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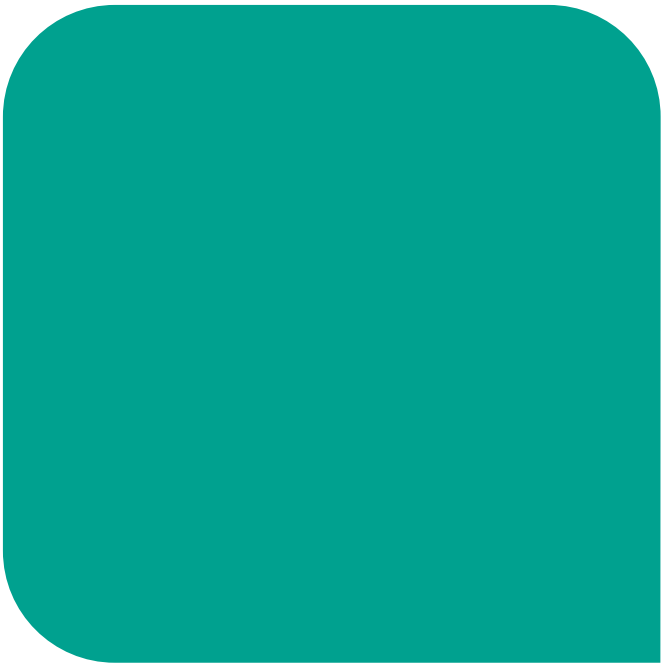
ADULTS' SERVICES REPORT 60

Safeguarding adults: multi-agency policy and procedures for the West Midlands



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Safeguarding adults: multi-agency policy and procedures for the West Midlands

Written by West Midlands Safeguarding Adults Policy and Procedure Group

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- Social Care Institute for Excellence
- Staffordshire and West Midlands Probation Trust
- Warwickshire Fire Service
- Warwickshire Police
- West Mercia Police
- West Mercia Probation Trust
- West Midlands Ambulance Service
- West Midlands Fire and Rescue Service
- West Midlands Joint Improvement Partnership
- West Midlands local authorities
- West Midlands Metropolitan Borough Councils
- West Midlands Police
- West Midlands Safeguarding Adults Network

Foreword

Living a life that is free from harm and abuse is a fundamental right of every person. All of us need to act as good neighbours and citizens in looking out for one another and seeking to prevent isolation, which can easily lead to abusive situations and put adults at risk of harm.

When abuse does take place, it needs to be dealt with swiftly, effectively and in ways which are proportionate to the issues and where the adult in need of protection stays as much in control of the decision-making as is possible. The right of the individual to be heard throughout this process is a critical element in the drive towards more personalised care and support.

In the West Midlands, as elsewhere, the main statutory agencies – local councils, the police and NHS organisations – need to work together *both* to promote safer communities to prevent harm and abuse *and* to deal well with suspected or actual cases. That is why we have come together to produce *Safeguarding adults: multi-agency policy and procedures for the West Midlands*. It is our firm belief that adults at risk are best protected when procedures between statutory agencies are consistent across the West Midlands region.

All staff, in whatever setting, have a key role in preventing harm or abuse occurring and in taking action where concerns arise. The policy and procedures set out here are designed to explain simply and clearly how agencies and individuals should work together to protect adults at risk. The target audience is professionals (including unqualified staff and volunteers) and front-line workers. Protection, prevention, partnership and personalisation are the cornerstones to protecting adults at risk of harm. Much progress has already been made. However, much more remains to be done. Our aim is to consolidate our experience to date and to encourage the development of work in order to better protect adults at risk throughout the West Midlands. This should therefore be seen as a 'living' document which will be updated regularly as both practice and policy develop. Comments and suggestions about this document should be directed to the Social Care Institute for Excellence (SCIE) (www.scie.org.uk) or to the safeguarding lead in your council.

Eddie Clarke, Lead Director for Adult Safeguarding, Association of Directors of Adult Social Services, West Midlands

Glossary and abbreviations

A&E (accident & emergency) a common name in the UK and Ireland for the emergency department of a hospital

abuse includes physical, sexual, emotional, psychological, financial, material, neglect, acts of omission, discriminatory and institutional abuse.

ACPO (Association of Chief Police Officers) an organisation that leads the development of police policy in England, Wales and Northern Ireland.

ADASS (Association of Directors of Adult Social Services) the national leadership association for directors of local authority adult social care services.

adult at risk a person aged 18 years or over who is or may be in need of community care services by reason of mental health, age or illness, and who is or may be unable to take care of themselves, or protect themselves against significant harm or exploitation. The term replaces 'vulnerable adult'.

advocacy taking action to help people say what they want, secure their rights, represent their interests and obtain the services they need.

alert a concern that an adult at risk is or may be a victim of abuse or neglect. An alert may be a result of a disclosure, an incident, or other signs or indicators.

alerter the person who raises a concern that an adult is being, has been, or is at risk of being abused or neglected. This could be the person themselves, a member of their family, a carer, a friend or neighbour, a member of staff or volunteer.

alerting manager the person in an organisation to whom the alerter is expected to report their concerns. They may also be the designated Safeguarding Adults lead within an organisation. It is the alerting manager who will in most cases make the referral and take part in the Safeguarding Adults process.

CAADA (Co-ordinated Action Against Domestic Abuse) a national charity supporting a strong multi-agency response to domestic violence. The CAADA-DASH (Domestic Abuse, Stalking and Harassment and Honour-based violence) risk identification checklist (RIC) was developed by CAADA and the Association of Chief Police Officers (ACPO).

capacity the ability to make a decision about a particular matter at the time the decision needs to be made.

care management the process of assessment of need, planning and co-ordinating care for people with physical and/or mental impairments to meet their long-term care needs, improve their quality of life and maintain their independence for as long as possible.

care setting/services includes health care, nursing care, social care, domiciliary care, social activities, support setting, emotional support, housing support, emergency housing, befriending and advice services and services provided in someone's own home by an organisation or paid employee for a person by means of a personal budget (PB), direct payment or funded by the person themselves.

carer refers to unpaid carers – for example, relatives or friends of the adult at risk. Paid workers, including personal assistants, whose job title may be 'carer', are called 'staff'.

case conference is multi-agency meeting held to discuss the outcome of the investigation/assessment and to put in place a protection or safety plan.

clinical governance the framework through which the National Health Service (NHS) improves the quality of its services and ensures high standards of care.

consent the voluntary and continuing permission of the person to the intervention based on an adequate knowledge of the purpose, nature, likely effects and risks of that intervention, including the likelihood of its success and any alternatives to it.

CPA (Care Programme Approach) introduced in England by the DH (Department of Health) in 1990 the CPA requires health authorities, in collaboration with social services departments, to put in place specified arrangements for the care and treatment of people with mental ill health in the community.

CPS (Crown Prosecution Service) the government department responsible for prosecuting criminal cases investigated by the police in England and Wales.

CQC (Care Quality Commission) responsible for the registration and regulation of health and social care in England.

CSA (Care Standards Act) is an **Act** of the **Parliament of the United Kingdom** which provides for the administration of a variety of care institutions, including children's homes, independent **hospitals**, **nursing homes** and **residential care** homes.

DH (Department of Health) the government strategic leadership for public health, the NHS and social care in England.

DHR (domestic homicide review) a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom she or he was related or with whom she or he was or had been in an intimate personal relationship, or (b) a member of the same household as herself or himself. A DHR is held with a view to identifying the lessons to be learned from the death.

DoLS (Deprivation of Liberty Safeguards) measures to protect people who lack the mental capacity to make specific decisions at specific times. The Safeguards came into effect in April 2009 using the principles of the Mental Capacity Act (MCA) 2005, and apply to people in care homes or hospitals where they may be deprived of their liberty.

DPA (Data Protection Act 1998) an Act to make provision for the regulation of the processing of information relating to individuals, including the obtaining, holding, use or disclosure of such information.

DVA (domestic violence and abuse) the definition of DVA is any violent or abusive behaviour, whether physical, sexual, psychological, emotional, financial or verbal, which is used by one person to control and dominate another with whom they have had an intimate or family-type relationship.

DVCVA (Domestic Violence, Crime and Victims Act 2004) is an Act of the Parliament of the United Kingdom. It is concerned with criminal justice and concentrates upon legal protection and assistance to victims of crime, particularly domestic violence. It also expands the provision for trials without a jury, brings in new rules for trials for causing the death of a child or vulnerable adult, and permits bailiffs to use force to enter homes

DVCV(A)A) (Domestic Violence, Crime and Victims (Amendment) Act 2012) Act to amend section 5 of the Domestic Violence, Crime and Victims Act 2004 to include serious harm to a child or vulnerable adult: to make consequential amendments to the act; and for connected purposes

DWP (Department for Work and Pensions) government department responsible for welfare and employment issues

emergency duty officer the social worker on duty in the emergency duty team (EDT) or out of hours service.

emergency duty team a social services team that responds to out-of-hours referrals where intervention from the council is required to protect a vulnerable child or adult at risk, and where it would not be safe, appropriate or lawful to delay that intervention to the next working day.

FGM (female genital mutilation) is defined by the **World Health Organisation** (WHO) as 'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.'

FGMA (Female Genital Mutilation Act 2003) An Act to restate and amend the law relating to female genital mutilation

GP (general practitioner) A general practitioner is a doctor who is responsible for diagnosing and treating a variety of injuries and diseases that fall under the general practice category. General practitioners (GPs) work in primary care. They are usually commissioned by primary care organisations, such as primary care trusts or clinical commissioning groups to deliver services.

HMIPs (Her Majesty's Inspectorate of Prisons) An independent inspectorate which reports on conditions for and treatment of those in prison, young offender institutions and immigration detention facilities.

HR (human resources) The division of an organisation that is focused on activities relating to employees. These activities normally include recruiting and hiring of new employees, orientation and training of current employees, employee benefits, and retention. Formerly called personnel**.**

HRA (Human Rights Act 2000) legislation introduced into domestic law for the whole of the UK in October 2000, in order to comply with the obligations set out in European Convention of Human Rights

HSCA (Health and Social Care Act 2012) provides legislative changes to the health and care system including giving GPs and other clinicians the primary responsibility for commissioning health care.

HSE (Health and Safety Executive) a national independent regulator that aims to reduce work-related death and serious injury across workplaces in the UK.

ill treatment Section 44 of the Mental Capacity Act (MCA) 2005 introduced a new offence of ill treatment of a person who lacks capacity by someone who is caring for them or acting as a deputy or attorney for them. That person can be guilty of ill treatment if they have deliberately ill treated a person who lacks capacity, or been reckless as to whether they were ill treating the person or not. It does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health.

IDVA (independent domestic violence adviser) a trained support worker who provides assistance and advice to victims of domestic violence.

IMCA (independent mental capacity advocate) established by the Mental Capacity Act (MCA) 2005 IMCAs are mainly instructed to represent people where there is no one independent of services, such as family or friend, who is able to represent them. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions about where they live, serious medical treatment options, care reviews or adult safeguarding concerns.

IPCC (The Independent Police Complaints Commission) oversees the police complaints system in England and Wales. It is independent, making its decisions entirely independently of the police, government and complainants.

intermediary someone appointed by the courts to help a vulnerable witness give their evidence either in a police interview or in court.

investigation/assessment a process to gather evidence to determine whether abuse has taken place and/or whether there is ongoing risk of harm to the adult at risk. In some local authorities this may be referred to as an 'inquiry'.

investigating/assessing officer the member of staff of any organisation who leads an investigation/assessment into an allegation of abuse. This is often a professional or manager in the organisation who has a duty to investigate.

ISA (Independent Safeguarding Authority) a public body set up to help prevent unsuitable people from working with children and vulnerable adults.

LINkS (Local Involvement Networks)are independent groups of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services.

managing officer a professional or manager (usually in a social work or mental health team) suitably qualified and experienced who has received Safeguarding Adults training. Managing officers are responsible for co-ordinating all Safeguarding Adults investigations by organisations in response to an allegation of abuse.

MAPPA (multi-agency public protection arrangements) statutory arrangements for managing sexual and violent offenders.

MARAC (multi-agency risk assessment conference) the multi-agency forum of organisations that manage high-risk cases of domestic abuse, stalking and 'honour'-based violence.

mental capacity refers to whether someone has the mental capacity to make a decision or not.

MCA (Mental Capacity Act 2005) The Mental Capacity Act 2005 provides a statutory framework to empower and protect people aged 16 and over who lack, or may lack, capacity to make certain decisions for themselves because of illness, a learning disability, or mental health problems. The act was fully implemented in October 2007 and applies in England and Wales.

MHA (Mental Health Act 2007) amends the Mental Health Act 1983 (the 1983 Act), the Mental Capacity Act 2005 (MCA) and the Domestic Violence, Crime and Victims Act 2004. This includes changing the way the 1983 Act defines mental disorder, so that a single definition applies throughout the Act, and abolishes references to categories of disorder.

Mental health team a team of professionals and support staff who provide specialist mental health services to people within their community.

National Health Service (NHS) the publicly funded health care system in the UK.

OASys (Offender Assessment System) a standardised process for the assessment of offenders, developed jointly by the Probation and the Prison Services.

OPG (Office of the Public Guardian) established in October 2007, the OPG supports the Public Guardian in registering enduring powers of attorney, lasting powers of attorney and in supervising Court of Protection appointed deputies.

PACE (Police and Criminal Evidence Act 1984) and the PACE codes of practice provide the core framework of police powers and safeguards around stop and search, arrest, detention, investigation, identification and interviewing detainees

PALS (Patient Advice and Liaison Service) a body created to provide advice and support to National Health Service (NHS) patients and their relatives and carers.

PCT (primary care trust) manage the provision of primary care services in a specific area. These include services provided by doctors surgeries, dental practices, opticians and pharmacies. NHS walk-in centres and the NHS Direct phone service are also managed by the local PCT.

person causing harm the term used to describe the person or adult who is alleged to have caused abuse or harm.

personal budget (PB) are allocated money for social care services, allocated based on the needs of the individual following an assessment. They could be managed by councils or another organisation (such as a Primary Care Trust or PCT) on behalf of individuals. They could also be paid as a direct payment, or a mixture of both.

PIDA (Public Interest Disclosure Act 1998) An Act to protect individuals who make certain disclosures of information inthe public interest; to allow such individuals to bring action in respect of victimisation; and for connected purposes.

PIPOT (person in a position of trust) someone in a position of trust who works with or cares for adults at risk in a paid or voluntary capacity. This includes 'shared lives' carers (previously known as adult foster carers).

police the generic term used in this document covering the following forces: West Midlands, Warwickshire and West Mercia.

PPO (Police, Prison and Probation Ombudsman) The Prisons and Probation Ombudsman is appointed by the Home Secretary, and is an independent point of appeal for prisoners and those supervised by the Probation Service. It will take appeals from offenders and ex-offenders who are not satisfied with the handling of a complaint by the Prison Service, a prison or the National Probation Service.

PPUs (Public Protection Units) the units within the police forces across the West Midlands area that deal with Safeguarding Adults and Children in the areas of high-risk domestic violence, sexual violence, child abuse, vulnerable adult abuse and registered sex offender management.

Prioritising Need a system for deciding how much support people with social care needs can expect to help them cope and keep them fit and well. Its aim is to help social care workers make fair and consistent decisions about the level of support needed, and whether the local council should pay for this.

protection plan a risk management plan aimed at removing or minimising risk to the person and others who may be affected if it is not possible to remove the risk altogether. It will need to be monitored, reviewed and amended/revised as circumstances arise and develop.

public interest a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others or society as a whole to protection.

QAF (Quality Assessment Framework) was introduced in 2003 and sets out the standards expected in the delivery of Supporting People services.

QIPP (quality, innovation, productivity and prevention) is a Department of Health (DH) initiative to help National Health Service (NHS) organisations to deliver sustainable services in better, more cost-efficient ways.

RCP (Royal College of Psychiatrists) is an independent professional membership organisation and registered charity, representing over 27,000 physicians in the UK and internationally.

referral a referral is the same as an alert; however an alert *becomes* a referral when the details lead to an adult safeguarding investigation/assessment relating to the concerns reported.

review the process of re-examining a protection plan and its effectiveness.

SAB (Safeguarding Adults Board) the SAB represents various organisations in a local authority who are involved in Safeguarding Adults.

Safeguarding Adults the term used to describe all work to help adults at risk stay safe from significant harm. It replaces ‘adult protection’.

Safeguarding Adults contact point the place where safeguarding alerts are raised within the local area. This could be a local authority single point of access, the relevant social work or mental health team or a ‘safeguarding hub’.

Safeguarding Adults co-ordinator/lead these titles or similar are used to describe an individual who has safeguarding lead responsibilities across an authority. For example, supporting the work of the Safeguarding Adults Board (SAB) and/or advising on Safeguarding Adults cases in the local authority. The role varies from council to council, and carries different titles.

Safeguarding Adults process refers to the decisions and subsequent actions taken on receipt of a referral. This process can include a strategy meeting or discussion, an investigation, a case conference, a care/protection/safety plan and monitoring and review arrangements.

SCR (serious case review) a review of the practice of agencies involved in a safeguarding matter. An SCR is commissioned by the Safeguarding Adults Board (SAB) when a serious incident(s) of adult abuse takes place or is suspected. The aim is for agencies and individuals to learn lessons to improve the way they work.

SHA (strategic health authority) are one branch of the National Health Service in England. In 2002, the existing NHS health authorities were renamed SHAs and merged to form 28 new Strategic Health Authorities. The same board and governance structures apply to SHAs as to all NHS trusts.

SIRI (serious incident requiring investigation) a term used by the National Patient Safety Agency (NPSA) in its national framework for serious incidents in the National Health Service (NHS) requiring investigation. It is defined as an incident that occurred in relation to NHS-funded services resulting in serious harm or unexpected or avoidable death of one or more patients, staff, visitors or members of the public.

significant harm is not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development.

SOCA (Serious Organised Crime Agency) a non-departmental public body of the government with a remit to tackle serious organised crime.

staff paid workers, including personal assistants, whose job title may be ‘carer’, are called ‘staff’. Volunteers are also classed as staff. See also *carer*.

strategy discussion/meeting a multi-agency discussion or meeting between relevant individuals to share information and agree how to proceed with the investigation/assessment, considering all known facts. It can be face to face or by telephone and should start to bring together the intelligence, held in different agencies, about the adult at risk, the person causing harm and approaches that each agency can take to instigate protective actions.

SVGA (Safeguarding Vulnerable Groups Act) to make provision in connection with the protection of children and vulnerable adults. The Act provides the legislative framework for Vetting and Barring Scheme, put into place by the Independent Safeguarding Authority.

ULO (user-led organisation) an organisation that is run and controlled by people who use support services including disabled people, mental health service users, people with learning difficulties, older people, and their families and carers.

vital interest a term used in the Data Protection Act (DPA) 1998 to permit sharing of information where it is critical to prevent serious harm or distress, or in life-threatening situations.

volunteer a person who works unpaid in a care setting/service.

wilful neglect an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves. Section 44 of the Mental Capacity Act (MCA) makes it a specific criminal offence to wilfully ill treat or neglect a person who lacks capacity.

YJCEA (Youth Justice and Criminal Evidence Act) an Act to provide for the referral of offenders under 18 to youth offender panels; to make provision in connection with the giving of evidence or information for the purposes of criminal proceedings; to amend section 51 of the Criminal Justice and Public Order Act 1994; to make pre-consolidation amendments relating to youth justice; and for connected purposes. This includes special measures directions in case of vulnerable and intimidated witnesses.

1 Introduction

This resource reflects the commitment of organisations in the West Midlands and allied local authorities to work together to safeguard adults at risk. The procedures outlined aim to make sure that:

- the needs and interests of adults at risk are always respected and upheld
- the human rights of adults at risk are respected and upheld
- a proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse
- all decisions and actions are taken in line with the Mental Capacity Act (MCA) 2005.

The procedures also aim to ensure that each adult at risk maintains:

- choice and control
- safety
- health
- quality of life
- dignity and respect.

1.1 Working together

The policy and procedures are aimed at different agencies and individuals involved in safeguarding adults, including managers, professionals, volunteers and staff working in public, voluntary and private sector organisations. They represent the commitment of organisations to:

- work together to prevent and protect adults at risk from abuse
- empower and support people to make their own choices
- investigate actual or suspected abuse and neglect
- support adults and provide a service to those at risk who are experiencing abuse, neglect and exploitation.

According to the *No secrets* government guidance,[1] local authorities have the lead role in co-ordinating work to safeguard adults. However, *No secrets* recognises that successful responses also require multi-agency and multi-disciplinary working.

1.2 Local implementation

Each local Safeguarding Adults Board (SAB) is asked to adopt the policy and procedures so that there is consistency across the West Midlands in the way in which adults at risk are safeguarded from abuse. However, some local SABs may want to adapt certain aspects of the procedures to meet their local needs. For example, some councils may have a slightly different approach to the thresholds for Safeguarding Adults action. Local SABs are therefore welcome to add an appendix to the policy and procedures outlining any regional variations.

1.3 Individual implementation

The policy and procedures described in this resource should also be used in conjunction with individual organisations' procedures on Safeguarding Adults and related issues such as domestic violence and abuse, fraud, disciplinary procedures and health and safety.

2 Policy

2.1 Principles and values

2.1.1 Adults at risk

- The services provided must be appropriate to the adult at risk and not discriminate because of disability, age, gender, sexual orientation, race, religion, culture or lifestyle.
- The primary focus/point of decision-making must be as close as possible to the adult at risk, and individuals must be supported to make their own choices. Adults at risk must be offered support services as appropriate to their needs.
- There is a presumption that adults have the mental capacity to make informed decisions about their lives. If someone has been assessed as not having mental capacity to make safeguarding decisions, those decisions will be made in their best interests as set out in the MCA 2005 and the MCA *Code of practice.*[2]
- Adults at risk should be given information, advice and support in a form that they can understand and have their views included in all forums that are making decisions about their lives.
- All decisions taken by professionals about a person's life should be timely, reasonable, justified, proportionate, ethical and fully recorded.

2.1.2 Organisations working with adults at risk

- Staff have a duty to report promptly any concerns or suspicions that an adult at risk is being, or is at risk of being, abused.
- Actions to protect the adult from abuse should always be given high priority by all organisations involved. Concerns or allegations should be reported without delay.
- Organisations working to safeguard adults at risk should make the dignity, safety and wellbeing of the individual a priority in their actions.
- As far as possible organisations must respect the rights of the person causing, or alleged to be causing, harm. If the person alleged to have caused harm is also an adult at risk they must receive support and their needs must be addressed. Staff should fully understand their role and responsibilities in regard to the policy and procedures.
- Every effort must be made to ensure that adults at risk are afforded appropriate protection under the law.
- Organisations will have their own internal operational procedures which relate and adhere to the policy and procedures, including complaints by service users

and by staff who raise concerns ('whistleblowers'), always in compliance with the Public Interest Disclosure Act (PIDA) 1998.

- Organisations will ensure that all staff and volunteers are familiar with policies relating to Safeguarding Adults, that they know how to recognise abuse and how to report and respond to it.
- Organisations will ensure that staff and volunteers have access to training that is appropriate to their level of responsibility and will receive clinical and/or management supervision that allows them to reflect on their practice and the impact of their actions on others.

2.1.3 Organisations working together

- Partner organisations will contribute to effective inter-agency working, multi-disciplinary assessments and joint working partnerships in order to provide the most effective means of Safeguarding Adults. Action taken under these procedures does not affect the obligations on partner organisations to comply with their statutory responsibilities, such as notification to regulatory authorities under the Health and Social Care Act (HSCA) 2008, employment legislation or other regulatory requirements.
- Organisations continue to have a duty of care to adults who purchase their own care through personal budgets (PBs) (including direct payments), and/or who fund their own care. Organisations are required to ensure that reasonable care is taken to avoid acts or omissions that are likely to cause harm to the adult at risk.
- Partner organisations will have information about individuals who may be at risk from abuse and may be asked to share this where appropriate, with due regard to confidentiality and information sharing protocols.

2.2 Adult(s) at risk and adult abuse

2.2.1 Definition

The term 'adult at risk' has been used to replace the term 'vulnerable adult 'in this Policy and Procedure. This is because 'vulnerable adult' may wrongly imply that some of the fault for the abuse lies with the adult being abused. Therefore 'adult at risk' is used as an *exact replacement* for 'vulnerable adult', but it is useful to understand in a bit more depth what the term can mean in practice.

An adult at risk, as defined in *No secrets*,[1] is:

> *a person aged 18 or over who is in receipt or who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.*

Although the following list is not exhaustive, an adult at risk may be a person who:

- is frail due to age, ill health, physical disability or cognitive impairment, or a combination of these
- has a learning disability
- has a physical disability and/or a sensory impairment
- has mental health needs including dementia or a personality disorder
- has a long-term illness/condition
- misuses substances or alcohol
- is a carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse
- is unable to demonstrate the capacity to make a decision and is in need of care and support.

For those who do not meet the criteria as an adult at risk of harm but who nevertheless appear to be at high risk there are alternative sources of referral and support. In such cases support may be found in local care management procedures or other local processes.

It is important to remember that just because someone is old, frail or has a disability, this does not mean they are inevitably ‘at risk’. For example, a person with a disability who has mental capacity to make decisions about their own safety may be perfectly able to make informed choices and protect themselves from harm. In the context of Safeguarding Adults, the vulnerability of the adult at risk is related to how able they are to make and exercise their own informed choices free from duress, pressure or undue influence of any sort, and the extent to which they can protect themselves from abuse, neglect and exploitation. It is equally important to note that people with capacity can also be vulnerable.

An adult at risk’s vulnerability is determined by a range of interconnected factors including personal characteristics, factors associated with their situation or environment, and social factors (see Table 2.1).

Table 2.1 Factors determining vulnerability

Personal characteristics of the adult at risk that increase vulnerability may include	Personal characteristics of the adult at risk that decrease vulnerability may include
• Not having mental capacity to make decisions about their own safety including fluctuating mental capacity associated with mental illness and other conditions • Communication difficulties • Physical dependency – being dependent on others for personal care and activities of daily life • Low self-esteem • Experience of abuse • Childhood experience of abuse	• Having mental capacity to make decisions about their own safety • Good physical and mental health • Having no communication difficulties or if so, having the right equipment/support • No physical dependency or, if needing help, able to self-direct care • Positive former life experiences • Self-confidence and high self-esteem
Social/situational factors that increase the risk of abuse may include	**Social/situational factors that decrease the risk of abuse may include**
• Being cared for in a care setting, i.e. more or less dependent on others • Not receiving the right amount or the right kind of care • Isolation and social exclusion • Stigma and discrimination • Lack of access to information and support • Being the focus of anti-social behaviour	• Good family relationships • Active social life and a circle of friends • Able to participate in the wider community • Good knowledge and access to a range of community facilities • Remaining independent and active • Access to sources of relevant information

2.3 Mental capacity

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

- to understand the implications of their situation
- to take action themselves to prevent abuse
- to participate to the fullest extent possible in decision-making about interventions.

The MCA 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf. This applies whether the decisions are life-changing events or everyday matters. All decisions taken in the Safeguarding Adults process must comply with the Act.[2]

2.3.1 Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) provide protection to people in hospitals and care homes. DoLs apply to people who have a mental disorder and who do not have mental capacity to decide whether or not they should be accommodated in the relevant care home or hospital to receive care or treatment.

Care homes must make requests to a local authority supervisory body for authorisation to deprive someone of their liberty if they believe it is in their best interests. Hospitals must make requests to the primary care trust (PCT). Some organisations may operate joint supervisory boards. All decisions on care and treatment must comply with the MCA and the DoLS codes of practice.[2, 3] Sometimes, for example in the case of serious dispute with the person's family, it is necessary for local authorities or PCTs to apply to the Court of Protection. Be mindful that case law is evolving in this area, see Neary case in particular.

2.3.2 Consent

It is always essential in safeguarding to consider whether the adult at risk is capable of giving informed consent in all aspects of their life. If they are able, their consent should be sought. This may be in relation to whether they give consent to:

- An activity that may be abusive – if consent to abuse or neglect was given under duress (e.g. as a result of exploitation, pressure, fear or intimidation), this apparent consent should be disregarded.[4]
- A Safeguarding Adults investigation/assessment going ahead in response to a concern that has been raised. Where an adult at risk with capacity has made a decision that they do not want action to be taken and there are no public

interest or vital interest considerations, their wishes must be respected. The person must be given information and have the opportunity to consider all the risks and fully understand the likely consequences of that decision over the short and long term.

- The recommendations of an individual protection plan being put in place.
- A medical examination.
- An interview
- Certain decisions and actions taken during the Safeguarding Adults process with the person or with people who know about their abuse and its impact on the adult at risk.

If, after discussion with the adult at risk who has mental capacity, they refuse any intervention, their wishes will be respected *unless*:

- there is an aspect of *public interest* (e.g. not acting will put other adults or children at risk)
- there is a *duty of care on a particular agency* to intervene for example the police if a crime has been or may be committed).

3 Abuse

For the purpose of the Safeguarding Adults policy and procedures the term *abuse* is defined as:

> *a violation of an individual's human and civil rights by any other person or* persons which may result in significant harm.[1]

Abuse may be:

- a single act or repeated acts
- an act of neglect or a failure to act
- multiple acts (e.g. an adult at risk may be neglected *and* financially abused).

Abuse is about the misuse of the power and control that one person has over another. Where there is dependency, there is a possibility of abuse or neglect unless adequate safeguards are put in place.

Intent is not necessarily an issue at the point of deciding whether an act or a failure to act is abuse; it is the impact of the act on the person and the harm or risk of harm to that individual.

Abuse can take place anywhere: a person's own home, day or residential centres, supported housing, educational establishments, nursing homes, clinics and hospitals.

A number of abusive acts are crimes and informing the police must be a key consideration.

3.1 Location of abuse

Abuse can take place anywhere. For example:

- the person's own home, whether living alone, with relatives or others
- day or residential centres
- supported housing
- work settings
- educational establishments
- nursing homes
- clinics
- hospitals
- prisons
- other places in the community.

3.2 Who might abuse?

Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the adult at risk. A wide range of people may harm adults. These include:

- a member of staff, owner or manager at a residential or nursing home
- a professional worker such as a nurse, social worker or general practitioner (GP)
- a volunteer or member of a 'community group' such as a social club or place of worship
- another service user
- a spouse, partner, relative or friend
- a carer
- a neighbour, member of the public or a stranger
- a person who deliberately targets adults at risk in order to exploit them.

3.3 Significant harm

In determining what justifies intervention and what sort of intervention is required, *No secrets* uses the concept of 'significant harm'.[1] This refers to:

- ill treatment (including sexual abuse and forms of ill treatment which are not physical)
- the impairment of, or an avoidable deterioration in, physical or mental health, and/or
- the impairment of physical, intellectual, emotional, social or behavioural development.

The importance of this definition is that, in deciding what action to take, consideration must be given not only to the immediate impact on and risk to the person, but also to the risk of future, longer-term harm.

Seriousness of harm, or the extent of the abuse, is not always clear at the point of the alert or referral. All reports of suspicions or concerns should be approached with an open mind and could give rise to action under the Safeguarding Adults policy and procedure.

It should be noted that Department of Health statutory guidance - on eligibility for help from social services – refers to 'serious abuse or neglect' in the critical category of eligibility, and to 'abuse or neglect' in the substantial category. Since the vast majority of local authorities have decided to assist people whose needs fall into both the critical and substantial categories, it follows that safeguarding is not confined to 'serious' abuse or neglect (*Prioritising Need in the context of Putting People First: A whole system approach to eligibility for Social Care (guidance on Eligibility Criteria for Adult Social Care England 2010**).***

No secrets puts forward the following factors to be taken into account when making an assessment of the seriousness of risk to the person:

- vulnerability of the person
- nature and extent of the abuse or neglect
- length of time the abuse or neglect has been occurring
- impact of the alleged abuse on the adult at risk
- risk of repeated or increasingly serious acts of abuse or neglect
- risk that serious harm could result if no action is taken
- illegality of the act or acts.

Abuse can be viewed in terms of the following categories (although this is not an exhaustive list):

- physical
- sexual
- psychological/emotional
- financial and material
- neglect and acts of omission
- discriminatory
- institutional.

Many abusive behaviours constitute a criminal offence. All suspected abuse must be investigated.

Many situations may involve more than one type of abuse. Consider the definition of each category in turn, together with their indicators. Be aware that the lists given below are *only an indication* that abuse is happening and disclosure from an individual may also be offered.

The presence of one or more of these signs does not confirm abuse. However, the presence of one or a number of these indicators may suggest the potential for abuse and a safeguarding alert must be made.

3.4 Physical abuse

Physical abuse includes hitting, slapping, pushing, kicking, misuse of medication, being locked in a room, inappropriate sanctions or force-feeding, inappropriate methods of restraint, and unlawfully depriving a person of their liberty.[5, 6]

3.4.1 Possible indicators

- Unexplained or inappropriately explained injuries.
- Person exhibiting untypical self-harm.
- Unexplained cuts or scratches to mouth, lips, gums, eyes or external genitalia.

- Unexplained bruising to the face, torso, arms, back, buttocks, thighs, in various stages of healing. Collections of bruises that form regular patterns which correspond to the shape of an object or which appear on several areas of the body.
- Unexplained burns on unlikely areas of the body (e.g. soles of the feet, palms of the hands, back), immersion burns (from scalding in hot water/liquid), rope burns, burns from an electrical appliance.
- Unexplained or inappropriately explained fractures at various stages of healing to any part of the body.
- Medical problems that go unattended.
- Sudden and unexplained urinary and/or faecal incontinence.
- Evidence of over-/under-medication.
- Person flinches at physical contact.
- Person appears frightened or subdued in the presence of particular people.
- Person asks not to be hurt.
- Person may repeat what the alleged abuser has said (e.g. 'Shut up or I'll hit you').
- Reluctance to undress or uncover parts of the body.
- Person wears clothes that cover all parts of their body or specific parts of their body.
- A person without capacity not being allowed to go out of a care home when they ask to.
- A person without capacity not being allowed to be discharged at the request of an unpaid carer/family member.

3.5 Sexual abuse

Sexual abuse includes rape and sexual assault or sexual acts that the adult at risk has not consented to or could not consent to, or was pressured into.

It includes penetration of any sort, incest and situations where the alleged abuser touches the abused person's body (e.g. breasts, buttocks, genital area), exposes his or her genitals (possibly encouraging the abused person to touch them) or coerces the abused person into participating in or looking at pornographic videos or photographs. Denial of a sexual life to consenting adults is also considered abusive practice.

Any sexual relationship that develops between adults where one is in a position of trust, power or authority in relation to the other (e.g. day centre worker/social worker/residential worker/health worker etc.) may also constitute sexual abuse (see Section 3.16).

3.5.1 Possible indicators

- Person has urinary tract infections, vaginal infections or sexually transmitted diseases that are not otherwise explained.
- Person appears unusually subdued, withdrawn or has poor concentration.
- Person exhibits significant changes in sexual behaviour or outlook.
- Person experiences pain, itching or bleeding in the genital/anal area.
- Person's underclothing is torn, stained or bloody.
- A woman who lacks the mental capacity to consent to sexual intercourse becomes pregnant.
- Sexual exploitation.

The sexual exploitation of adults at risk involves exploitative situations, contexts and relationships where adults at risk (or a third person or persons) receive 'something' (e.g. food, accommodation, drugs, alcohol, cigarettes, affection, gifts, money) as a result of performing, and/or others performing on them, sexual activities.

Sexual exploitation can occur through the use of technology without the person's immediate recognition –this can include, being persuaded to post sexual images on the internet/a mobile phone with no immediate payment or gain or being sent such an image by the person alleged to be causing harm. In all cases those exploiting the adult at risk have power over them by virtue of their age, gender, intellect, physical strength and/or economic or other resources.

3.6 Psychological abuse

Psychological abuse includes 'emotional abuse' and takes the form of threats of harm or abandonment, deprivation of contact, humiliation, rejection, blaming, controlling, intimidation, coercion, indifference, harassment, verbal abuse (including shouting or swearing), and isolation or withdrawal from services or support networks.

Psychological abuse is the denial of a person's human and civil rights including choice and opinion, privacy and dignity and being able to follow one's own spiritual and cultural beliefs or sexual orientation.

It includes preventing the adult from using services that would otherwise support them and enhance their lives. It also includes the intentional and/or unintentional withholding of information (e.g. information not being available in different formats/languages etc.).

3.6.1 Possible indicators

- Untypical ambivalence, deference, passivity, resignation.
- Person appears anxious or withdrawn, especially in the presence of the alleged abuser.
- Person exhibits low self-esteem.
- Untypical changes in behaviour (e.g. continence problems, sleep disturbance).

- Person is not allowed visitors/phone calls.
- Person is locked in a room/in their home.
- Person is denied access to aids or equipment, (e.g. glasses, dentures, hearing aid, crutches, etc.)
- Person's access to personal hygiene and toilet is restricted.
- Person's movement is restricted by use of furniture or other equipment.
- Bullying via social networking internet sites and persistent texting.

3.7 Financial or material abuse

This includes theft, fraud, exploitation, pressure in connection with wills or property and the misappropriation of property or benefits. It also includes the withholding of money or the unauthorised or improper use of a person's money or property, usually to the disadvantage of the person to whom it belongs. Staff borrowing money or objects from a service user is also considered financial abuse.

3.7.1 Possible indicators

- Lack of money, especially after benefit day.
- Inadequately explained withdrawals from accounts.
- Disparity between assets/income and living conditions.
- Power of attorney obtained when the person lacks the capacity to make this decision.
- Recent changes of deeds/title of house.
- Recent acquaintances expressing sudden or disproportionate interest in the person and their money.
- Service user not in control of their direct payment or individualised budget.
- Mis-selling/selling by door-to-door traders/cold calling.
- Illegal money-lending.

3.8 Neglect and acts of omission

These include ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, and the withholding of the necessities of life such as medication, adequate nutrition and heating. Neglect also includes a failure to intervene in situations that are dangerous to the person concerned or to others, particularly when the person lacks the mental capacity to assess risk for themselves.

Neglect and poor professional practice may take the form of isolated incidents or pervasive ill treatment and gross misconduct. Neglect of this type may happen within a person's own home or in an institution. Repeated instances of poor care may be an indication of more serious problems. Neglect can be intentional or unintentional.

3.8.1 Possible indicators

- Person has inadequate heating and/or lighting.
- Person**'**s physical condition/appearance is poor **(**e.g. ulcers, pressure sores, soiled or wet clothing).
- Person is malnourished, has sudden or continuous weight loss and/or is dehydrated.
- Person cannot access appropriate medication or medical care.
- Person is not afforded appropriate privacy or dignity.
- Person and/or a carer has inconsistent or reluctant contact with health and social services.
- Callers/visitors are refused access to the person.
- Person is exposed to unacceptable risk.

3.9 Discriminatory abuse

This includes discrimination on the grounds of race, faith or religion, age, disability, gender, sexual orientation and political views, along with racist, sexist, homophobic or ageist comments or jokes, or comments and jokes based on a person's disability or any other form of harassment. It also includes not responding to dietary needs and not providing appropriate spiritual support. Excluding a person from activities on the basis they are 'not liked' is also discriminatory abuse (see also Section 3.12.1).

3.9.1 Possible Indicators

Indicators for discriminatory abuse may not always be obvious and may also be linked to acts of physical abuse and assault, sexual abuse and assault, financial abuse, neglect, psychological abuse and harassment, so all the indicators listed above may apply to discriminatory abuse.

- A person may reject their own cultural background and/or racial origin or other personal beliefs, sexual practices or lifestyle choices.
- A person making complaints about the service not meeting their needs.

3.10 Institutional abuse

Institutional abuse is the mistreatment, abuse or neglect of an adult at risk by a regime or individuals in a setting or service where the adult at risk lives or that they use. Such abuse violates the person's dignity and represents a lack of respect for their human rights.

Institutional abuse occurs when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affect the whole setting and deny, restrict or curtail the dignity, privacy, choice, independence or fulfilment of adults at risk.[7]

Institutional abuse can occur in any setting providing health or social care. A number of inquiries into care in residential settings have highlighted that institutional abuse is most likely to occur when staff:

- receive little support from management
- are inadequately trained
- are poorly supervised and poorly supported in their work
- receive inadequate guidance

Such abuse is also more likely where there are inadequate quality assurance and monitoring systems in place.

3.10.1 Possible indicators

- Unnecessary or inappropriate rules and regulations.
- Lack of stimulation or the development of individual interests.
- Inappropriate staff behaviour, such as the development of factions, misuse of drugs or alcohol, failure to respond to leadership.
- Restriction of external contacts or opportunities to socialise.

3.11 Related issues

3.11.1 Personal budgets and self-directed care

Increasingly people are deciding to use less traditional ways of having their eligible social care and health care needs met. Many are taking the opportunity to exercise greater choice and control over what kinds of services they receive, who provides them and the way in which they are delivered. This revolution brings with it opportunities and challenges from the perspective of risk enablement and safeguarding.

Regardless of the person's preferred method of managing a PB (e.g. council managed account, direct payment, individual service account or a combination of these), the local authority still retains its duty of care with regard to the person and their protection from abuse. However, the balance of power and consequently how risk is managed can be significantly different from previous, traditional, models of social care management. This model is more about the co-production of risk enablement, with the person having a greater say and therefore greater control over how risk is managed. This is therefore an inherently less risk averse arrangement than before.

Throughout the process, from self-assessment (supported or otherwise) through to PB-setting, arranging direct payments or other PB management arrangements, to final sign-off of a support plan, appropriate risk assessment should be taking place with the individual and their supporters.

At the various key stages in the process, risk and safety should be considered.

- *Self-assessment:* initial identification of any safeguarding issues, either one-off or ongoing. If these needs are being met, how is this being done? If they are not being met, they need to be clearly identified.

- *Budget-setting:* if significant safeguarding risks are identified as unmet needs, will the amount of the PB be sufficient to reduce or mitigate them?
- *Support planning:* how will the support plan meet the safeguarding needs in outcome terms? What services are best suited to meet the person's needs and how will they be delivered in a person-centred way?
- *Sign-off:* authorisation of the support to ensure it is legal, safe and affordable.

In this arrangement people using PBs, to a greater or lesser degree, are the commissioners of their own services, particularly where they are using direct payments to manage them.

Different arrangements exist to support people through the process of setting up a support package. In some areas this may be the responsibility of local authority adult social care staff, independent brokerage services or user-led organisations (ULOs). The kinds of support available may include:

- advice about safe recruitment
- advice about safeguarding and dignity
- using approved or accredited providers of services
- employment advice and services
- advice and support in relation to the quality of services
- contractual issues

It should be remembered that, where someone has capacity to make their own decisions in these matters, they may choose *not* to seek or use such advice or support services. This does not necessarily have a detrimental impact on the legality or safety of the support plan.

People with PBs and support plans which utilise direct payments are subject to the same reviewing arrangements as those in receipt other services (i.e. a minimum of once per year).

3.11.2 Those who fund their own care arrangements

People who fund their own care arrangements are legally entitled to receive support if subject to abuse or neglect in exactly the same way as those supported or funded by the local authority.

3.11.3 Self-neglect

Self-neglect does not come under the scope of these procedures – which relate to circumstances where there is a person or agent, other than the adult at risk, who is causing significant harm. However, some local authorities will apply their safeguarding procedures to protect individuals who self-neglect where there is not a person alleged to have caused harm. Practitioners should refer to local procedures relating to this issue.

3.12 Other areas of abuse

3.12.1 Hate crime

A hate crime is any criminal offence that is motivated by hostility or prejudice based upon the victim's:

- disability
- race
- religion or belief
- sexual orientation
- transgender identity.

Hate crime can take many forms including:

- physical attacks such as physical assault, damage to property, offensive graffiti and arson
- threat of attack including offensive letters, abusive or obscene telephone calls, groups hanging around to intimidate and unfounded, malicious complaints
- verbal abuse, insults or harassment – taunting, offensive leaflets and posters, abusive gestures, dumping of rubbish outside homes or through letterboxes, and bullying at school or in the workplace.

3.12.2 Domestic abuse

Domestic abuse is defined as 'any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members regardless of gender or sexuality'.[8] 'Family members' are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.

Whatever form it takes, domestic abuse is rarely a one-off incident and should instead be seen as a pattern of abusive and controlling behaviour through which the abuser seeks power over the victim. Domestic abuse occurs across society, regardless of age, gender, race, sexuality, wealth and geography. The figures from reported incidents show, however, that it consists mainly of violence by men against women. Children are also affected both directly and indirectly and there is also a strong correlation between domestic violence and child abuse.[9]

Effective safeguarding is achieved when agencies share information to obtain an accurate picture of the risk and then work together to ensure that the safety of the adult at risk is prioritised. In high-risk situations it may be relevant to access the multi-agency risk assessment conference (MARAC) process.

A MARAC is a meeting where information is shared on the highest risk domestic abuse cases between representatives of the local police, probation, health, children and Adults Safeguarding bodies, housing practitioners, substance misuse services, independent

domestic violence advisers (IDVAs) and other specialists from the statutory and voluntary sectors.

The four aims of a MARAC are as follows:

- to safeguard adult victims who are at high risk of future domestic violence
- to make links with other public protection arrangements in relation to children, people causing harm and vulnerable adults
- to safeguard agency staff
- to work towards addressing and managing the behaviour of the person causing harm.

Domestic homicide reviews (DHRs) were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (DVCVA) 2004. This provision came into force on 13 April 2011 and the purpose is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result
- apply these lessons to service responses including changes to policies and procedures as appropriate
- prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra- and inter-agency working.

DHRs are not inquiries into how the victim died or into who is culpable and are not specifically part of any disciplinary inquiry or process. The rationale for the review process is to ensure agencies are responding appropriately to victims of domestic violence by offering and putting in place:

- appropriate support mechanisms
- procedures
- resources and interventions with the aim of avoiding future incidents of domestic homicide and violence.

A DHR will also assess whether agencies have sufficient and robust procedures and protocols in place, which were in turn understood and adhered to by staff. The DHR process is similar to that of adult and children's serious case reviews (SCRs). The main purpose is to learn lessons.

3.12.3 Honour-based violence

Honour-based violence is a crime, and referring to the police must always be considered. It has or may have been committed when families feel that dishonour has

been brought to them. Women are predominantly (but not exclusively) the victims, and the violence is often committed with a degree of

collusion from family members and/or the community. Many of these victims will contact the police or other organisations. However, many others are so isolated and controlled that they are unable to seek help.

Alerts that may indicate honour-based violence include domestic violence, concerns about forced marriage, enforced house arrest and missing persons reports. If a concern is raised through a Safeguarding Adults referral, and there is a suspicion that the adult is the victim of honour-based violence, referring to the police must always be considered as they have the necessary expertise to manage the risk.

3.12.4 Female genital mutilation

Female genital mutilation (FGM) involves procedures that intentionally alter or injure female genital organs for non-medical reasons. The procedure has no health benefits for girls and women. The Female Genital Mutilation Act (FGMA) was introduced in 2003 and came into effect in March 2004. The Act makes it illegal to practise FGM in the UK or to take girls who are British nationals or permanent residents of the UK abroad for FGM whether or not it is lawful in another country. It also makes it illegal to aid, abet, counsel or procure the carrying out of FGM abroad.

3.12.5 Forced marriage

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

In a situation where there is concern that an adult at risk is being forced into a marriage they do not or cannot consent to, there will be an overlap between action taken under the forced marriage provisions and the Safeguarding Adults process. In this case action will be co-ordinated with the police and other relevant organisations.

The police must always be contacted in such cases as urgent action may need to be taken.

3.12.6 Human trafficking

Human trafficking involves an act of recruiting, transporting, transferring, harbouring or receiving a person through a use of force, coercion or other means, for the purpose of exploiting them.

If an identified victim of human trafficking is also an adult at risk, the response will be co-ordinated under the Safeguarding Adults process. The police are the lead agency in managing responses to adults who are the victims of human trafficking.

There is a national framework to assist in the formal identification and help to coordinate the referral of victims to appropriate services, known as the National Referral Mechanism.

3.12.7 Exploitation by radicalisers who promote violence

Individuals may be susceptible to recruitment into violent extremism by radicalisers. Violent extremists often use a persuasive rationale and charismatic individuals to attract people to their cause. The aim is to attract people to their reasoning, inspire new recruits, embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause. The Home Office leads on the anti-terrorism strategy. See Prevent Strategy 2011.

3.12.8 Abuse by another adult at risk

Where the person causing the harm is also an adult at risk, the safety of the person who may have been abused is paramount. Organisations may also have responsibilities towards the person causing the harm, and certainly will have if they are both in a care setting or have contact because they attend the same place (e.g. a day centre). In this situation it is important that the needs of the adult at risk who is the alleged victim are addressed *separately* from the needs of the person allegedly causing harm.

It may be necessary to reassess the adult allegedly causing the harm. This will involve a meeting where the following could be addressed:

- the extent to which the person causing the harm is able to understand his or her actions
- the extent to which the abuse or neglect reflects the needs of the person causing the harm not being met (e.g. risk assessment recommendations not being met)
- the likelihood that the person causing the harm will further abuse the victim or others.

The principles and responsibilities of reporting a crime apply regardless of whether the person causing harm is deemed to be an adult at risk.

3.13 Multi-agency public protection arrangements

The purpose of the multi-agency public protection arrangements (MAPPA) framework is to reduce the risks posed by sexual and violent offenders in order to protect the public, including previous victims, from serious harm. The responsible authorities in respect of MAPPA are the Police, Prison and Probation Services who have a duty to ensure that MAPPA is established in each of their geographic areas and to undertake the risk assessment and management of all identified MAPPA offenders (primarily violent offenders on licence or mental health orders and all registered sex offenders). The Police, Prison and Probation Services have a clear statutory duty to share information for MAPPA purposes.

Other organisations have a duty to co-operate with the responsible authority, including the sharing of information. These include:

- local authority children, family and adult social care services
- PCTs, other health trusts and strategic health authorities (SHAs)
- Jobcentre Plus

- youth offender teams
- local housing authorities
- registered social landlords with accommodation for MAPPA offenders.

3.14 Prisoners

No Secrets[1] does not explicitly reference prisoners and there is likely to be a significant number whose health and social care needs would result in them being at risk or being harmed were they living in the wider community.

The Association of Directors of Adult Social Services (ADASS) aims to ensure that directors are aware that local safeguarding teams may be contacted by Inspectors working on behalf of Her Majesty's Inspectorate of Prisons (HMIPs) if they identify possible abuse of adults at risk in prison.

The Law Commission consultation[10] suggests that the omission of explicit reference to prisoners should not prevent them from being safeguarded under the same principles as adults at risk in the community.

HMIP is keen to support prisons in developing a confident approach to safeguarding and will assist in this. HMIP inspectors are being briefed that if they come across suspected abuse of adults at risk they should contact the local safeguarding team, while informing the prison governor and the local director of adult social services.

In order to build a base for this work ADASS suggests that councils with prisons in their area invite governors to be part of the SAB process as well as informing local safeguarding teams of potential contact and agreeing possible outcomes.

This does not mean that the local safeguarding team will necessarily intervene as it may be more appropriate for the prison to do this. However, it provides the opportunity for local dialogue on the best approach.

Prisoners are assessed and can receive special help and support if they have identified needs such as:

- drug or alcohol problems
- HIV or AIDS
- a mental health condition
- a disability or a learning difficulty.

Also, some 18-year-olds remain in **secure children's homes, secure training centres and young offender institutions when** they only have a short period of their sentence to serve, to avoid disrupting their regimes.

HM prisons have codes of practice requiring staff to be trained in safeguarding and to follow local procedures. They have rules, regulations and guidelines by which they are run. These cover a wide range of issues with possible relevance to safeguarding. Three examples are:

- CARATs (counselling, assessment, referral, advice and through care services) relating to drugs interventions

- use of force
- suicide and self-harm.

When things go wrong prisoners can complain within the prison, or externally to an independent monitoring board. A complaint can escalate to the Prisons and Probation Ombudsman (PPO).

3.15 Allegations against carers who are relatives or friends

There is a clear difference between unintentional harm caused inadvertently and a deliberate act of either harm or omission, however contact must be made with the police, if a crime has been or may be committed

In cases where unintentional harm has occurred this may be due to lack of knowledge or due to the fact that the carer's own physical or mental needs make them unable to care adequately for the adult at risk. The carer may also be an adult at risk. In this situation the aim of Safeguarding Adults work will be to help the carer to provide support and make changes in their behaviour in order to decrease the risk of further harm to the person they are caring for.

A carer's assessment should follow the legal requirements of the Carers and Disabled Children Act 2000 and take into account the following factors:

- whether the adult for whom they care has a learning disability, mental health problems or a chronic progressive disabling illness that creates caring needs which exceed the carer's ability to meet them
- the emotional and/or social isolation of the carer and the adult at risk
- whether there is minimal or no communication between the adult at risk and the carer *either* through choice, mental incapacity or poor relationship
- whether the carer is or is not in receipt of any practical and/or emotional support from other family members or professionals
- financial difficulties
- whether the carer has an enduring or lasting power of attorney or appointeeship
- whether there is a personal or family history of violent behaviour, alcoholism, substance misuse or mental illness
- the physical and mental health and wellbeing of the carer.

See local procedures/ guidance.

3.16 Persons in a position of trust

For the purposes of this policy a person in a position of trust (PIPOT) is someone who works with or cares for adults at risk in a paid or voluntary capacity and about whom allegations of adult abuse or neglect are made. This includes 'shared lives carers' (previously known as 'adult foster carers').

PIPOT local arrangements should be followed in all cases in which there is an allegation or suspicion that a person working with adults at risk has:

- behaved in a way that has harmed or may have harmed an adult at risk
- possibly committed a criminal offence against or related to an adult at risk
- behaved towards an adult at risk in a way that indicates she or he is unsuitable to work with such adults
- behaved in a way that has harmed children or may have harmed children which means their ability to provide a service to adults at risk must be reviewed
- been subject to abuse themselves, which means their ability to provide a service to adults at risk must be reviewed.

Adults at risk can be subjected to abuse by those who work with them in any and every setting. All allegations of abuse, neglect or maltreatment of adults at risk by a PIPOT must be taken seriously and treated in accordance with consistent procedures. All adults at risk are entitled to the same level and standard of protection from harm, regardless of whether they are receiving statutory or other services or if they are receiving none.

The scope of PIPOT procedures applies to all cases where concern, suspicion or allegation arises in connection with:

- the PIPOT's own work/voluntary activity
- the PIPOT's life outside work (i.e. concerning adults at risk in the family or the social circle, risks to children, whether the individual's own children or other children).

The procedures apply whether the concern is current *or* historical.

See local arrangements/guidance.

3.17 Abuse by children

If a child or children is or are causing harm to an adult at risk, this should be dealt with under the Safeguarding Adults policy and procedures, but will also need to involve the local authority children’s services.

3.18 Child protection

The Children Act (CA) 1989 provides the legislative framework for agencies to take decisions on behalf of children and to take action to protect them from abuse and neglect.

Everyone must be aware that in situations where there is a concern that an adult at risk is or could be being abused or neglected and there are children in the same household, they too could be at risk. Reference should be made to the local child protection procedures, the local Safeguarding Children Board, inter-agency guidelines and internal protocols dealing with cross-boundary working if there are concerns about abuse or neglect of children and young people under the age of 18. Referral must be made to the

relevant children and families department and any multi-agency safeguarding children policy and procedures.

See local procedures/guidance.

3.19 Transitions (care leavers)

Robust joint working arrangements between children's and adults' services should be in place to ensure that the medical, psychosocial and vocational needs of children leaving care are assessed as they move into adulthood and begin to require support from adult services.

The care needs of the young person should be at the forefront of any support planning and require a co-ordinated multi-agency approach. Assessments of care needs at this stage should include issues of safeguarding and risk. Care planning needs to ensure that the young adult's safety is not put at risk through delays in providing the services they need to maintain their independence, wellbeing and choice.

The MCA 2005 applies to young people aged 16 years and over apart from the following aspects:

- only people aged 18 or over can make a lasting power of attorney
- the law generally does not allow anyone below the age of 18 to make a will
- DOLS authorisations under the MCA apply only to people aged 18 or over.

Information on decisions to refuse treatment made in advance by young people under the age of 18 is available at www.dh.gov.uk/consent.

See local procedures/guidance.

4 Safeguarding Adults

Great efforts are being made to raise awareness to encourage everybody to be alert and to report.

4.1 Adult at risk

In safeguarding situations the adult at risk must be involved from the outset (unless doing so would put them at greater risk of harm). They must be seen by a worker from the investigating/assessing team to discuss the allegation or disclosure. The discussion must include how they view the risk, and their opinions and desired outcomes from the investigation must be sought. They must be included throughout the process and at the conclusion a check must be made to establish whether their desired outcomes from the investigation have been met.

4.2 Family and friends

Family, friends and other relevant people who are not implicated in the allegation of abuse often have an important part to play in the Safeguarding Adults process, and can provide valuable support to the individual. In some cases they can also assist in managing the risk.

If appropriate and possible, and where the adult at risk has mental capacity and gives their consent, and there are no evidential constraints, family and friends should be consulted.

If the adult does not have mental capacity, family and friends must be consulted in accordance with the principles of the MCA 2005.

A record should be made of the decision to consult or not to consult family and friends with reasons being given and recorded.

4.3 Advocates

As part of the safeguarding process consideration should be given to whether an adult at risk may benefit from the support of an independent advocate. There are two distinct types of advocacy – instructed and non-instructed – and it is important that people involved in the Safeguarding Adults process are aware of which type of advocate is representing the person and supporting them to express their views.

Instructed advocates take their instructions from the person they are representing. For example, they will only attend meetings or express views with the permission of that person. *Non-instructed advocates* work with people who lack capacity to make decisions about how the advocate should represent them. Non-instructed advocates independently decide how best to represent the person.

Advocates should be invited to the case conference (see Section 5.6) (other than in exceptional circumstances – e.g. where the relationship between the adult at risk and the advocate is considered abusive), either accompanying the adult at risk or attending on their behalf, to represent the person's views and wishes. Instructed advocates would attend only with the permission of the adult at risk.

4.4 Witness support and special measures

If there is a police investigation, the police will ensure that interviews with the adult at risk who is a vulnerable or intimidated witness are conducted in accordance with *Achieving best evidence in criminal proceedings*.[11]

'Special measures' are those specified in the YJCEA 1999 and can be used to assist eligible witnesses. The measures can include the use of screens in court proceedings, the removal of wigs and gowns, the sharing of visually recorded evidence-in-chief (the evidence given by a witness for the party who called him or her), cross-examination and re-examination and the use of intermediaries and aids to communication.

Intermediaries play an important role in improving access to justice for some of the most vulnerable people in society, giving them a voice within the criminal justice process. They help children and adults who have communication difficulties to understand the questions that are put to them and to have their answers understood, enabling them to deliver their best evidence for the police and the courts.

The Witness Service is free and independent of the police or courts and provides practical and emotional support to victims and witnesses (either for the defence or the prosecution). The support is available before, during and after a court case to enable the witness, their family and friends to have information about the court proceedings, and can include arrangements to visit the court in advance of the trial.

4.5 Victim support

Victim Support is a national charity which provides support for victims and witnesses of crime in England and Wales. It provides free and confidential help to family, friends and anyone else affected by crime. This includes information, emotional support and practical assistance. Help can be accessed either directly from local branches or through the Victim Support helpline.

4.6 All staff, volunteers and organisations

The first priority of all staff and volunteers must always be to ensure the safety and protection of the adult at risk.

All staff and volunteers from any service or setting should be aware of the multi-agency and local safeguarding policy and procedures and have a responsibility to be aware of issues of abuse, neglect or exploitation. This includes personal assistants paid for from direct payments or PBs.

All staff and volunteers have a *duty to act* in a timely manner on any concern or suspicion that an adult who is at risk is being, or is at risk of being, abused, neglected or exploited and to ensure that the situation is assessed and investigated.

All organisations that provide services to adults at risk have a responsibility to make sure that their staff are fit to work with such adults. In particular, human resources (HR) departments (or the equivalent) should make sure that:

- Safeguarding Adults is taken into account in all appropriate HR strategies, systems, policies and procedures
- national safe recruitment and employment practices are adhered to, including the guidelines issued by the Independent Safeguarding Authority (ISA)
- staff and volunteers in contact with adults at risk have regular supervision and support, and appropriate training to help them identify and respond to possible abuse and neglect.

4.7 Managers

The role and responsibility of the manager is:

- to ensure the alleged victim is made safe and to preserve any evidence relating to the abuse
- to ensure that any member of staff or volunteer who may have caused harm is not in contact with the alleged victim, other service users or others who may be at risk (e.g. 'whistleblowers' – see Section 4.19.4).
- to ensure that safeguarding alerts are raised as appropriate
- to ensure that appropriate information is provided in accordance with local policy guidance and timeframes.

The primary responsibility for co-ordinating information in response to a Safeguarding Adult concern is vested in the local authority managing officer, but the investigation/assessment may be undertaken by another organisation (e.g. the police or a health trust). All managers in all organisations have a key role to play.

All managers should ensure that they:

- make staff aware of their duty to report any allegations or suspicions of abuse to their line manager, or if the line manager is implicated, to another responsible person or to the local authority, and the procedure for doing so
- meet their legal responsibilities, particularly under the HSCA 2008 and the Care Standards Act (CSA) 2000, and ensure compliance with registration, outcomes and guidance on compliance, quality, safeguarding and safety standards
- operate safe recruitment practices and routinely take up and check references
- adhere to and operate within their own organisation's 'whistleblowing' policy and support staff who raise concerns
- ensure all staff receive training in safeguarding adults consistent with their job roles and responsibilities.

Managers of regulated activity providers must fulfil their legal obligations under the Safeguarding Vulnerable Groups Act (SVGA) 2006 and the Vetting and Barring Scheme as administered by the Independent Safeguarding Authority (ISA). Managers have a

responsibility for making checks on and referring staff and volunteers who have been found to have harmed an adult at risk or put an adult at risk at risk of harm.

Managers in health settings should report concerns as a 'serious incident requiring investigation' (SIRI), in line with clinical governance procedures, and a decision must be made whether the circumstances meet the criteria for referral to the Safeguarding Adults process in line with the multi-agency safeguarding policy and procedures.

Managing officers should also be aware of their responsibility to consider a case for an SCR if an adult at risk of harm has:

- died (including suicide) and abuse or neglect is known or suspected to be a factor
- sustained a serious or life-threatening injury or permanent impairment and abuse or neglect is known or suspected to be a factor
- there is in addition cause for concern about the way in which organisations and professionals involved in the case have worked together to safeguard and promote the welfare of the adult at risk.

See local procedure/guidance re Serious Case Reviews.

4.8 Local authorities

4.8.1 Safeguarding Adults Boards

SABs are multi-agency boards established in each local authority to promote, inform and support Safeguarding Adults work. They ensure that priority is given to the prevention of abuse and that adult safeguarding is integrated into other community initiatives and services.

A local SAB may be chaired by a director of adult social services, an assistant director, a senior elected member or, where partner agencies have agreed, by an independent chair. SAB members from partner organisations should have a lead role in their organisation with regard to Safeguarding Adults and be of sufficient seniority that they can represent their organisation with authority, make multi-agency agreements and take issues back for action.

See local guidance.

4.8.2 Lead co-ordinating agency

Local authorities have the lead role in co-ordinating the multi-agency approach to safeguard adults at risk. This includes the co-ordination of the application of this policy and procedures, co-ordination of activity between organisations, review of practice, facilitation of joint training, dissemination of information and monitoring and review of progress within the local authority area.

In addition to this strategic co-ordinating role, the local authority adult social care department, joint health and social care teams and mental health teams also have responsibility for co-ordinating the action taken by organisations in response to concerns that an adult at risk is being, or is at risk of being, abused or neglected.

The local authority should:

- ensure that any Safeguarding Adults concern is acted on in line with this policy and procedure
- coordinate the actions that relevant organisations take in accordance with their own duties and responsibilities. This does not mean that local authorities undertake *all* activities under Safeguarding Adults – relevant organisations have their own roles and responsibilities
- ensure a continued focus on the adult at risk and due consideration to other adults or children
- ensure that key decisions are made to an agreed timescale
- ensure that an interim and a final protection plan are put in place with adequate arrangements for review and monitoring
- ensure that actions leading from investigation/assessment are proportionate to the level of risk and enable the adult at risk to be in control, unless there are clear recorded reasons why this should not be the case
- ensure independent scrutiny of circumstances leading to the concern and to Safeguarding Adults work
- facilitate learning lessons from practice and communicating these to partners.

4.8.3 Lead councillor for Safeguarding Adults

The lead councillor for Safeguarding Adults has a responsibility to make sure that the director of adult social services and the SAB are effectively discharging their responsibilities in relation to adults at risk.

4.8.4 Director of adult social services

The director of adult social services has specific responsibilities under statutory guidance issued by the Department of Health (DH). Within adult social services, the director has a responsibility to:

- maintain a clear organisational and operational focus on Safeguarding Adults
- make sure relevant statutory requirements and other national standards are met
- make sure Independent ISA standards are met.

The director is also responsible for either chairing, or ensuring the effective chairing of, a local SAB.

4.8.5 Safeguarding Adults co-ordinator/leads

In each local authority there will be one or more lead for Safeguarding Adults. The roles of these leads may include responsibility for ensuring the effective functioning of the local SAB and/or safeguarding adults systems across the local authority. They may also advise in complex cases.

4.8.6 Managing officers

'Managing officers' (there will be local name variations – see local guidance)

have a lead co-ordinating role in relation to individual cases. A managing officer must be informed of any safeguarding concern arising in any organisation and has overall responsibility for co-ordinating the Safeguarding Adults process.

The managing officer has overall responsibility to ensure that:

- the action being taken by organisations is co-ordinated and monitored
- the adult at risk is involved in all decisions that affect their daily life as far as possible
- those who need to know are kept informed
- a decision is made in consultation with other relevant organisations to instigate the Safeguarding Adults process
- a multi-agency strategy meeting or discussion is held to determine how the Safeguarding Adults process will be conducted and who will conduct any investigation, and that decisions are recorded and copied to relevant organisations
- the response of the organisations involved in the Safeguarding Adults process is co-ordinated: the aim is to agree that where indicated a joint investigation will take place with agreement to share information in line with the information-sharing protocol
- if required a multi-agency case conference is convened and chaired, a record made of the decisions taken and this information circulated to all relevant organisations
- if required a protection plan is agreed with the adult at risk if they have mental capacity to participate in this, or in the best interests of the person if they have been assessed not to have mental capacity
- all safeguarding documentation is completed including monitoring information.

4.8.7 Out of hours services and emergency duty teams

Local out of hours teams (social services and health) and emergency duty teams operate out of normal working hours, at weekends and over statutory holidays.

If an alert is made to the out of hours service which indicates an immediate or urgent risk, the officer receiving the alert will take any steps necessary to protect the adult at risk including arranging emergency medical treatment, contacting the police and taking

any other action to ensure that the adult at risk is safe. Out of hours staff must also be aware that, if responding to an emergency, other adults may also be at risk.

A member of the out of hours service would not be responsible for a Safeguarding Adults investigation but it may be necessary to interview the alleged victim where:

- the allegation is serious – that is, life-threatening or likely to result in serious injury (in which case action would be co-ordinated with the police to ensure any evidence is preserved)
- the alert is unclear
- there is a need to interview the adult at risk to ensure they can be safeguarded against further abuse if necessary (if appropriate this would need to be co-ordinated with the police to ensure the preservation of evidence).

Whether or not any immediate action is necessary the out of hours worker or emergency duty officer will record the facts concerning the alleged abuse or neglect and pass all relevant information to the appropriate duty team in adult social care or to a mental health team on the next working day. If the case is already allocated the out of hours worker will notify the allocated worker.

In a situation where staff who work for other organisations, including health services and those who work out of hours, become aware that an adult at risk is being abused or neglected, they should call the emergency services if the adult is at serious risk of immediate harm, and the local authority emergency duty team or emergency out of hours service if an immediate protection plan needs to be put in place. If this action has been taken, the emergency duty team or out of hours service will then deal with the alert as above.

If the situation does not indicate an immediate risk of harm, staff working out of hours will refer to the appropriate local authority referral point on the next working day. They will also refer to the appropriate point in their own organisation.

4.8.8 Complaints officers

Local authorities have statutory complaints procedures. If a complaint received by a complaints officer could indicate that an adult is at risk, the officer will bring this to the attention of the relevant Safeguarding Adults lead or other manager.

If a complaint is made to the local authority that leads to a Safeguarding Adults investigation/assessment, the local authority can decide not to commence the complaints investigation if this would compromise the investigation/assessment. The complainant would be informed of this course of action and the reason for it.

See local Complaints procedures/guidance

4.9 Police

Every member of the community deserves protection from exploitation and abuse by those entrusted with their care and the people they should be able to rely on to keep them safe. The police should take any crime against an adult at risk seriously, and will investigate it thoroughly, professionally and empathetically. The police work very closely with partner agencies to ensure effective information sharing, risk assessment and decision-making takes place every time an incident of abuse is reported.

- The police will hold people causing abuse accountable for their actions. Where criminal proceedings are deemed inappropriate the police will work closely with partners to identify the most suitable course of action.
- The police will work in effective partnership with other agencies to safeguard adults at risk.
- Where a criminal offence appears to have been committed, the police will be the lead investigating agency and will direct investigations in line with legal and other procedural protocols. A police investigation will be initiated at the outset and a comprehensive initial risk assessment undertaken.
- It is the responsibility of the police to secure and preserve evidence. The police will interview the alleged victim, the alleged person causing harm and any witnesses. Where the police are the lead investigating agency they will work closely with the local authority and other partner agencies in line with the Safeguarding Adults policy and procedures to ensure that the identified risks are acted on and a risk management or protection plan is agreed at an early stage.
- There are now special measures that can be put into place to help vulnerable people through the court process. These measures have allowed many people who may once have been denied access to the criminal justice system the opportunity to give their evidence in court. The police will discuss these special measures with victims at the earliest stage possible in the investigation.

Some adults at risk can be abused by strangers and the role of the police is to work in partnership with key agencies where a potential crime has been committed and on the development of a protection plan.

See local police force safeguarding procedures.

4.10 NHS-funded services

The National Health Service (NHS) has a commitment and a duty to safeguard adults at risk. This duty is to be found in regulation 11 of SI 2010/781, *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010*. The duty is defined in Outcome 7 of the *Essential standards of quality and safety*,[12] published by the Care Quality Commission which underpins the HSCA 2008.

In order to achieve this, health organisations need to:

- ensure that robust systems and policies are in place and are followed consistently
- provide training and supervision to enable staff to recognise and report incidents of adult abuse
- provide expert advice
- reduce the risks to adults at risk.

NHS providers must work collaboratively with other statutory, voluntary and charitable organisations to ensure the safety and wellbeing of any person deemed to be vulnerable. The primary aim is to prevent abuse where possible but, if this fails, robust procedures must be in place for the effective management and investigation of incidents of abuse.

The DH has published four guidance documents concerning the statutory duties relating to safeguard adults:

- *Safeguarding adults: the role of NHS commissioners*[13]
- *Safeguarding adults: the role of health service managers and their boards*[14]
- *Safeguarding adults: the role of health service practitioners*[15]
- *Safeguarding adults: measuring effectiveness through assurance.*[16]

Health commissioners (currently PCTs) must ensure that adult safeguarding standards are included in all commissioning arrangements and are reflected in organisational change to meet the needs of people who live in their local health area. *Liberating the NHS*[17] states that GP clinical commissioning groups have a duty to promote equalities and work in SABs with local authorities in relation to health and social care, early years, public health, safeguarding and the wellbeing of the local population.

The provision of high quality, safe services continues to be a key priority for the NHS and remains an organising principle for current NHS reform. The NHS has a duty of care to protect adults at risk from neglect and abuse and to provide appropriate health care in a timely, effective and appropriate manner. Government reform maintains that health providers will be held to account by patients, the public, their commissioners and regulators. Managers of health services and their boards play an essential role in safeguarding patients in the most vulnerable situations.[14]

Safeguarding must be integrated with NHS clinical governance arrangements, with greater openness and transparency about clinical incidents, both in terms of clear reporting, shared learning and improved SAB working. Non-executive directors and lay members of trusts also have a vital role to play in promoting the safeguarding agenda. They have the opportunity to provide independent scrutiny and hold services to account.

Six basic measures will help managers and their health boards comply with legislation and achieve good outcomes at a local level:

1. Use the safeguarding principles to shape strategic and operational safeguarding arrangements.
2. Set Safeguarding Adults within the service's strategic objectives.
3. Use integrated governance systems and processes to prevent abuse occurring and respond effectively where harm does occur.
4. Work with the local SAB, patients and community partners to create safeguards for patients.
5. Provide leadership to safeguard adults.
6. Ensure accountability and use learning within the service and the SAB to bring about improvement.

Health care staff often work with patients who, for a range of reasons, may find it difficult to protect themselves from neglect, harm or abuse, and all staff have a duty towards such people. These duties stem from a common law duty of care and from professional codes of practice. In addition, their employers have an explicit duty under the Regulated Activity Regulations A number of guidelines have been developed with the aim of assisting managers/practitioners in this role:[15]

- ensure staff and volunteers recognise poor practice and respond appropriately
- work with clear operational procedures for all staff and volunteers
- access relevant training appropriate to level of responsibility
- ensure attendance at clinical and managerial supervision which allows staff to reflect on their practice and the impact of their actions on others
- ensure appropriate clinical risk assessments are undertaken to support timely and appropriate action
- work collaboratively with service users and carers, support witnesses and people causing harm who are also adults at risk
- ensure information is shared according to agreed information sharing protocols
- ensure accessible information is available to adults and carers that explains what abuse is and how they can raise a concern
- ensure an alert is raised to a Safeguarding Adults contact point, in line with these procedures should staff suspect or know of abuse
- where appropriate play an active role in strategy discussions or meetings, case conferences and protection planning
- designate a manager at a senior level to lead on the implementation, monitoring and development of Safeguarding Adults activities within the organisation.

It is essential for health care organisations to have systems and processes in place in order to review and benchmark their Safeguarding Adults arrangements and to provide assurance and accountability for the organisation and its commissioners, partners and patients.[16] Safeguarding Adults activity in health care should not be measured in isolation, and it is fundamental that assurance processes support multi-agency Safeguarding Adults objectives. The assurance framework and outcomes tools

developed in local organisations should draw on existing standards and inspection frameworks. Services must be accountable to patients for the quality of care, shared decision-making should become the norm and patient safety must always be put above all else.

4.10.1 General practitioners

GPs have a significant role in Safeguarding Adults. This includes:

- raising an alert to a Safeguarding Adults contact should they suspect or know of abuse, in line with these procedures
- playing an active role in strategy discussions or meetings, case conferences and protection planning.

GP consortia should make sure that effective training and reporting systems are in place to support GPs and GP practices in this work.[18]

4.10.2 Strategic health authorities

The role of the SHA has been suggested by the DH as:

- providing executive leadership with responsibility for the overall monitoring of Safeguarding Adults best practice. The executive lead will also develop other leadership roles at different levels within the SHA as part of their portfolio
- supporting the development of adult safeguarding within the region with a focus on promoting and embedding joint working processes and influencing PCT plans to include Safeguarding Adults
- developing and rolling out a performance framework to measure the effectiveness of local systems
- setting up local health networks which will provide support and advice, deliver key messages, enhance communication within the region and promote the implementation of new policy and guidance. The SHA will also ensure that actions resulting from serious incidents requiring investigation/ serious untoward incidents are fully implemented across the region and that relevant lessons are learned
- assuring safeguarding systems are in place across providers/commissioners and working collaboratively with deputy regional directors to ensure that all opportunities are taken to share best practice across the local health system.

4.10.3 Patient advice, liaison and complaints

Patient Advice and Liaison Services (PALS), along with complaints departments provided by acute, specialist and community NHS health trusts, have been established to provide confidential advice and support to patients, families and carers, including confidential assistance in resolving problems and concerns. PALS acts as a focal point for feedback from patients to inform service developments and as such can act as an early warning system.

PALS staff should be in a position to recognise that a concern raised by a patient, carer or friend could indicate that a person is at risk of abuse or neglect. They are then able to raise this concern within their own health organisation in line with its safeguarding/complaints policy. This policy will in turn ensure that appropriate action is taken.

4.10.4 Local Involvement Networks and Healthwatch

Service users often feel they do not have a strong enough voice to change aspects of their health or social care. Local Involvement Networks (LINks) are part of a wider process to help people have a stronger local voice. The role of LINks is to:

- ask local people what they think about health care services and provide an opportunity to suggest ideas for improvement
- investigate specific issues of concern to the community
- hold services to account and get results
- ask for information and receive an answer in a specified amount of time
- carry out spot-checks to assess whether services are working well
- make reports and recommendations and receive a response
- refer issues to the local Overview and Scrutiny Committee (OSC).

Overseen by the Care Quality Commission (CQC), Healthwatch will be the new 'consumer champion', operating at both local and national levels, and will replace LINks. in accordance with The Health and Social Care Act 2012

4.10.5 West Midlands Ambulance Service

There are a number of ways in which ambulance staff may receive information or make observations which suggest that an adult at risk has been abused or is at risk of harm. Ambulance staff will often be the first professionals on the scene and their actions and recording of information may be crucial to subsequent enquiries.

Ambulance staff will not investigate suspicions and, if there is someone else present, will not reveal their concerns. If the patient is conveyed to hospital, ambulance staff will inform a senior member of the accident & emergency (A&E) team (or of the nursing staff if the patient is taken to another department) of their concerns about possible abuse. They will complete a patient report form and give a copy to hospital staff. Ambulance staff should also follow local procedures for contacting the local authority.

4.11 Fire Service

Fire Service personnel visit people in their homes when carrying out home fire safety visits. In cases where they have a concern about an adult at risk they will inform their line manager who will then take appropriate action, which may involve referral to another agency.

The Fire Service has officers who are trained to recognise and report concerns that an adult may be at risk of harm, in line with the local Safeguarding Adults procedure.

See local fire services.

4.12 Care Quality Commission

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

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

- one or more registered people are directly implicated
- urgent or complex regulatory action is indicated
- a form of enforcement action has been commenced or is under consideration in relation to the service involved.[19]

4.13 Court of Protection

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

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

4.14 Housing

4.14.1 The Supporting People Programme

Housing organisation staff are in a position to identify tenants who are vulnerable and at risk of abuse, neglect and exploitation. The Supporting People Programme is run by the government and is involved in funding, planning and monitoring housing-related support services for adults with a wide range of needs. The quality of the service is regulated by the Quality Assessment Framework (QAF), which includes standards relating to safeguarding adults from abuse.

4.14.2 Local authority housing services

Local authority housing services are responsible under homeless legislation to assist people who are:

- homeless – people who are currently homeless
- priority – people who are in accommodation but have a priority need for council accommodation
- eligible- people who are not a priority but nevertheless eligible

There is a duty on housing authorities to ensure that advice and information about homelessness, and preventing homelessness, is available to everyone in their district free of charge. Authorities are also required to assist individuals and families who are homeless or threatened with homelessness and who apply for help. Authorities should not wait until homelessness is likely or is imminent before providing advice and assistance. There is an emphasis on the need for joint working between housing authorities, social services and other statutory, voluntary and private sector partners in tackling homelessness more effectively to safeguard adults.

4.15 Crown Prosecution Service

The Crown Prosecution Service (CPS) is the principal public prosecuting authority for England and Wales and is headed by the Director of Public Prosecutions. The CPS has produced a policy on prosecuting crimes against older people which is equally applicable to adults at risk, who may also be vulnerable witnesses.

Support is available within the judicial system for those at risk to enable them to bring cases to court and to give the best evidence. If a person has been the victim of abuse that is also a crime, their support needs can be identified by the police, the CPS and others who have contact with the adult at risk. Witness Care Units exist in all judicial areas and are run jointly by the CPS and the police.

The CPS has a key role to play in making sure that special measures are put in place to support vulnerable or intimidated witnesses. Special measures were introduced by the Youth Justice and Criminal Evidence Act (YJCEA) 1999 and are available in both Crown and the magistrates' courts. They include the use of screens, trained intermediaries to help with communication and arrangements for evidence and cross-examination to be given by video link.

4.16 The coroner

Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths, sudden deaths of unknown cause and deaths in custody, which must be reported to them. The coroner may have specific questions arising from the death of an adult at risk. These are likely to fall within one of the following categories:

- where there is an obvious and serious failing by one or more organisations
- where there are no obvious failings, but the actions taken by organisations require further exploration/explanation
- where a death has occurred and there are concerns for others in the same household or other setting (such as a care home)
- where a death falls outside the requirement to hold an inquest but follow-up enquiries/actions are identified by the coroner or his or her officers

In the above situations the local SAB should give serious consideration to instigating an SCR where an adult at risk is involved, and the review procedure should be agreed with the coroner.

4.17 The Probation Service

The Probation Service protects the public by working with offenders to reduce reoffending and harm. It works jointly with other public and voluntary services to identify, assess and manage the risk in the community of offenders who have the potential to do harm. Probation officers use the Offender Assessment System (OASys) to assess risk and identify factors that have contributed to offending. The Probation Service also has a remit to be involved with victims of serious sexual and other violent crimes.

The Probation Service shares information and works with SABs from other agencies including local authorities and health services, and contributes to local MAPPA procedures to help reduce the reoffending behaviour of sexual and violent offenders, so as to protect the public and previous victims from serious harm.

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

4.18 Commissioning

Commissioners of services should set out clear expectations for provider agencies and monitor compliance. Commissioners have a responsibility to:

- ensure that people who commission their own care are given the right information and support to do so from providers who engage with Safeguarding Adults principles and protocols
- ensure that agencies from whom services are commissioned know about and adhere to relevant registration requirements and guidance
- ensure that all documents such as service specifications, invitations to tender, service contracts and service-level agreements adhere to the multi-agency Safeguarding Adults policy and procedures
- ensure that managers are clear about their leadership role in Safeguarding Adults in ensuring the quality of the service, the supervision and support of staff, and responding to and investigating a concern about an adult at risk
- commission a workforce with the right skills to understand and implement Safeguarding Adults principles
- ensure staff have received induction and training appropriate to their levels of responsibility
- liaise with the local SAB and regulatory bodies and make regular assessments of the ability of service providers to effectively safeguard service users

- ensure that services routinely provide service users with information in an accessible form about how to make a complaint and how complaints will be dealt with
- ensure that commissioners (and regulators) regularly audit reports of risk of harm and require providers to address any issues identified.

4.19 Supporting processes

4.19.1 Information sharing

Local information sharing protocols for Safeguarding Adults exist for all statutory partner organisations. These protocols recognise that information sharing between organisations is essential to safeguard adults at risk of abuse, neglect and exploitation.

Decisions about what information is shared and with whom will be taken on a case-by-case basis. Whether or not information is shared with or without the adult at risk's consent, the information should be:

- necessary for the purpose for which it is being shared
- shared only with those who have a need for it
- be accurate and up to date
- be shared in a timely fashion
- be shared accurately
- be shared securely.

See local Information sharing protocols

4.19.2 Risk assessment and management

The assessment of the risk of abuse, neglect and exploitation of people using services should be integral in all assessment and planning processes, including assessments for self-directed support and the setting up of PB arrangements. Assessment of risk is dynamic and ongoing, especially during the Safeguarding Adults process, and should be reviewed throughout so that adjustments can be made in response to changes in the levels and nature of risk. The primary aim of a Safeguarding Adults risk assessment is to establish:

- current risks that people face
- potential risks that they and other adults may face.

See local procedures/guidance for additional information

4.19.3 Complaints

Complaints received from any source about Safeguarding Adults practice or arising from the Safeguarding Adults process should be handled by the relevant complaints procedures of the organisation about which the complaint has been made.

See local Complaints procedures for additional information.

4.19.4 Whistleblowing

The PIDA 1998 provides a framework for whistleblowing across the private, public and voluntary sectors. Each member organisation of the SAB will have its own whistleblowing policy. These policies should provide people in the workplace with protection from victimisation when genuine concerns have been raised about malpractice. The aim is to reassure workers that it is safe for them to raise concerns, and partner organisations should establish proper procedures for dealing with such concerns.

See local procedure/guidance for additional information.

4.19.5 Cross-boundary and inter-authority investigations

Risks may be increased by complicated cross-boundary arrangements, and it would be dangerous and unproductive for local authorities to argue over whose responsibility it is to investigate cross-boundary safeguarding incidents.

Clarity is crucial to assist effective processes and this section builds on the protocol previously established by ADASS to provide the West Midlands procedure for investigations across local authority boundaries.

The 'placing local authority' continues to hold responsibility for commissioning and funding a placement. However, many people at risk live in residential settings outside their own placing area. In addition, a safeguarding incident might occur during a short-term health or social care stay, or on a trip, requiring police action in that area or immediate steps to protect the person while they are in that area.

The initial lead in response to a safeguarding alert should *always* be taken by the local authority *where the incident occurred*. This is known as the 'host local authority'. This might include taking immediate action to ensure the safety of the person, or arranging an early discussion with the police when a criminal offence is suspected.

The host local authority will:

- receive the alert
- gather initial information
- take immediate steps to protect the individual
- notify the placing local authority and gather information from that authority
- involve the placing local authority's nominated link person in the decision-making processes
- coordinate the investigation of any incident where care arrangements exist across boundaries.

The placing local authority continues to have responsibilities to the person who is the subject of the alert, and will take action as needed by:

- negotiating the safeguarding arrangements that are included in any provider's service specifications and monitoring these

- reacting promptly when there is an alert, following these procedures and the procedures of the host local authority
- nominating a 'link person' to liaise between the two local authorities
- providing information and other assistance to support the host authority's investigation
- providing support for adults for whom they have responsibility towards and who are identified as at risk or harmed, whether perpetrators or victims
- meeting any care needs that are identified by the investigation and are within its responsibility.

In terms of renegotiation, dispute resolution and uncertainty between two local authorities, the 'default' position is described in the paragraphs above. However, the responsibility for the investigation of an alert could be negotiated, with authorities agreeing alternative arrangements when these are in the best interests of the vulnerable adult, or when it is more appropriate and practical to do this. For example, during a short stay outside the 'host' or 'placing' area.

4.19.5.1 Residents in an acute hospital setting

When hospitals provide clinical care to residents from a wide surrounding area, there may be negotiation about which local authority should take responsibility for investigating alerts that come to light in the hospital but which actually occurred in the placing authority's area. In cases of dispute, the default position must apply.

4.19.5.2 Section 117

Special rules apply to adults at risk who are also subject to Section 117 (After Care) of the MHA 1983. Case law has established that the duty falls in the first place on the authority for the area in which the patient was resident *before* being detained in hospital, *even if* the patient does not return to that area on discharge. If (but only if) no such residence can be established, the duty will fall on the authority for the area where the patient is to reside on discharge from hospital.

4.19.5.3 Risk resulting from disputes over responsibility

Increased risk may result from intractable disputes over responsibility. All responses must still take place within the timescales of these procedures, using the default position if necessary. In such cases staff must alert their SAB so that discussions can take place.

5 Procedure

5.1 Introduction

The Safeguarding Adults multi-agency procedure for the West Midlands is the result of a collaboration between the following local authorities: Birmingham, Coventry, Dudley, Herefordshire, Sandwell, Shropshire, Solihull, Telford and Wrekin, Walsall, Warwickshire, Worcestershire and Wolverhampton.

This procedure is governed by a set of key principles and themes, so as to ensure that people who are subject to abuse, neglect and exploitation experience the process in such a way that it is sensitive to individual circumstances, is person-centred and is outcome-focused. It is vital for successful safeguarding that the procedures in this section are understood and applied consistently by all organisations.

Although the responsibility for the co-ordination of Safeguarding Adults arrangements lies with local authorities, the implementation of these procedures is a collaborative responsibility and effective work must be based on a multi-agency approach.

The key principles which govern this procedure are set out in the May 2011 DH statement of policy on Safeguarding Adults:[20]

- *empowerment:* presumption of person-led decisions and informed consent; consulting the person about their desired outcome throughout the safeguarding process
- *protection:* ensuring that people are safe and that they have support and representation as necessary during the process
- *prevention:* minimising the likelihood of repeated abuse and recognising the person's contribution to this in safeguarding plans
- *proportionality:* the ways in which the safeguarding procedure is used are proportionate, as unintrusive as possible and appropriate to the risk presented
- *partnership:* people can be satisfied that agencies are working constructively to make them safe
- *accountability:* the way in which the safeguarding process is conducted should be transparent and consistent; it should always be borne in mind that safeguarding procedures may be subject to external scrutiny (e.g. the courts).

The procedures are a *framework*. Safeguarding Adults is a dynamic process that must be undertaken *with* people and not *to* people. The following key themes run throughout the Safeguarding Adults process:

- *User outcomes:* at the beginning and at every stage of the process what the individual wants to achieve must be identified and revisited. To what extent these wants/wishes have been met must be reviewed at the end of the safeguarding process regardless of at what stage it is concluded.

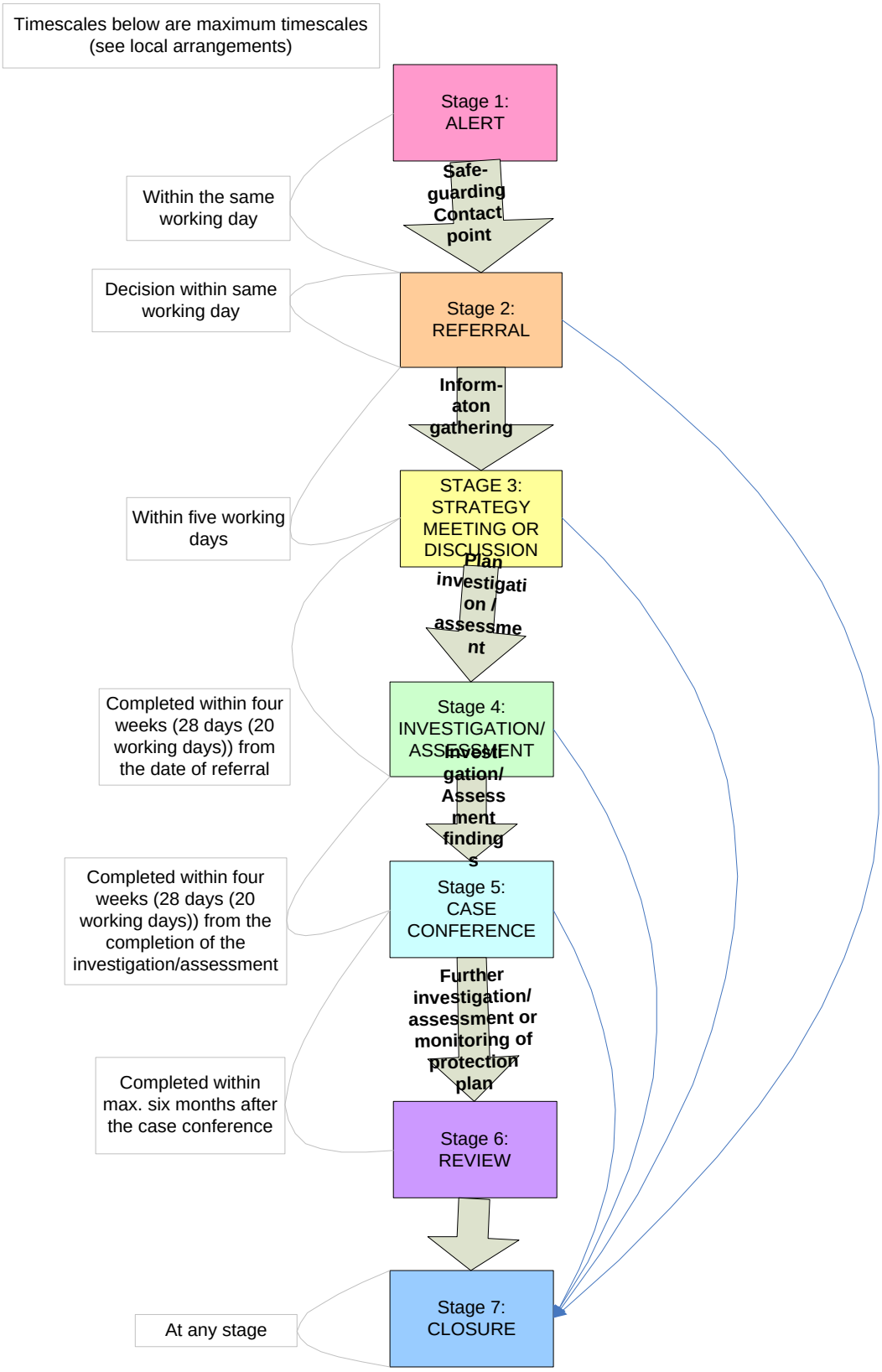
- *Risk assessment and management:* these are central to the Safeguarding Adults process. Assessments of risk should be carried out with the individual at each stage of the process so that adjustments can be made in response to changes in the levels and nature of risk. Risks to others must also be considered.
- *Mental capacity:* the MCA 2005 requires an assumption that an adult (aged 16 or over) has full legal capacity to make decisions unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made. Individuals must be given all appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision-making process. Unwise decisions do not necessarily indicate lack of capacity. Any decision made, or action taken, on behalf of someone who lacks the capacity to make the decision or act for themselves must be made in their best interests. It is important that an individual's mental capacity is considered at each stage of the Safeguarding Adults process.
- *Protection* planning*:* in response to identified risks a protection plan can be developed and implemented at any time in the Safeguarding Adults process. The multi-agency plan aims to:
  - prevent further abuse or neglect
  - keep the risk of abuse or neglect at a level that is acceptable to the person being abused or neglected and the agencies supporting them
  - support the individual to continue in the risky situation if that is their choice and they have the capacity to make that decision.

  Protection planning also involves supporting anyone who has been abused or neglected to recover from that experience.
- *Information sharing:* this is key to delivering better and more efficient services that are co-ordinated around the needs of the individual. It is essential to enable early intervention and preventative work, for safeguarding, for promoting welfare and for wider public protection. Information sharing is a vital element in improving outcomes for all. Nevertheless, It is important to understand that most people want to be confident that their personal information is kept safe and secure and that practitioners maintain their privacy, while sharing appropriate information to deliver better services.
- *Recording:* good record-keeping is an essential part of the accountability of organisations to those who use their services. Maintaining proper records is vital to individuals' care and safety. If records are inaccurate, future decisions may be wrong and harm may be caused to the individual. Where an allegation of abuse is made all agencies have a responsibility to keep clear and accurate records. It is fundamental to ensure that evidence is protected and to show what action has been taken and what decisions have been made and why.

- *Feedback:* at each stage of the Safeguarding Adults process it is important to ensure feedback is given to the adult at risk, alerters and partners. Alerters are entitled to be given appropriate information regarding the status of the alert they have made. The extent of this feedback will depend on various things (e.g. the relationship they have with the victim, confidentiality issues and the risk of compromising an investigation). At the very least it should be possible to advise alerters whether their alert has led to an investigation. Partners in provider organisations require feedback to allow them to continue to provide appropriate support and make staffing decisions.
- *Closing:* the Safeguarding Adults process may be closed at any stage if it is agreed that an ongoing investigation is not needed or if the investigation has been completed and a protection plan agreed and put in place, or protection plan is no longer required.

Finally, it is equally important that these procedures are managed and administered in such a way as to comply with all the articles of the Human Rights Act (HRA) 1998 (in particular Articles 5 and 8). What this means is that both the process and the outcome must be the least restrictive, proportionate and enable risk where appropriate. In addition, any actions falling under these procedures should be consistent with current legislation as it relates to social care, health, housing and education.

Safeguarding Adults Process

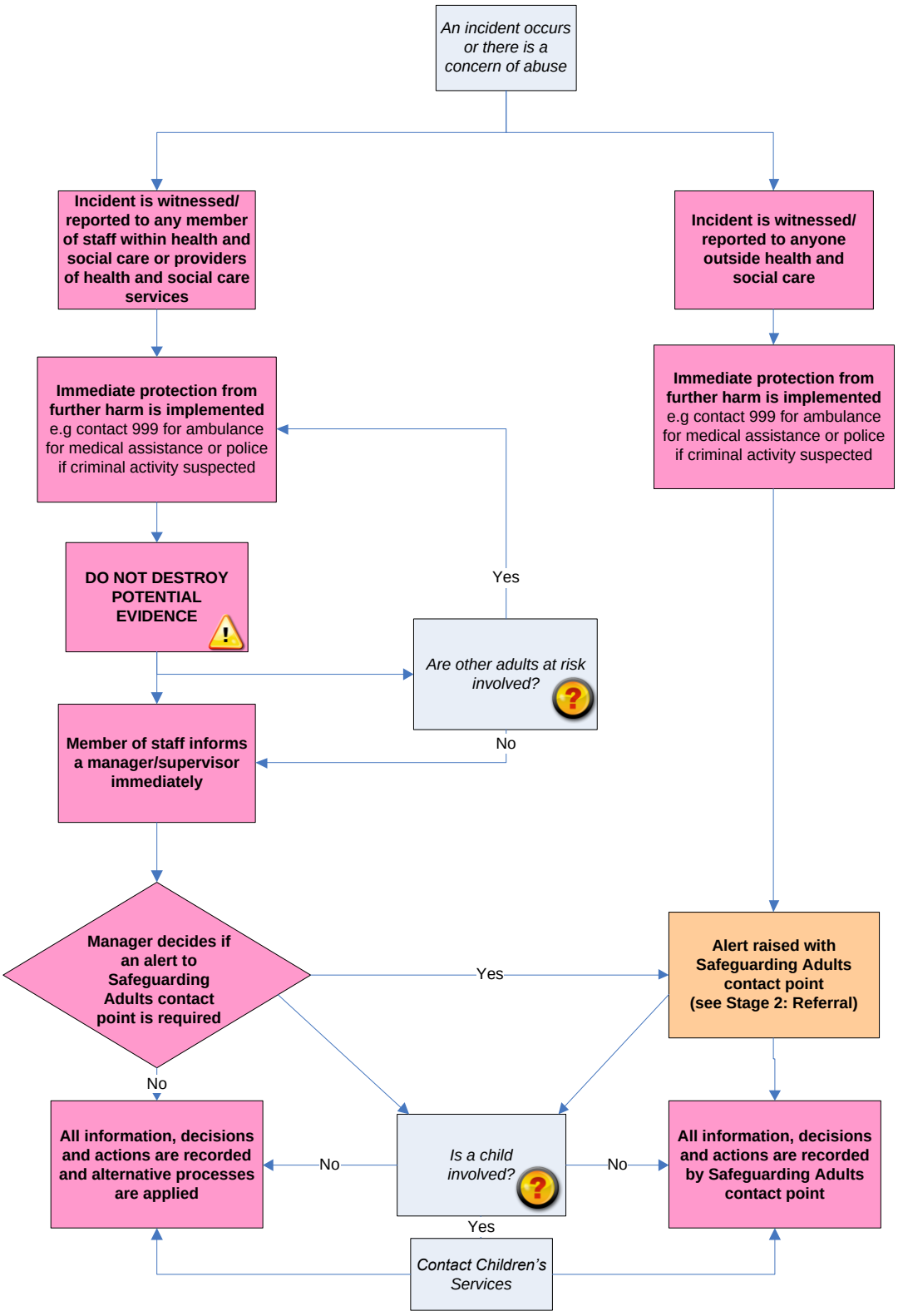


5.2 Stage 1: Raising an alert

See below.

Stage 1: Alert

Within the same working day



5.2.1 Definition of an alert

An alert is a report made to the lead agency for the safeguarding process to raise concerns that an adult at risk may have been, is, or might be, abused. An alert may arise as a result of a disclosure, an incident, or other signs or indicators.

5.2.2 Purpose of an alert

The purpose of an alert is to bring the concern to the attention of the lead agency for the safeguarding process.

An alert should be made when there is concern that:

- an adult is at risk of harm and
- is being abused and
- risks significant harm.

5.2.3 Roles and responsibilities

An alert can be raised by anyone including the person at risk, family, friends, professionals and other members of the public.

Any individual can respond to a concern raised about an adult at risk. This can include making an alert and seeking support to protect individuals from harm (e.g. by contacting the police).

5.2.4 Timescales

- Immediate action may be required to safeguard the adult at risk, when they request this or when they cannot safeguard themselves.
- Alerts must be notified to the lead agency for safeguarding within the same working day.

The following guidance is primarily intended for people working (paid and/or unpaid) with adults at risk of harm, but anyone may use it as guidance to protect individuals from harm.

5.2.5 Process

5.2.5.1 Acting to protect the adult at risk and deal with immediate needs

- Make an immediate evaluation of the risk and take steps to ensure that the adult at risk is in no immediate danger. Consider whether a protection plan is required. Are there any other adults at risk who need safeguarding? Evaluate the risk to them and the need for a protection plan.
  Where appropriate, dial 999 for an ambulance if there is need for emergency medical treatment.
- Consider supporting and encouraging the adult at risk to contact the police if a crime has been or may have been committed.
- Do not disturb or move articles that could be used in evidence, and secure the scene (e.g. by locking the door to a room).

- Contact the children and families department if a child is also at risk.
- If possible, make sure that other service users are not at risk.

5.2.5.2 Responding to an adult at risk who is making a disclosure

- Assure them that you are taking them seriously.
- Listen carefully to what they are telling you, stay calm, get as clear a picture as you can, but avoid asking too many questions at this stage.
- Do not give promises of complete confidentiality.
- Explain that you have a duty to tell your manager or other designated person, and that the adult at risk's concerns may be shared with others who could have a part to play in protecting them.
- Reassure them that they will be involved in decisions about what will happen.
- Explain that you will try to take steps to protect them from further abuse or neglect.
- If they have specific communication needs, provide support and information in a way that is most appropriate to them.
- Do not be judgemental or jump to conclusions.

5.2.5.3 Reporting to line manager

- If you are concerned that a member of staff has abused an adult at risk, you have a duty to report these concerns. You *must* inform your line manager immediately.
- If you are concerned that your line manager has abused an adult at risk, you must inform a senior manager in your organisation, or another designated manager for Safeguarding Adults.
- If you are concerned that an adult at risk may have abused another adult at risk, inform your line manager.

5.2.5.4 Taking immediate management action to identify and address the risk

- An alerting manager is the person within an organisation, care or support setting designated to receive alerts and to make Safeguarding Adult referrals. Once the concern has been raised with the alerting manager, they must decide without delay on the most appropriate course of action.
- Organisations should ensure that they have procedures in place to cover the role of the person who is the alerting manager when they are unavailable, on leave or where services operate extended or 24-hour cover.
- Health staff will need to refer to their trust's procedures on clinical governance and Safeguarding Adults as well as the Safeguarding Adults policy and procedures.

5.2.5.6 Supporting immediate needs

In line with information sharing considerations, the alerting manager may need to take the following action.

- Make an immediate evaluation of the risk to the adult at risk.
- Take reasonable and practical steps to safeguard the adult at risk as appropriate.
- Consider referring to the police if the suspected abuse is a crime.
- If the matter is to be referred to the police, discuss risk management and any potential forensic considerations with the police.
- Arrange any necessary emergency medical treatment. Note that offences of a sexual nature will require expert advice from the police.
- If there is a need for an immediate protection plan, refer to the relevant adult social care services or mental health team, or the relevant adult care services emergency duty team if out of hours.
- If the person alleged to have caused the harm is also an adult at risk, arrange for a member of staff to attend to their needs.
- Make sure that other people are not at risk.
- Take action in line with the organisation's disciplinary procedures, as appropriate, if a member of staff is alleged to have caused harm.

5.2.5.7 Speaking to the adult at risk

It may be appropriate for the alerting manager to speak to the adult at risk. In doing this, they should consider the following.

- Speaking to them in a private and safe place and informing them of any concerns. It is essential to ensure that the person alleged to have caused harm is not present.
- Getting their views on what has happened and what they want done about it.
- Giving them information about the Safeguarding Adults process and how that could help to make them safer.
- Explaining confidentiality issues, how they will be kept informed and how they will be supported.
- Identifying communication needs, personal care arrangements and access requests.
- Discussing what could be done to ensure their safety.

If it is felt that the adult at risk may not have the capacity to understand the relevant issues and to make a decision, it should be explained to them as far as possible, given the person's communication needs. They should also be given the opportunity to express their wishes and feelings.

It is important to establish whether the adult at risk has the capacity to make decisions. This may require the assistance of other professionals. In the event of the adult at risk not having capacity, relevant decisions and/or actions must be taken in the person's best interests. The appropriate decision-maker will depend on the decision to be made.

5.2.5.8 Considering the person alleged to have caused harm

The alerter should not discuss the concern with the person alleged to have caused harm, *unless* the immediate welfare of the adult at risk makes this unavoidable.

The manager should consider liaison with the police regarding the management of risks involved. However, if the person is a member of staff an immediate decision has to be made regarding appropriate formal action under disciplinary procedures, and the person has a right to know in broad terms what allegations or concerns have been raised about them.

If the person causing harm is another service user, action taken could include removing them from contact with the adult at risk. In this situation, arrangements must be put in place to ensure that the needs of the person causing harm are also met.

It is important to ensure that any staff or volunteer who has caused risk or harm is not in contact with service users and others who may be at risk (e.g. whistleblowers).

5.5.5.9 Alerting and sharing information with the local authority

If the alert is *raised* by a member of staff (or a volunteer), it will normally be *made* by their line manager or the designated Safeguarding Adults lead. However, *anyone* can make an alert and should do so in situations where, for example, discussion with a manager will involve delay in a high-risk situation or where the person has already raised concerns with their manager but no action has been taken.

As well as deciding whether or not to alert a Safeguarding Adults referral point, the alerting manager must also decide whether to follow other relevant organisational reporting procedures. For example, NHS colleagues may still need to report under clinical governance or serious incident processes. Where an alert indicates that a member of staff may have caused harm, referral to the organisation's disciplinary procedures should also be considered.

An alert must always be made when the person is an adult at risk and there is a concern that they are being, or are at risk of being, abused or neglected, or are at risk of, or have experienced, significant harm

5.2.5.10 Factors to consider

- Is there any doubt about the mental capacity of an adult at risk to make decisions about their own safety? Remember capacity can be undermined by the experience of abuse and where the person is being exploited, coerced, groomed or subjected to undue influence or duress.
- How vulnerable is the adult at risk? What personal, environmental and social factors contribute to this?

- What is the nature and extent of the abuse?
- Is the abuse a real or potential crime?
- How long has it been happening? Is it a one-off incident or a pattern of repeated actions?
- What impact is this having on the individual? What physical and/or psychological harm is being caused? What are the immediate and likely longer-term effects of the abuse on their independence and wellbeing?
- What impact is the abuse having on others?
- What is the risk of repeated or increasingly serious acts involving the person causing the harm?
- Is a child (under 18 years) at risk?

If in any doubt the alerting manager should make contact with the managing officer to discuss the situation.

5.2.5.11 Obtaining consent

The mental capacity of the adult at risk and their ability to give their informed consent to an alert being made and action being taken under these procedures is significant but not the only factor in deciding what action to take.

The test of capacity in this case is to find out if the adult at risk has the mental capacity to make informed decisions:

- about an alert
- about actions that may be taken under multi-agency policy and procedures
- about their own safety, including an understanding of the potential for longer-term harm as well as immediate effects and
- an ability to take action to protect themselves from future harm.

5.2.5.12 Alerting without consent

If there is an overriding public interest or vital interest, or if gaining consent would put the adult at further risk, an alert *must* be made. This includes situations where:

- other people or children could be at risk from the person causing harm
- it is necessary to prevent crime or if a serious crime may have been committed
- there is a high risk to the health and safety of the adult at risk
- the person lacks capacity to consent.

The adult at risk would normally be informed of the decision to alert and the reasons for this, unless telling them would jeopardise their safety or the safety of others.

If the adult at risk is assessed as not having mental capacity to make decisions about their own safety and to consent to an alert being made, the alerting manager must make a decision in their best interests in accordance with the provisions set out in the MCA 2005.

The key issue in deciding whether to make an alert is the harm or risk of harm to the adult at risk and any other adults who may have contact with the person causing harm or with the same organisation, service or care setting.

If the alerting manager is unsure whether to alert, they should contact the relevant Safeguarding Adults referral point for advice.

5.2.5.13 Evidence-gathering and victim care

The police will always be responsible for the gathering and preservation of evidence to pursue criminal allegations against people causing harm and should be contacted immediately. However, other organisations and individuals can play a vital role in the preservation of evidence to ensure that vital information or forensics are not lost. The police are required to obtain oral (spoken) evidence in specific ways as defined by the Police and Criminal Evidence Act (PACE) 1984. For some vulnerable witnesses this means that their evidence has to be obtained in accordance with the YJCEA 1999, which is designed to help them to give evidence and provides a number of 'special measures' to enable them to do this.

5.2.5.14 Preserving evidence

The first concern must be to ensure the safety and wellbeing of the alleged victim. However, in situations where there has been, or may have been, a crime and the police are called they will be responsible for the gathering of forensic and other evidence. The police will attend the scene, and agencies and individuals can play an important part in ensuring that evidence is not contaminated or lost. Remember that evidence may be present even if you cannot actually see anything.

- Try not to disturb the scene, clothing or victim if at all possible.
- If the allegation or disclosure concerns a possible rape or sexual assault, try to discourage the adult at risk from washing, showering or bathing, or from washing their clothes.
- Secure the scene (e.g. lock the door).
- Preserve all containers, documents and locations.
- If in doubt contact the police and ask for advice.

5.2.5.15 Recording

It is vital that a written record of any incident or allegation of crime is made as soon as possible after the information is obtained. Written records must reflect as accurately as possible what was said and done by the people initially involved in the incident either as a victim, suspect or potential witness. The notes must be kept safe as it may be necessary to make records available as evidence and to disclose them to a court.

You must make an accurate record *at the time*, including:

- Date and time of the incident.
- The appearance and behaviour of the adult at risk.
- Any injuries observed.

- Exactly what the adult at risk said, using their own words (i.e. their account) about the abuse and how it occurred. Alternatively, this may take the form of exactly what has been reported to you.
- The views and wishes of the adult at risk.
- Any actions and decisions taken at this point.
- Exactly what you saw if you witnessed the incident.
- A record of what any witnesses said.
- The name and signature of the person making the record.

The record should be factual. However, if it contains your opinion or an assessment, it should be clearly stated as such and be backed up by factual evidence. Information from another person should be clearly attributed to them.

5.2.5.16 Who else should be informed?

Where relevant the alerting manager should consider informing:

- the unit or service manager responsible for the management of the service
- the Safeguarding Adults lead in the organisation or service
- the police, if a crime has been, or may have been, committed
- the area CQC if the adult is living in a care home, receiving personal care or another registered resource or service
- the relevant children and families team if children are also at risk from harm.

5.2.5.17 Supporting staff

Managers are responsible for:

- supporting any member of staff or volunteer who raised the concern
- enabling and supporting relevant staff to play an active part in the Safeguarding Adults process
- ensuring that any staff delivering a service to the adult at risk are kept up to date on a need-to-know basis and do not take actions that may prejudice the investigation.

5.2.6 Anonymous alerts

5.2.6.1 Paid employees and volunteers

While every effort will be made to protect the identity of workers who are raising concerns, the anonymity of alerters cannot be guaranteed throughout the process. It is particularly important to remember the following.

- In cases where the police are pursuing a criminal prosecution, workers may be required to give evidence in court.

- All information from the adult safeguarding and disciplinary investigations will be shared with the person identified as causing harm where a referral to the ISA is made.
- There is a possibility that a worker may be asked to give evidence at an employment tribunal.
- Anybody can be requested to give evidence when the employer has referred a member of staff to a professional body such as the Nursing and Midwifery Council (NMC), the General Social Care Council (GSCC) or the General Medical Council (GMC).
- The person causing harm may request to see information held about them under the Date Protection Act (DPA) 1998.

5.2.6.2 Members of the public

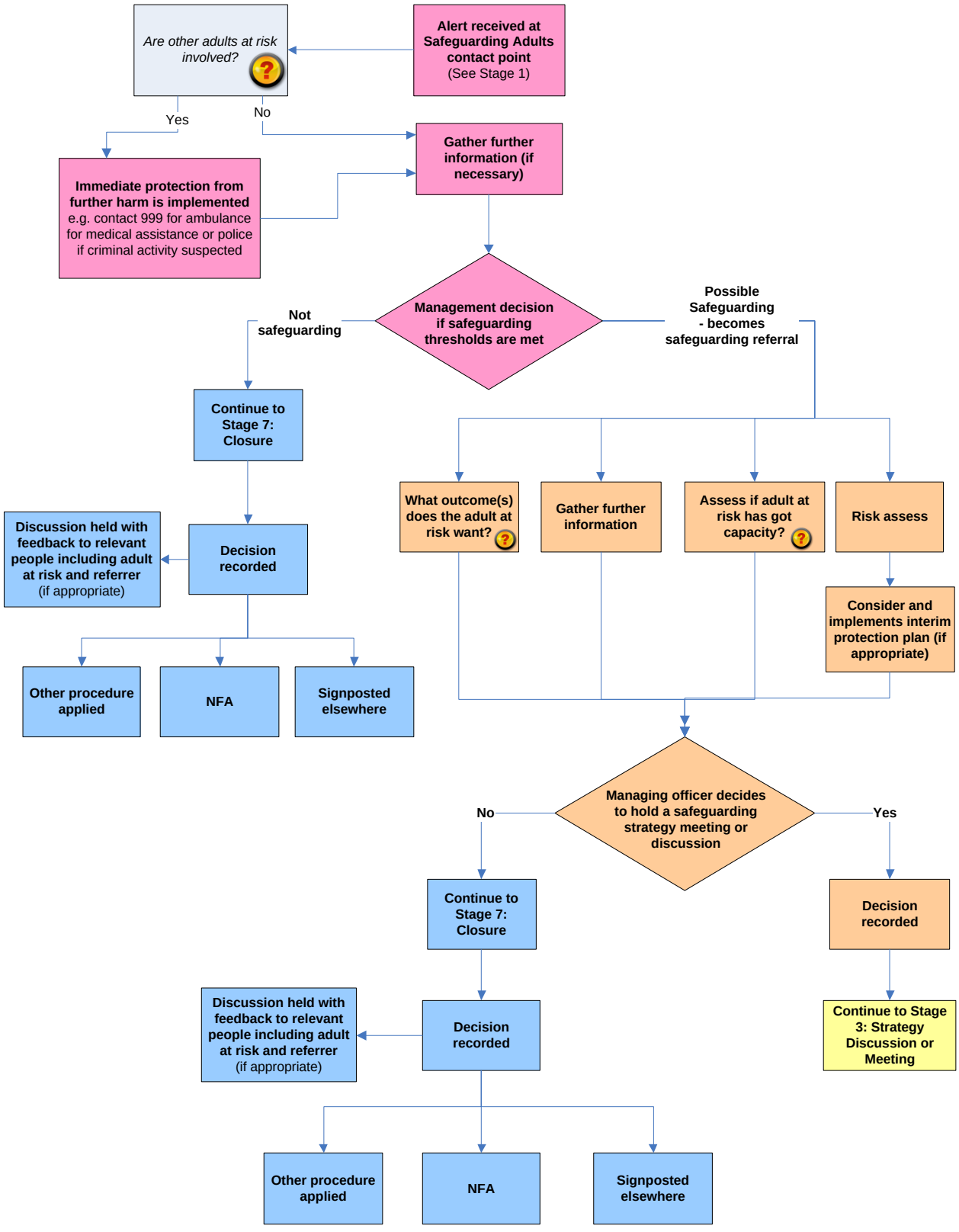
It is preferable to know who is making an alert. However, a member of the public cannot be made to give their personal details. If the identity of the referrer has been withheld, the investigation will proceed in the usual way. This will include information being recorded as an Adult Safeguarding alert.

5.3 Stage 2: Referral

See below.

Stage 2: Referral

Decision within same working day



5.3.1 Definition of a referral

An alert becomes a referral when the details reported lead to an adult safeguarding investigation/assessment. Accepting a referral begins a process of gathering facts, assessment of the allegation, assessment of the adult at risk's needs and a risk assessment to decide whether the Safeguarding Adults policy applies. This should be done in consultation with the alerting manager and all relevant organisations.

5.3.2 Purpose of a referral

The purpose of a referral is to initiate action under the Safeguarding Adults procedures.

5.3.3 Roles and responsibilities

The receiving team will decide if the criteria for safeguarding have been met.

Alerts to the relevant Safeguarding Adults referral point will be taken from *anyone* who has a concern that an adult is at risk. However, when potential significant harm is identified to an adult at risk this will trigger a referral into Safeguarding Adults procedures.

The alerter may also be asked to complete a multi-agency alert form in accordance with local guidance and send it to the relevant referral point as instructed on the form. If the alert is made by a member of the public, a member of the family, a friend, a carer, a neighbour or anonymously, a written alert would not be expected but they could be offered a meeting to discuss their concerns.

The relevant local alert/referral process should be used.

5.3.4 Timescales

A decision whether or not to start the safeguarding procedure must be made on the same working day as the alert reaches the appropriate team.

5.3.5 Process

5.3.5.1 Gathering initial information and clarify facts

On receipt of an alert the Safeguarding Adults referral point should take the following action.

- Clarify basic facts, including who is involved in the allegation. Practitioners must be aware that this is not an investigation, but that facts are being collected and/or clarified to enable decisions to be made about the level of risk and the process to be followed. This could involve contact with the referrer and a brief discussion with the adult at risk, but *not* with the person alleged to have caused harm.
- If the allegation concerns a potential crime there must be immediate liaison with the police to avoid contamination of evidence.
- Other relevant organisations should be informed of the nature of the allegation and the actions being taken.

- Previous contacts and history should be checked for both the adult at risk and the person alleged to have caused harm, including any information about possible risks to workers visiting.

Where possible, include as much information under the following headings.

Details of the alerter

- Name, address and telephone number.
- Relationship to the adult at risk.
- Name of the person raising the alert if different.
- Name of the organisation, if the alert is made from a care setting.
- Anonymous alerts will be accepted and acted on. However, the alerter should be encouraged to give contact details.

Details of the adult at risk

- Name, address and telephone number.
- Date of birth, or age.
- Details of any other members of the household including children.
- Information about the primary care needs of the adult (i.e. disability or illness).
- Funding authority, if relevant.
- Ethnic origin and religion.
- Gender (including transgender and sexuality).
- Communication needs due to sensory or other impairments (including dementia), including any interpreter or communication requirements.
- Whether the adult at risk knows about the referral.
- Whether the adult at risk has consented to the alert and, if not, on what grounds the decision was made to raise the alert.
- What is known of the person's mental capacity.
- What are their views about the abuse or neglect.
- What they want done about it (if that is known at this stage).
- Details of how to gain access to the person and who can be contacted if there are difficulties.

Information about the abuse, neglect or harm

- How and when did the concern come to light?
- When did the alleged abuse occur?
- Where did the alleged abuse take place?
- What are the details of the alleged abuse?

- What impact is this having on the adult at risk?
- What is the adult at risk saying about the abuse?
- Are there details of any witnesses?
- Is there any potential risk to anyone visiting the adult at risk to find out what is happening?
- Is a child (under 18 years) at risk?

Details of the person alleged to have caused the harm (if known)

- Name, age and gender.
- What is their relationship to the adult at risk?
- Are they the adult at risk's main carer?
- Are they living with the adult at risk?
- Are they a member of staff, paid carer or volunteer?
- What is their role?
- Are they employed through a PB?
- Which organisation are they employed by?
- Are there other people at risk from the person causing the harm?

Any immediate actions that have been taken

- Were emergency services contacted? If so, which?
- What action was taken?
- What is the crime number if a report has been made to the police?
- Details of any immediate plan that has been put in place to protect the adult at risk from further harm.
- Have children's services been informed if a child (under 18 years) is a risk?

The alerting agency may be asked to confirm the alert in writing if this is a locally agreed requirement. If all the above information is not available, the referral should still be made. If in doubt, always make the referral.

5.3.5.2 Deciding to accept a Safeguarding Adults referral

In the following situations, action should be taken under the Safeguarding Adults procedures even if the adult at risk does not want any action taken. They should be informed of the decision, the reason for it and be reassured that no actions will be taken which affect them personally without their involvement.

- The adult at risk may not have the mental capacity to make decisions about their own safety.
- The person causing the harm is a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service.

- Other people are at risk from the person causing harm and they are also adults at risk.

In other situations (e.g. domestic abuse), if, in consultation with relevant organisations, there is seen to be a high level of risk, a multi-agency strategy discussion or meeting may be held even if the adult at risk does not want any action taken. This would enable discussions about providing the adult at risk with support and signposting to relevant organisations (e.g. Victim Support, counselling services and Safer Neighbourhoods).

5.3.5.3 When the adult at risk lacks mental capacity to consent

Where there is concern that the adult at risk may not have mental capacity to make relevant decisions, it is important that their capacity is appropriately assessed as soon as possible. It may be established that, with appropriate support, they are able to make their own decisions.

If it is established that the adult at risk lacks capacity, feedback will be given to them and anyone who is acting in their best interests (e.g. their attorney or court-appointed deputy), unless they are implicated in the allegation.

If the person has no suitable family or friend who can be consulted regarding their best interests, an advocate or an independent mental capacity advocate (IMCA) should be instructed in line with the local IMCA referral policy. An IMCA may be instructed if it is felt that it will be beneficial to the adult at risk, even if they have family, friends and carers available to consult.

The managing officer must ensure that contact is made with a carer or personal representative. The managing officer will also decide in consultation with other relevant organisations what will be fed back at this point to the person causing the harm.

5.3.5.4 When the adult at risk has capacity

If the adult at risk has mental capacity to make decisions about their safety, consideration must be given to:

- finding out from them what is happening
- talking to them about their concerns
- carrying out a risk assessment with them to find out if they understand the risk and what help they may need to support them to reduce the risk if that is what they want
- being satisfied that their ability to make an informed decision is not being undermined by the harm they are experiencing and is not affected by intimidation, misuse of authority or undue influence, pressure or exploitation if they decline assistance
- reassuring them that they will be involved and supported in all relevant decisions and actions that are taken to protect them and informing them that in certain circumstances action will have to be taken even if they disagree (e.g. if a child or another adult at risk is also at risk of harm).

5.3.5.5 When the Safeguarding Adults procedures may not be used

It may be decided not to use the Safeguarding Adults procedures when there is enough information to decide that:

- No harm has been caused.
- The situation appears to be a one-off incident with a low level of risk, in which case management action or other intervention would be appropriate.
- The situation does not involve abuse, in which case another service may be appropriate.
- The adult at risk is not an adult who is covered by these procedures; if so they can then be directed to other services or resources.

The adult at risk has the mental capacity to make an informed choice about their own safety, there are no public interest or vital interest considerations and they choose to live in a situation in which there is risk or potential risk. They can then be directed to other services or resources and/or reassured that they can come back in the future. It is essential that the reasons for not invoking safeguarding procedures are fully recorded. Local guidance is best consulted in situations .of self neglect

Concerns regarding adults with so-called 'low-level needs' will not be excluded from action under the procedures where there is a danger that the harm to the person puts their independence and wellbeing at risk and leads to a deterioration in their ability to protect themselves. Such adults include:

- those with low-level mental health problems/borderline personality disorder
- older people living independently in the community
- those with low-level learning disabilities
- those with substance misuse problems
- those who are self-directing their care.

Guidance provided in *Putting people first*[21] states that a Safeguarding Adults concern will escalate a person's need to the top of the hierarchy of needs (critical or substantial), creating a legal obligation to carry out an assessment of needs for community care services under Section 47 of the NHS and Community Care Act (NHSCCA) 1990. If in doubt follow the Safeguarding Adults procedures. If a decision is made not to follow the procedures a record must be made of this, giving the reasons why not.

5.3.5.6 Gathering information and evaluating risk

To help workers and managers to evaluate the information received in order to determine how the concerns should be addressed and what priority they should take, a risk assessment needs to be undertaken.

Information may need to be gathered from various sources in order to inform the risk assessment and subsequent decision-making.

Further information may need to be sought from:

- the police
- the coroner
- another local authority
- the CQC
- a mental health team
- the health trust/cluster where Nursing Home or nursing service is involved
- a children, young persons and families team
- contract monitoring team if an agency contracted with the directorate is concerned
- the appointee and court deputy section and/or the Department of Work and Pensions (DWP) if financial abuse is alleged
- the customer relations service of any involved organisations
- an IMCA or other advocate if appointed.

5.3.5.7 Management decision about the alert

To proceed with the Safeguarding Adults process the manager must consider all the information available and decide on the same working day whether:

- the individual meets the definition of an adult at risk
- the person has suffered, or is at risk of, significant harm from others.

The options at this point are that the alert is accepted as a Safeguarding Adults referral, in which case consideration should be given to:

- whether this is this a case involving multiple service users/a whole service; if so then local guidance for handling such cases should be consulted
- whether there needs to be an immediate/interim protection plan (see Section 5.3.5.11).

Or that further information is required before a decision can be made on how to proceed with the alert.

Or that no further action need be taken in respect of the Safeguarding Adults procedure. Care management involvement or referral to another agency may nevertheless be required.

In all situations the responsible manager must ensure that:

- any action(s) to be taken are recorded along with the reasons for any decisions made – either arranging a strategy discussion/meeting or no further action
- the alerter is notified of the decision (the manager should first agree with the relevant worker what information to give to the alerter).

The alerter must also be informed of the decision in a timely way, the reasons for it, and information about any alternative services which have been offered, if this does not breach the adult at risk's confidentiality.

The manager will designate the most appropriate person to feed back to the adult at risk. Where the person does not have mental capacity, they should still be included in the process. Feedback will also be given to the person acting in their best interests (e.g. their carer or court-appointed deputy, unless they are the person alleged to be causing harm). If there are alleged safeguarding concerns in relation to a appointed deputy these must be brought to the attention of the Court of Protection.

5.3.5.8 Supporting an adult at risk who makes repeated allegations

An adult at risk who makes repeated allegations that have been investigated and are unfounded should be treated *without prejudice*.

- Each allegation must be responded to under these procedures.
- A risk assessment must be undertaken and measures taken to protect staff and others, where appropriate.
- Each incident must be recorded.
- Organisations should have procedures for responding to such allegations that respect the rights of the individual, while protecting staff from the risk of unfounded allegations.

5.3.5.9 Responding to family members, friends and neighbours who make repeated allegations

Allegations of abuse made by family members, friends and neighbours should be investigated *without prejudice*. However, where repeated allegations are made and there is no foundation to them and further investigation is not in the best interests of the adult at risk, then local procedures apply for dealing with multiple, unfounded complaints.

5.3.5.10 Medical treatment and examination

In cases of physical abuse it may be unclear whether injuries have been caused by abuse or some other means (e.g. accidentally). Medical or specialist advice should be sought.

If medical treatment is needed, an immediate referral should be made to the person's GP, A&E or a relevant specialist health team.

If forensic evidence needs to be collected, the police should always be contacted. They will normally arrange for a police surgeon (forensic medical examiner) to be involved.

Consent of the adult at risk should be sought. Where the person does not have capacity to consent to medical examination, a decision should be made on the basis of whether it is in the person's best interests for a possibly intrusive medical examination to be conducted.

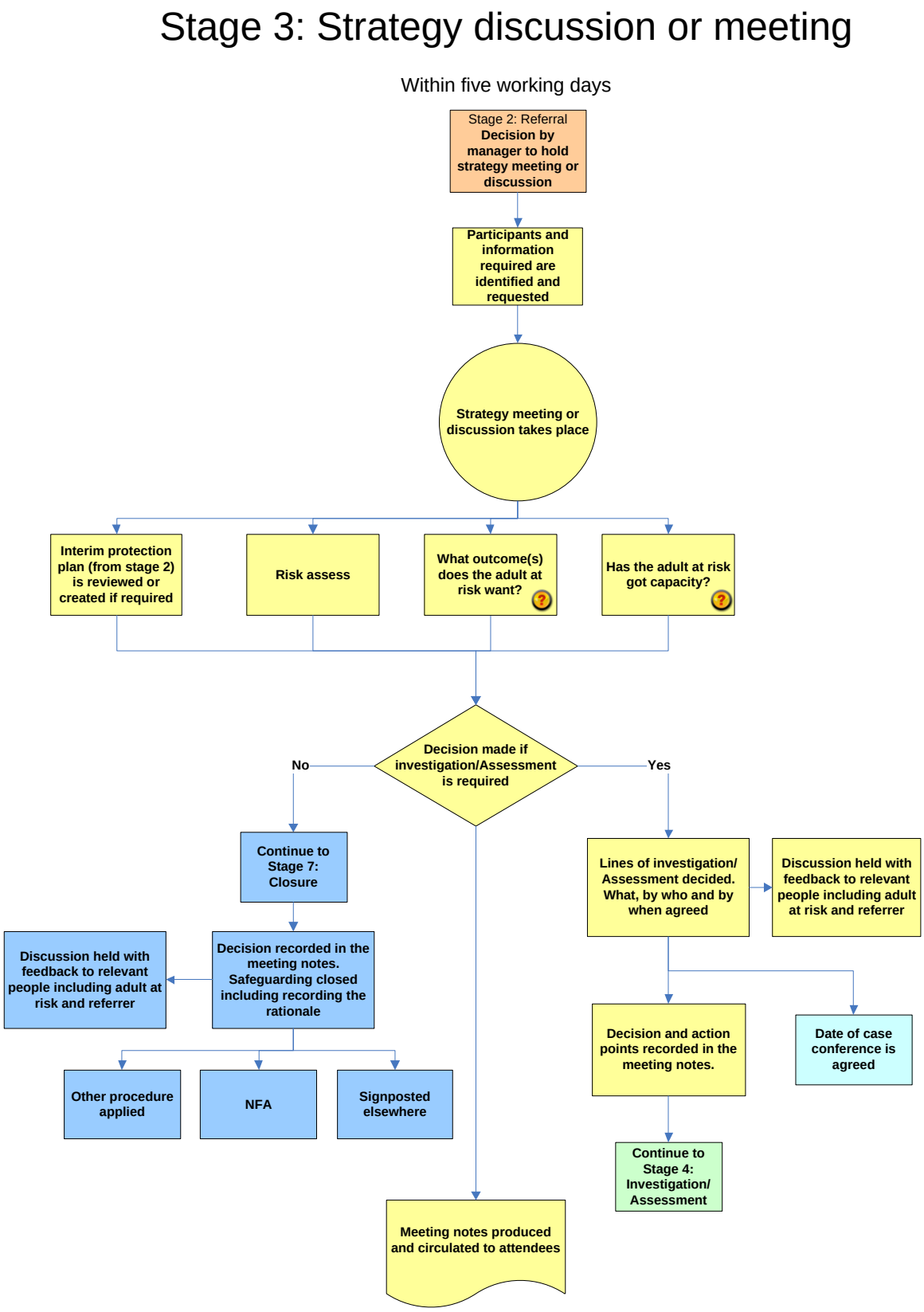
Should it be necessary as part of the investigation to arrange for a medical examination, the following points should be considered:

- the rights of the adult at risk
- issues of consent and ability to consent
- the need to preserve forensic evidence
- the involvement of any family members or carers
- the need to accompany and support the adult at risk and provide reassurance, and the identification of someone appropriate to do so (consider an advocate).

5.3.5.11 Agreeing interim protection plan

At this point a police investigation may well have already begun. In all cases any immediate actions required to protect the adult at risk must be considered and agreed. This can include an immediate 'safe and well' check if appropriate. An interim protection plan will more usually be considered and agreed as part of the strategy discussion/meeting.

5.4 Stage 3: Strategy discussion or meeting



5.4.1 Definition of a strategy discussion or meeting

The strategy discussion or meeting is a multi-agency discussion between relevant individuals involved in order to share information, plan and agree how to proceed with the investigation, considering all the known facts. It can be face to face or by telephone.

5.4.2 Purpose of the strategy discussion or meeting

The purpose of the strategy discussion or meeting is:

- to assess the immediate risk to the person who is being harmed and ensure an interim protection plan is agreed to protect the adult at risk while the investigation is completed
- to discuss the allegations, share information with all relevant parties and agree whether further investigation(s) is/are needed and if so, plan *who* is to investigate *what* in *which order* with agreed *target dates for agreed actions*
- to consider the wishes of the adult at risk or, if they lack mental capacity, their representative
- to co-ordinate the collection of information about the abuse or neglect
- to consider what support is needed for the adult at risk
- to consider whether support is needed for the person alleged to be causing harm (particularly if they are also an adult at risk)
- to consider if other adults at risk are affected
- to identify any possible personal safety issues for the person who will conduct the investigation and plan to address these
- to make a clear record of the decisions made and record what information has been shared
- to agree a communication strategy including feeding back to the referrer
- to consider whether a child (under 18 years) may be at risk and agree a referral to the children and families team
- to circulate decisions to all invitees within locally agreed timescales using the appropriate pro forma.

5.4.3 Roles and responsibilities

The relevant managing officer will ensure that a multi-agency strategy discussion or meeting takes place, is recorded and decisions circulated. The chair should be the managing officer, a senior practitioner or other more senior manager if the nature of the inquiry indicates that this is appropriate (e.g. for a large-scale inquiry). The managing officer needs to follow local guidance for co-ordination and local roles and responsibilities. The meeting should also identify any support to be given to the investigating officer by staff from other agencies (e.g. tissue viability nurses, police, housing, service provider).

Agreement must be reached at the meeting about the respective roles and responsibilities of organisations during the investigation in terms of lead responsibilities, specific tasks, co-operation, communication and the best use of skills.

- Action that may lead to legal proceedings should take precedence over other proceedings and there should be discussion and co-ordination of those processes to avoid prejudicing such investigations.
- If there is going to be a police investigation that could lead to criminal proceedings, there should be early identification of the likely need for witness support and special measures made available to witnesses as required.
- If there are going to be a number of investigations, the meeting or discussion will decide in what order the various investigations, assessments and inquiries should take place.
- Where joint investigations or assessments are planned, there should be clear agreement between the organisations concerned as to their respective roles and responsibilities.
- Non-police investigations should always be led by a suitably experienced and competent worker.

5.4.4 Timescales

The strategy discussion or meeting should take place within five working days of accepting the alert as a safeguarding referral and before any investigation begins. The commencement of a police investigation is an exception to this, when vital evidence-gathering is required. An organisation should not begin an investigation prior to a decision by the multi-agency strategy meeting or discussion.

5.4.5 Process

5.4.5.1 Discussion or meeting?

The strategy stage could be a discussion (telephone or face to face) or a meeting. A discussion would take place when:

- if holding a meeting would involve a delay and place the person at greater risk
- where the concerns are assessed to involve a low/medium risk of harm and/or a minimal number of organisations are involved and a meeting is not necessary to ensure that a protection plan is put in place

If a discussion is held, it may still be necessary to hold a follow-up meeting when the investigation is deemed complex and/or there is a high risk of harm.

Where immediate action is needed to protect the adult at risk, the information should be passed to the organisation that is in the best position to carry this out as quickly as possible. Agreement should be reached on what action will be taken.

A meeting will be held when the concerns are assessed to involve medium/high risk of harm and several organisations are involved.

A decision not to hold a strategy meeting or discussion may be made because there is sufficient information to indicate that:

- The person is not at risk of abuse or neglect and there is no need to investigate or take further action under the procedures. The decision will be recorded with the reasons and an alternative plan formulated if necessary.
- No formal investigation is needed and a protection plan can be put in place to remove or reduce the risk to the adult. The adult at risk agrees with this decision and with the plan. The plan should specify a time for review and indicators of risk that might trigger further action under the procedures.

5.4.5.2 Who participates?

Attendance at the strategy meeting should be limited to those who need to know and can contribute to the decision-making process. Participants will be individuals from any organisation who have a role in investigating the allegation of abuse and/or in the assessment of the risk to the adult at risk, or in relation to the person alleged to be causing the harm.

Participants should have sufficient seniority to make decisions at the meeting, particularly concerning their organisation's role and the resources they may contribute to the agreed protection plan.

The list below is not exhaustive and participation at a strategy meeting should be decided on the circumstances of the case. However, a meeting will generally be attended by:

- the person with responsibility for chairing the meeting
- the investigating worker
- the social services care manager or key worker (if different)
- a health professional (e.g. GP, district nurse, community mental health nurse)
- the police, if there are concerns that a crime has been committed
- the person making the referral, if they are a professional
- an officer from the CQC in line with its Safeguarding Adults protocol with regard to regulated services
- an IMCA or other advocate (if an IMCA has not been instructed a decision must be made as to whether to do so; an organisation that does not have authority to appoint an IMCA should discuss this with the relevant manager, who can ensure that one is instructed as necessary)
- other staff from adult social care who have a role to play/relevant involvement
- the manager of a provider service unless they are named in the allegation, in which case a senior representative of the organisation would be invited
- a representative from the placing authority if different to where the harm occurred
- a representative of the council legal department or a client affairs officer
- a representative of any other organisation which has a role to play

- a child protection co-ordinator if there are also child protection concerns
- the Safeguarding Adults organisational leads as appropriate
- a commissioner or member of quality compliance/contracting monitoring team
- an HR officer (for the employer if the allegation involves a member of staff or a paid carer).

Every effort should be made prior to the meeting to explain its purpose to the adult at risk and to discover their concerns, what they wish to happen and how they want to be involved in what is decided. The meeting must decide who will feed back any decisions made to the adult at risk.

Any organisation requested to attend a strategy meeting should regard the request as a priority. If no one from the organisation is able to attend, they should provide information as requested and make sure it is available at the meeting. The strategy discussion/meeting will need to decide on a number of issues, as listed below.

5.4.5.3 The adult at risk

- Clarify the key issues of risk faced by the adult.

Decide who will interview and record the account of the adult at risk, with timescales.

- Decide who will ensure the adult at risk is involved in the process to the maximum of their willingness and ability, and how this will be achieved.
- Decide who will support the adult at risk in a formal investigation and ensure that their needs for support and protection are met.
- Clarify the mental capacity of the adult at risk to make decisions about their own safety. Arrange for an assessment by the most appropriate person, if required.
- If the person does not have mental capacity, decide how they will be supported to be involved as much as they are able, who is a suitable person to act in the person's best interests and whether an IMCA should be instructed.
- Identify whether the person needs advice, support, assistance or services under community care legislation.
- Identify any communication needs of the adult at risk.
- Identify any equality issues that need to be addressed.
- Identify who will keep the adult at risk informed and what information can be shared with them.
- Where the adult has capacity, ensure their wishes are respected as to sharing of information with relatives and/or carers (unless there is a duty to override their decision).

5.4.5.4 The person allegedly causing harm

- If there is a criminal investigation advice must be sought from the police as to when it would be appropriate to speak to the person allegedly causing the harm.
- Decide who will interview the person allegedly causing harm and/or give them information about the allegations (and when this should happen). This may well be the interviewing officer of the organisation that has a duty to investigate.
- If the person allegedly causing harm is a member of staff or a volunteer, confirm that the relevant regulatory authority has been informed. It is important at all times to preserve the confidentiality of all concerned, including staff members under the Safeguarding Adults information sharing protocols.
- The primary concern must be the safety of the adult at risk, but the person allegedly causing harm has a right to receive information about any accusations and the process that will be followed.
- Decisions about notifying the person allegedly causing harm need to be made at the strategy meeting, weighing up potential repercussions or further risk of harm.
- If the person allegedly causing harm is also an adult at risk, a decision must be made about how their needs are to be met during the investigation. For example, if they lack capacity, they will also need someone who can represent them, possibly an IMCA.
- Identify whether the person needs advice, support, assistance or services under community care legislation.
- A decision should be made whether an organisation in which the alleged abuse or neglect has occurred may undertake an investigation on the basis of an assessment of risk and harm to the adult.

5.4.5.5 Decision-making

Safeguarding investigations can involve more than one line of inquiry, and these need to be discussed and carefully co-ordinated at the strategy stage. Where a criminal investigation is taking place decisions must be reached in a strategy discussion or meeting between the police and other involved organisations about what actions they can take and when. This ensures that the criminal investigation is not compromised and that other organisations are able to take necessary action at the appropriate time.

Any organisation responsible for all or part of the investigation should have regard to their other responsibilities or legal powers in relation to employment law, criminal law and clinical governance. The person identified to undertake the investigation will be designated as the ‘investigating officer’ for the purpose of the Safeguarding Adults process. A decision must be made about who will receive all information and any reports that are subsequently produced.

5.4.5.6 Specific decisions regarding the adult at risk

Always consider and reach agreement on the following areas:

- identification of who should be involved in the investigation and the development of an interim protection plan
- the potential risk to the person being harmed
- the risks to others from the person alleged to have caused harm
- whether any action is required concerning the person alleged to have caused harm
- whether there is likely to be a criminal prosecution (if known at this point)
- what information needs to be shared and with whom
- whether there may be a number of investigations by different organisations
- whether there may be legal or regulatory action
- whether the allegation involves a member of staff/volunteer or the safety of a service
- whether the situation could attract media attention.

5.4.5.7 Specific decisions when the person alleged to have caused harm is also an adult at risk

The primary focus of the strategy meeting or discussion is the adult at risk. Therefore it may be necessary to hold a separate multi-agency meeting to meet the needs and address the behaviour of the person alleged to be causing the harm. Whether or not this is the case the initial meeting must cover the following issues.

- How to co-ordinate action in relation to the adult at risk alleged to be causing the harm.
- Identification and allocation of a separate care manager/care co-ordinator in order to ensure that their needs are met and that a care plan is devised to ensure that other adults at risk are not also put at risk by the person's actions.
- Whether there is likely to be a criminal prosecution (if known at this point).
- What information needs to be shared, and with whom.
- Cases where the person alleged to have caused harm is a family member, friend or carer need to be treated with particular sensitivity. For example, work may need to be done to make sure the person alleged to have caused harm understands what abuse is.
- A carer will usually be entitled to and may need a carer's assessment.

5.4.5.8 Resolution of disagreements

Where there are disagreements that cannot be resolved by discussions or at meetings the issues should be recorded and if appropriate brought to the attention of line managers, lead managers and Safeguarding Adults leads.

Practitioners should always refer to local guidance in such cases.

5.4.5.9 Possible outcomes

If a decision is taken at the strategy stage to continue with an investigation under the procedures, agreement should be reached on the following areas.

- Whether the strategy will need to be reviewed during the investigation and risk assessment and if so when.
- The timescale in which the investigation should take place. The investigation should begin as soon as possible after the strategy meeting or discussion and be completed within 20 days of the Safeguarding Adults referral. If, due to the complexity of the investigation, it is clear from the outset that a longer timescale will be required, this must be agreed by all relevant organisations and a record made of this decision.
- In a complex situation, whether it may be necessary to hold further strategy meetings to ensure that the investigation is progressing appropriately or to consider new information.
- The date for the case conference.

Other Investigations and processes could be triggered by a safeguarding referral. Different situations can be risk assessed and investigated by various agencies, and these should be clearly agreed at the strategy discussion/meeting (see Table 5.1).

Table 5.1 Type of investigation or risk assessment and agency responsible

Type of investigation/risk assessment	Agency responsible
Criminal (including assault, theft, fraud, hate crime, domestic violence and abuse or wilful neglect of a person lacking capacity)	Police
Domestic violence – serious risk of harm	Police coordinate the MARAC process
Fitness of registered service provider	CQC
Unresolved serious complaint in health care setting	CQC, Health Service Ombudsman
Breach of rights of person detained under the MCA 2007 Deprivation of Liberty Safeguards (DoLS)	CQC local authority, primary care trust, OPG/Court of Protection.
Breach of terms of employment/disciplinary procedures	Employer
Breach of professional code of conduct	Professional regulatory body
Breach of health and safety legislation and regulations	HSE
Complaint regarding failure of service provision (including neglect of provision of care and failure to protect one service user from the actions of another)	Manager/proprietor of service/complaints department Ombudsman (if unresolved through complaints procedure)
Breach of contract to provide care and support	Service commissioner (e.g. social services, PCT)
Assessment of need for health and social care provision (service users and carers)	Social services/PCT/mental health team/care trust
Access to health and social care services to reduce the risk of abuse/neglect	Social services/PCT/mental health team/care trust
Misuse of enduring or lasting power of attorney or misconduct of a court-appointed deputy	OPG/Court of Protection/police
Inappropriate person making decisions about the care and wellbeing of an adult at risk who does not have mental capacity to make decisions about their safety and which are not in their best interests	OPG/Court of Protection
Misuse of appointeeship or agency	DWP
Antisocial behaviour (e.g. harassment, nuisance by neighbours)	Community safety team

Breach of tenancy agreement (e.g. harassment, nuisance by neighbours)	Landlord/registered social landlord/housing trust/community safety team
Bogus callers or rogue traders	Police and Trading Standards officers

A decision not to proceed with a safeguarding investigation and end the safeguarding process will be made when:

- There is no identified risk of harm or evidence of abuse.
- There are Safeguarding Adults concerns, but the adult at risk has mental capacity, is living at home, is confident that they can protect themselves from further harm and does not wish any action to be taken. Practitioners must be confident that the adult at risk is making this decision without undue influence, threats or intimidation.
- If there are no other people at risk from the person causing the harm and the adult at risk wishes no action to be taken, there will be no more action under the procedures at this time. In this situation there should be express agreement with the adult at risk that there will be no more action under the procedures. They should be given information about abuse and neglect, possible sources of help and support and who they can contact if they should change their mind or the situation changes and they no longer feel able to protect themselves.

If a concern persists and the adult at risk's refusal to consent to action is seen to have resulted from fear, loyalty, coercion or disempowerment as a result of long-term or persistent abuse, action under the procedures will continue and a multi-agency decision will be made about the best way to engage with the person and consider the legal powers available to intervene with the person(s) causing the harm.

The reasons for closing the Safeguarding Adults process should be recorded and a copy sent to any strategy meeting attendees.

5.4.5.10 Recording and sharing information

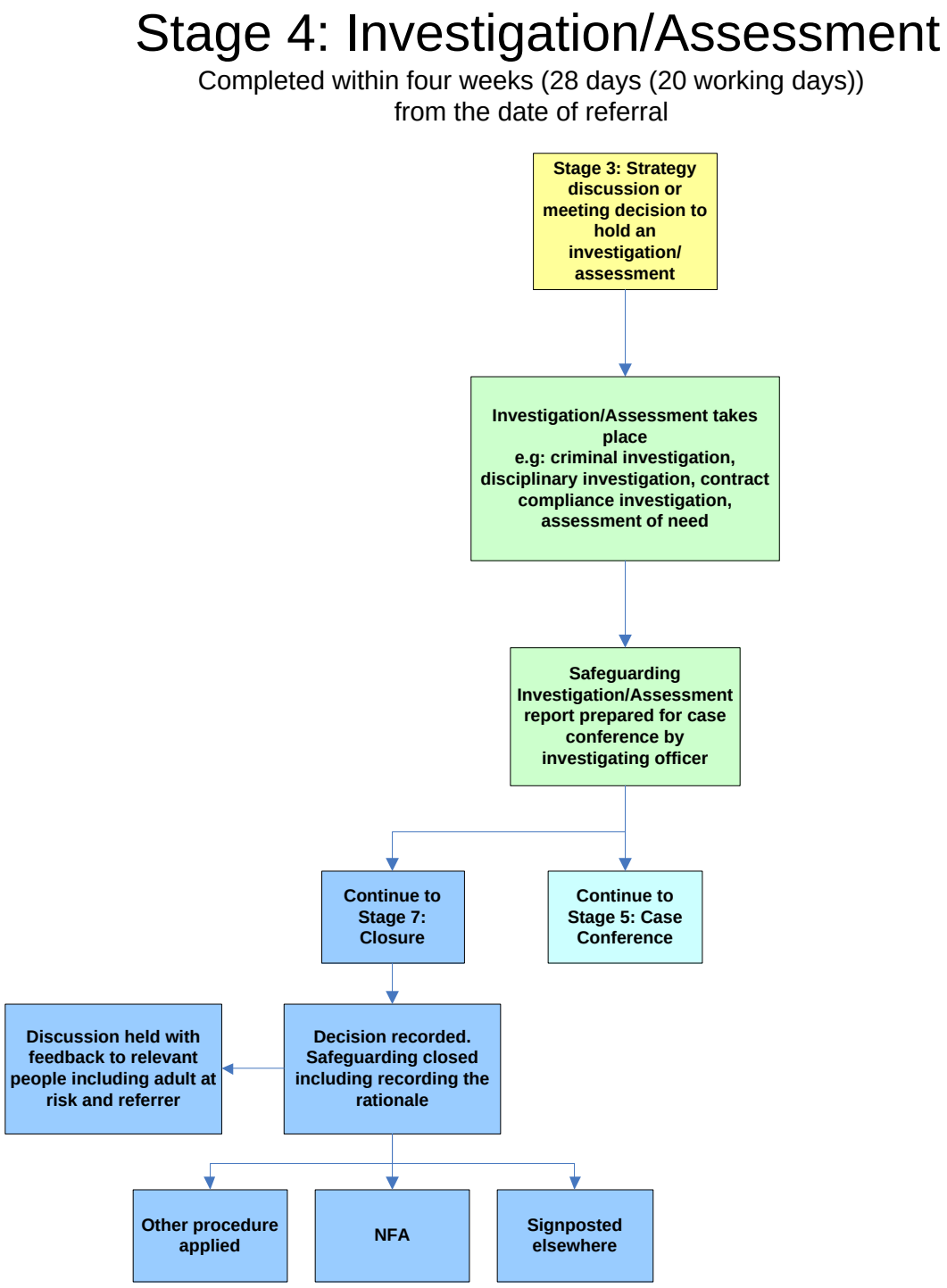
A record should be made of the decisions and actions agreed.

Minutes of the meeting will be distributed within agreed local timescales. Regard should be given to confidentiality and data protection issues.

The information should not be shared for any purpose other than the protection and care of the adult(s) at risk of abuse and/or neglect.

Local SABs may have their own standard agendas and templates for the structure and recording of strategy meetings and discussions.

5.5 Stage 4: Investigation and assessment



5.5.1 Definition of investigation and assessment

Investigation and assessment is a process of gathering and analysing information and evidence to determine whether:

- abuse has taken place
- there is ongoing risk of harm to the adult at risk.

5.5.2 Purpose of investigation and assessment

The purpose of investigation and assessment is to establish the facts and contributing factors which led to the referral. Central to this is establishing the views and wishes of the person at risk and what outcome they require or desire. In addition there are responsibilities to identify and manage risk in order to ensure the safety of the individual and others.

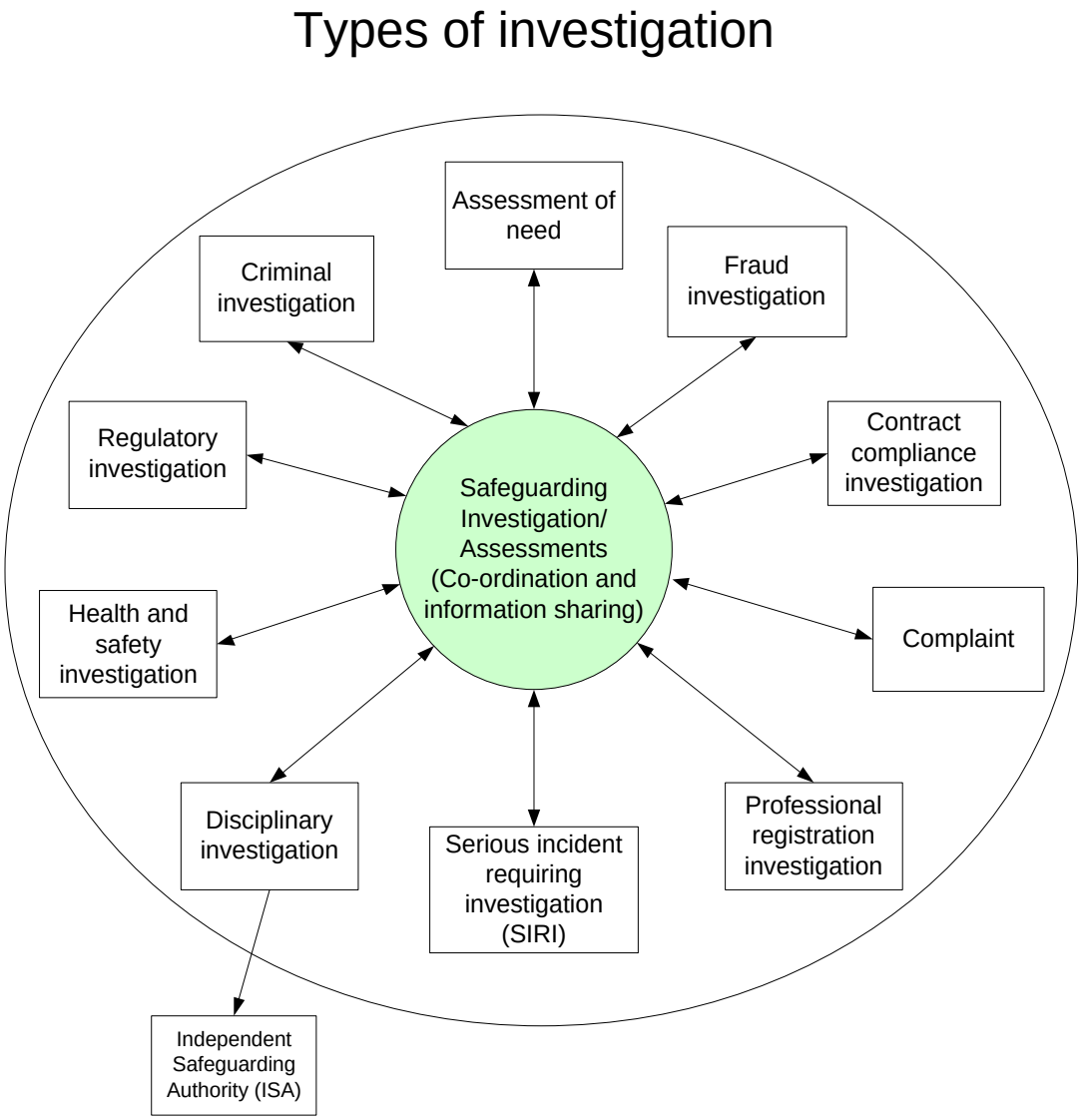
5.5.3 Roles and responsibilities

It is the responsibility of the host local authority where the alleged abuse occurred to co-ordinate the investigation process to avoid any duplication or mistakes. Different types of investigation/assessment may be undertaken simultaneously, therefore all staff leading these investigations/assessments must keep in regular contact to ensure that one investigation does not impact or interfere with any other.

No individual agency can delegate their statutory responsibility to another. Each agency must act in accordance with its duty of care to safeguard adults at risk when it is satisfied that action is appropriate.

Agencies will have their own operational policies and internal procedures applicable to their staff, which should be read in conjunction with these procedures.

Below is a framework demonstrating the range of investigations which may apply.



5.5.3.1 The managing officer where the local authority are leading the investigation

The managing officer will ensure that:

- enough information is available to allow prioritisation and allocation of investigations
- the investigation is allocated to a worker with the necessary competence and experience
- supervision and support is available to the investigating officer
- individual cases are monitored to ensure adequacy of protection measures
- all investigations/assessments are conducted in accordance with this procedure and anti-discriminatory practice.

The managing officer must confirm and sign off the accuracy of all records relating to a Safeguarding Adults investigation/assessment, including records of:

- the initial investigation, risk assessment and protection plan
- any decisions taken at strategy meetings
- the investigation/risk assessment and interview(s)
- any decision taken to close the investigation/assessment.

5.5.3.2 The investigating officer

The investigating officer should be a suitably experienced and competent member of staff working under the supervision of a manager. Care must always be taken to ensure complete independence of the investigator from the person alleged to have caused harm. The investigating officer is responsible for leading and co-ordinating the safeguarding investigation/assessment in line with the agreed decisions made at the strategy discussion/meeting. The investigation will involve:

- face-to-face contact with the adult at risk of harm
- ascertaining the views and wishes of the adult at risk and providing appropriate support
- undertaking an assessment of risk of harm
- collating all evidence and information gathered and completing an investigator's report.

5.5.3.3 The police

PACE 1984 governs the conduct of police interviews and evidence-taking.

When the interview involves a suspect who is mentally vulnerable or mentally disordered, then there is an obligation under PACE to provide an Appropriate Adult.

If there is a possibility of criminal proceedings, it is important that repeat interviews are avoided as evidence can become contaminated. In such cases the police will direct any disclosure interview(s).

The interview should be planned in advance and a record made of the plan.

Achieving Best Evidence guidance, and the Youth Justice and Criminal Evidence Act 1999 (special measures) details special measures which apply to vulnerable adults as victims.

The YJCEA 1999 details measures available to people under 18 years of age when giving evidence or information for the purpose of a criminal investigation.

5.5.3.4 All organisations

Each organisation must designate a suitably experienced and competent member of staff to ensure that it carries out its role and responsibilities in the plan as agreed at the strategy stage. This will include ensuring that the organisation carries out agreed actions within agreed timescales.

In addition the designated manager in each organisation will ensure that:

- actions to safeguard adults at risk are given top priority and are supported throughout the process
- clear records are kept of any contact with, or actions taken to support or care for, the adult at risk
- there is support and supervision for staff carrying out this work
- the organisation actively co-operates with other organisations taking part in the investigation and risk assessment
- the investigating officer is kept up to date and informed of any new information or changes in the situation or the plan as soon as possible
- any agreed inquiries are completed within agreed timescales
- written evidence is kept of any investigation findings
- a written report of the findings is prepared and sent to the person designated to receive any reports required at the case conference to contribute to the protection plan.

5.5.4 Timescales

The safeguarding investigation must be completed within four weeks (a maximum of 28 days, 20 working days) from the date of the referral.

When there is a possibility of a criminal offence having occurred, the police should be consulted and, during their involvement, will be the lead agency for the investigation. However, the local authority continues to remain responsible for co-ordinating the safeguarding process, including the risk of harm assessment and the protection plan.

5.5.5 Process

5.5.5.1 Undertaking the investigation/assessment

Investigators must have the appropriate competencies and experience.

In line with the agreed decisions made at the strategy discussion/meeting, the investigating officer will:

- Make an assessment of immediate risk of harm and offer appropriate protective measures to protect the adult at risk, if this has not already been done.
- Address any communication needs (e.g. interpreters, intermediaries, advocates).
- Identify and take into account any equality issues.
- Undertake a face-to-face interview with the adult at risk which will include obtaining their views and an attempt to ascertain what they would wish as the outcome of the investigation.

- Ensure that the person alleged to have caused harm is not present when the adult at risk is interviewed. Sensitivity to the needs and wishes of the adult at risk should be maintained at all times.
- Discuss issues of confidentiality and information sharing with the adult at risk and, if there are no others at risk, seek permission to share information with other organisations as required. If there are others at risk (e.g. paid carers going into the person's home), the investigating officer will inform the adult at risk of their duty to share information to protect others (see Section 2.3.2).
- Obtain the views of the adult at risk even if it is clear that they may not have the mental capacity to provide a view on the outcome. It is always appropriate to carry out a mental capacity assessment and may be necessary to appoint an IMCA.
- Undertake interviews with relevant individuals, including the person alleged to have caused harm, any witnesses and significant others.
- Gather appropriate information and evidence from a variety of sources.
- Immediately inform the appropriate safeguarding children's team if there are concerns that a child or young person living in the same household as the adult at risk could also be at risk.
- Gather information to inform the risk assessment.
- Keep the managing officer updated of all actions.
- Ensure all recording is in line with organisational procedures.
- Ensure all information is shared in an appropriate manner, observing information sharing protocols.
- Produce a report and recommendations within the agreed timescales, which will form the basis of discussion at the case conference.

If the investigation cannot be completed within the 28 days (20 working days), consideration must be given to holding another strategy discussion/meeting to ensure that the interim protection plan is providing adequate safeguards for the adult at risk (and other individuals at risk if necessary), and to formally extend the time limit for the investigation.

Refer to local guidance for further information on roles and responsibilities and on conducting interviews.

5.5.5.2 The investigator's report

The report should contain a clear summary of the investigation along with:

- personal details of the adult at risk including a record of their desired outcomes
- details of the investigating officer and date(s) of the investigation/assessment

- summary of the adult at risk's assessed needs and relevant background information
- assessment of capacity if relevant
- outline of the current allegations and any previous allegations
- chronology of events
- summary of investigation/assessment
- outcomes of the assessment
- list of supporting evidence
- conclusions and recommendations including a protection plan.

The above list is not exhaustive and local guidance should always be consulted.

5.5.5.3 Completing the investigation

The investigating officer will discuss the findings with the managing officer and a decision will be made on the following:

- whether to share the report with partner agencies involved in the investigation
- whether on the balance of probability abuse has occurred
- whether a protection plan is required
- whether a case conference is required
- whether the case can be closed with the agreement of multi-agency partners (see Section 5.8).

The managing officer will formally record agreement to the contents and conclusions of the report.

Some investigations may be delayed for justifiable reasons but all effort must be made to progress and complete an investigation within agreed timescales. However, all outcomes or processes may not be completed within this time frame (e.g. a criminal prosecution).

The case conference should be held in order that information can be shared to address current risks and the likelihood of further risk as well as to ensure that all partners are satisfied that an appropriate protection plan is in place.

In some situations it may not be necessary to undertake a case conference. For example:

- the investigation/assessment has concluded and there is no evidence of risk of significant harm to the person at risk or others
- the investigation/assessment is complete and the person at risk is at either a low risk or no risk of harm and a protection plan is in place.

5.5.5.4 If the adult at risk dies during the Safeguarding Adults process

Should an adult at risk or person alleged to have caused harm die during an investigation, even if the death is not related to the allegation of abuse, the Safeguarding Adults process should continue to a conclusion.

An immediate review must take place to decide whether the death was as a result of the inadequacy of the protection plan or whether poor inter-agency working was a contributory factor. In either of these situations the police may be involved where there is evidence or suspicion:

- that the actions leading to harm were intended
- that adverse consequences were intended
- of gross negligence and/or recklessness in a serious safety incident.

If the incident occurred in a health or social care setting and involved unsafe equipment or systems of work, a referral may be made to the Health and Safety Executive (HSE). The HSE will decide whether or not to investigate.

Following a death, more than one investigation into the circumstances may need to be instigated because more than one organisation may have been involved with the individual. A strategy meeting of the relevant organisations should be convened to review the allegation or complaint and to agree a co-ordinated investigation. Any police investigation will take priority. As with any other safeguarding situation giving rise to action under the Safeguarding Adults procedures, there is an expectation that all organisations will co-operate in the agreed process.

The coroner will be informed by the police of the death as soon as possible (and before burial or cremation) if abuse or neglect is suspected to be a contributory factor (i.e. it is thought that the death was not a natural one).

Consideration should always be given to whether or not there should be an independent manager's review or an SCR to examine the circumstances involved (see Section 6).

5.5.5.5 If the adult at risk moves during the Safeguarding Adults process

In such a case the managing officer must:

- ensure that action is taken to ascertain their whereabouts and their safety/wellbeing
- notify the new local authority, in writing, of action taken under the Safeguarding Adults process and what action remains outstanding; the new local authority area will need to agree to the case transfer, if this is what is being requested
- send fully documented and relevant information and summaries as appropriate
- reach agreement with a senior manager in the new local authority about future action, roles and responsibilities; acknowledgement of receipt of the information should be obtained in writing
- advise any other organisations that have been involved in the investigation.

If an adult at risk moves to a residential or nursing home outside the local authority, and the local authority retains financial responsibility, it should liaise with the host authority.

If appropriate, the protection plan will be incorporated into the residential care plan. In this case the funding authority retains a duty of care.

Special rules apply to adults who are subject to Section 117 of the MHA 1983 (aftercare). Where this applies, the mental health service in the original local authority retains responsibility for the patient until this responsibility is accepted by the mental health services of the new area.

In some cases family, friends or carers may remove an adult from the UK before a full investigation can be carried out and protective measures put in place. If there is any indication that such a removal is being planned, legal advice must be sought urgently. If removal does occur, legal guidance must still be sought.

5.5.5.6 If the person alleged to be causing harm moves during the Safeguarding Adults process

Where a police investigation is already underway, it will continue even if the person causing harm moves away.

If the person causing the harm is a paid worker or a volunteer, their situation is covered by the provisions of the SVGA 2006. Regulated activity providers now have a duty to refer to the ISA the names of staff and volunteers who have been found to have harmed or put at risk of harm a child or adult at risk. This includes the names of those who would have been dismissed because they harmed or put at risk of harm a child or adult at risk. The ISA will make a judgement on the evidence whether the person should be barred from any future employment or activity with adults at risk or children. For guidance on referral processes to the ISA, see www.isa-gov.org .

A person who is barred from working with adults at risk and/or children who seeks such employment commits an offence punishable with up to five years' imprisonment. An employer is also committing an offence if they knowingly employ someone who is barred from such employment.

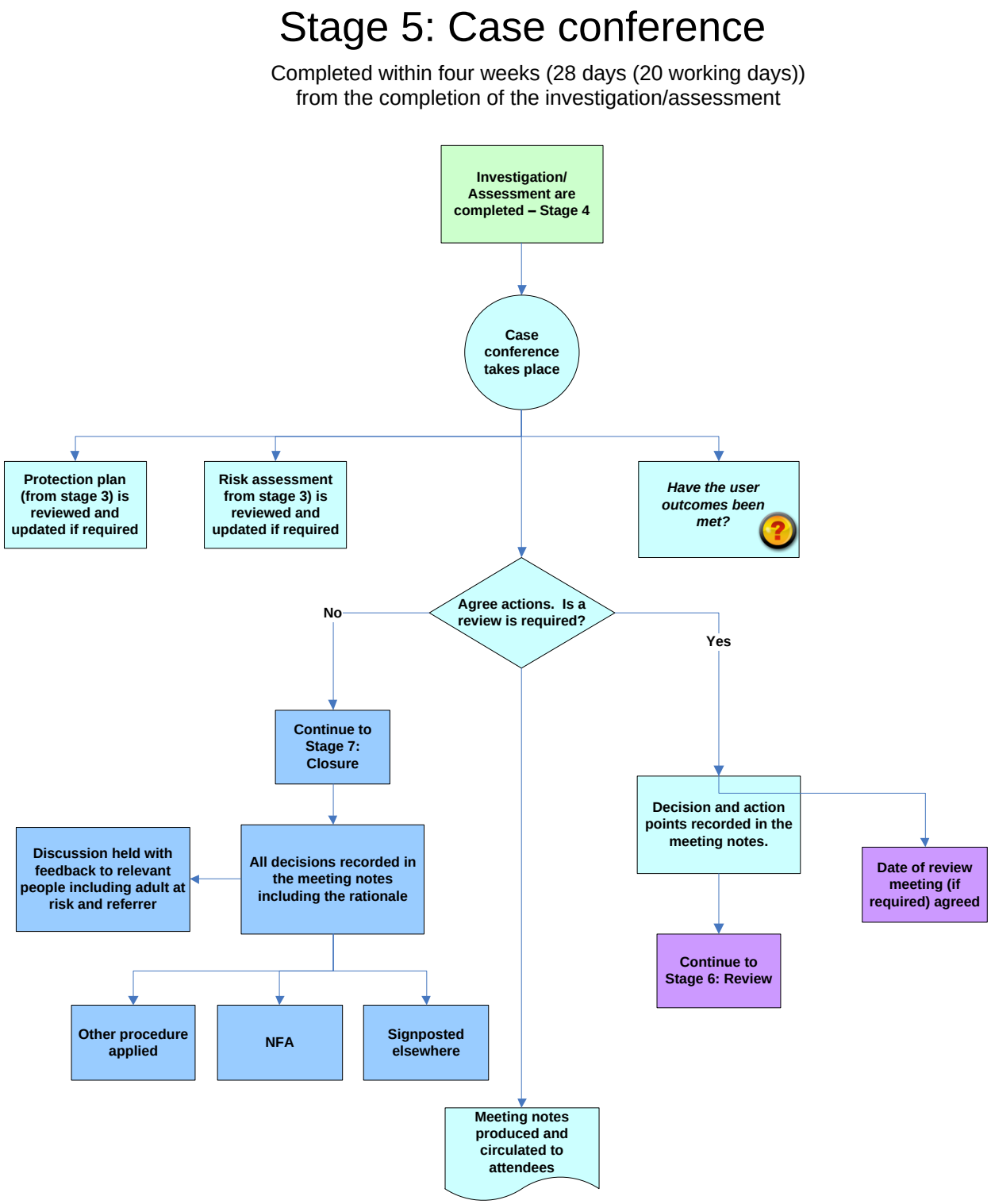
5.5.5.7 If an alert, referral or complaint is received after an adult at risk has died

The alert, referral or complaint could contain an allegation or suspicion that abuse or neglect may have been a contributory factor in the person's death. The allegation may be made by a family member or friend, a concerned member of staff who is 'whistleblowing', or as a result of a report from the coroner. Such a referral will give rise to action under the Safeguarding Adults policy and procedures.

It is important to ensure that no other adults are at risk from the same source and, if they are, to take steps to ensure their safety.

Decisions may also be taken about whether an SCR will be undertaken (see Section 6).

5.6 Stage 5: Case conference



5.6.1 Definition of a case conference

A case conference is a multi-agency meeting held to discuss the outcome of the safeguarding investigation/assessment and to put in place a long-term protection or safety plan. It is essential that the adult at risk is invited to, supported at and enabled to attend the case conference.

5.6.2 Purpose of a case conference

- To consider the findings and outcomes of the investigation/assessment.
- To decide whether abuse took place.
- To assesses ongoing risk.
- To produce or revise a protection plan.
- To ascertain whether the adult at risk is satisfied with the outcome of the investigation.

5.6.3 Roles and responsibilities

The managing officer ensures that a case conference is convened, chaired and minutes taken (see local guidance for chairing arrangements).

In large-scale investigations a more senior/independent person may take the chair. The investigating officer will submit a report summarising the findings of the investigation/assessment and will attend the case conference. Any reports made to date will be available to the meeting and will form the basis of discussion. They should be recalled by the chair at the end of the meeting, and any exceptions to this must be agreed by the chair.

5.6.4 Timescales

The case conference should take place within four weeks (maximum of 28 days, 20 working days) from the completion of the investigation/assessment.

5.6.5 Process

Wherever possible the adult at risk should be involved and assisted to participate in the case conference. It is essential that the adult at risk is given information about the purpose of the conference in advance, and who will be there. In some cases, in order to meet the adult at risk's access and communication needs (e.g. if specialist facilities are needed), a separate protection plan meeting could be held in a different venue. Such a meeting should be held on a date as close to the case conference as possible.

In some cases the conference will be divided into two parts (e.g. where the information being discussed may compromise a future criminal investigation, where confidential or sensitive information relating to a third party needs to be discussed, or where actions relating to the person alleged to have caused harm need to be discussed). In such cases the first part of the meeting is attended by professionals only, and the adult at risk and/or their representative will attend the second part.

5.6.5.1 Who should attend?

- The adult at risk and/or their representative.
- The chair.
- The investigating officer.
- A minute-taker.
- A competent and experienced manager from each organisation involved.
- Representatives from any other relevant organisations who are able to contribute to the protection plan.
- The care manager, care co-ordinator or key worker for the adult at risk.
- Any other relevant professionals (e.g. the police, CQC representative, service contracts/ commissioning staff, GP, psychiatrist or other health care workers involved with the adult at risk.
- A representative from the Council's legal department may also need to be invited.

If any relevant professional is unable to attend, they must provide their contributory information in writing to the meeting.

All those attending should have the delegated authority to agree to make decisions about the provision of resources and services that will contribute to the protection plan.

5.6.5.2 Involving the adult at risk

The adult at risk should be:

- invited, supported and enabled to attend the case conference or equivalent part of the meeting as appropriate where it is safe for them to do so and they wish to participate
- supported to play an active part in the development of their protection plan.

If the person at risk has capacity to make decisions about their own safety, their views should be taken into account about:

- whether they wish to attend
- whether they wish to attend and bring someone else with them
- whether they wish to nominate someone to attend on their behalf and who this is.

If the adult at risk has mental capacity but does not wish to attend the case conference, they should be consulted beforehand about their views and these should in turn be given at the meeting by a representative, advocate or key worker.

If the adult at risk does not have capacity a decision needs to be made about who the key decision-makers should be, in line with the MCA *Code of practice*.[2]

The meeting should be held at a venue which enables the adult at risk to fully participate. In some cases this may be in their own home.

If the adult at risk does not attend the meeting the reasons for this should be recorded.

The meeting should decide and record:

- who will feed back any decisions about the protection plan to the adult at risk if they do not attend
- who they can contact if they do not agree with the protection plan or wish to comment on it.

5.6.5.3 Decisions about others who may wish to attend

- Family members do not have an automatic right to attend a case conference and should only be invited at the express wish of the adult at risk. If the adult does not have capacity to make that decision, it may be made in their best interests, or with the consent of an attorney or deputy.
- The person alleged to have caused harm will not ordinarily be invited to attend the meeting. If the meeting decides there are actions to be taken with regard to this person, it must also decide who will inform them of this and the reasons this decision has been taken. If the person alleged to have caused harm is a staff member or volunteer, the employer will do this.

5.6.5.4 Conducting the case conference

The case conference will:

- receive and consider the investigating officer's report(s) including the stated wishes of the adult at risk
- receive and consider reports from other involved agencies
- evaluate the information in order to assess the levels of current risk(s)
- assess the likelihood of risk(s) reoccurring
- consider whether any further action or information is required
- consider whether legal advice and guidance is required
- consider whether any statutory/regulatory action is required (e.g. referral to professional bodies and regulators)
- review any existing protection plan to ensure it is relevant and appropriate, or agree a protection plan with the adult at risk (or the person representing them or their best interests)
- decide which organisation(s)/individual(s) will monitor and co-ordinate the protection plan
- agree contingency measures if the protection plan does not work

- agree how the protection plan will be shared with partners, taking into account information sharing considerations
- review any actions taken so far in relation to the person alleged to have caused harm and decide what further action is/may be needed for the adult at risk and/or the person causing harm (protection and/or support plan)
- decide what action is appropriate if the allegation has not been proved or was unfounded but concerns remain about standards of care
- provide support and services to meet the needs of the adult at risk and their carer(s)
- determine what additional information needs to be shared and with whom
- set a date for a review if there are concerns that the protection plan may not lead to a reduction of the risk or where the investigation is incomplete at the time of the case conference
- determine on the balance of probabilities whether abuse has occurred.

The fact that there is insufficient evidence for a criminal prosecution does not necessarily mean that action cannot be taken under civil proceedings (e.g. seeking an injunction) or disciplinary proceedings, because there are differing burdens of proof. Discussions about this may form part of the case conference, although final decisions may be made at a later date (e.g. it may not be possible to state with certainty that civil proceedings will take place or the final outcome of disciplinary investigations).

5.6.6 Outcomes

5.6.6.1 The protection plan

The Safeguarding Adults protection plan aims to remove or minimise risk to the person and others who may be affected, if it is not possible to remove the risk altogether. It will need to be monitored, reviewed and amended as circumstances arise and develop. Those attending the case conference will:

- review any existing protection plan to ensure it remains relevant and appropriate, or agree a new or revised plan with the adult at risk (or the person representing them or their best interests), and decide which organisation will monitor and co-ordinate the plan
- agree contingency actions if the protection plan does not work
- designate a protection plan co-ordinator (this is likely to be different to the role of the managing officer and may be a social worker)
- agree how the plan will be shared with partners, taking information sharing considerations into account
- determine what additional information needs to be shared and with whom

- set a date for a review unless all the organisations involved agree that this can take place as part of the care management/ care programme approach CPA or health and social care process
- set a review date no later than *three months* from the date of the conference if there are concerns that the protection plan may not lead to a reduction of risk or where the investigation is incomplete at the time of the case conference.

The protection plan will *not* include actions taken against the person causing harm. Protection plans are case-specific but are likely to include:

- action to ensure the safety of the adult at risk
- action to ensure the continued involvement of the adult at risk and where appropriate their carer or advocate
- details of support services, treatment or therapy available to the adult at risk, either in the immediate or the longer term.

It is imperative that practical steps are taken to ascertain the wishes and views of the adult at risk in relation to the protection plan.

5.6.6.2 Deciding to hold a separate protection plan meeting

Normally a protection plan will be agreed as part of the case conference. However, a separate protection plan meeting may be considered necessary if:

- the strategy meeting decided that it was possible to agree a protection plan without a formal investigation and a case conference
- the investigation was complex or lengthy and there were confidentiality issues resulting in the adult at risk being absent for a significant part of the meeting; their interests would then be best served by having a separate meeting they are able attend
- there are clinical considerations regarding the person's ability to engage in the process at a given time, as agreed by the agencies concerned
- the protection plan meeting needs to take place in the person's own home or in another setting.

Supporting the person to make decisions about what can be done to help them will mean that they are given information about:

- the process and the organisations that may be involved
- the actions that may be taken
- which organisations may be able to offer support
- what the risks may be from not taking any action and what to do if they change their mind at a later date (e.g. if the abuse gets worse and they need help to reduce the risk of further harm).

The individual should also be offered the options of:

- receiving emotional support if necessary
- taking part in activities which increase their ability to protect themselves
- making contact with a named organisation if they change their mind about the protection plan, or if they do not wish any further involvement.

5.6.6.3 Possible outcomes for the person causing harm, the provider or the institution

- Criminal prosecution/formal caution (e.g. individuals, company directors).
- Police action.
- Offer of assessment/services.
- Removal from property/support, advice, services.
- Management of access to adult at risk.
- Referral to the ISA.

A referral to the ISA must be made by the regulated activity provider:

- if they have withdrawn permission for the person (a member of staff or volunteer) to engage in regulated activity, or would have done so if the person had not resigned, retired, been made redundant or been transferred to a position that is not a regulated or controlled activity
- if they think the person has:
  - engaged in relevant conduct or
  - satisfied the harm test (i.e. they have harmed or put at risk of harm the adult at risk)
- if they have received a caution or conviction for a relevant offence.

Other potential outcomes are:

- referral to regulatory body (e.g. NMC, GSCC, BMA)
- disciplinary action
- action by the CQC (e.g. de-registration)
- implementation of requirements made by the commissioner of services
- continued monitoring
- counselling/training
- referral to court mandated treatment
- referral to MAPPA
- action under the MHA 1983 (as amended by the MHA 2007)
- action by contract compliance (e.g. suspension or termination of a contract by a commissioner)
- exoneration

- no further action.

In addition, organisational changes may be implemented following a review (e.g. to staffing, recruitment, training, working practices and culture, improvement of risk monitoring and quality assurance). Changes may also be made in response to recommendations from any complaints process. Such changes can include the setting up of an SCR or serious incident process if there are concerns about the Safeguarding Adults process and/or inter-agency working by partners.

5.6.6.4 Information that may be shared with others

Where concerns have been identified about the quality of care from a particular provider, following the investigation/assessment:

- the CQC should be informed if a local authority or a health organisation has concerns about the standards of care within a care setting
- factual information regarding concerns about standards of care can be shared with local authorities on a need-to-know basis.

One of the functions of the case conference is to evaluate the evidence and to determine the outcome on the balance of probability. The NHS Information Centre for Health and Social Care (Abuse of Vulnerable Adults (AVA)) has identified four possible outcomes:

- *substantiated:* if, for a given referral, all allegations of abuse can be proved on the balance of probability then the case conclusion should be recorded as *substantiated*
- *partly substantiated:* if some, but not all, allegations of abuse can be proved on the balance of probability, then the referral is *partly substantiated*
- *not substantiated:* if none of the allegations of abuse can be proved on the balance of probability (i.e. there is insufficient evidence to support any of the allegations or there is evidence to disprove all the allegations, or a combination of the two), the case conclusion should be recorded as *not substantiated*
- *not determined/inconclusive:* the case conclusion should only be recorded as *not determined/inconclusive* when it is not possible to record the outcome against any of the other outcome categories (this is expected to be an infrequently used category).

It is important to note that the standard of proof for a *criminal* prosecution is higher, as the case has to be proved *beyond reasonable doubt*. For civil, disciplinary or regulatory investigations the standard of proof is based on the balance of probability.

5.6.7 Recording and feedback

Staff must keep records in keeping with their local guidelines/processes

5.6.7.1 Case conference minutes

Minutes should be recorded on the relevant local authority or agreed multi-agency pro forma and approved by the chair of the meeting. The minutes record the decisions of the case conference and evidence of how the decisions were reached. This may involve recording separate decisions and outcomes for each allegation.

The minutes should be circulated within agreed timescales to:

- the alerting manager and the protection plan co-ordinator
- all attendees and invitees to the meeting
- all those contributing to the protection plan
- the CQC where the case conference relates to a service that it regulates
- all other relevant regulatory bodies, as appropriate.

Unless this would increase the levels of risk, a copy of the protection plan should be sent to the adult at risk or, with their permission, to another person. If the adult at risk does not have mental capacity, a decision should be made in their best interests about to whom to send the minutes. If the adult at risk has attended the case conference then the minutes will be shared with them subject to an assessment of risk. Where there is information that cannot be shared, it should be deleted from any documents sent out. It is imperative that DPA 1998 principles are adhered to.

Where information is sent to a carer, with permission of the adult at risk or in their best interests, the managing officer will decide what information can be shared about the person causing the harm.

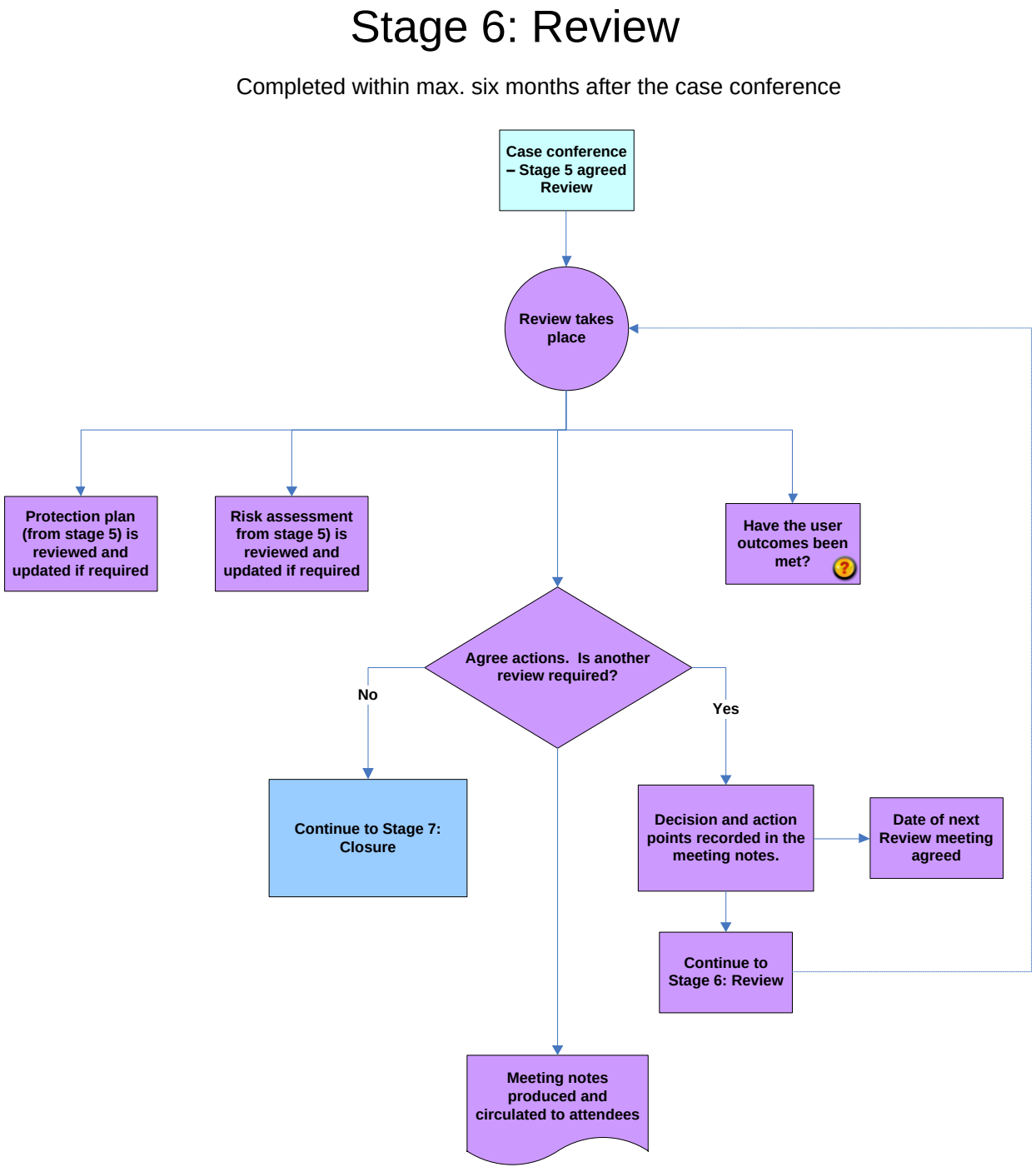
Whether or not minutes of the meeting are sent to the adult at risk, the managing officer will decide who is the best person to report back to them the outcome of the meeting. This should take place as soon as possible after the meeting. The adult at risk should be enabled to raise any issues they may have about the decisions taken and the protection plan that has been developed and agreed upon.

Feedback should also be given to the person who made the referral, taking into account confidentiality and data protection issues.

5.6.7.2 Feedback to the person alleged to be causing the harm

A decision must be made at the meeting about what feedback should be provided to the person alleged to be causing harm and the organisation that employs that person (if relevant), and who should provide it. If the person alleged to be causing the harm does not have mental capacity (and is also an adult at risk), feedback will be given to the person acting in their best interests.

5.7 Stage 6: Review



5.7.1 Definition of review

A review is a meeting of those previously involved in the development of the protection plan, including the adult at risk. The aim is to monitor the progress and effectiveness of the protection plan. The review meeting can only take place following an investigation or if urgent action has been taken to protect an adult at risk.

5.7.2 Purpose of review

The purpose of the review is to ensure that the actions agreed in the protection plan have been implemented and to decide whether further action is needed if any. This can include closure of the safeguarding process and/or referral to other processes such as care management or the care programme approach CPA.

5.7.3 Roles and responsibilities

The managing officer will ensure that a review is undertaken. All parties to the protection plan must contribute to the review by attendance at the meeting or by producing a report if they are unable to attend.

5.7.4 Timescales

A review should be held no later than six months after the case conference but can be called earlier depending on the case or local arrangements. If a date for a review was fixed at the case conference, an earlier review may nevertheless be required in the following circumstances:

- if the adult at risk has capacity to understand the nature of a review and requests one
- if the person representing the best interests of the person at risk requests a review
- if the situation is seen as high risk
- where a review is requested by any organisation involved in the delivery of the protection plan
- as a result of a request by the person co-ordinating the protection plan.

If a decision is taken at the case conference that a review is not necessary, the Safeguarding Adults process will be closed. In this case a decision can be taken that the protection plan should be reviewed as part of the ongoing care management or CPA processes.

If during the review a new concern of abuse or neglect is raised, this should be considered as a new alert/referral.

5.7.5 Process

The review should be attended by all those who are involved in the protection plan and any services that may be able to provide support or need to be involved in the future.

The adult at risk should be enabled to participate in the review on the same basis as for the case conference. The meeting should be held at a venue which enables the adult at risk to fully participate, and this may be in their own home.

The attendance at the review of a carer or a personal representative is on the same basis as their attendance at a case conference.

5.7.5.1 Actions

The review should:

- establish to what extent the desired outcomes of the case conference have been met
- review the risk assessment
- decide in consultation with the adult at risk or their personal representative what changes, if any, need to be made to the protection plan to decrease risk or to make the plan fit more closely with their wishes
- establish the views of the adult at risk or their personal representative about the protection plan and/or other matters of importance to them
- decide whether any changes/additions are needed to an existing care plan or whether any additional assessments are required
- establish whether there is any new information about the incident which requires further action (e.g. referral to the police or the ISA)
- review who will be responsible for individual actions within the protection plan
- decide about ongoing responsibility for the co-ordination of the protection plan
- decide whether there is need for a further review and, if so, set a date
- decide whether to close the Safeguarding Adults process.

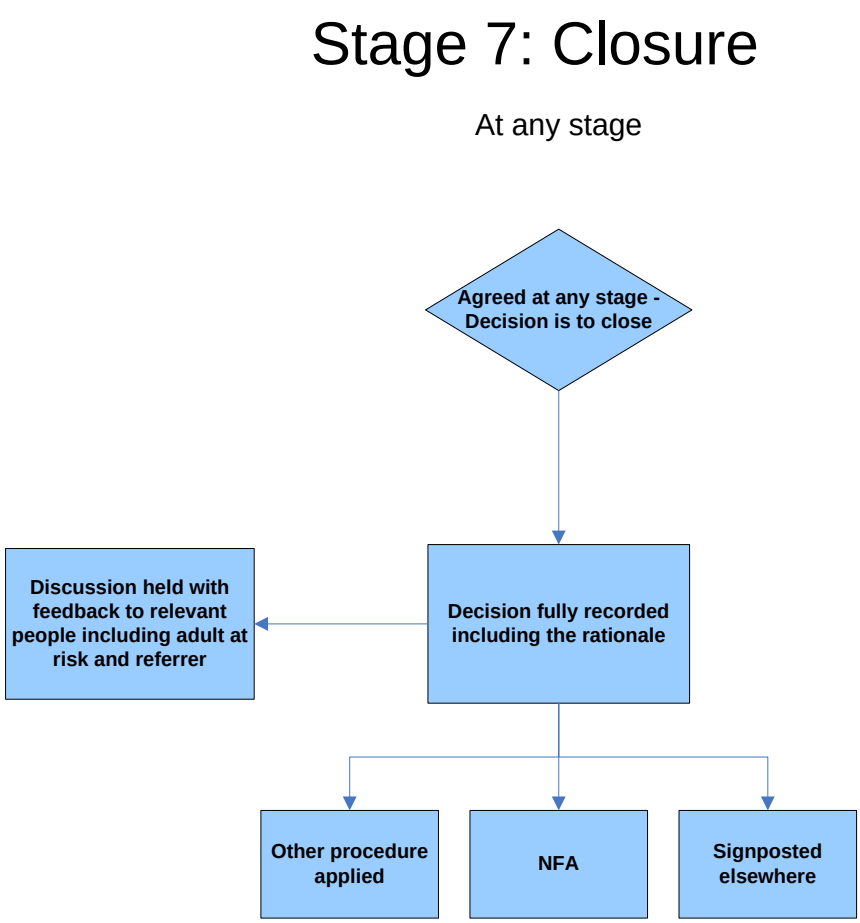
5.7.5.2 Recording and feedback

At the review the following should be recorded and disseminated:

- feedback on the protection plan, including the views of the adult at risk and whether their desired outcomes have been met
- any decisions and actions naming organisations and individuals who have a role to play in the protection plan and who have been undertaking actions agreed during the review
- the review notes, copies of which should be sent to the adult at risk or their personal representative if the adult at risk gives their permission.

If the adult at risk does not have mental capacity and does not attend the review, agreement should be reached about feedback arrangements in accordance with their best interests. This feedback should be provided as soon as possible after the review.

5.8 Stage 7: Closure



5.8.1 Definition of closure

Closure is when the Safeguarding Adults investigation is concluded. This includes all corresponding actions being completed and where relevant the development of an effective protection plan for the adult at risk.

5.8.2 Purpose of closure

The purpose of closure is to ensure all actions are completed or are in progress, including that:

- all records are completed and contain all relevant information
- the adult at risk knows the outcome of the investigation
- the adult at risk knows that the process is concluded and who to contact if they have any future concerns about abuse
- feedback has been given to all relevant parties including the alerter, the person alleged to have caused harm and any significant others
- all those involved with the person know how to re-refer if there are renewed or additional concerns.

5.8.3 Roles and responsibilities

The managing officer must reach agreement to close the process with all organisations that have been involved in the investigation and protection plan. The closing process must be signed off by the managing officer.

5.8.4 Timescales

Closure can take place at any stage of the process if:

- the level of harm has been assessed as low and an information-gathering, sharing and protection plan can be evidenced
- the allegation of abuse has not been substantiated
- the adult at risk has the capacity to decide that they want no further intervention and there are no other adults or children at risk
- the status of the allegation has been determined and the adult at risk is protected.

It is usual that a case will remain in the Safeguarding Adults process if the risk of harm to an individual remains high or very high. However, there are individuals who have the capacity to choose to remain in high or very high risk situations. In these circumstances, it is imperative that all stages of the safeguarding process have been followed to ensure that *all* options have been offered to the adult at risk and can be fully evidenced.

5.8.5 Process

The decision to complete and close an investigation, taken at a strategy discussion/meeting, a case conference or a review is a *multi-agency* one. It is essential that the discussion and/or meeting identifies the risk of harm to the individual and the potential risk of harm to others if relevant, and that the minutes clearly reflect the decisions taken.

The case may remain open to care management or CPA systems, in which case the situation will be reviewed and monitored through those processes. This will include monitoring and review of the protection plan as necessary.

At the point of closure the following actions will be completed:

- all evidence and decisions are adequately recorded
- the necessary monitoring forms and all data monitoring systems are completed
- the referrer is notified of completion
- all relevant partner organisations are informed about the closure
- referral is made to appropriate professional bodies where necessary
- notifiable occupation schemes are informed and, if proven, action is taken to remove a member of staff from a professional register or refer the matter to the ISA.

5.8.6 Other factors

Feedback must routinely be sought from the adult at risk about their experience of the process and whether their wishes and outcomes have been met and they now feel safer.

Through the SAB, any partner agency can request that a serious incident investigation, serious case review or independent management review is undertaken if there was a ‘near-miss’ or a fatality, procedures do not appear to have been followed or agencies did not work together effectively (see Section 6).

6 Major investigations

6.1 Definition

A large-scale Safeguarding Adults investigation would be indicated when there has been an allegation of institutional abuse or a number of adults at risk have been allegedly abused, or patterns or trends are emerging from data that suggest serious concerns about poor quality of care:

- in a particular resource/establishment
- where the same person is suspected of causing the abuse or neglect
- where a group of individuals are alleged to be causing the harm.

No secrets[1] states that 'institutional abuse' can include:

- repeated instances of poor care
- poor professional practice
- rigid routines
- lack of positive responses to complex needs
- inadequate staffing
- insufficient knowledge within a service
- unacceptable treatments or programmes which include sanctions or punishment, such as withholding food or drink
- unnecessary and unauthorised use of control and restraint.

The Royal College of Psychiatrists (RCP)[22] Institutional abuse of older adults ,Council Report 2001 states that:

> *Institutional abuse includes individual acts or omissions and managerial failings in which the regime of the institution itself may be abusive.*

'Institutional settings' include:

- care homes
- day services
- hospitals, including wards
- residential colleges
- adult placements
- sheltered accommodation
- rehabilitation units
- custodial settings.

6.2 Purpose

To have in place multi-agency arrangements to respond to a complex/large-scale incident, with the local authority, the police, the PCT, the CQC and any commissioners of implicated services being key partners.

Such arrangements would enable:

- the co-ordination of investigations/assessments and the collation of information
- agreement upon required action to respond to the identified risk of harm
- agreement upon required action in response to any organisational failure identified
- agreement upon required action in relation to any person found to have caused harm or risk.

The outcome would be the:

- safety and wellbeing for all those individuals identified as at risk
- improved service quality and performance.

6.3 Serious case review

An SCR is a review of the practice of agencies involved in a safeguarding incident. An SCR is commissioned by the SAB when a serious incident or incidents of adult abuse take place or are suspected. The aim is for agencies and individuals to learn lessons and improve the way in which they work.

6.3.1 Responsibility

The local SAB has the lead responsibility for conducting an SCR. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case. This guidance follows best practice as laid down by ADASS in February 2010.[23]

6.3.2 Purpose

The purpose of an SCR is *not* to apportion blame as to who is responsible for the death of or significant harm to a vulnerable adult and how this came about: that duty falls to the criminal justice system and/or coroner's office. The purpose of an SCR is to:

- establish whether there are lessons to be learned from the case
- identify what those lessons are, how they will be acted upon and what is expected to change as a result within a given timescale in terms of improvements to practice
- inform and improve local inter-agency working
- review the effectiveness of procedures (both multi-agency and those of individual organisations) and make recommendations for improvements
- prepare or commission an overview report which brings together and analyses the overall findings.

Always refer to any available local guidance in relation to the setting up of an SCR.

References

1 DH (Department of Health) (2000) *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, London: DH.

2 DfCA (2007) (Department for Constitutional Affairs) *Mental capacity act 2005: code of practice*, London: TSO.

3 DH (Department of Health) (2008) *Mental capacity act 2005: deprivation of liverty safeguards – code of practice to supplement the main mental capacity act 2005 code of practice*, London: DH.

4 British and Irish Legal Information Institute (BAILII) (2012) England and Wales Court of Appeal (Civil Division) Decisions
http://www.bailii.org/ew/cases/EWCA/Civ/2012/253.html

5 DH (2005) The Mental Capacity Act 2005
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6 SCIE (2009) Managing risk, minimising restraint (AAG 16)
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7 The Care Quality Commission(CQC) are the independent regulator of all health and social care services in England. **www.cqc.org.uk**

8 ACPO (Association of Chief Police Officers) (2008) *Guidance on investigating domestic abuse*, Wyboston Lakes: ACPO/National Policing Improvement Agency.

9 DH (2007)* Standard 5: Safeguarding and promoting the welfare of children and young people*.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4867814

10 Law Commission (2011) *Adult social care*
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11 Ministry of Justice (2011) *Achieving best evidence in criminal proceedings: guidance on interviewing victims and witnesses, and guidance on using special measures*, London: Ministry of Justice.

12 CQC (Care Quality Commission) (2010) *Essential standards of quality and safety*, London: CQC.

13 DH (Department of Health) (2011) Safeguarding adults: the role of NHS commissioners, London DH

14 DH (Department of Health) (2011) Safeguarding adults: the role of health service managers and their boards, London: DH

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16 DH (Department of Health) (2011) Safeguarding adults: measuring effectiveness through assurance, London: DH

17 DH (Department of Health) (2010) *Liberating the NHS*: *legislative framework and the next steps*, London: DH.

18 BMA (British Medical Association) The Safeguarding Vulnerable Adults – A toolkit for general practitioners (Oct 2011)

19 CQC (Care Quality Commission) Safeguarding Adults Protocol (2010)

20 DH (Department of Health) (2011) statement of policy on Safeguarding Adults.http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_126748

21 DH (Department of Health) (2007) Putting people first: a shared vision and commitment to the transformation of adult social care, London: DH

22 RCP (Royal College of Psychiatrists) Institutional abuse of older adults ,Council Report 2001

23 ADASS (Association of Directors of Adult Social Services Association) The Vulnerable Adult Serious Case Review guidance 2010

Online and other resources (Hyperlinks)

Hate crime

Domestice Violence (MARAC)

Domestic Violence, Crime and Victims Act (2004)

Honour-based violence

Female Genital Mutilation Act 2003

Forced Marriage Unit

Ministry of Justice

Forced Marriage (Civil Protection) Act 2007

Association of Directors of Adult Social Services

The Not So Big Society

UK Human Trafficking Centre (part of Serious Organised Crime Agency)

Prevent Strategy 2011 (Home Office)

Multi Agency Public Protection arrangements MAPPA reports

HM Prisons

Victim Support helpline

IDEA – Councillors' briefing: safeguarding adults

Healthwatch

Office of the Public Guardian

Homeless code of guidance for local authorities

Crown Prosecution Service

Whistleblowing in the workplace

Information and Guidance on the Abuse of Vulnerable Adults Collection (AVA)

Care Quality Commission

Independent Safety Authority

JULY 2012

Safeguarding adults: multi-agency policy and procedures for the West Midlands

This resource reflects the commitment of organisations in the West Midlands and allied local authorities to work together to safeguard adults at risk. The procedures outlined aim to make sure that:

- the needs and interests of adults at risk are always respected and upheld
- the human rights of adults at risk are respected and upheld
- a proportionate, timely, professional and ethical response is made to any adult at risk who may be experiencing abuse
- all decisions and actions are taken in line with the Mental Capacity Act (MCA) 2005.

The procedures also aim to ensure that each adult at risk maintains:

- choice and control
- safety
- health
- quality of life
- dignity and respect.

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