaperone procedure

A7 - Safeguarding Adult Concerns Report Form

A8- Legal and Welfare Service (LAWS) Safeguarding Process

## Appendix 1: Scheme of delegation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Current document** |  |  |  |  |  |
| **SU Consultation:** (Method and date) | - |  |  |  | |
| **Staff Consultation:**  (Method and date) | CS |  |  |  | |
| **Reviewed by HR** (date)**:** | - | **Training in place** (where required)**:** | **Yes** | No | n/a |
| **E&D impact assessment**  (date): | - see section 16 | **Action plan in place to address –ve impact(s)** | yes | no | **n/a** |
| **Reviewed by Finance**  (date)**:** | - N/A | **Financial resources in place**  (where required) | **Yes** | No | n/a |
| **Reviewed by Facilities Manager (H&S)** (date)**:** | - N/A | **H&S requirements in place** (where required)**:** | **Yes** | No | n/a |
| **Reviewed by QA Manager**  (date)**:** | -N/A | **Monitoring requirements in place:** | **Yes** |  |  |
| **Date Intranet updated:** | 26.02.24 |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Review process** |  | |  |
| **Date review to commence:** | 1.10.24 | Responsible person(s): | DNCS / Adult  Safeguarding  Lead |
| Date draft to go out for consultation (date): | 15.10.24 | |  |
| Date draft to go to SMT: |  | |  |
| Date draft to go to PSE: |  | |  |



Chair of the trustees



Director of Clinical Services



Chief Executive



Designated Safeguarding Adults



Lead



Directors of non



-



clinical



departments



Clinical Services Manager in the centre



Heads of Clinical Services

Non

-

clinical Department

managers

|  |  |  |
| --- | --- | --- |
| Clinical department staff |  | Staff from outside the clinical department |

## Appendix 2 - Key contacts

**Our Designated Adult Safeguarding Lead is:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Office** | **Tel/text** | **Mobile** | **Email**  **@freedomfromtorture.org** |
| **Ann Salter** | Manchester | Teams call | 07590056321 | ASalter @ freedomfromtorture.org |

In the event that the Designated Adult’s Safeguarding Lead is not available, please contact:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Office** | **Tel/text** | **Mobile** | **Email**  **@freedomfromtorture.org** |
| **Paula Shiels** | Scotland | 0141 420  3161 | 07590056321 | pshiels@freedomfromtorture.org |
| **Stephanie Lai** | Newcastle | Teams Call | office number: 0191 261 5825 | slai@freedomfromtorture.org |
| **Stephanie Lai** | Birmingham | Teams Call | office number: 0191 261 5825 | slai@freedomfromtorture.org |
| **Laura Kemmis** | London | 020 7697 7416 | 07534856547 | LKemmis@ freedomfromtorture.org |

In the event that none of the above contacts are available and in the event for cases of high risk, or needing further discussion, please contact:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Office** | **Tel/text** | **Mobile** | **Email**  **@freedomfromtorture.org** |
| **Jacqui Gratton** | Associate Director of Clinical Services | Teams Call | 07904447737 | [jgratton@freedomfromtorture.org](mailto:jgratton@freedomfromtorture.org) |
| **Helen McColl** | Director of Clinical Services | Teams Call | 07904998868 | hmccoll@freedomfromtorture.org |

In the event that none of the above contacts from Clinical Services are available, please notify the CEO:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Office** | **Tel/text** | **Mobile** | **Email**  **@freedomfromtorture.org** |
| **Sonya Sceats** | Chief Executive |  |  | sonyasceats@freedomfromtorture.org |

Flowchart to show adult safeguarding procedures

When a staff member has a concern about adult safeguarding:

1. **The staff member confirms the next steps with the service user using the dos and don’ts section for reference.**
2. **Any immediate safety issues are addressed (e.g. contacting the police if required). If it is thought a child has suffered sexual abuse or severe harm or is at risk of immediate harm, the police must be contacted immediately.**

**WITHIN THE SAME DAY the staff member reports the concern to line manager using the safeguarding adults reports form (Appendix 3).**

**The reporter and manager meet to agree the next steps. If the manager is not clinical, please consult with a Head of Clinical Services or Safeguarding Adults Lead for guidance.**

Where it is agreed that the concern meets the criteria for safeguarding adults, the following action is required:

1. **Complete a reporting form for the local authority where the abuse or neglect is suspected to have occurred.**
2. **Consider whether there is a safeguarding children concern and if there is, follow the safeguarding children’s procedures**
3. **Add a note to Daylight to record this decision & upload the completed form.**
4. **The Head of Clinical Services updates the safeguarding adult’s tracker and alerts the Designated Safeguarding Lead. If the person raising the concern is not part of the clinical services directorate, please liaise directly with the Head of Clinical Services for the centre, or the Designated Safeguarding Adult’s Lead.** **If neither the line manager nor the Heads of Clinical Services (HoCS) is available, then the Associate Director of Clinical Services (ADCS) or National Director of Clinical Services (NDCS) should be** notified. In the event that there is no manager available from Clinical Services, then the CEO should be notified.

**An outcome is sought from the safeguarding board WITHIN ONE WEEK. The tracker is updated with the outcome and safeguarding lead updated. Please have the confidence to challenge any decisions you disagree with.**

**Where it is considered that the concern does not meet the criteria for safeguarding adults:**

|  |
| --- |
|  |
| **Make a Daylight entry that confirms the rationale and decision making progress.** |
|  |
| **Consider any other actions required under other procedures, including risk planning** |
|  |
| **with the service user. Update the service user and continue to review regularly.** |
|  |

**The Safeguarding Adults Lead is available in a consultative role to discuss any safeguarding adult concerns.**

*NB If incident is not treated as a safeguarding issue and reporter remains concerned; they MUST report these concerns both to their Head of Department (i.e. their line manager’s line manager) and to the CEO, who then have a duty to reconsider. Where the line manager is the CEO, the report must go to the Chair of the Board of Trustees.*

*In case of any uncertainty the designated safeguarding Lead for the organisation can be contacted, or the National Director of Clinical Services in the safeguarding leads absence.*

Please note, just because there is not a safeguarding matter it does not mean that there are not risks that need to be mitigated. Always consider what risk planning is required with the service user and consider whether there are any other needs that need to be addressed.

## App*e*ndix 4 Decision making checklist when making referrals

|  |  |
| --- | --- |
|  | The alleged victim is an adult who is:  Aged 18 or over (Or 16 years and older in Scotland)  Has needs for care and support (whether or not those needs are being met)  As a result of those needs is unable to protect him or herself against the abuse, neglect or the risk of it. |
|  | AND |
|  | The alleged victim is experiencing, or at risk of experiencing, abuse or neglect |
|  | AND |

|  |  |
| --- | --- |
|  | The alleged victim has mental capacity to make decisions about their own safety and wants this referral to happen  OR  The alleged victim has been assessed as not having mental capacity to make a decision about their own safety, but a decision has been made in their best interest to make a referral.  OR  A crime has been, or may have been, committed against an adult at risk without mental capacity and a best interest decision is made  OR  The abuse or neglect is a serious crime and not proceeding would prejudice the detection or prevention of the crime  OR  The abuse or neglect has been caused by a member of staff or a volunteer and other adults or children are at risk from the person causing the harm OR The concern is about institutional or systemic abuse  OR  There is a concern that the abuse or neglect may cause serious harm to the adult or others  OR  There is a concern that a person is not able to freely consent because they have been threatened or coerced  OR  Seeing consent would be too dangerous, putting either the adult or others at further risk of harm. |

## Appendix 5: Considerations for domestic abuse concerns

|  |  |  |
| --- | --- | --- |
| **Case meets MARAC Criteria**  (People aged 16 or over)  1. Be clear with the victim about confidentiality and MARAC procedures. 2. Complete the MARAC Risk Checklist:  [http://www.safelives.org.uk/sites/default/files/res ources/Dash%20risk%20checklist%20quick%20sta rt%20guidance%20FINAL\_1.pdf w](http://www.safelives.org.uk/sites/default/files/resources/Dash%20risk%20checklist%20quick%20start%20guidance%20FINAL_1.pdf)ith the victim where possible. 3. Complete MARAC referral form. 4. Make referral to Victim Support for an  Independent Domestic Violence Advisor (IDVA) or Independent Sexual Violence Advisor (ISVA). 5.  Manager makes a referral to MARAC   1. IDVA or ISVA will contact the victim. 2. MARAC meeting takes place and victim’s views are presented by IDVA/ISVA. 3. Action plan is developed.     Where the case is visible high risk (14 ticks); or based on your professional judgement you have serious concerns about a victim’s situation you **must** make a referral into MARAC.    **Please note children will always impacted by domestic abuse.**  **They are at risk of harm by direct abuse and from hearing or witnessing incidents. This must be dealt with by safeguarding children procedures.** | **Case meets safeguarding adults criteria** Domestic abuse is a form of abuse covered by multi-agency safeguarding adult’s policy and procedures.  Where the victim of domestic abuse is an adult at risk as defined by the Care Act 2014: aged  18 or over; and has needs for care and support (whether or  not those needs are being met); and as a result of those needs is unable to protect  him or herself against the abuse or neglect or the risk of it.    A safeguarding adult’s referral must be made.    It is good practice to make a safeguarding adults and a MARAC referral if both criteria are met.              **Please note children will always impacted by domestic abuse.**  **They are at risk of harm by direct abuse and from hearing or witnessing incidents. This must be dealt with by safeguarding children procedures.** | **Case does not meet MARAC or safeguarding adults criteria**  You still need to take action and support the victim.   1. Consider immediate and long term risks. 2. Develop a safety plan with the victim (taking into consideration any dependents they may have). 3. Signpost/refer the victim to domestic abuse support services. 4. Share information with other relevant agencies. 5. Regularly revisit level of risk in terms of MARAC and safeguarding action. |

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## Appendix 6: Use of Chaperones

There is no common definition of a chaperone, and their role varies considerably depending on the support or examination a service user requires. Broadly speaking their role can be considered in any of the following areas:

* Providing emotional support or comfort or reassurance to service user. If the service user has capacity this is only likely to be for medical examinations and not routine therapy appointments.
* To provide protection to health care professionals/ clinician from unfounded allegation of improper behaviour.
* All chaperones will have successfully completed a suitable training program identified by the Head of Clinical Services of the centre concerned.
* The name of the chaperone should be recorded in the clinical note on Daylight.
* An experienced chaperone will identify unusual or unacceptable behaviour on the part of the clinician /health care professional.
* A chaperone is present as a safeguard for all parties (service user and practitioner) and is witness to continuing consent of the procedure. An advocate whose role is to support a client should not be considered a chaperone. Consent should always be proportionate to the examination or intervention being carried out. It is unlikely that a Chaperone would be required to support routine therapy appointments for a capacitated adult.
* An interpreter may be present but is not a chaperone. However, they can bear witness to consent and can hear what is being said during interactions and have a duty to report any concerns to the centre manager.  Where any intimate examinations are conducted by doctors, this would be out of sight of the interpreter but within hearing, for instance, behind a screen.
* In the case of a child the chaperone would normally be a parent or guardian or someone they know, and trust and they should understand the procedure/intervention being carried out. If they have capacity to consent, then this can be given if Gillick competent and choose not to have one and the clinician agrees with this decision.
* All staff should have an awareness of the role of the chaperone and inform them of how to raise a concern. All details of the examination and for the chaperone should be documented on Daylight.

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## Appendix 7: Safeguarding Adult Concerns Report Form

|  |  |
| --- | --- |
| **Date of incident:** | **MF ID:** |
| **Name & title of reporter:** | **Safeguarding?** Y / N  **If Y, type of abuse alleged** (see 6.3 above)**:** |
| **Centre:** |

**Description of alleged abuse or neglect:**

**Signature: .................................................. Date: ...............................................**

**Please give this form to your line manager as soon as possible**

For manager’s use:

Record action taken and outcome (if not safeguarding issue, please record how this decision was reached)

|  |  |  |  |
| --- | --- | --- | --- |
| **Action to be taken/authorities**  **informed** | **By whom** | **By when** | **Date completed** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Name ....................................... Form received on(date):................................

Signature ............................................................

**Appendix 8: Legal And Welfare Service (LAWS) Safeguarding Process**

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The LAWS Team work directly with therapy clients and may identify client safeguarding concerns through this work.

The LAWS Team works on a referral basis; the advisors do not undertake end-to-end casework, so will only be intermittently involved with a client during their time in treatment. However, all of the clients that LAWS works with will have an allocated key-worker, either a clinician or a care coordinator, who is responsible for the client during their treatment.

Generally, if a LAWS Team member identifies a safeguarding concern about a client, they will alert the client’s key-worker to their concerns immediately. Where they do so by email, they will copy in the appropriate CSM, or key-worker’s line manager if different, and their own line manager. Where they do so by speaking to the key-worker, they will email their line-manager details of the concerns and outcome of the conversation with the key-worker.

In all cases, once notified, the client’s key-worker (or their line-manager if they are not available) will be responsible for progressing the matter in line with FfT’s Safeguarding Adults/Children Policies.

Where an emergency situation of immediate risk to a child or adult’s life, health or welfare arises and a LAWS Team member is the only staff member in a position to take any immediately necessary action, such as notifying the emergency services, they can do this, as long as it is in keeping with their professional duties.

In such situations, the LAWS Team member will follow the procedures set out in FfT’s Safeguarding Adults/Children Policies, as appropriate. This includes, where possible, obtaining the client’s consent to provide confidential information to third parties.

Where it is not possible to obtain the client’s consent, the LAWS Team member will provide the third party with the minimum information necessary to address the risk to the client or other individual. It must be understood that doing so would be a breach of the solicitors’ duty of confidentiality. Breaching confidentiality in such circumstances is likely to be justifiable, at least for those solicitors practicing in England and Wales and OISC accredited advisors, in line with the SRA’s guidance on the solicitor’s duty of confidentiality.1 However, each case will be considered on its facts, and the LAWS Team member must be able to justify the breach.

If a LAWS Team member has to take immediately necessary action as above, with or without the client’s consent, they must inform the client’s key worker, CSM and their own line manager as soon as possible and on the same day as the incident. The line manager (if anyone other than the Head of LAWS) must notify the Head of LAWS immediately.

Where a LAWS Team member has had to disclose confidential client information without consent, it is possible that LAWS will no longer be able to offer their services to the client. This will need to be considered on a case-by-case basis by the Head of LAWS.