Blackpool Safeguarding Adults Board

Multi-Agency Safeguarding Policy & Procedures

This document is divided into three parts –

Part One – Policy
This section of the document provides the scope and guiding principles of the procedures, definitions.

Part Two– Procedures
This section describes the actions required of individuals and organisations to respond to suspected or actual abuse of an adult at risk. Actions within the procedures should be informed by the policy.

Part three - Guidance
This section described roles and responsibilities and linkages to other agendas or specialist services and a reference point for considerations to be made throughout the process.

Additional guidance will be developed for related areas of work in response to the Care Act and its associated statutory guidance.

Document Information

Version/Issue Number	Final (1)
Document Status	Final
Approved	January 2015
Review Date	12 months – to include Safeguarding Adults Review findings, national legislative changes and local or national legal update.

Scope

The policy, procedures and guidance apply to both statutory and non-statutory organisations involved in safeguarding adults, including managers, professionals, volunteers and staff working in public, voluntary and private sector organisations.

Equality and Diversity

It is every person's human right to live a life free from abuse and neglect. Every adult at risk has an equal right to support and protection within these procedures regardless of their individual differences or circumstances.

The Blackpool Safeguarding Adults Policy, Procedures and Guidance apply equally to:

- all adults at risk as defined within this policy
- all agencies
- all settings,
- and all forms of abuse

At each stage of these procedures due regard must be given to individual differences, including age, gender reassignment, disability, religion or belief, sex, sexual orientation, race or racial group, caring responsibilities, class, culture, language, pregnancy and marital or civil partnership status.

Review of Document

This document will be reviewed in 12 months and amended to include findings from Safeguarding Adults Reviews (undertaken by the Blackpool Safeguarding Adults Board), any national legislative changes and local or national legal updates.

If you identify areas of omission or potential improvements to this policy and procedure document please inform us by contacting safeguarding.adultsboard@blackpool.gov.uk

Contents

1. Introduction

The purpose of this Blackpool Safeguarding Adults Policy & Procedure document is to provide a multi-agency framework which aims to prevent and reduce the risk of significant harm to "adults at risk" from abuse, neglect or other types of exploitation, whilst supporting them in maintaining control over their lives.

The Care Act 2014 sets out, for the first time, a clear legal framework for how local authorities and health, civil and criminal justice systems should protect adults at risk of abuse or neglect. This Policy, Procedure & Guidance document incorporates relevant content of both the Care Act 2014 and its associated regulations and guidance. The Care Act supersedes the Department of Health publication "No Secrets" (2000).

Care Act 2014 - http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
Care Act Guidance - https://www.gov.uk/government/publications/care-act-2014-statutory-guidance-for-implementation

All agencies have a role to safeguard and protect adults at risk; specific organisations roles and responsibilities are described in section 11.1 of the guidance.

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about people and organisations working together to prevent and stop both the risks and experience of abuse or neglect, while at the same time making sure that the adult's wellbeing is promoted. This includes, where appropriate, having regard to their views, wishes, feelings and beliefs in deciding on any action. We must recognise that adults sometimes have complex interpersonal relationships and may be very clear about their wishes despite professional's perspectives, ambivalent, unclear or unrealistic about their personal circumstances.

Statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of:

- whether those needs are being met , and
- whether the adult lacks mental capacity or not, and
- setting - other than prisons and approved premises where prison governors and National Offender Management Service (NOMS) respectively have responsibility.

(However, in the latter case, they may ask for advice from the local authority when faced with a safeguarding issue that they are finding particularly challenging).

The aims of adult safeguarding are to:

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

The Mental Capacity Act and Making Safeguarding Personal are significant in relation to safeguarding adults within the community, in ensuring that people who wish to become safe are helped to do so. Anyone who lacks mental capacity in relation to safeguarding must have a best interests decision made about their safety.

In order to achieve these aims, it is necessary to:

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

Organisations should always promote the adult's wellbeing in their safeguarding arrangements. People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and other staff should not be advocating "safety" measures that do not take account of individual well-being, as defined in Section 1 of the Care Act. Subsections 2 and 3 of Part 1 of the Care Act are critical to ensuring the person is in control of what happens to them in all aspects of their life, is fully included in all decisions, risks and choices are balanced, and restrictions minimised – for more detailed information see hyperlink above to Care Act and Guidance.

Safeguarding is not a substitute for:

- providers' responsibilities to provide safe and high quality care and support;
- commissioners regularly assuring themselves of the safety and effectiveness of commissioned services;
- the Care Quality Commission (CQC) ensuring that regulated providers comply with the fundamental standards of care or by taking enforcement action; and
- the core duties of the police to prevent and detect crime and protect life and property
- discussion with the individual about concerns professionals have about choices the individual is making and consequent risks

2. Principles

The following six principles apply to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider local authority functions and the criminal justice system. The principles should inform the ways in which professionals and other staff work with adults.

Empowerment – People being supported and encouraged to make their own

decisions and informed consent.

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

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

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

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

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

Protection – Support and representation for those in greatest need.

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

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

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

Accountability – Accountability and transparency in delivering safeguarding.

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

2.1. Wellbeing

A general duty under the Care Act is to promote that individual's wellbeing. Wellbeing, in relates to any of the following:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional well-being;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and
- support, or support, provided to the individual and the way in which
- it is provided);
- participation in work, education, training or recreation;
- social and economic well-being;
- domestic, family and personal relationships;
- suitability of living accommodation;
- the individual's contribution to society.

2.2. Making Safeguarding Personal

In addition to these principles, it is also important that all partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences,

histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised.

Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

Nevertheless, there are key issues that local authorities and their partners should consider if they suspect or are made aware of abuse or neglect. The state has a fundamental duty to protect its citizens from serious harm and to protect the public, therefore if an adult with care and support needs is at risk of serious harm, from which they are unable to protect themselves, or if others are at risk, then consent can be overridden.

3. Part One – Policy

3.1. Definitions

3.1.1. Who is an adult at risk?

An adult at risk is someone who:

- is aged 18 or over;
- has needs for care and support (whether or not the local authority is or may be meeting any of those needs) and;
- as a result of those care and support needs is unable to protect themselves from either;
    - the risk of, or
    - experiencing abuse or neglect.

An adult at risk would include therefore be an adult who is unable to protect themselves as a result of their care and support needs, and for example:

- Is an older person who is frail due to ill health, physical disability or cognitive impairment
- Someone who has a learning disability
- Someone who 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 / alcohol
- Is a carer such as a family member or friend who provides personal assistance and care to adults and is subject to abuse Lacks the mental capacity to make particular decisions and is in need of care and support.

****This list is not exhaustive****

3.1.2. What is abuse and neglect?

For the purposes of this 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 results in significant harm"

(Department of Health, "No Secrets" 2000).

Organisations should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered; although the adult must be an adult at risk (as described above) before the issue is considered as a safeguarding concern.

Abuse may consist of:

- a single or repeated acts;
- an act of commission or omission;
- multiple acts, for example, an adult at risk may be neglected and also being financially abused;
- a pattern which involves more than one person;

Professionals and others should look beyond single incidents or individuals to identify patterns of harm. Repeated instances of poor care may be an indication of more serious problems and of what we now describe as organisational abuse. In order to see these patterns it is important that information is recorded and appropriately shared. Safeguarding must be seen within the context of someone's life.

Abuse may be intentional or unintentional. It may involve the misuse of power and control that one person has over another. Some abusive acts or omissions are crimes, and informing the police must be a key consideration.

The term ***'harm'*** is described in *No Secrets* as involving:

- 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 or what protection measures to put in place. Consideration must be given not only to the immediate impact and risk to the person, but also to the risk of future longer-term harm, significant harm which may have been avoided (for example incorrect medication given which did not harm the person in this circumstance but had the potential to cause significant harm if not identified).

The level of harm should also be balanced with the need for more than one agency to respond to the concerns – for example the level of harm caused to the individual may appear to be relatively low however it may turn out to be a complex case where a number of agencies should work with the individual to help them feel safe.

Acts and omissions that affect a person's wellbeing should also be considered, (see section 2.1 above). Whenever any safeguarding activities are undertaken relating to an individual, agencies must act to promote wellbeing – they should consider all of the aspects above in looking at how to meet a person's needs and support them to achieve their desired outcomes. However, in individual cases, it is likely that some aspects of wellbeing will be more relevant to the person than others. For example, for some people the ability to engage in work or education will be a more important outcome than for others, and in these cases "promoting their wellbeing" effectively may mean taking particular consideration of this aspect. A flexible approach should be adopted that allows for a focus on which aspects of wellbeing matter most to the individual concerned.

3.1.3. Types of abuse

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

- **Physical abuse –** including assault, hitting, slapping, pushing, misuse of medication, restraint, female genital mutilation (FGM), or inappropriate physical sanctions.

- **Domestic abuse** – including psychological, physical, sexual, financial, emotional abuse, forced marriage and so called 'honour' based violence. (for further information please see Section 12.7).

- **Sexual abuse** – including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, indecent images, subjection to pornography or

witnessing sexual acts, indecent exposure and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

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

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

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

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

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

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

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

3.1.4. Patterns of Abuse

Patterns of abuse vary and include:

- Domestic Abuse within where one member of a household or family/partnership uses abuse to control the behaviour of another. The highest risk from serious harm from domestic abuse is when the pattern of abuse has been challenged e.g. if the victim has disclosed and is getting support or has left.

- Serial abusing in which the perpetrator seeks out and 'grooms' individuals. Sexual abuse sometimes falls into this pattern as do some forms of financial abuse and exploitation.

- Long-term abuse in the context of an ongoing family relationship such as domestic abuse between spouses or generations or persistent psychological abuse.

- Opportunistic abuse such as theft occurring because money or jewellery has been left lying around.

- Situational abuse arises because pressures have built up and/or because of difficult or challenging behaviour.

- Neglect of a person's needs because of those around him or her are not able to be responsible for their care, for example if their carer has difficulties caused by debt, alcohol or mental health problems.

- Organisational abuse which features poor care standards, lack of positive response to feedback e.g. from visitors, isolation from sources of best practice, lack of positive responses to complex needs, rigid routines, inadequate staffing and/or insufficient knowledge based within the service;

- Unacceptable "treatments" or programmes which include sanctions or punishment such as withholding of food or drink, seclusion, unnecessary and unauthorised use of control and restraint or over-medication.

- Failure of agencies to ensure staff receive appropriate guidance on anti-discriminatory practice including, harassment, victimisation and hate crime.

- Failure to access key services such as health care, social care assessments, psychological and behavioural support, dentistry, prosthetics services.

- Misappropriation of benefits and/or use of the person's money by other members of the household.

- Fraud or intimidation in connection with a will or property, or other assets.

Abuse can happen anywhere - for example:

- when someone lives alone or with others;
- in someone's own home;
- in a public place;
- in hospital;
- in a care home or in college.

It is important to understand the circumstances of abuse, including the wider context such as whether others may be at risk of abuse, whether others have witnessed abuse and the role of family members and paid staff or professionals.

3.1.5. Who Might Commit Abuse?

(See also, Section 12.4 – Responsibilities to those who are alleged to have caused harm)

Anyone can carry out abuse or neglect, including:

- spouses/partners;
- other family members;
- neighbours;
- friends;
- acquaintances;
- local residents;

- people who deliberately exploit adults they perceive as vulnerable to abuse;
- paid staff or professionals;
- volunteers and strangers;
- Other adults at risk

If someone has concerns about the actions of an attorney acting under a registered Enduring Power of Attorney (EPA) or Lasting Power of Attorney (LPA), or a Deputy appointed by the Court of Protection, they should contact the Office of the Public Guardian (OPG). The OPG can investigate the actions of a Deputy or Attorney and can also refer concerns to other relevant agencies. When it makes a referral, the OPG will make sure that the relevant agency keeps it informed of the action it takes. The OPG can also make an application to the Court of Protection if it needs to take possible action against the attorney or deputy. Whilst the OPG primarily investigates financial abuse, it is important to note that that it also has a duty to investigate concerns about the actions of an attorney acting under a health and welfare Lasting Power of Attorney or a personal welfare deputy. The OPG can investigate concerns about an attorney acting under a registered Enduring or Lasting Power of Attorney, regardless of the adult's capacity to make decisions.

3.2. Prevention

Whilst the safeguarding adults procedures focus on responding to incidents of abuse, its prevention must always be the primary objective. Members of the public, staff, volunteers and organisations all have a role in preventing abuse.

Agencies should stress the need for preventing abuse and neglect wherever possible. Observant professionals and other staff making early, positive interventions with individuals and families can make a huge difference to their lives, preventing the deterioration of a situation or breakdown of a support network. It is often when people become increasingly isolated and cut off from families and friends that they become extremely vulnerable to abuse and neglect. Agencies should implement robust risk management processes in order to prevent concerns escalating to a crisis point and requiring intervention under safeguarding adult procedures.

Partners should ensure that they have the mechanisms in place that enable early identification and assessment of risk through timely information sharing and targeted multiagency intervention.

Members of the public can help prevent abuse, by encouraging people they are concerned about to recognise risks, to seek support, to access services they need. This might be by helping friends or family members to recognise abuse or to plan ahead as to how they manage their finances and affairs. This could also involve helping people to access information and advice or to understand their rights and responsibilities.

3.2.1. Dignity

The Social Care Institute for Excellence (SCIE) have identified eight factors in relation to dignity, which in turn promotes self-respect (see http://www.scie.org.uk/publications/guides/guide15/factors/index.asp) and each have a role in helping prevent abuse. These are:

- Choice and control;
- Communication;
- Eating and nutritional care;
- Pain management;
- Personal hygiene;

- Personal assistance;
- Privacy;
- Social inclusion.

3.3. Framework for Adult Safeguarding

3.3.1. Human Rights

Each stage of the safeguarding adults procedures should consider an outcome which supports or offers the opportunity to develop or to maintain a private life which includes those people with whom the adult at risk wishes to establish, develop or continue a relationship and a right to make an informed choice.

Intervention should be proportionate to the harm caused, or the possibility of future harm. As well as thinking about an individual's physical safety it is necessary to also consider the outcome that they want to see and take into account their overall wellbeing. For example, someone with mental capacity may choose to overlook a relative taking money from them when they do the shopping for the sake of their relationship with that relative, because the relationship has the overall effect (outcome) of improving the life of the adult, including their safety, happiness and mental well-being.

The assessment of risk should be based on the fact that some risk is an inevitable consequence of life. The objective is not necessarily to eliminate risk, but to reduce risk so as to enable a person to safely maintain their independence and well-being wherever possible. Where the person has capacity, positive risk taking should be encouraged.

Assessments of risk should be undertaken in partnership with the person at risk, who should be supported to weigh up risks against possible solutions. People need to be able to decide for themselves where the balance lies in their own life, between living with an identified risk and the impact of any protection plan on their independence and/or lifestyle.

It is important to listen to the adult at risk; both in terms of the alleged abuse and in terms of what resolution they want. The adult at risk's views should be taken seriously and acted upon in an appropriate manner. Individuals have a right to privacy; to be treated with dignity and to be enabled to live an independent life.

3.3.2. Mental Capacity

The law presumes that adults have mental capacity to make their own decisions. However there will be times and situations in which an individual lacks mental capacity in relation to particular decisions.

Issues of mental capacity and the ability to give informed consent are central to decisions and actions within the safeguarding adults process. 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.

The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack mental 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 within the safeguarding adults procedures must comply with the Act.

The Act says that:

"… a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or brain" *(Mental Capacity Act 2005)*.

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

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

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

Professionals and other staff need to understand and always work in line with the Mental Capacity Act 2005 (MCA). They should use their professional judgement and balance many competing views. They will need considerable guidance and support from their employers if they are to help adults manage risk in ways and put them in control of decision making if possible.

Regular face-to-face supervision from skilled managers is essential to enable staff to work confidently and competently in difficult and sensitive situations.

Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the MCA in adult safeguarding enquiries challenges many professionals and requires utmost care, particularly where it appears an adult has capacity for making specific decisions that nevertheless places them at risk of being abused or neglected.

The MCA created the criminal offences of ill-treatment and wilful neglect in respect of people who lack the ability to make decisions. The offences can be committed by anyone responsible for that adult's care and support – paid staff but also family carers as well as people who have the legal authority to act on that adult's behalf (i.e. persons with power of attorney or Court-appointed deputies). There are also provisions within section 127 of the Mental Health Act (1983) for prosecution in specific circumstances.

These offences are punishable by fines or imprisonment. Ill-treatment covers both deliberate acts of ill-treatment and also those acts which are reckless which results in ill treatment. Wilful neglect requires a serious departure from the required standards of treatment and usually means that a person has deliberately failed to carry out an act that they knew they were under a duty to perform.

3.3.3. Principles of the Mental Capacity Act 2005

The Mental Capacity Act has five statutory principles that can be applied to adult safeguarding procedures, as follows:

- an adult at risk has the right to make their own decisions and must be assumed to have mental capacity to make decisions about their own safety unless it is established that they lack mental capacity;

- adults at risk must receive all appropriate help and support to make decisions before anyone concludes that they cannot make their own decisions;

- adults at risk have the right to make decisions that others might regard as being unwise or eccentric and a person cannot be treated as lacking mental capacity for these reasons;

- decisions made on behalf of a person who lacks mental capacity must be done in their best interests and should be the least restrictive of their basic rights and freedoms before any act is undertaken or before any decision is made on behalf of an adult at risk who lacks mental capacity, consideration must be given as to whether the same outcome can be achieved in a way that is less restrictive on the person's rights and freedoms;

- In the event that a person does not have the mental capacity to consent to decisions about their own welfare, a "best interests" decision will need to be made in line with the Mental Capacity Act and Mental Capacity Act Code of Practice.

Recording consent to share information is a key practice issue within adult safeguarding, other areas where consent in relation to adults at risk may be:

- An activity that may be abusive – if consent to abuse or neglect was given under duress for example, as a result of exploitation, pressure, fear or intimidation the adult at risk's consent to it should be disregarded.

- The progression of an adult safeguarding enquiry – where an adult at risk with capacity has made a decision that they do not want any action to be taken and there are no public interest or vital interest considerations their wishes must be respected. However, they must be given information and have the opportunity to consider all the risks and fully understand the likely consequences of that decision over the long and short term.

- The recommendations of an individual protection plan being put into 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 an adult at risk who has mental capacity refuses support (including involvement in the safeguarding adults process), their wishes will be respected unless:

- There is a public interest, for example, not acting will put other adults or children at risk
- There is a duty of care to intervene, for example a crime has been or may be committed
- There is evidence to suggest that the adult at risk has been unduly coerced / threatened into not seeking intervention.
- There is risk of death or serious injury to the adult
- There is any other overriding public duty

3.3.4. Criminal Offences and Adult Safeguarding

Everyone is entitled to the protection of the law and access to justice. Behaviour which amounts to abuse and neglect, for example physical or sexual assault or rape, psychological abuse or hate crime,

wilful neglect, unlawful imprisonment, theft and fraud and certain forms of discrimination also often constitute specific criminal offences under various pieces of legislation. Although the local authority has the lead role in making enquiries, where criminal activity is suspected, then the early involvement of the police is likely to have benefits in many cases.

For the purpose of court proceedings, a witness is competent if they can understand the questions and respond in a way that the court can understand. Police have a duty under legislation to assist those witnesses who are vulnerable and intimidated. A range of special measures are available to facilitate the gathering and giving of evidence by vulnerable and intimidated witnesses. Consideration of specials measures should occur from the onset of a police investigation. In particular:

- immediate referral or consultation with the police will enable the police to establish whether a criminal act has been committed and this will give an opportunity of determining if, and at what stage, the police need to become involved further and undertake a criminal investigation;

- the police have powers to initiate specific protective actions which may apply, such as Domestic Violence Protection Orders (DVPO);

- a higher standard of proof is required in criminal proceedings ("beyond reasonable doubt") than in disciplinary or regulatory proceedings (where the test is the balance of probabilities) and so early contact with police may assist in obtaining and securing evidence and witness statements;

- early involvement of the police will help ensure that forensic evidence is not lost or contaminated;

- police officers need to have considerable skill in investigating and interviewing adults with a range of disabilities and communication needs if early involvement is to prevent the adult being interviewed unnecessarily on subsequent occasions. Research has found that sometimes evidence from victims and witnesses with learning disabilities is discounted. This may also be true of others such as people with dementia. It is crucial that reasonable adjustments are made and appropriate support given, so people can get equal access to justice;

- police investigations should be coordinated with health and social care enquiries but they may take priority;

- guidance should include reference to support relating to criminal justice matters which is available locally from such organisations as Victim Support and court preparation schemes;

- some witnesses will need protection; and

- the police may be able to get victim support in place.

Special Measures were introduced through legislation in the Youth Justice and Criminal Evidence Act 1999 (YJCEA) and include a range of measures to support witnesses to give their best evidence and to help reduce some of the anxiety when attending court. Measures in place include the use of screens around the witness box, the use of live-link or recorded evidence-in-chief and the use of an intermediary to help witnesses understand the questions they are being asked and to give their answers accurately.

Vulnerable Adult Witnesses
(S.16 Youth Justice and Criminal Evidence Act 1999)

YJCEA describes Vulnerable Adult witnesses as having a:

- mental disorder;
- learning disability; or
- physical disability.

These witnesses are only eligible for special measures if the quality of evidence that is given by them is likely to be diminished by reason of the disorder or disability.

3.3.5. Intimidated Witnesses
(S.17 Youth Justice and Criminal Evidence Act 1999)

YJCEA describes Intimidated witnesses as those whose quality of evidence is likely to be diminished by reason of fear or distress. In determining whether a witness falls into this category the court takes account of:

- the nature and alleged circumstances of the offence;
- the age of the witness;
- the social and cultural background and ethnic origins of the witness;
- the domestic and employment circumstances of the witness;
- any religious beliefs or political opinions of the witness;
- any behaviour towards the witness by the accused or third party.

Also falling into this category are:

- complainants in cases of sexual assault;
- witnesses to specified gun and knife offences;
- victims of and witnesses to domestic abuse, racially motivated crime, crime motivated by reasons relating to religion, homophobic crime, gang related violence and repeat victimisation;
- those who are older and frail; and,
- the families of homicide victims.

Registered Intermediaries (RIs) have been facilitating communication with vulnerable witnesses in the criminal justice system in England and Wales since 2004.

A criminal investigation by the police takes priority over all other enquiries, although a multi-agency approach should be agreed to ensure that the interests and personal wishes of the adult will be considered throughout, even if they do not wish to provide any evidence or support a prosecution. The welfare of the adult and others, including children, is paramount and requires continued risk assessment to ensure the outcome is in their interests and enhances their wellbeing.

If the adult has the mental capacity to make informed decisions about their safety and they do not want any action to be taken, this does not preclude the sharing of information with relevant professional colleagues. This is to enable professionals to assess the risk of harm and to be confident that the adult is not being unduly influenced, coerced or intimidated and is aware of all the options. This will also enable professionals to check the safety and validity of decisions made. It is good practice to inform the adult that this action is being taken unless doing so would increase the risk of harm.

3.3.6. Information Sharing

Information sharing between organisations is essential to safeguard adults at risk of abuse, neglect and exploitation. In this context "organisations" mean not only statutory organisations but also voluntary and independent sector organisations, housing authorities, the police and Crown Prosecution Service, and organisations which provide advocacy and support.

The person's wishes in respect to information sharing should always be considered, however the following principles are also relevant:

- information given to an individual member of staff belongs to the organisation and not to the individual employee. An individual employee cannot give a personal assurance of confidentiality to an adult at risk;

- an organisation should ordinarily obtain the adult at risk's consent to share information and should routinely explain what information may be shared with other people or organisations, where appropriate;

- however, it may not be possible to seek the consent of the adult at risk, due to lack of mental capacity or other reasons, and in some circumstances it may still be necessary to share information even where consent is not given, for example, where there is a risk to other people;

- difficulties in working within the principles of maintaining the confidentiality of an adult should not lead to a failure to take action to protect the adult from abuse or harm;
- confidentiality must not be confused with secrecy, that is, the need to protect the management interests of an organisation should not override the need to protect the adult at risk;

- staff reporting concerns at work ("whistleblowing") are entitled to protection under the Public Interest Disclosure Act 1998.

3.3.7. Record-keeping

Good record keeping is a vital component of professional practice. Whenever a complaint or allegation of abuse is made, all agencies should keep clear and accurate records and each agency should identify procedures for incorporating, on receipt of a complaint or allegation, all relevant records into a file to record all action taken. When abuse or neglect is raised managers need to look for past incidents, concerns, risks and patterns. We know that in many situations, abuse and neglect arise from a range of incidents over a period of time. In the case of providers registered with CQC, records of these should be available to service commissioners and the CQC so they can take the necessary action.

Staff should be given clear direction as to what information should be recorded and in what format. The following questions are a guide:

- What information do staff need to know in order to provide a high quality response to the adult concerned?
- What information do staff need to know in order to keep adults safe under the service's duty to protect people from harm?
- What information is not necessary?

- What is the basis for any decision to share (or not) information with a third party?

Records should be kept in such a way that the information can easily be collated for local use and national data collections.

All agencies should identify arrangements, consistent with principles and rules of fairness, confidentiality and data protection for making records available to those adults affected by, and subject to, an enquiry. If the alleged abuser is using care and support themselves, then information about their involvement in an adult safeguarding enquiry, including the outcome, should be included in their case record. If it is assessed that the individual continues to pose a threat to other people then this should be included in any information that is passed on to service providers or other people who need to know.

In order to carry out its functions, SABs will need access to information that a wide number of people or other organisations may hold. Some of these may be SAB members, such as the NHS and the police. Others will not be, such as private health and care providers or housing providers/housing support providers or education providers.

In the past, there have been instances where the withholding of information has prevented organisations being fully able to understand what "went wrong" and so has hindered them identifying, to the best of their ability, the lessons to be applied to prevent or reduce the risks of such cases reoccurring. If someone knows that abuse or neglect is happening they must act upon that knowledge, not wait to be asked for information.

An SAB may request a person to supply information to it or to another person. The person who receives the request must provide the information provided to the SAB if:

- the request is made in order to enable or assist the SAB to do its job;

- the request is made of a person who is likely to have relevant information and then either:
  i. the information requested relates to the person to whom the request is made and their functions or activities or;
  ii. the information requested has already been supplied to another person subject to a SAB request for information.

3.3.8. Confidentiality

Agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information, based on the welfare of the adult or of other potentially affected adults. Any agreement should be consistent with the principles set out in the Caldicott Review ensuring that:

- information will only be shared on a 'need to know' basis when it is in the interests of the adult; confidentiality must not be confused with secrecy;

- informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement; and

- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.

Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (e.g. because there is a risk that others are at risk of serious harm) and wherever possible, the appropriate Caldicott Guardian should be involved.

Decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework.

Principles of confidentiality designed to safeguard and promote the interests of an adult should not be confused with those designed to protect the management interests of an organisation. These have a legitimate role but must never be allowed to conflict with the welfare of an adult. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of the adult then a duty arises to make full disclosure in the public interest.

In certain circumstances, it will be necessary to exchange or disclose personal information which will need to be in accordance with the law on confidentiality and the Data Protection Act 1998 where this applies. The Home Office and the Office of the Information Commissioner have issued general guidance on the preparation and use of information sharing protocols.

3.3.9. The Caldicott Principles

The Information Governance Review – To Share or Not to Share?

- Justify the purpose(s). Every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed, by an appropriate guardian.

- Don't use personal confidential data unless it is absolutely necessary. Personal confidential data items should not be included unless it is essential for the specified purpose(s) of that flow. The need for adults to be identified should be considered at each stage of satisfying the purpose(s).

- Use the minimum necessary personal confidential data. Where use of personal confidential data is considered to be essential, the inclusion of each individual item of data should be considered and justified so that the minimum amount of personal confidential data is transferred or accessible as is necessary for a given function to be carried out.

- Access to personal confidential data should be on a strict need-to-know basis. Only those individuals who need access to personal confidential data should have access to it, and they should only have access to the data items that they need to see. This may mean introducing access controls or splitting data flows where one data flow is used for several purposes.

- Everyone with access to personal confidential data should be aware of their responsibilities. Action should be taken to ensure that all those handling personal confidential data are made fully aware of their responsibilities and obligations to respect individuals' confidentiality.

- Comply with the law. Every use of personal confidential data must be lawful. Someone in each organisation handling personal confidential data should be responsible for ensuring that the organisation complies with legal requirements.

- The duty to share information can be as important as the duty to protect confidentiality. Health and social care professionals and other staff should have the confidence to share information in the best interests of adults within the framework set out by these principles.

They should be supported by the policies of their employers, regulators and professional bodies.

3.3.10. Duty of care

Everyone has a clear moral and/or professional responsibility to prevent or act on incidents or concerns of abuse and/or neglect. A duty of care to adults at risk is fulfilled when all the acts reasonably expected of a person in their role have been carried out with appropriate care, attention and prudence. Duty of care will involve actions to keep a person safe but will also "include respecting the person's wishes and protecting and respecting their rights" (DoH, 2011 Safeguarding Adults: Role of Health Service Practitioner).

The nature of an individual's duty of care will vary according to their role. In all cases however, it will involve taking allegations or concerns seriously, and owning one's responsibilities to safeguard adults at risk.

3.3.11. Defensible decision making

Responding to safeguarding adults concerns or allegations requires decision making and professional judgements. A duty of care in relation to those decisions or judgements will be considered to be met where:

- all reasonable steps have been taken;
- reliable assessment methods have been used;
- information has been collated and thoroughly evaluated;
- decisions are recorded, communicated and thoroughly evaluated;
- policies and procedures have been followed;
- practitioners and their managers adopt an investigative approach and are proactive.

(Kemshall, H. 2008, reported in DoH 2011 Safeguarding Adults: The Role of Health Practitioners)

Defensible decision making is about making sure that the reasons for decisions, as well as the decision itself, have been thought through and can be explained.

3.4. Commissioning

3.4.1. Commissioning governance

Commissioners of services should set out clear expectations of the contracted organisation and monitor compliance. Commissioners have a responsibility to:

- ensure that their contracted organisations 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 safeguarding adults policies and procedures are always included in the monitoring arrangements for contracts and service-level agreements;

- ensure that contracted organisation managers are clear about their leadership role in safeguarding adults ;

- liaise with safeguarding adult leads and regulatory bodies and make regular assessments of the ability of service providers to effectively safeguard service users;

- commission a service with staff that have the right skills to understand and implement safeguarding adults principles and practice;

- 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 contracted organisations give information to service users about abuse, how to recognise it and how and to whom they can raise a concern;

- ensure that contracted organisations regularly review incidents and take actions to address any issues identified.

In addition, sector specific guidance was produced by *Department of Health Safeguarding Adults: Role of NHS Commissioners (March 2011).*

3.4.2. Commissioned services

All commissioned service providers should work within internal guidelines that are consistent with the multi-agency safeguarding adults policy and procedures. These should set out the responsibilities of staff, clear internal reporting procedures and clear procedures for reporting to the local safeguarding adults procedures.

In addition, provider organisation's internal guidelines should cover:

- a "whistle-blowing" policy which sets out assurances and protection for staff to raise concerns;
- how to work within best practice as specified in contracts;
- how to meet the standards in the Health and Social Care Act 2008 (regulated activities) and the Care Quality Commission Regulations;
- how to fulfil their legal obligations under the Disclosure and Barring Service;
- Mental Capacity Act;
- Deprivation of Liberty Safeguards (DoLS) (hospitals and care homes only);
- robust recruitment arrangements;
- induction and ongoing training and supervision for staff.

Provider organisations should routinely provide users of their service with information on the safeguarding adult's procedures and on how to make a complaint.

3.4.3. Personal budgets and self-directed care

Personal budgets are the amount of money the Local Authority assesses needs to be spent to meet an individual's eligible needs. A direct payment is where the service user gets that sum, (less any contribution they are assessed as having to contribute), to arrange their care.

People receiving a direct payment may use it to employ a personal assistant. Some personal assistants, like others in a caring capacity, could harm or abuse the person who is employing them. In such circumstances, the person who is being harmed or abused is in a difficult legal and emotional situation. Whilst perhaps dependent on their abuser for their personal care and social and emotional

support, and fearful of this person, they are also the abuser's employer and expected to act in ways consistent with employment law.

Such employers may be reluctant to disclose problems of abuse as they may be fearful of having their payment suspended and losing necessary support. The fear of losing their independence and choice can leave the person in an even more vulnerable position.

No Secrets states that "anyone who is purchasing his or her own services through the direct payments system... should be made aware of the arrangements for the management of [safeguarding adults] in their area so that they may access help and advice through the appropriate channels" (No Secrets, 2000).

Partner agencies providing direct payments need to support adults to recognise and understand risks and how these can be managed.

Recipients of direct payments/ should be supported and enabled to understand safe employment practices and how to respond to abuse by their employees or other people.

4. Part Two - Safeguarding Adults Procedures

What happens as a result of an enquiry should reflect the adult's wishes wherever possible, as stated by them or by their representative or advocate. If they lack capacity it should be in their best interests if they are not able to make the decision, and be proportionate to the level of concern.

These procedures explain how a safeguarding alert is made and the process which is followed once that alert is received. The procedures follow six stages as outlined below. Prior to and throughout all these stages, the principles set out within the policy and guidance should be followed. Refer also to specialist support services & linked agenda section of the guidance document (see section 12) Agreement can be reached via multi-agency discussion at any stage that the full procedures are not necessary, for example during a strategy meeting.

4.1.1. Introduction to the safeguarding adults stages

The six key stages of the safeguarding adults procedures are as follows:

Stage One - Making an **Alert**
Stage Two - **Referra**l into safeguarding adults procedures
Stage Three - **Strategy** discussion or meeting
Stage Four - **Enquiry**
Stage Five – **Reporting Meeting**
Stage Six - **Review** of the protection plan

These stages are summarised in Section 4.1.3 and described in detail throughout the subsequent sections of these procedures.

4.1.2. Roles within the safeguarding adults procedures

The following roles are established by the safeguarding adults procedures. Each organisation will need to determine which groups of staff may fill relevant key roles.

Person Raising a Concern
Anyone who has concerns about potential abuse or neglect should tell someone. They may go on to be an alerter (see below). In some cases however, the person raising a concern wishes to tell a friend or someone in authority because they need support and would prefer someone else to be the alerter.

Alerter
Anyone who has concerns about potential abuse or neglect can be an alerter. The alerter is the person who makes the safeguarding alert. They should report their concerns to the Initial Contact team at Blackpool Adult Social Care (for contact details see page 47). If the alerter works for an organisation they should follow their safeguarding adults procedures and ensure immediate safety for example call an ambulance or contact the police.

The alerter could be the adult at risk, their friend, relative or member of the public. The alerter may also be a member of staff or volunteer. In an organisation the alerter may be a manager, (in line with the organisation's internal procedure for raising an alert). However any member of staff (or volunteer) may need to undertake these actions, for example, where the need is urgent or the nominated manager is unavailable.

Internal procedures for all organisations should identify who is responsible within the organisation for:

- how it is decided whether an alert is needed when a concern is raised;
- who should make an alert on behalf of their organisation;
- ensuring that immediate safety issues are addressed, other parties notified (such as their regulator) and that staff are supported;
- ensuring they are informed as soon as possible when another member of staff (or volunteer) has made an alert;
- establishing what outcome the adult at risk desires.

Safeguarding Lead
This will be a named individual identified from Adult Social Care staff to coordinating the multi-agency safeguarding enquiry. There will be only one named safeguarding lead overseeing a particular safeguarding enquiry.

The role is to ensure that :

- the outcome the adult at risk wishes is established
- decisions are made on the need to carry out enquiries or identifying an alternative response
- the police are consulted if a crime has been committed
- the strategy meeting/discussion is convened and the safeguarding lead will chair this meeting
- co-ordinating the safeguarding enquiry
- overseeing the actions of the safeguarding investigating officers (there may be more than one, from different multi-agency partners, depending on the circumstances of the enquiry)
- chairing reporting meetings where required
- ensuring records are kept and outcomes recorded in line with local systems – ensuring information from all partner agencies gathered as a part of the safeguarding enquiry are stored together.

Chairing the Reporting Meeting
This is a multi-agency meeting which will be required after the enquiries have been completed. The purpose of the meeting is to consider the findings of the enquiries, risk and the protection plan.

The role of the safeguarding lead in chairing this meeting is to:

- ensure decisions concerning the adult at risk reflect their wishes and needs where they are able to express these
- enable all parties at the reporting meeting to participate
- ensure the views of all relevant parties are represented
- ensure decision making is fair and objective
- provide challenge where required in order to ensure good practice is achieved

The chair will facilitate discussions and decision making in respect of:

- the findings of the enquiries
- the assessment of risk, the protection plan and any further actions required
- how any protection plan will be reviewed and monitored
- whether on a balance of probabilities abuse or neglect has occurred

Safeguarding Investigating Officers
There may be a need for a number of people, from different partner organisations, to make enquiries in response to a safeguarding concern or allegation, such as the police, complaints staff, serious incident investigators, or people undertaking disciplinary investigations. It will be the responsibility of the safeguarding lead to draw the information together from all the safeguarding investigating officers for the reporting meeting. Each safeguarding investigating officer will collect information from their own enquiries and from those of others as appropriate, as part of the process of establishing whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom. These findings will inform the risk assessment and the protection plan.

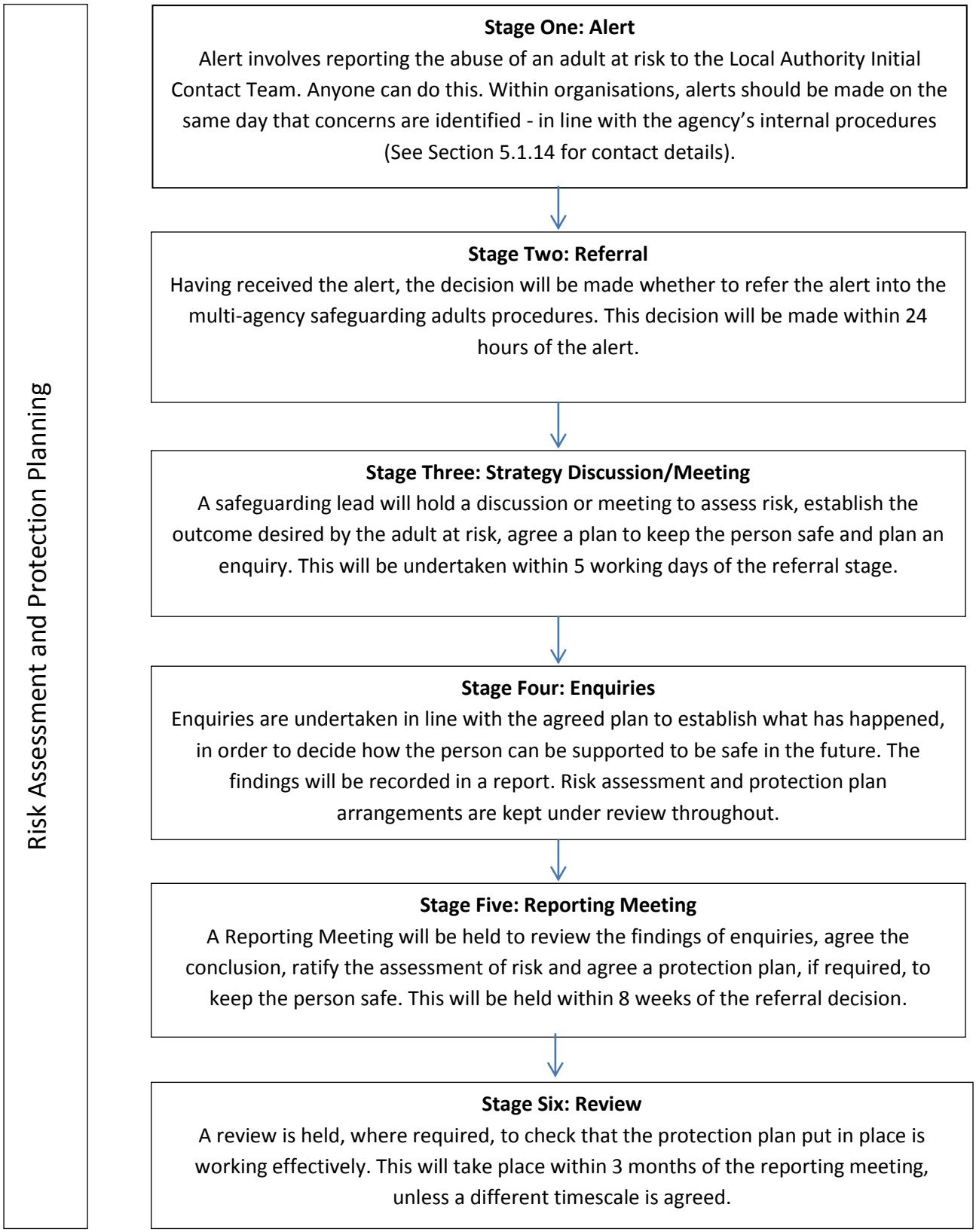
The safeguarding investigating officers will be nominated people from appropriate organisations and will work to the safeguarding enquiry plan agreed at the strategy discussion/meeting.

4.1.3. Stages flowchart

Blackpool Safeguarding Adults procedures have six stages. The following chart provides a summary overview of each stage. For more detailed information refer to the relevant section of the procedures. The wishes and needs of the individual should be considered and recorded at all stages of the process.

It is recognised that timely work is good practice, however the key factor for consideration is the needs of the individual and their desired outcomes – therefore the timescales set out in this document are to be considered as guidelines to prevent drift. Where these timescales are not to be met due to the needs of the individual and their desired outcomes, this should be clearly documented on the case record.

Safeguarding stages



SAFEGUARDING STAGES			
Stage	**Main Activities**	**Responsibility**	**Target timescales** (organisations only)
Stage 1: Alert	• Witness or suspect abuse, receive a disclosure • Raise a concern • Inform the manager if appropriate (applies to organisations only) • Gather information • Evaluate risk and ensure safety of the adult at risk • Establish wishes and best interests of adult at risk • Record issues and actions	Any person: All staff or volunteers Adult at risk, carer, friend, relative Alerter/ manager Safeguarding adults lead Any staff in an emergency	Alerting manager to be informed of concerns about possible abuse without delay
Decisions	• Decide if a safeguarding alert is required. If no, consider and document what other appropriate actions will be taken • Make a safeguarding alert if appropriate • Report to emergency services if required (police/ambulance) • Notify regulator (if a registered service) • Record actions and decisions	Alerter or manager (in an organisation)	Make the decision to make an alert, and then make the alert: Immediately where urgent and serious Or Within same working day
Stage 2: Referral	• Establish wishes and best interests of the adult at risk • Gather information on the safeguarding alert received • Evaluate risk and ensure safety of the adult at risk • Report to police if required	Adult Social Care (Intake team, or other nominated social worker)	Decision (and act of making a referral): Immediately or within 24 hours of alert being received
Decisions	• Decide if safeguarding adults procedures apply • If yes, refer to strategy discussion/meeting to plan enquiry • Check interim protection plan • Notify alerter of decision • Record actions and decisions	Adult Social Care (Intake team, or other nominated social worker)	Decision (and act of making a referral): Immediately or within 24 hours of alert being received
Stage 3: Strategy Discussion/ Meeting	• Establish wishes and best interests of the adult at risk (consider need for advocacy) • Hold strategy discussion/meeting • Evaluate risk and ensure safety of the adult at risk	Safeguarding lead with relevant partner agencies and adult at risk as appropriate	Within five working days of referral being received

SAFEGUARDING STAGES			
Stage	**Main Activities**	**Responsibility**	**Target timescales** (organisations only)
Decisions	• Decide to proceed to safeguarding enquiry (or exit with alternative actions) • Plan an enquiry • Coordinate agencies involvement • Agree interim protection plan • Record actions and decisions	Safeguarding lead	Within five working days of referral being received
Stage 4 Enquiry	• Conduct enquiry as agreed in strategy discussion/meeting • Review risk and protection planning arrangements as required. • Produce an overall enquiry report	Safeguarding investigating officers	Report submitted to safeguarding lead 7 working days before a reporting meeting
Decisions	• Check all concerns have been addressed as planned • Check all planned activities have been undertaken • Check the safeguarding enquiry report to ensure the findings are backed up by evidence	Safeguarding lead	Report submitted to safeguarding lead 7 working days before reporting meeting
Stage 5: Reporting Meeting	• Receive enquiry report • Evaluate findings and risks • Establish wishes and best interests of the adult at risk (consider need for advocacy) • Ensure all relevant views are considered, including those of the person alleged to have caused harm	Safeguarding lead with partner agencies	Within 8 weeks* from safeguarding referral decision * to be achieved earlier where possible
Decisions	• Agree case conclusion • Agree outcomes for adult at risk/person alleged to have caused harm • Agree protection plan • Agree whether review required • Close safeguarding adults procedures if required	Safeguarding lead with partner agencies	Within 8 weeks* from safeguarding referral decision. * to be achieved earlier where possible

SAFEGUARDING STAGES			
Stage	**Main Activities**	**Responsibility**	**Target timescales** (organisations only)
Stage 6: Review	• Evaluate ongoing risk • Review the protection plan (consider need for advocacy)	Safeguarding lead with partner agencies and adult at risk	Within 3 months of reporting meeting or as agreed at reporting meeting
Decisions	• Agree further review arrangements if required • Exit safeguarding adults procedures if required		Within 3 months of reporting meeting or as agreed at reporting meeting

5. Stage One: Alert

5.1.1. What is an alert?

Making an alert means reporting your concerns, suspicions or allegations of abuse or neglect of an adult at risk into the multi-agency safeguarding adults procedures. This section describes how to make an alert.

5.1.2. Making a safeguarding alert

Any person who has contact with an adult at risk and has concerns about potential abuse or neglect can make a safeguarding alert This includes those at risk of abuse, their friends, family members, and informal carers, other members of the public, paid carers, professionals and organisations.

An adult at risk is someone who is at risk of or experiencing abuse or neglect and:

- is aged 18 or over;
- has needs for care and support (whether or not the local authority is or may be meeting any of those needs) and;
- as a result of those care and support needs is unable to protect themselves from either the abuse or neglect (or the risk of it).

Note: When adults are funding or commissioning their own care arrangements, the multi-agency safeguarding process applies as it would with any other adult at risk.

A concern may be:

- something you have been told by the adult at risk or another person, such as staff members or volunteers, others using the service, a carer or a member of the public
- an observation of the behaviour of the adult at risk, or the behaviour of another person(s) towards the adult at risk or the behaviour of one service user towards another

For information about different types of abuse, please see section 3.1.3 in Policy Section.

Practitioners should wherever practicable seek the consent of the adult before taking action. However, there may be circumstances when consent cannot be obtained because the adult lacks the capacity to give it, but it is in their best interests to undertake an enquiry. Whether or not the adult has capacity to give consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action because a criminal offence has occurred.

It is the responsibility of all staff and members of the public to act on any suspicion or evidence of abuse or neglect and to pass on their concerns to a responsible person or agency. If you have become aware of concerns through the course of your work, seek advice from your manager or safeguarding adults lead in your organisation and refer to your internal safeguarding adults procedures if required.

In your role as an alerter, the first priority should always be to ensure the safety and well-being of the adult. You may also need to inform the police (if a crime has taken place or is taking place) or seek medical attention for the adult at risk – see section 12.5.2 guidance.

Early sharing of information is the key to providing an effective response where there are emerging concerns and confidentiality section.

Organisations must have arrangements in place which set out clearly the processes and the principles for sharing information between each other, with other professionals,

No professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to suffer abuse or neglect, then they should share the information with the local authority and, or, the police if they believe or suspect that a crime has been committed.

For the contact details and sources of advice needed to make a safeguarding alert refer to Section 5.1.14

5.1.3. Safeguarding alerts from organisations

All registered health and social care organisations should have safeguarding policies and procedures detailing the responsibilities of all staff (and volunteers) within these procedures.

5.1.4. Organisation's internal procedures

Within organisations staff (and volunteers) must always follow their internal procedures for raising an alert. If the concerns relate to the nominated manager, inform an alternative or more senior manager within your organisation of the concerns.

These internal procedures should stipulate:

- who / how alerts should be made
- how to decide whether a safeguarding alert should be made
- what immediate actions are required, wherever possible, to ensure the adult at risk is safe from harm.

However, where a situation is urgent or serious, **any member of staff** (or volunteer) may need to undertake these actions, particularly where:

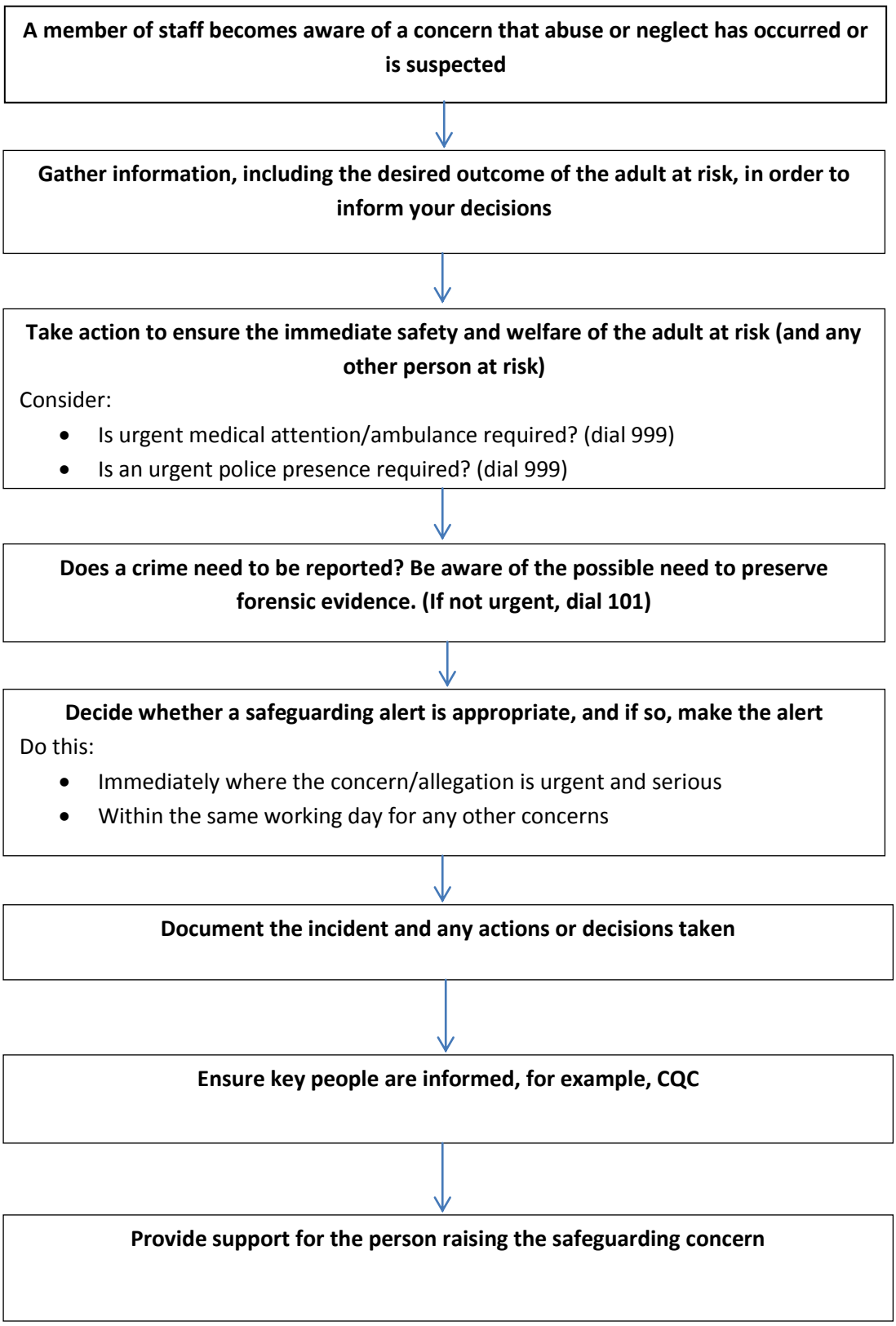
- contacting a manager would result in undue delay and thereby place someone at risk
- the manager has been contacted and they have not taken action
- the concern relates to the manager and there is no other appropriate alternative manager to contact
- you have authority in your own right to decide whether to make a safeguarding adult alert and professional/service practice allows for this

Suggested internal organisational process for raising an alert (see also above "Raising a safeguarding concern"

The flowchart below should be followed within organisations prior to the decision to raise a safeguarding alert (and incorporated within single agency's procedures). However, where a manager is unavailable to support in undertaking these tasks, or actions are required immediately, **any**

members of staff or volunteers may need to make the alert – in which case they should follow this guidance.

Alert flowchart



Additional Key Considerations:

- Responsibilities to those who are alleged to have caused harm **(section 12.4 of Guidance)**
- Mental Capacity and Consent **(section 12.5 of Guidance)**
- Deciding whether to report an incident to the police **(section 12.5.2 of Guidance)**
- Risk assessment and protection planning **(section 8.1.2 of Guidance)**
- Guidance for referral into adult safeguarding procedures **(Appendix F of Guidance)**
- Domestic Abuse **(section 12.7 of Guidance)**
- Self-Neglect **(section 12.8 of Guidance)**
- Involving the adult at risk **(section 12.3 of Guidance)**

5.1.5. Gathering information in order to inform your decisions

If you are made aware of harm to an individual or allegations of harm, you must take them seriously however trivial they might initially seem.

You may need to gather some information in order to decide whether you should make a safeguarding alert and to decide the most appropriate action to keep the person safe. This may involve checking relevant records, ascertaining concerns from colleagues, gathering background information, etc.

This is not the enquiry stage - Gather only the information you need in order to make the decision about whether to make an alert and to keep the person safe.

It may be appropriate for the relevant manager to speak to the adult at risk. To do this, the alerting manager should consider:

- getting their views on what has happened and what they want to happen now (consider mental capacity and consent issues)
- speaking to them in a private and safe place and informing them of any concerns
- providing them with information about the safeguarding adults procedures and how that could help to make them safer
- identifying communication needs, personal care arrangements
- explaining how they will be kept informed and supported
- discussing what could be done to ensure their safety

5.1.6. Take action to ensure the immediate safety of the adult at risk

Consideration must be given as to whether there are any immediate actions they need to take in order to keep the person, or others, safe from harm.

This may mean taking action in relation to the adult at risk *and* others, and could include:

- making an immediate evaluation of the risk to the adult at risk;
- taking reasonable and practical steps to protect the adult at risk as appropriate;
- considering if an immediate police presence is required to keep any person safe;

- liaising with the police where an immediate police presence is required or to discuss any risk management issues;
- arrange any necessary emergency medical treatment; note that offences of a sexual nature will require expert advice from the police;
- making sure that other service users (and staff/volunteers) are not at risk.

It may also involve taking actions in relation to the person or organisation alleged to have caused harm, including:

- liaising with the police wherever possible regarding actions that may impact upon a subsequent criminal investigation, such as where the protective arrangements may forewarn the person alleged to have caused harm of an impending criminal investigation and potentially prejudice the collection of evidence;

- ensuring that any staff (or volunteers) who have caused harm are not in contact with service users and others who may be at risk, for example, "whistle-blowers".

Note:

- Do not discuss the concern with the person alleged to have caused harm, unless the immediate welfare of the adult at risk or other people makes this unavoidable.

- If the person alleged to have caused harm is a member of staff and an immediate decision is required to suspend them, the person has a right to know in broad terms what allegations or concerns have been made about them. Care however should be undertaken not to jeopardise any resulting police investigation or safeguarding enquiry.

- If the allegation involves agency staff, the agency should also be notified of the safeguarding alert having been made.

- If the person alleged to have caused harm is another service user, action taken may 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 alleged to have caused harm are also met.

5.1.7. Deciding whether to make a safeguarding alert

In deciding whether to make an alert, consider initially the following questions:

- Is the person an adult at risk? (See Section 5.1.2, above)
- Does it appear likely that the adult at risk is experiencing harm from abuse or neglect (or is at risk of abuse if an alert is not made)?
- Does the person have mental capacity to consent?
- If so, has the person given consent for a safeguarding alert?
- Are the circumstances such, that it is appropriate to make an alert without the person's consent?

Reference should be made to guidance which is used by the Local Authority to decide whether to refer the case into the safeguarding adults process - this guidance can be found at Appendix F**.** Although it is not the responsibility of the alerter to make this decision, this guidance may support them in thinking about what factors to consider in making an alert. Part of this decision should include consideration as to whether more than one organisation is needed to work together to support this individual in achieving the outcomes they would like – the safeguarding adults provides the opportunity to do this.

Where required, take advice from your agency's safeguarding adults lead and **if in doubt make an alert.**

A record must be made of the concern, the wishes of the adult at risk and of the decision about whether or not to make an alert, with reasons. A record should also be made of what information was provided to the adult at risk about the decision.

As well as deciding whether or not to make a safeguarding alert, a decision must be made whether to follow other relevant organisational reporting procedures . For example, NHS colleagues may still need to report under clinical governance or serious incident procedures. Where an alert indicates that a member of staff may have caused harm, the organisation's disciplinary procedures may also need to be followed. Providers who are registered with CQC will need to follow their regulatory reporting requirements.

5.1.8. Document the incident and any actions or decisions taken

Ensure all actions and decisions are fully recorded. It is possible that your records may be required as part of an investigation or safeguarding enquiry. Be as clear and accurate as you can. Record the information about the concern/allegations, your decisions and any advice given to, or by, you in making these decisions.

Ensure that appropriate records are maintained, including details of:

- the nature of the safeguarding concern/allegation;
- the wishes of the adult at risk;
- the support and information provided to enable the adult at risk to make an informed decision;
- assessments of mental capacity, where indicated;
- the decision of the organisation to make or not make a safeguarding alert.

5.1.9. Ensure key people are informed

Where relevant, the alerting manager should inform:

- CQC if the adult is living in a care home, receiving personal care or another registered resource or service
- the commissioner's department for the adult at risk (where relevant)
- child protection services, if children are also at risk from harm
- relatives of the adult at risk according to their wishes, or in their "best interests" where they lack the mental capacity to make this decision for themselves
- their line manager (and safeguarding adults lead if different) of their decisions and actions in line with these procedures
- their Human Resources Manager if allegations/concerns relate to a member of staff
- staff delivering a service on a need-to-know basis so that they do not take actions that may prejudice any criminal or disciplinary investigations

5.1.10. Provide support for the person raising a safeguarding concern

Incidents of alleged or actual abuse can be very distressing. People who have witnessed abuse or had abuse disclosed to them may need support in their own right. Organisational procedures should ensure provision is made 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 procedures.

5.1.11. In an emergency or out of hours

When dealing with an incident that involves the abuse of an adult at risk, staff may need to call the police and/or ambulance (dial 999), if for example:

- someone is alleging that they have been sexually assaulted;
- someone has been injured as a result of a physical assault;
- an allegation is made regarding a recent incident of theft;
- the person alleged to have caused harm needs to be removed;
- the person alleged to have caused harm is still believed to be near the premises;
- there is reason to believe that a crime is in progress;
- there is likely to be evidence that needs to be preserved, in the case of physical or sexual assault the police will be able to arrange for medical evidence to be collected.

****This list is by no means exhaustive****

Employees without access to a supervising manager, (such as those working outside office hours) will need to be aware of the circumstances under which the police should be called in an emergency. If the police do not need to be contacted but you still have immediate concerns and it is out of normal working hours, the local authority "emergency duty team" can be contacted (see Section 5.1.4 for contact details).

5.1.12. Emergency Duty Team (EDT) and out of hours services

Local EDT or out-of hours teams (social services and health) operate out of normal working hours, at weekends and over statutory holidays. If a referral is made to the EDT which indicates an immediate or urgent risk, the officer will take any immediate 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.

EDT staff must also be aware that, if responding to an emergency, other adults may also be at risk. A member of the EDT would not be responsible for undertaking a safeguarding adults enquiry but it may be necessary to speak to 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 coordinated with the police to ensure that any evidence is preserved)
- the referral is unclear

Whether or not any immediate action is necessary the Emergency Duty Officer (EDO) will record the facts concerning the alleged abuse or neglect and pass all relevant information to the Initial Contact Team.

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 emergency services if the adult is at serious risk of immediate harm, and the local authority EDT or emergency out-of-hours service if an immediate protection plan needs to be put in place. If this action has been taken, the EDT or out-of-hours service deal with the referral as above.

If the situation does not indicate an immediate risk of harm, staff working out of hours will refer to the Initial Contact Team on the next working day (see below for contact details). They will also refer to the appropriate point in their own organisation.

5.1.13. Whistle-blowing – Public Interest Disclosure Act 1998

Members of staff working within an organisation may become aware of safeguarding concerns or allegations but be concerned about the impact on their employment if they were to report them.

Where people have these concerns, they should refer to their employer's Public Interest Disclosure Policy, sometimes called the "Whistle-blowing" Policy. The policy is so named, because it provides advice in relation to those circumstances when an employee is protected for reporting concerns.

Where an employer does not have a "whistle-blowing" policy or the policy is unclear or if further advice is needed, independent advice can be obtained from "whistle-blowing" advice services such as those provided by:

- Mencap: www.mencap.org.uk/organisations/whistleblowing-helpline
- Care Quality Commission: www.cqc.org.uk/contact-us
- Public Concern at Work: www.pcaw.org.uk

5.1.14. How to make a safeguarding alert

When making an alert, the alerter will be asked to provide information. Refer to Appendix A, "Information required when making a safeguarding alert", for guidance.

To raise a safeguarding alert (including out of hours) in Blackpool, contact the Adult Social Care Initial Contact Team

- by telephone on **01253 477592**
- Or an alert may be raised by e mail **Adult.socialcare@blackpool.gov.uk** (please ensure your include "Safeguarding Alert" in the subject line).

6. Stage Two: Safeguarding Adults Referral

6.1. Purpose of the safeguarding adult referral

Once an alert has been received by Blackpool Adult Social Care a decision will be taken as to how to proceed by a social worker within the relevant Adult Social Care Team. This decision is known as the "Threshold Decision". This decision making process may have three possible outcomes:

- Not safeguarding
- Incident only
- Safeguarding procedures

Where a person is already known to Adult Social Care the person creating the alert may pass the alert to the worker or team already involved for a referral decision. In these circumstances the caseworker will then decide the outcome of the alert and any other course of action .This may include simply recording the outcome of the alert as "not safeguarding" or "incident only". If a decision is taken to proceed to a safeguarding enquiry, the social worker involved must then pass the decision to the relevant safeguarding lead to proceed with the case. This is to ensure that decisions made about referral to multi-agency safeguarding processes are done within the context of information already known about the individual and any ongoing work.

Where a person is not already known to Adult Social Care, the duty and intake team will consider the information and an alert should be created. If an alert is created the duty social worker will be responsible for taking the decision whether to record the concern as "not safeguarding", "incident only" or into the multi-agency safeguarding procedure.

In all cases the social worker taking the decision on a safeguarding alert must seek approval for this decision from a team safeguarding lead.

The decision should consider an outcome which supports or offers the opportunity to develop, or maintain, a private life which includes those people with whom the adult at risk wishes to establish, develop or continue a relationship.

The decision making within the referral stage involves:

- establishing the wishes and best interests of the person at risk
- gathering information about the allegations/concerns
- ensuring the person at risk is protected from further harm
- deciding whether the concern/allegation requires referral into the multi-agency safeguarding process, where a strategy discussion/ meeting is required
- establishing if this alert fit within a pattern of previous alerts, relating to the same service user, the same address or the same alleged perpetrator.

Where it is felt that the adult at risk is experiencing, or at risk of abuse or neglect (following the referral considerations below), the local authority **must** make enquiries, or cause others to do so (i.e. refer into the multi-agency safeguarding adults process).

The adult should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse. If the adult has substantial difficulty in being involved, and where there is no one appropriate to support them, then the local authority must

arrange for an independent advocate to represent them for the purpose of facilitating their involvement

For information about the management of self-neglect cases, please see section 12.8.

Target Timescale:
The decision to proceed to strategy discussion/meeting must be made immediately or within 24 hours of the alert being received.

Overview of information gathering and referral decision making

- Is the person an adult at risk as defined within this policy/procedure? (refer to **Section 3.1.1** of guidance if required)

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- Abuse is "a violation of an individual's human or civil rights by any other person or persons". Has the person experienced one of the following forms of abuse?
  - Physical abuse
  - Domestic abuse
  - Sexual abuse
  - Psychological abuse
  - Neglect and acts of omission
  - Financial or material abuse
  - Modern Slavery
  - Discriminatory abuse
  - Organisational abuse
  - Self-neglect

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- Does the person appear to have experienced harm? **Or**
- Is the person (or other people) at risk of harm if a referral is not made?

  Consider the need for interim protection arrangements.

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- Consider the views of the adult at risk as to what has happened and what they want to happen now.
- Adults at risk should be supported to express an informed view of what happens next. These views should be respected unless there are additional considerations as summarised below.

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- Is there any reason to question the mental capacity of the adult at risk in relation to decisions within these procedures? If so, assess mental capacity as required by the Mental Capacity Act 2005
- If the person does not have mental capacity, decide and act in the person's "best interests" as detailed in the Mental Capacity Act 2005: Code of Practice.

- If the person has mental capacity, and declines support, consider if there are justifiable reasons to act contrary to the adult at risk's expressed wishes. See Section 10.4.11.

- If the person has mental capacity, and declines support within these procedures, and there are no justifiable reasons to act contrary to their wishes, their decision should be respected. Take steps to check the person has made an informed decision and knows how to access support to manage risk (even if they do not wish an enquiry to be undertaken) and they know they can change their mind.

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- Other considerations:
- If there is uncertainty as to whether the safeguarding adults procedures should be used, seek advice. Contact the lead(s) for safeguarding adults within your organisation.
- If a safeguarding adult enquiry is not required, the person may still need advice as to alternative sources of support.
- Determine whether the police need to be informed of a crime or possible crime.

Information gathering begins the process of the enquiry (should a referral be made into the multi-agency safeguarding process). This should begin with a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry (under the multi-agency safeguarding adults process, Section 42 of the Care Act). Whatever the course of subsequent action, the professional concerned should record the concern, the adult's views and wishes, any immediate action has taken and the reasons for those actions. Additional information gathering from other sources will be used to enable a decision on whether a safeguarding referral (or alternative process/action) is required. This may involve consulting other agencies or departments.

The alerter should always be contacted in relation to their alert in order to:

- acknowledge receipt of their alert
- acknowledge the alerter's concerns, and
- clarify and/or gather more information about the allegation/concern.

6.1.1. Referral decision considerations

In deciding whether an alert should be referred into the multi-agency safeguarding process, and a strategy discussion/meeting arranged to plan it, the following considerations should be taken into account.

These considerations will need to be revisited within the strategy discussion/meeting when reviewing the decision to investigate and also if new information suggests the decision should be re-considered.

The guidance at appendix F will be used as a framework to guide decision making as to whether a referral should be made into the safeguarding adults procedure

The purpose of undertaking enquiries should also be considered when deciding to refer into the multi-agency process - "to decide whether or not the local authority or another organisation, or person, should do something to help and protect the adult."

6.1.2. Assessing harm

The safeguarding adults procedures are relevant where harm is being experienced as a result of abuse, by an adult at risk.

Harm is defined in No Secrets (2000).

"*Harm should be taken to include 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*".

The safeguarding incident may impact on people differently, it is therefore important to consider the impact of an incident and not just its nature.

6.1.3. Risk of abuse

In the event that an alert is received, not because abuse has actually occurred, but due to the risk of it occurring, consider the most appropriate means to respond to that risk. Section 6.1.11 provides examples of the kinds of alternative responses to safeguarding adults procedures that may be most appropriate to respond to such circumstances. However, use of the safeguarding adults procedures may also be appropriate, where it is a proportionate response to the concerns, and alternative responses are not, or have not previously proved to be, sufficiently robust to address a clear risk of abuse or neglect to an adult at risk.

6.1.4. Poor practice and abuse

Distinguishing between poor practice and neglect/abuse will often require a professional judgement. Consider the impact of the incident on the adult at risk. Where practice is resulting in harm, a response using the safeguarding adults procedures will be indicated.

The risk of harm occurring through poor practice can usually be addressed by other processes, such as contract monitoring processes; care management reviews, complaint investigations; human resource processes, incident or serious incident investigation procedures. The most appropriate and proportionate response is required.

6.1.5. Organisational abuse

The Care Act Guidance 2014 describes **organisational abuse** as:

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

Organisational abuse is also defined by certain characteristics:

- It is **widespread** within the setting (e.g. the abusive practice is not confined to the practice of a single staff member)
- It is evidenced by **repeated** instances of poor care/professional practice
- It is generally **accepted** – it is not seen as poor practice
- It is **sanctioned** – it is encouraged or condoned by line managers
- There is an **absence of effective monitoring or management oversight** by managers that has allowed the practice to have occurred
- There are **environmental factors** (e.g. unsuitable buildings, lack of equipment, reliance on temporary staff) that adversely affects the quality of care
- It is **systemic** (e.g. factors such as a lack of training, poor operational procedures, poor supervision and management all significantly contribute to the development of institutionally abusive practice)
- Organisational abuse may also be indicated by a number of service users experiencing harm. However, this type of abuse may also occur in relation to a single service user. This could occur for example where a person is the sole user of a service or has differing needs to other service users.

It is not necessary for all of these characteristics to be present. However, the presence of one or more characteristic increases the likelihood that organisational abuse is taking place.

6.1.6. Large scale enquiries – Provider Pathways

A large scale enquiry may be required where there are concerns for a number of adults at risk within one provider setting. A large scale enquiry will need to follow these safeguarding adults procedures, but will be additionally complex due to the scale of the issues to be addressed.

A large scale enquiry may be required where:

- an enquiry is required concerning the safety of a service or organisational abuse
- there are a number of related allegations of abuse involving the same person or organisation alleged to have caused harm
- concerns in relation to one adult at risk reveal additional concerns about the care of others within the same service

6.1.7. Responding to abuse and neglect in a regulated care setting

It is important that all partners are clear where responsibility lies where abuse or neglect is carried out by employees or in a regulated setting, such as a care home, hospital, or college. The first responsibility to act must be with the employing organisation as provider of the service. However, social workers or counsellors may need to be involved in order to support the adult to recover.

When an employer is aware of abuse or neglect in their organisation, then they are under a duty to correct this and protect the adult from harm as soon as possible and inform the local authority, CQC and CCG where the latter is the commissioner. Where a local authority has reasonable cause to suspect that an adult may be experiencing or at risk of abuse or neglect, then it is still under a duty to make (or cause to be made) whatever enquiries it thinks necessary to decide what if any action needs to be taken and by whom. The local authority may well be reassured by the employer's response so that no further action is required. However, a local authority would have to satisfy itself that an employer's response has been sufficient to deal with the safeguarding issue and, if not, to undertake any enquiry of its own and any appropriate follow up action (e.g. referral to CQC, professional regulators).

The employer should investigate any concern (and provide any additional support that the adult may need) unless there is compelling reason why it is inappropriate or unsafe to do this. For example, this could be a serious conflict of interest on the part of the employer, concerns having been raised about non-effective past enquiries or serious, multiple concerns, or a matter that requires investigation by the police.

An example of a conflict of interest where it is better for an external person to be appointed to investigate may be the case of a family-run business where institutional abuse is alleged, or where the manager or owner of the service is implicated. The circumstances where an external person should be appointed will be determined in local protocols. All those carrying out such enquiries should have received appropriate training.

There should be a clear understanding between partners at a local level when other agencies such as the local authority, CQC or CCG need to be notified or involved and what role they have. ADASS, CQC, LGA, ACPO and NHS England have jointly produced a high level guide on these roles and responsibilities. The focus should be on promoting the wellbeing of those adults at risk. It may be that additional training or supervision will be the appropriate response, but the impact of this should be assessed. Commissioners of care or other professionals should only use safeguarding procedures in a way that reflects the principles above not as a means of intimidating providers or families. Transparency, open-mindedness and timeliness are important features of fair and effective safeguarding enquiries. CQC and commissioners have alternative means of raising standards of service, including support for staff training, contract compliance and, in the case of CQC, enforcement powers.

Commissioners should encourage an open culture around safeguarding, working in partnership with providers to ensure the best outcome for the adult. A disciplinary investigation, and potentially a hearing, may result in the employer taking informal or formal measures which may include dismissal and possibly referral to the Disclosure and Barring Service.

If someone is removed by being either dismissed or redeployed to a non-regulated activity, from their role providing regulated activity following a safeguarding incident, or a person leaves their role (resignation, retirement) to avoid a disciplinary hearing following a safeguarding incident and the employer/volunteer organisation feels they would have dismissed the person based on the information they hold, the regulated activity provider has a legal duty to refer to the Disclosure and Barring Service. If an agency or personnel supplier has provided the person, then the legal duty sits with that agency. In circumstances where these actions are not undertaken then the local authority can make such a referral.

Additional guidance will be developed as appropriate in line with the above information in respect of provider safeguarding pathways.

6.1.8. Repeated allegations

An adult at risk (or representative such as a family member) who makes repeated allegations where enquiries have been undertaken and are proven to be unfounded should be treated without prejudice. The following considerations should be taken into account:

- each allegation must be considered in its own right;
- each incident must be recorded;
- organisations should have procedures for responding to such allegations. These will involve an assessment of risk, ensuring both the rights of the individual are respected, while protecting staff from the risk of unfounded allegations;
- safeguarding processes in these cases should consider the historical information in the round in order to address the person's situation as a whole;
- consideration must be given to the likelihood of repeated abuse being the cause of repeated allegations, despite the information to date indicating unfounded prior allegations and the risk that 'unfounded' means insufficient evidence so far rather than it did not happen.

6.1.9. Abuse in relation to a person without mental capacity

Those people who are unable, for reasons of mental capacity, to make decisions about their safety and well-being are often those most in need of protection within these safeguarding adults procedures.

Where a person is without the mental capacity to make decisions about their personal welfare and safety, actions within these procedures will need to be undertaken in their best interests in accordance with the Mental Capacity Act (2005) and its Code of Practice.

In some circumstances, due to mental impairment, a person may not be aware of an incident occurring. This should not preclude undertaking enquiries within the safeguarding adults procedures. The definition of harm within these procedures includes "ill-treatment"; an understanding of that ill-treatment however it is not always a necessary factor. For example, a person with advanced dementia or a profound learning disability may not comprehend abusive/insulting comments by a paid carer. However the ill-treatment and loss of perceived dignity will still amount to emotional/psychological abuse.

The Mental Capacity Act introduced the offence of "Ill-treatment or Wilful Neglect" (Section 44) specifically to safeguard people without mental capacity.

6.1.10. Recognising individual circumstances

It is essential to consider individual circumstances in order to recognise the extent of harm and the appropriateness of the safeguarding adults procedures. Each person's circumstances will be unique. An understanding of a person's individual circumstances is essential in determining appropriate and proportionate responses:

Consider:	Decide:
The vulnerability of the adult at risk	• Does the person lack mental capacity to assess risk or to make decisions about their safety or welfare? • Is the person unable to communicate concerns, describe incidents or recall what has happened? • Is the person unable to ensure their own human or civil rights are met or unable to respond to an identified risk? • Is the person reliant on the assistance of others to meet their basic needs? • Are there others in control of the person's life, either by controlling access to services, delivering care or by exerting undue influence? • Does the person feel powerless and unable to change their situation? • Has the person been subject to abuse previously? • Is the person without access to supportive family, friends or advocates that can help safeguard their interests?
Nature and extent of the concern	• What is the adult at risk's assessment of the concern? What do they want to happen?

	• Abuse can consist of a single incident or a series of incidents that result in harm over a period of time. • Does the allegation suggest other adults at risk may also be experiencing harm? • Is institutional abuse indicated? • Has the adult at risk been targeted or "groomed"? • Was the abuse opportunistic? • Do the allegations concern a serial perpetrator? • Are there underlying unmet needs of an adult at risk or their carer?
Length of time it has been occurring	• Is there a pattern of incidents suggesting this is not a one-off event and that there is a pattern of abuse or neglect occurring? • Even minor incidents can result in harm if they are repeated or longstanding.
The impact of the incident	• The impact of abuse may not always be immediately visible. A physical assault might not cause a physical injury but the emotional/psychological impact might be even more serious. Consider the impact on the person's overall health and well-being. • Even minor acts can be devastating if committed by someone the person trusts or is their only source of support. • Whether abuse is intentional or not, is irrelevant, what is important is the harm done and whether the abuse might be repeated.
Risk of repeated incidents for the victim	• Is the incident likely to reoccur because the person or organisation alleged to have caused harm is also responsible for their care or lives with them? • Is there a risk that the person is being directly targeted by people who have set out to exploit them? • Is the person alleged to have caused harm addicted to substances or do they have unmet support needs of their own? • Has anything changed since the incident that makes it more or less likely to happen again? • Is the person alleged to have caused harm dependent on the adult at risk's income? • Is the person alleged to have caused harm working in a position of trust?
Risk of repeated incidents for others	• Are others at risk if actions are not taken under these procedures? • Do the concerns relate to a person or organisation employed or engaged to work with adults at risk? • Has anything changed since the incident that makes it more or less likely to happen to someone else? • Is there a need to make a safeguarding children referral?
Needs of the informal carer	• Is it unintentional harm caused inadvertently by a carer or a deliberate act of either harm or neglect? • Does the informal carer need a carer's assessment to include: o whether carer demands exceed the carer's ability or capacity o the emotional and/or social isolation of the carer and the adult at risk o communication barriers between the adult at risk and the

	carer ○ whether the carer is in receipt of any practical and/or emotional support from other family members or professionals ○ financial difficulties ○ whether the carer has a lasting power of attorney or appointeeship ○ a personal or family history of violent behaviour, alcoholism, substance misuse or mental illness ○ the physical and mental health and well-being of the carer

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

Additional Key Considerations:

- Responsibilities to those who are alleged to have caused harm **(section 12.4 of Guidance)**
- Mental Capacity and Consent **(section 12.5 of Guidance)**
- Deciding whether to report an incident to the police **(section 12.5.2 of Guidance)**
- Risk assessment and protection planning **(section 8.1.2 of Guidance)**
- Guidance for referral into adult safeguarding procedures **(Appendix F of Guidance)**
- Domestic Abuse **(section 12.7 of Guidance)**
- Self-Neglect **(section 12.8 of Guidance)**
- Involving the adult at risk **(section 12.3 of Guidance)**

6.1.11. Alternatives to referral into safeguarding adults procedures

Where the alert is recorded as "incident only" or "not safeguarding", the following list of alternative processes should be considered in directing people towards ways which may address their concerns.

- Assessment of health and social care needs; including a carers assessment
- Disciplinary procedures
- Complaint to, or concern raised with, Care Quality Commission
- Incident Investigation
- Contract monitoring/quality assurance processes
- Police/Criminal Investigation
- Referral/notification of MAPPA (Multi-Agency Public Protection Arrangements)
- Trading Standards Investigation
- Review of needs and services
- Complaint Investigation
- Training and supervision needs
- Serious Incident investigation

- Advice and support to access other services
- Referral to Anti-Social Behavioural Service
- Referral into the domestic abuse MARAC (Multi-Agency Risk Assessment Conference) process

****This list is by no means exhaustive****

NB: These processes will sometimes need to take place alongside, and be coordinated with, a safeguarding enquiry. The strategy discussion/meeting may decide to exit the safeguarding adults procedures and deal with the concern/allegation through an alternative process.

6.1.12. Who should be informed of the decision?

The decision maker will designate the most appropriate person to feedback to the adult at risk. This will often be the alerter (if this is appropriate). Where the person does not have mental capacity, they should still be included in the process as far as possible. Feedback will also be given to the person acting in their best interests, for example, their carer or court-appointed deputy.
The safeguarding lead will need to consider how the person or organisation alleged to have caused harm is informed about a safeguarding enquiry. Legal advice may be required in complex cases.
The alerter should be notified of the decision to proceed to a safeguarding adult referral as soon as practicable. Where the alerter is a member of the public, no details of subsequent actions should be shared without the consent of the adult at risk.

6.1.13. Recording the referral outcome

A record should be made of the decisions and actions required on the locally agreed recording systems and paperwork.

7. Stage Three: Strategy Discussion or Meeting

7.1. Purpose of the strategy discussion or meeting

After making a referral decision that a safeguarding enquiry may be required, the safeguarding lead is responsible for convening a strategy discussion or strategy meeting. The aim of the strategy discussion/meeting is to:

- share information regarding the safeguarding concern/allegation;
- consider the adult at risk's wishes and/or best interests regarding the enquiry;
- consider how the adult at risk will be involved and included within the safeguarding adults procedures and any support they may require (including advocacy);
- address the current level of risk to the person/others;
- assess risk and agree an interim protection plan;
- confirm that a safeguarding enquiry continues to be necessary under the safeguarding adults procedure;
- plan the continuation of the safeguarding enquiry;
- consider the involvement / needs of the alleged abuser.

With the exception of a police investigation, where vital evidence gathering is required, the strategy discussion or meeting should take place before any safeguarding enquiry.

The approach taken by the strategy discussion/meeting should be to support the adult at risk to manage the risks they face. This includes offering support to develop or maintain a private life including relationships with people of their choice. The adult should experience the safeguarding process as empowering and supportive.

It is important to listen to the adult at risk; both in terms of the alleged abuse and the resolution they want. What they have to say must be taken seriously and acted upon in an appropriate manner. Individuals have a right to privacy, to be treated with dignity and to be enabled to live an independent life. These values should be respected.

The safeguarding lead will arrange and chair the strategy discussion/meeting ensuring that minutes are taken and circulated.

Target Timescale:
The strategy discussion/meeting should be held within 5 working days of the referral decision.

7.1.1. Deciding whether to hold a strategy meeting or discussion

It may not be necessary to hold a strategy meeting in all cases, and where a strategy meeting is not required, the safeguarding lead may hold a strategy discussion. This decision will need to be a professional judgement and be a proportional response to the nature of the issues.

A strategy meeting will however be indicated where:

- there are significant risk or protection planning arrangements for the adult at risk (or others);
- several organisations have concerns and need to share information;
- there may be a number of investigations by different organisations;
- there may be legal or regulatory actions;
- a serious crime may have occurred;
- the allegation involves a member of staff/volunteer;
- the situation could attract media attention;
- there are concerns about the safety of the service/institutional abuse;
- a large scale investigation is being considered.

7.1.2. Who should be involved in a strategy discussion/meeting

The safeguarding lead (and potentially the person themselves), will need to decide who to involve in a strategy discussion/meeting. Attendance/involvement should include those who need to know and who can contribute to the decision making process. This may include an appropriate representative of any organisation that has a specific role:

- investigating the allegation of abuse or neglect;
- assessing the risk;
- developing or carrying out the interim protection plan;
- taking action in relation to the person alleged to have caused harm;
- undertaking related investigations such as those relating to complaints, serious incident, disciplinary, criminal investigation etc.

The ADASS: Protocol for inter-authority investigation details respective responsibilities when abuse or neglect occurs in one local authority area, but the person receives services funded/commissioned by another. The protocol is adopted as part of these procedures and should be considered in these circumstances when deciding who to involve in the strategy discussion/meeting.

See web link below for further information:
http://www.adass.org.uk/AdassMedia/stories/Policy%20Networks/Safeguarding_Adults/Key_Documents/ADASS_GuidanceInterAuthoritySafeguardingArrangementsDec12.pdf

Participants should be of sufficient seniority to make decisions concerning the organisation's role within any proposed enquiry and the resources they may contribute to the protection plan.

It may be appropriate to invite the adult at risk to a strategy meeting or to part of it, to contribute their views and needs directly to the meeting. In the event that the adult at risk is not able or does not wish to attend, or it is not appropriate for them to attend, every effort should be made to explain its purpose to the adult at risk, to find out their concerns, what they want to happen, how they want to be involved and the support they feel they need in order to be safe. Consideration should also be given as to how adult at risk's advocate may need to be involved. The same information will need to be sought within strategy discussions. Support should be provided to enable them to participate for example via advocate, family member, friend or personal assistant.

Where a person is without the mental capacity to decide about their involvement, a decision will need to be made and recorded in their "best interests". Where an IMCA has been appointed they will ordinarily be invited to attend/participate. The strategy discussion/meeting must decide who will liaise with the adult at risk about decisions reached or required if not present.

Any organisation requested to participate in a strategy meeting should regard the request as a priority. If no one from the organisation is able to attend a meeting, they should provide information as requested and make sure it is available to the safeguarding lead in advance.

Additional Key Considerations:

- Responsibilities to those who are alleged to have caused harm **(section 12.4 of Guidance)**
- Mental Capacity and Consent **(section 12.5 of Guidance)**
- Deciding whether to report an incident to the police **(section 12.5.2 of Guidance)**
- Risk assessment and protection planning **(section 8.1.2 of Guidance)**
- Guidance for referral into adult safeguarding procedures **(Appendix F of Guidance)**
- Domestic Abuse **(section 12.7 of Guidance)**
- Self-Neglect **(section 12.8 of Guidance)**
- Involving the adult at risk **(section 12.3 of Guidance)**

7.1.3. Deciding whether to proceed to a safeguarding enquiry

The strategy discussion/meeting should decide on the appropriateness of proceed further with a safeguarding adults enquiry. If the decision to proceed to a safeguarding enquiry is endorsed, a plan for the enquiry process will be developed at this point.

If the strategy discussion/meeting decides it is not appropriate to proceed within the safeguarding adults procedures, this should be clearly recorded within the minutes. Reasons for exiting the safeguarding adults procedures may include:

An alternative process is to be followed: A decision may be reached that the incident does not require a safeguarding enquiry, and can be robustly addressed (and evidenced as such), through an alternative process, for example, assessment of health and social care needs, complaint processes, training, disciplinary processes.

Adult at risk declines any assistance: Where an adult at risk has mental capacity and does not wish for any action to be taken under the safeguarding adults procedures, practitioners must seek to ensure that the adult at risk is making an informed decision without undue influence, threats and intimidation. If there are no other people at risk from the person or organisation alleged to have caused the harm, there will be no more action under the procedures at this time.

Note: The adult at risk should be given information about possible sources of help and support and whom they can contact if they should change their mind or the situation changes and they no longer feel able to protect themselves.

7.1.4. Safeguarding enquiry plan

Although the local authority is the lead agency for making enquiries, it may require others to undertake them. The specific circumstances will often determine who the right person to begin the enquiry is. In many cases a professional who already knows the adult will be the best person. They may be a social worker, a housing support worker, a GP or other health worker such as a community nurse. The local authority retains the responsibility for ensuring that the enquiry is referred to the

right place and is acted upon, the safeguarding lead should be clear about timescales, the need to know the outcomes of the enquiry and what action will follow if this is not done.

The local authority, in its lead and coordinating role, should assure itself that the enquiry satisfies its duty under Section 42 of the Care Act to decide what action (if any) is necessary to help and protect the adult and by whom and to ensure that such action is taken when necessary. In this role if the local authority has asked someone else to make enquiries, it is able to challenge the body making the enquiry if it considers that the process and/or outcome is unsatisfactory

The scope of that enquiry, who leads it and its nature, and how long it takes, will depend on the particular circumstances. It will usually start with asking the adult their view and wishes which will often determine what next steps to take. Everyone involved in an enquiry must focus on improving the adult's well-being and work together to that shared aim. At this stage, the local authority also has a duty to consider whether the adult requires an independent advocate to represent and support the adult in the enquiry.

It is important, when considering the management of any intervention or enquiry, to approach reports of incidents or allegations with an open mind. In considering how to respond the following factors need to be considered:

- the adult's needs for care and support;
- the adult's risk of abuse or neglect;
- the adult's ability to protect themselves or the ability of their networks to increase the support they offer;
- the impact on the adult, their wishes;
- the possible impact on important relationships;
- potential of action and increasing risk to the adult;
- the risk of repeated or increasingly serious acts involving children, or another adult at risk of abuse or neglect;
- the responsibility of the person or organisation that has caused the abuse or neglect; and
- research evidence to support any intervention.

The safeguarding enquiry will need to draw together relevant information from all the various activities detailed in the enquiry plan and produce a summary for the reporting meeting.
A range of enquiries will need to be coordinated within the safeguarding enquiry plan. This may include:

- activities required of the safeguarding investigation officers
- activities of other organisations, such as provision of expert reports e.g. specialist health reports, CQC, commissioners etc
- activities being undertaken by organisations through other processes, e.g. police investigations, serious incident, complaint and disciplinary investigations. See Table at section 7.3 for a list of related investigation process.

The safeguarding enquiry plan should be devised making the best use of skills, expertise and resources, and may involve asking another person or organisation, such as the current service provider manager to undertake particular activities, for example, to interview a member of their staff team.

The enquiry plan will need to coordinate all these various elements. It should set out how this all this information is to be captured, and who will be responsible for the various elements.

The enquiry plan will also need to:

- Reflect the wishes and feelings of the adult at risk;
- clearly define the concerns or allegations to be investigated;
- distinguish any elements which do not need to fall within the remit of the safeguarding procedures, and the alternative process (if any) being followed;
- reflect the involvement, support and communication needs of the adult at risk;
- reflect the involvement, support and communication needs of the person or organisation alleged to have caused harm;
- provide, wherever practicable, for the person or organisation alleged to have caused harm to respond to allegations and the safeguarding enquiry findings concerning them. The timing of such actions also needs to be considered, so that this does not prejudice any investigation required or place any person at risk;
- reflect how the risk to any party in undertaking the enquiry should be managed;
- set dates for completion of the enquiry reports;
- set dates for the reporting meeting.

7.1.5. Additional guidance on coordinating multi-agency response

The Care Act Guidance 2014 mandates that the local authority and its partners must co-operate in order to protect the adult. In their turn each relevant partner must also co-operate with the local authority.

The strategy discussion/meeting will need to consider respective roles and responsibilities of organisations, specific tasks required, issues of cooperation, communication and the best use of skills, expertise and resources. A summary table of potential investigative processes is included in Section 7.3**.**

The Department of Health Guidance, "No Secrets" published in 2000 establishes key guiding principles that are relevant to the coordination of enquiries:

i. "*A properly coordinated joint enquiry will achieve more than a series of separate enquiries. It will ensure that evidence is shared, repeat interviewing is avoided and will cause less distress for the person who may have suffered abuse."*

ii. "…. no individual agency's statutory responsibility can be delegated to another. Each agency must act in accordance with its duty when it is satisfied that the action is appropriate. Joint enquiry there may be, but the shared information flowing from that must be constantly evaluated and reviewed by each agency."

Each organisation must look for opportunities to work in partnership. Organisations however must be responsible and accountable for their own actions and decisions. In deciding how the enquiry should be are coordinated, the following principles should be taken into account:

- the safety of the adult at risk should be the focus of decisions as to how actions are coordinated;

- where a crime is suspected and referred to the police, then the police must lead the criminal investigations, with the local authority's support where appropriate, for example by providing information and assistance. The local authority has an ongoing duty to promote the wellbeing of the adult in these circumstances. Any other processes should not commence without their prior agreement. This does not preclude, where appropriate and agreed, joint interviews and information sharing;

- when joint interviews or assessments are planned, there should be clear agreement between the organisations concerned about the scope of their investigations and respective roles and responsibilities;

- the timing of the various investigations needs to be considered;

- where possible, sharing of information may prevent the need for repeat investigation into the same issues or concerns. Refer to information sharing guidance as required.

7.1.6. Determining the safeguarding investigating officers

The safeguarding investigating officers will be appropriate, nominated persons agreed by the safeguarding lead at the strategy discussion/ meeting. A decision for a service provider manager to act as a safeguarding investigating officer will need to be made will due regard to **section** 7.1.7(below).

7.1.7. The service provider manager as a safeguarding investigating officer

The service provider manager in the organisation in which alleged abuse or neglect has occurred may act as a safeguarding investigating officer, where agreed by the strategy discussion/ meeting. A clear record of this decision must be made with reasons for the decision recorded. This decision will need to be a proportionate one, reflecting the particular circumstances, and take into account the following:

- issues are such that they can be investigated impartially by the service provider (and will be perceived to be);
- institutional abuse is not indicated or suspected;
- no other organisation is needing to contribute to the safeguarding enquiry;
- a serious crime is not indicated;
- no regulatory or contracting authority actions are indicated;
- there is no reoccurring pattern of incidents of abuse indicated.

The manager within the organisation responsible for undertaking the enquiry must ensure that:

- only essential information is shared within the organisation on a need-to-know basis;
- the enquiry follows the agreed plan, as discussed within the strategy discussion/meeting;
- the relevant safeguarding lead is kept informed of the progress of the enquiry and is informed of any additional issues arising during its course;
- a safeguarding enquiry report is completed in the required format and to the required standard;

- the safeguarding enquiries are completed within the timescale agreed with the safeguarding lead.

The safeguarding lead must ensure that the safeguarding enquiry has been undertaken thoroughly and has followed the plan agreed in the strategy discussion/meeting. They may need to ask for additional actions to be undertaken, where these have been omitted from the enquiries or are subsequently indicated.

The resulting safeguarding enquiry report must be free from bias and vested interests of the service provider. If the safeguarding lead finds this is not achievable, an independent safeguarding investigating officer may be asked to re-investigate the concerns.

7.1.8. Recording and sharing information

The records should be distributed to all relevant individuals and organisations in line with data protection requirements.

7.2. Distribution of strategy discussion/meeting minutes

The safeguarding lead will decide who to include in the distribution of minutes. This will usually include:

- all attendees and invitees to a strategy meeting;
- relevant persons contributing to the protection plan or enquiry;
- the CQC where the case conference relates to a service that it regulates;
- other relevant regulatory bodies, as appropriate.

If not present, a copy of the minutes should be sent to the adult at risk or, with their permission, to another person. This however may not always be appropriate, for example, if to do so may increase the level of risk, breach confidentiality, or compromise the enquiry. If the adult at risk does not have mental capacity, a decision should be made in their best interests about who to send the minutes to. Where information is sent to a carer (with permission of the adult at risk or in their best interests) the safeguarding lead will need to decide what information can be shared about the person alleged to have caused harm.

Where there is specific information that cannot be shared, it should be deleted (also referred to as redacted) from versions of documents sent out. Data Protection Act 1998 principles must be adhered to. For example, where a person was requested to leave the room during part of the strategy meeting, consideration will need to be given to whether the section of the minutes relating to that part of the meeting should be redacted from the copy sent to the person concerned.

Target Timescale:
Strategy discussion/meeting minutes should be circulated within 5 working days of the discussion/meeting.

7.3. Types of investigation or risk assessment and agency responsible

The table below illustrates a number of parallel types of investigation (and their associated lead agency), which may be useful as a part of the safeguarding enquiry – or run on parallel.

Types of investigation/ risk assessment	Agency responsible
Criminal (including assault, theft, fraud, hate crime, domestic abuse and abuse or wilful neglect of a person lacking capacity)	Police
Domestic abuse – serious risk of harm	Multi-Agency Risk Assessment Conference in high risk cases. Also domestic abuse teams /organisations, police
Fitness of registered service provider	Care Quality Commission
Unresolved serious complaint in healthcare setting	Care Quality Commission, Health Service Ombudsman
Breach of rights of person detained under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS)	Care Quality Commission, Local Authority, CCG, 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	Health and Safety Executive (HSE)
Complaint regarding failure of service provision	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, clinical commissioning groups)
Assessment of need for health and social care provision (service users and carers)	Social Services/CCG/community mental health team/care trust
Access to health and social care services to reduce the risk of abuse/neglect	Social services/CCG/community mental health team/care trust
Misuse of enduring or lasting power of attorney or misconduct of a court-appointed deputy	Office of the Public Guardian/Court of Protection/Police
Inappropriate person making decisions about the care and well-being of an adult at risk who does not have mental capacity to make decisions about their safety which is not in their best interests	Office of the Public Guardian/Court of Protection
Misuse of benefits by appointee or agent	Department for Work and Pensions
Anti-social behaviour (e.g. harassment, and nuisance by neighbours)	Community Safety Team
Breach of tenancy agreement (e.g. harassment, and nuisance by neighbours)	Landlord/Registered social landlord/Housing Trust/Community Safety Team
Bogus callers or rogue traders	Police and Trading Standards Service

8. Stage Four: The Safeguarding Enquiry

8.1.1. Purpose of the enquiry

The objectives of an enquiry into abuse or neglect are to:

- establish facts;
- ascertain the adult's views and wishes;
- assess the needs of the adult for protection, support and redress and how they might be met;
- protect from the abuse and neglect, in accordance with the wishes of the adult;
- make decisions as to what follow-up action should be taken with regard to the person or organisation responsible for the abuse or neglect; and
- enable the adult to achieve resolution and recovery.

Target Timescale
The safeguarding enquiry reports should be received by the safeguarding lead 7 working days in advance of the reporting meeting.

8.1.2. Risk Assessment and Protection Planning

During the period while undertaking the safeguarding enquiry, the protection plan arrangements will need to be kept under review as agreed within the strategy discussion/meeting. New information or changes of circumstance may require the risk to the individual or others to re-assessed and the protection plan amended. The safeguarding lead should always be informed as to potential changes in the level of risk or concerns about the effectiveness of the protection plan. A further meeting will sometimes be required.

Any intervention in family or personal relationships needs to be carefully considered.
While abusive relationships never contribute to the wellbeing of an adult, interventions which remove all contact with family members may also be experienced as abusive interventions and risk breaching the adult's right to family life if not justified or proportionate. Safeguarding needs to recognise that the right to safety needs to be balanced with other rights, such as rights to liberty and autonomy, and rights to family life. Action might be primarily supportive or therapeutic, or it might involve the application of civil orders, sanctions, suspension, regulatory activity or criminal prosecution, disciplinary action or de-registration from a professional body.

Additional Key Considerations:

- Responsibilities to those who are alleged to have caused harm **(section 12.4 of Guidance)**
- Mental Capacity and Consent **(section 12.5 of Guidance)**
- Deciding whether to report an incident to the police **(section 12.5.2 of Guidance)**
- Risk assessment and protection planning **(section 8.1.2 of Guidance)**
- Guidance for referral into adult safeguarding procedures **(Appendix F of Guidance)**
- Domestic Abuse **(section 12.7 of Guidance)**
- Self-Neglect **(section 12.8 of Guidance)**
- Involving the adult at risk **(section 12.3 Guidance)**

8.1.3. Role of the safeguarding investigating officers

The safeguarding investigating officers should be suitably qualified and experienced members of staff from nominated organisations as agreed at the strategy discussion/meeting. The safeguarding investigating officers will need to follow the enquiry plan as agreed within the strategy discussion/meeting, with support and direction from the safeguarding lead. They will draw together from various sources and make enquiries as agreed by the scope of the enquiry plan.

Professionals and other staff need to handle enquiries in a sensitive and skilled way to ensure distress to the adult is minimised. It is likely that many enquiries will require the input and supervision of a social worker, particularly the more complex situations and to support the adult to realise the outcomes they want and to reach a resolution or recovery.

Whilst work with the adult may frequently require the input of a social worker, other aspects of enquiries may be best undertaken by others with more appropriate skills and knowledge. For example, health professionals should undertake enquiries relating to treatment plans, medicines management or pressure sores.

8.1.4. Undertaking Enquiries

The safeguarding enquiry should be focused on the specific concerns/allegations agreed within the strategy discussion/meeting, ensuring that:

- the adult at risk has the opportunity to give their account of what has happened to them and what outcomes they would like;
- the safeguarding enquiry is undertaken objectively, based upon the establishment of facts;
- the safeguarding enquiry is always sufficiently thorough to ensure a balanced perspective is obtained in relation to any abuse occurring (or alleged to have occurred);
- wherever practicable, a person or organisation alleged to have caused harm should be enabled to respond to allegations and the safeguarding enquiry's findings in respect to their actions/conduct. However, there will need to be consideration about the timing of this, so that it does not prejudice any other investigation or place any person at risk.

Safeguarding enquiries may involve a range of activities, including:

- examination of documentary evidence such as files, accident and incident reports, daily logs, accounts, medical records etc;
- discussion with the adult at risk, witnesses, the person alleged to have caused harm or representative(s) of the organisation alleged to have caused harm, and others who can provide relevant information;
- assessing relevant information provided by partner agencies learning from own;
- observations obtained while undertaking the enquiries.

Safeguarding investigating officers should keep accurate records, stating what the facts are and what are the known opinions of professionals and others and differentiating between fact and opinion. It

is vital that the views of the adult are sought and recorded. These should include the outcomes that the adult wants, such as feeling safe at home, access to community facilities, restricted or no contact with certain individuals or pursuing the matter through the criminal justice system.

The safeguarding enquiry may be informed by other investigations, for example, serious/incident investigations or disciplinary investigations. In using information obtained from other investigation processes, the investigating officer will need to review the activities undertaken and their findings and undertake any additional actions as required, to form their own view about the occurrence of abuse or neglect and the protection planning needs of the adult at risk.

8.1.5. Amendment to the safeguarding enquiry plan

Safeguarding investigating officers should immediately inform the safeguarding lead, if during the course of their enquiries:

- new information comes to light that suggests new sources of information should be considered, or additional conversations should be undertaken;
- new/additional safeguarding allegations/concerns are identified;
- the concern which the enquiry relates to is proving to be more or less serious than initially assessed.

The safeguarding lead may then need to review the safeguarding enquiry plan. A multi-agency review meeting can be convened, if helpful, to review the information and any implications for protection arrangements.

A new safeguarding alert and separate enquiry may be required if substantial new concerns or allegations emerge during the course of the enquiries.

8.1.6. Planning discussions

Any discussion with staff, the adult at risk or alleged abuser need to take into account the particular needs of the person, including:

- Does the person wish to be accompanied during the discussion to provide emotional support or personal assistant?
- Are there particular communication needs that need to be catered for?
- Are there relevant cultural, spiritual or gender issues or particular support needs that need to be planned for?
- Has the discussion format and content taken into account a person's cognitive abilities (for example, the person's concentration span, the complexity of questions being asked)?

Always ensure:

- the purpose of the discussion is fully explained;
- the venue for the discussion is appropriate and private;
- the person is aware of how the information they are sharing will be used;
- that the individual understands what is taking place throughout;
- the discussion is conducted at the individual's own pace; this may involve breaks or more than one session;
- the conversation with the adult at risk does not take place in the presence of the person alleged to have caused harm;
- that everything is recorded as fully and accurately as possible;
- that conversations are carried out sensitively and without any prejudgement of the issues;

- to avoid, wherever possible, repeat meetings with a person about the same incident.

8.1.7. Medical treatment and examination

When considering medical treatment and examination, it needs to be timely. In cases of physical abuse it may be unclear whether injuries have been caused by abuse or some other means (for example, an accident). Medical or specialist clinical advice may need to be sought. If forensic evidence needs to be collected, the police should always be contacted and they will normally arrange for a police surgeon (forensic medical examiner) to be involved.

Consent of the adult at risk should be sought for medical examination or the taking of photographs. Where the person does not have mental capacity to consent to medical examination or the taking of photographs, a decision should be made on the basis of whether it is in the person's best interest.

Should it be necessary as part of the enquiries to arrange for a medical examination to be conducted, 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/support the adult at risk, provide reassurance and how this can be provided (consider an advocate)

8.1.8. Delays to Enquiries

The safeguarding investigating officers must keep the safeguarding lead informed of the progress of their enquiries. If for any reason the enquiries cannot be completed within the agreed timescales, a revised agreement about timescales and any necessary action(s) to be taken must be reached with the safeguarding lead and other relevant organisations and recorded. Revised timescales will ordinarily be communicated to the adult at risk and the person alleged to have caused harm.

8.1.9. Standards of proof

In determining whether abuse has occurred, the standard of evidence for safeguarding enquiries is "on the balance of probability". This is in contrast to the standard of proof for a criminal prosecution which is established as "beyond reasonable doubt".

If a person or organisation alleged to have caused harm has not been informed of allegations, it may not be possible to reach a decision as to the occurrence or not of abuse, in which case the sole focus of the safeguarding adult procedures will be on protection planning.

8.1.10. Compiling the safeguarding enquiry report

The safeguarding investigating officers will need to produce a report. This report should provide a summary of their activities and information obtained. In compiling the report, the following principles should be adhered to:

- the report should be based upon the facts established within the enquiries;

- any opinions expressed within the report should be referenced as such;

- the report should be focused on the experience of abuse and what actions can safeguard the adult at risk from future harm;

- if any person could not be interviewed or if certain records could not be accessed, the report should record this and the reasons why;

- the report should make clear where information from different sources is contradictory;

- the report should evidence how conclusions or recommendations have been reached;

- information concerning the adult at risk, the person alleged to have caused harm or any other parties that is usually identifiable, should be kept to the minimum necessary for the purposes of the report;

- the report may contain information that relates to different individuals. It may be necessary for reports to be written in a way that enables particular sections to be shared as appropriate or be anonymised through use of initials or removal of names;

- the report should be signed off by the safeguarding lead prior to the reporting meeting.

The safeguarding lead should check the reports received against the safeguarding enquiry plan to ensure that all activities have been undertaken as planned. A check should also be made that the recommendations are based on the analysis of the evidence obtained, that the report is robust and will stand up to scrutiny. Once satisfied, the lead should sign off the report so that it can proceed to the reporting meeting.

9. Stage Five: Reporting Meeting

9.1. Purpose of the reporting meeting

Once the wishes of the adult have been ascertained and an initial enquiry undertaken, discussions should be undertaken with them as to whether further enquiry is needed and what further action could be taken.

The purpose of the reporting meeting is to conclude the safeguarding adults enquiry and to develop protection arrangements on the basis of those conclusions. The reporting meeting should:

- consider the evidence gained through the safeguarding enquiry;
- agree a protection plan where required;
- assess the level of any ongoing risk;
- agree outcomes, taking into account the adult at risk's wishes and best interests;
- decide how any protection plan is reviewed and monitored;
- determine whether, on the balance of probabilities, abuse or neglect has occurred.

The approach taken by the reporting meeting should be to support the adult at risk to manage the risks they face. This includes offering support to develop or maintain a private life including relationships with people of their choice.

Other courses of action or support which could be recommended at the reporting meeting include: it could include disciplinary, complaints or criminal investigations or work by contracts managers and CQC to improve care standards.

Those discussions should enable the adult to understand what their options might be and how their wishes might best be realised. Social workers must be able to set out both the civil and criminal justice approaches that are open and other approaches that might help to promote their wellbeing, such as therapeutic or family work, mediation and conflict resolution, peer or circles of support. In complex domestic circumstances, it may take the adult some time to gain the confidence and self-esteem to protect themselves and take action and their wishes may change. The police, health service and others may need to be involved to help ensure these wishes are realised.

A reporting meeting should also consider, where appropriate, whether to recommend the need for a Safeguarding Adults Review be undertaken (see Section 10.2.4 and appendix B).

Target Timescale:
The reporting meeting should be held within 8 weeks* of safeguarding referral decision.
****To be achieved earlier where possible***

9.1.1. Reporting Meeting

A reporting meeting will be chaired by the safeguarding lead.

When a reporting meeting is held, the safeguarding lead will liaise with the safeguarding investigating officers and other relevant parties as required to reach their decision whether abuse has occurred. Such a decision, wherever possible, will take into account the views of the adult at risk and the person or organisation alleged to have caused harm.

Any decisions about protection arrangements should be undertaken in consultation with the adult at risk and other relevant parties such as their representatives (e.g. advocates or family members). Where a person is without mental capacity in relation to decisions about their safety, plans will need to be agreed in their best interests.

Good practice is to plan the provisional date and venue of the reporting meeting at the time of the strategy discussion/meeting, allowing attendees sufficient notice to attend.

9.1.2. Invitations to reporting meetings

The safeguarding lead will need to determine who to invite to the reporting meeting and how the views of any relevant people who are not to be invited will be represented. The decision who to involve in a reporting meeting should include those who need to know and who can contribute to the decision-making process. This may need to include a representative of any organisation that has a specific role in:

- investigating the allegation of abuse or neglect
- assessing the risk
- developing or carrying out the protection plan, or
- taking action in relation to the person alleged to have caused harm

The person participating should be of sufficient seniority to make decisions concerning the organisation's role.

Invitations should include the adult at risk. Where the adult at risk lacks the mental capacity to decide about attendance a best interest decision will be required. The adult at risk is entitled to be supported by an appropriate person(s), such as a family member, friend, advocate or personal assistant (according to their wishes, or decided in their "best interests" where they lack the mental capacity to decide for themselves). The adult at risk may also choose not to attend and have their views reported via a representative or in writing. Where an IMCA has been appointed, they will be invited to attend.

The person alleged to have caused harm should be invited to the reporting meeting where practicable, however any decision reached must be in accordance with the needs, wishes and best interests of the adult at risk. The decision will need to be made by the safeguarding lead. Where a person is invited to attend, they are entitled to be supported by an appropriate person, such as a family member, friend or advocate.

However, if the person or representative of an organisation alleged to have caused harm is not to be present, wherever practicable they should be made aware of the reporting meeting and their views included as appropriate.

The most appropriate representative from an organisation alleged to have caused harm needs to be invited to attend the reporting meeting. This will depend on the nature and severity of the allegations.

Arrangements will need to be planned so as to enable both the adult at risk and representatives of the organisation to participate as appropriate.

Where the allegation/concern involves abuse occurring within a regulated or contracted service, the safeguarding lead should consider involving, as appropriate:

- Care Quality Commission

- Contracting/Commissioning Department

Any organisation requested to participate in a reporting meeting should regard the request as a priority. If the invited person (or an appropriate representative) is unable to attend a reporting meeting, they should provide information in writing as requested and make sure it is available for the chair (safeguarding lead) in advance of the meeting.

Only people invited to attend the reporting meeting should do so. Unexpected people may not be permitted to attend the meeting. Any person that would like to bring an additional person, a friend or family member or a colleague from their organisation for example should inform the chair (safeguarding lead) in advance of the meeting.

For reasons of confidentiality it may be necessary for any person to absent themselves for part of the meeting as requested by the chair.

9.2. Role of legal representatives at a reporting meeting

If the adult at risk, their representative or another interested party wishes to bring a legal representative with them to a reporting meeting, the chair of the meeting should be advised of this in advance. Other invitees may need to be informed of the proposed attendance.

Any legal representative attending should be advised before the meeting by the safeguarding investigating officers or safeguarding lead immediately before the meeting begins, that they are welcome to attend in the role of a 'silent supporter', that is, they are attending as a support and not to actively participate or comment during the reporting meeting. If the attendee who has requested that a solicitor accompany them is not agreeable to this condition, advice should be sought by the chair of the reporting meeting from the local authority's legal services and where needed the reporting meeting should be adjourned.

9.3. Information provided through the safeguarding investigating officers reports

It is very important that safeguarding enquiries are thorough, properly conducted and provide the safeguarding lead with the relevant information to allow for effective and informed decision making.

Where a reporting meeting is being held, the safeguarding investigating officer's reports must be forwarded to the safeguarding lead (chair) 7 working days prior to the meeting.

It is important that the safeguarding investigating officers reports should be seen by all those involved in the enquiry and by reporting meeting attendees. This is to ensure that all interested parties have had an opportunity to consider the findings. In particular, they should be able to consider whether there is any additional relevant information that should be taken into account and provide this to the reporting meeting.

Safeguarding enquiry reports will ordinarily be distributed to attendees 5 working days in advance of a reporting meeting. In some exceptional circumstances, due to issues of confidentiality, sensitivity and risk, it may be important for reports not to be shared ahead of the meeting. In such circumstances, the reasons must be clearly recorded and explained, and reports can be shared at the commencement of the meeting, with time scheduled for attendees to read them.

Where an attendee realises that because they were unaware of the contents of the safeguarding report they have not brought pertinent information to the meeting, it may be necessary to adjourn the reporting meeting and reconvene so that this information can be considered. This is particularly relevant for any person or organisation alleged to have caused harm.

The safeguarding lead will decide how the reports are to be shared. Local information sharing protocols, policies and guidance must be followed.

9.3.1. Views of the adult(s) at risk

The person's view regarding the allegation should always be sought, noted and carefully considered by the safeguarding lead in a reporting meeting.

For example the person feels that they have been harmed or abused and this should be noted and respected. Others may take a view that abuse has taken place because of the nature and context of the allegation (e.g. that the person responsible is in a position of trust). Factors such as this should be clearly recorded and any protection plan should take account of these issues accordingly.

When the adult at risk is present at the reporting meeting it may be difficult for them to express their feelings/views. The chair needs to ensure ways are identified to support them in doing this effectively.

Where the case conclusion is deemed not substantiated or inconclusive, this does not negate the importance of the view and feelings of the adult at risk. This should be stressed by the chair in a reporting meeting. Particular thought should be given regarding what support the adult at risk may require to express these views and feelings.

9.3.2. Views of the person(s) or organisation alleged to have caused harm

The view of the person(s) or organisations alleged to have caused harm should always be sought, noted and carefully considered by the safeguarding lead in a reporting meeting.

It may not always be appropriate to invite the person alleged to have caused harm to the reporting meeting but their views should be fully considered within the decision making process.

9.3.3. Case conclusions

The primary focus of the safeguarding adults procedures is protection and empowerment. It is necessary to establish whether, on the balance of probabilities, abuse has occurred in order to assess the extent of any ongoing risk. This assessment of risk will guide the development of any “protection plan” that is needed to keep the person safe from future harm.

Case conclusions record whether abuse has occurred, and if so, the type of abuse experienced. They should only be reached in relation to allegations specifically investigated and where the enquiry has been sufficiently robust to reach a fair and defensible decision.

New or emerging issues that are beyond the scope of the initial enquiries undertaken will need to be considered in their own right. This may require a new safeguarding referral/ enquiry or an appropriate alternative response/process.

9.3.4. Case conclusion for each type of abuse

A case conclusion for each type of alleged abuse is needed, for example physical or financial abuse. The decision will need to be made on the basis of the evidence gathered during the enquiry.

The burden of proof should be consistent with the civil standard of proof required for internal discipline referred to in “No Secrets” which is “on the balance of probabilities”.

There are four possible outcomes to this decision:

- ***Substantiated*** – *fully* - This refers to cases where "on the balance of probabilities" it was concluded that all the allegations made against the individual or organisation were verified "on the balance of probabilities". Where allegations of multiple types of abuse are being considered against an individual or organisation then all will need to be proved for it to be defined as fully substantiated.

- ***Inconclusive*** - This refers to cases where there is insufficient evidence to allow a conclusion to be reached. This will include cases where, for example, the individual subject to the referral, the individual believed to be the source of the risk or a key witness passed away before they could provide statements as part of the enquiry

- ***Not substantiated*** - This refers to cases where "on the balance of probabilities" the allegations are unfounded, unsupported or disproved.

- ***Enquiry ceased at individual's request*** [1]- This refers to cases where the individual at risk does not wish for an enquiry to proceed for whatever reason and so preclude a conclusion being reached. Referrals which proceed despite this, for example where a local authority has duty of care to protect other residents in a care home setting or multiple individuals in supported housing, will not come under this definition.

Note: For each type of abuse there may be more than one incident or allegation. If just one incident or allegation amounting to abuse is found to have occurred, then that type of abuse has been substantiated (regardless of findings in relation to other incidents or allegations).

9.3.5. Overall case conclusion

It will also be necessary to record an overall case conclusion whether there was one type of abuse or more. The following guidance should be followed.

The burden of proof should be consistent with the civil standard of proof required for internal discipline referred to in "No Secrets" which is "on the balance of probabilities".

There are five possible outcomes to this decision:

- ***Substantiated – fully*** **-** This refers to cases where "on the balance of probabilities" it was concluded that all the allegations made against the individual or organisation were verified "on the balance of probabilities". Where allegations of multiple types of abuse are being considered against an individual or organisation then all will need to be proved for it to be defined as fully substantiated.

- ***Substantiated – partially*** - This refers to cases where there are allegations of multiple types of abuse being considered against an individual or organisation. Verification will be partial where "on the balance of probabilities" it was concluded that one or more, but not all, of the alleged types of abuse were proved. For example, a referral that includes allegations of physical abuse and neglect, where the physical abuse can be proved on the balance of probabilities, but there is not enough evidence to support the allegation of neglect will be partially substantiated.

[1] This option is currently not available on Frameworki (January 2015), however the system will be amended to include this option.

- ***Inconclusive -*** This refers to cases where there is insufficient evidence to allow a conclusion to be reached. This will include cases where, for example, the individual subject to the referral, the individual believed to be the source of the risk or a key witness passed away before they could provide statements as part of the enquiry.

- ***Not substantiated*** - This refers to cases where "on the balance of probabilities" the allegations are unfounded, unsupported or disproved.

- ***Enquiry ceased at individual's request*** [2]- This refers to cases where the individual at risk does not wish for an enquiry to proceed for whatever reason and so preclude a conclusion being reached. Referrals which proceed despite this, for example where a local authority has duty of care to protect other residents in a care home setting or multiple individuals in supported housing, will not come under this definition.

9.3.6. Reporting meeting decision making

It is the role of the chair (safeguarding lead) in a reporting meeting to facilitate the collective decision making process. No one individual can make this decision. This decision is a multi-agency/ multi-disciplinary responsibility that must be made and owned by those professionals attending who represent the statutory agencies and key organisations involved in the enquiry. Parties involved in the collective decision making process must have no vested interest in the allegations and outline clear, evidence based reasons for their views that are recorded in the minutes. Decision making must take into account the views of all relevant parties, including the adult at risk and the person or organisation alleged to have caused harm.

If there is disagreement about the case conclusion for any type of abuse, every effort should be made through discussion, led by the chair of the reporting meeting, to resolve any differing views. Where it is not possible to reach a clear consensus decision amongst relevant professionals, the case conclusion should be recorded as 'inconclusive' because it has not been possible to reach a shared decision, on balance of probabilities, as to whether the type of abuse is substantiated or not substantiated.

In the event that any attendee is not in agreement with the decision, this should be noted in the reporting meeting minutes along with their reasons for disagreement.

9.3.7. Assessment of risk

Assessments of risk will need to be reviewed in light of the decision as to whether abuse has occurred and, if so its type. The findings of the enquiry may impact on the assessed risk to the adult at risk or other people. There may also be changes in the adult at risk's circumstances (or that of the person alleged to have caused harm) that impact on the risk. Any changes in the assessment of risk will need to be reflected in the protection plan.

An adult at risk that has the mental capacity to make decisions about their safety should be involved in the assessment of risk. Where the adult at risk lacks mental capacity in relation to decisions about their safety appropriate representation needs to be taken into account.

[2] This option is currently not available on Frameworki (January 2015), however the system will be amended to include this option.

9.3.8. Agreeing a protection plan

Once the facts have been established, a further discussion of the needs and wishes of the adult is likely to take place. This could be focused safeguarding planning to enable the adult to achieve resolution or recovery, or fuller assessments by health and social care agencies (e.g. a needs assessment under the Care Act).This will entail joint discussion, decision taking and planning with the adult for their future safety and well-being. This applies if it is concluded that the allegation is true or otherwise, as many enquiries may be inconclusive.

The local authority must determine what further action is necessary. Where the local authority determines that it should itself take further action (e.g. a protection plan), then the authority would be under a duty to do so.

The MCA is clear that local authorities must presume that an adult has the capacity to make a decision until there is a reason to suspect that capacity is in some way compromised; the adult is best placed to make choices about their wellbeing which may involve taking certain risks. Of course, where the adult may lack capacity to make decisions about arrangements for enquiries or managing any abusive situation, then their capacity must always be assessed and any decision made in their best interests. If the adult has the capacity to make decisions in this area of their life and declines assistance, this can limit the intervention that organisations can make. The focus should therefore be, on harm reduction.

It should not however limit the action that may be required to protect others who are at risk of harm. The potential for 'undue influence' will need to be considered if relevant. If the adult is thought to be refusing intervention on the grounds of duress then action must be taken.
The protection plan is the risk management plan that is put in place to remove or reduce the risk of harm. The protection plan should serve to safeguard the person's safety.

In order to make sound decisions, the adult's emotional, physical, intellectual and mental capacity in relation to self-determination and consent and any intimidation, misuse of authority or undue influence will have to be assessed.

Wherever possible any protection plan for the adult at risk should be developed in partnership with them, taking into account their wishes and the impact on their lifestyle and independence.

In relation to the adult this plan should set out:

- what steps are to be taken to assure their safety in future;
- the provision of any support, treatment or therapy including on-going advocacy;
- any modifications needed in the way services are provided (e.g. same gender care or placement; appointment of an OPG deputy);
- how best to support the adult through any action they take to seek justice or redress;
- any on-going risk management strategy as appropriate;
- any action to be taken in relation to the person or organisation that has caused the concern.

An adult at risk with mental capacity may decide not to accept a protection plan. However, protection arrangements should be offered and work undertaken to understand the reason for not accepting support. It may be possible and should be explored with the individual if support can be offered in more acceptable manner.

Where a person is without mental capacity to make decisions about their safety, decisions about protective arrangements should be made in their best interests taking into account their wishes, feelings, beliefs and values (Mental Capacity Act 2005).

The NHS Information Centre for Health and Social Care identifies a range of possible outcomes for both the adult at risk and person alleged to have caused harm:

- No further action under safeguarding
- Actions under safeguarding
  - Risk remains
  - Risk reduced
  - Risk removed

The safeguarding lead will need to seek reassurance that agreed protection arrangements are implemented. Any party that is unable to complete an agreed action should notify the safeguarding lead at the earliest opportunity.

There is a legal duty on regulated activity providers and personnel suppliers to make a disclosure and barring service referral, where the criteria are met. The guidance produced by the disclosure and barring service should be consulted in reaching a decision as to the appropriateness of a referral. Where this action is agreed as part of a reporting meeting, confirmation must be provided to the safeguarding lead when this has been done.

Additional Key Considerations:

- Responsibilities to those who are alleged to have caused harm **(section 12.4 of Guidance)**
- Mental Capacity and Consent **(section 12.5 of Guidance)**
- Deciding whether to report an incident to the police **(section 12.5.2 of Guidance)**
- Risk assessment and protection planning **(section 8.1.2 of Guidance)**
- Domestic Abuse **(section 12.7 of Guidance)**
- Self-Neglect **(section 12.8 of Guidance)**
- Involving the adult at risk **(section 12.3 Guidance)**

9.3.9. Reporting meeting minutes

Reporting meeting minutes should be recorded on the agreed multi-agency template and approved by the chair (safeguarding lead). The minutes will record the decisions of the reporting meeting and evidence of how the decisions were reached. This may involve recording separate decisions and outcomes for each type of abuse alleged.

Reporting meeting minutes will ordinarily be distributed, according to agreement at the reporting meeting, to:

- all attendees and invitees to the meeting
- all those contributing to the protection plan
- the CQC where the reporting meeting relates to a service that it regulates
- all other relevant regulatory bodies, as appropriate

A copy of reporting meeting minutes should be sent to the adult at risk or, with their permission, to another person unless it would increase the level of risk. If the adult at risk does not have mental capacity, a decision should be made in their best interests about who to send the minutes to.

Where reporting meeting minutes are sent to a carer (with permission of the adult at risk or in their best interests) the reporting meeting will need to decide what information can be shared about the person alleged to have caused harm.

Where there is information that cannot be shared, it should be deleted (also referred to as redacted) from versions of documents sent out. Data Protection Act 1998 principles must be adhered to. For example, where a person was requested to leave the room during part of the case conference meeting will need to consider whether the section of the minutes relating to that part of the meeting should be redacted from the copy sent to the person concerned.

9.3.10. Reporting meeting minutes timescales:

The following target timescales apply in relation to reporting meetings:

Target Timescales:

- ***reporting meeting minutes to be circulated within 10 working days of the reporting meeting;***

- ***requested amendments from participants received – within 1 week of the draft case reporting meeting minutes being distributed;***

- ***reporting meeting minutes amended and redistributed – within 1 further week*** .

9.3.11. Feedback to the adult at risk (if not present)

Whether or not minutes are sent to the adult at risk, the reporting meeting will need to agree who is the best person to feedback to them the outcome of the meeting. This should take place as soon as possible. The adult at risk should be supported to raise any issues they may have about the decisions taken and the protection plan that has been developed/proposed.

Feedback to the person who made the safeguarding alert needs to be considered, taking into account confidentiality and data protection issues.

9.3.12. Feedback to the person or organisation causing the harm (if not present)

A decision must be made at the reporting meeting about what feedback should be provided to the person alleged to have caused harm and the organisation that employs the person if relevant, and who should provide it. The management of feedback may need to take into account the legal responsibilities of employers in relation to any disciplinary procedures being followed.

If the person alleged to have caused harm does not have mental capacity (and is also an adult at risk), feedback will be given to the person acting in their best interest.

9.3.13. Decision to close or review

If a decision is taken that a review is not necessary, the safeguarding adults procedures will be exited (see Section 10.1.4). The protection plan may continue to be reviewed as part of the ongoing care management or Care Programme Approach (CPA) processes.

10. Stage Six: Review

10.1. Purpose of the review

Any subsequent review meeting will be chaired by the safeguarding lead who chaired the reporting meeting wherever possible.

The purpose of the review is to ensure that the actions agreed in the protection plan have been implemented, the risk is being managed and to decide whether further actions are required. In some circumstances, more than one review meeting will be required within the safeguarding procedures.

For review processes in relation to self-neglect safeguarding issues please see section 12.8 Guidance.

Target Timescale:
A review meeting should be held within 3 months (or as agreed at reporting meeting).

10.1.1. Who should attend?

The safeguarding lead will need to determine the appropriate invitees for the review. This may need to include an appropriate representative of any organisation that has a specific role in:

- assessing risk
- developing or carrying out the protection plan

Invitations should include the adult at risk. Where the adult at risk lacks the mental capacity to decide about attendance a decision will be required in their "best interests" as to whether they should be invited and should attend. The adult at risk is entitled to be supported by an appropriate person(s), such as a family member, friend, advocate or personal assistant (according to their wishes, or decided in their "best interests" where they lack the mental capacity to decide for themselves). The adult at risk may also choose not to attend and have their views reported by a representative or in writing. Where an IMCA has been appointed, they will be invited to attend.

10.1.2. Actions required during the review

The review will:

- record the feedback of the adult at risk or their personal representative about the protection plan and/or other matters of importance to them
- re-evaluate the risk of harm
- ensure all required actions have been or are being taken
- decide in consultation with the adult at risk and/or their personal representative what changes, if any, need to be made to the protection plan to decrease the risk or to make the plan fit more closely with their wishes
- make decisions about what changes/additions are needed to the care plan
- decide whether to exit the safeguarding adults procedures
- decide whether there is need for a further review and, if so, set a date

10.1.3. Recording and feedback

The safeguarding lead will need to ensure that:

- any decisions and actions are recorded with the names of responsible individuals/ organisations identified
- all those involved in the review and the care plan have a copy of the review notes, including the adult at risk or their personal representative if the adult at risk gives them permission
- agreement is reached about feedback arrangements in accordance with the adult at risk's wishes (or best interests if they do not have mental capacity) and do not attend the review. This feedback should be provided as soon as possible after the review meeting

Some organisations may wish to progress their organisational learning through undertaking surveys such as customer listening reviews.

10.1.4. Exiting the Safeguarding Adults Procedures

The safeguarding adults procedures may be exited at any of the following stages:

Referral stage:
Where an alternative response is more appropriate than following the safeguarding adults procedures, feedback should be provided to the alerter that actions are not proceeding within the safeguarding adults procedures. Advice on alternative process(es), should be provided where appropriate.

Strategy stage:
Where an alternative response to safeguarding is more appropriate than following the safeguarding adults procedures, feedback should be provided to the alerter that actions are not proceeding within the safeguarding adults procedures. Advice on alternative process(es), by which their concerns can be addressed should be provided where appropriate.

Enquiry stage:
All enquiries must be concluded by holding a reporting meeting.

Reporting Meeting stage:
The safeguarding adults procedures will be closed at this stage unless there is a need for a review meeting. The purpose of the review meeting will be to review the protection plan to ensure it is meeting its aims.

Where a review meeting is not required within the safeguarding adults procedures, they can be exited. This does not preclude a review being undertaken within other processes, such as care management or Care Programme Approach, as required.

Review stage:
Where a review has been undertaken that concludes that the safeguarding adults procedures are no longer required, they may be exited. This does not preclude a review being undertaken within other processes, such as care management or Care Programme Approach, as required.

10.1.5. Actions on exiting the safeguarding adults procedures

The safeguarding lead should check that the following actions have been taken:

Recording:

- all records are completed;

- case records contain all relevant information and satisfactorily completed forms;
- all evidence, decisions and outcomes are adequately recorded;
- the necessary monitoring forms and all data monitoring systems are completed.

Adult at risk:

- the person at risk knows that the process is concluded and where/who to contact if they have any future concerns about abuse.

Person alleged to have caused harm:

- the person alleged to have caused harm knows the process is concluded and is aware of any decisions relating to themselves;
- where appropriate, notification to the Disclosure and Barring Service or professional regulatory body is made.

Communication with other agencies:

- all those involved with the person know how to re-refer if there are renewed or additional concerns;
- all relevant partner organisations are informed about the closure

10.1.6. Record keeping and confidentiality

Organisations should refer to their own internal policies and procedures for additional guidance on recording and storage of records.

Detailed factual records must be kept. This includes a record of all decisions taken relating to the process.

Records may be disclosed in court as part of the evidence in a criminal action/case or may be required if the regulatory authority (CQC) decides to take legal action against a provider.
Records kept by providers of services should be available to service commissioners and to regulatory authorities.

Agencies should identify arrangements, consistent with the principle of fairness, for making records available to those affected by, and subject to enquiry, with due regard to confidentiality.
Where the person alleged to have caused harm is also another service user, information about that person's involvement in a safeguarding adults enquiry, including the conclusion and outcome of the enquiry, should be included in their records.

10.2. Complaints

10.2.1. What Happens when Agencies Cannot Agree?

Stage 1:
If professionals are unable to reach agreement about the way forward regarding an individual issue then their disagreement must be addressed by more senior staff. In most cases this will mean the first line managers of the agencies involved discussing the issue of dispute and seeking to reach a resolution.

Stage 2:

If the issue cannot be resolved at this level then the matter must be referred up through each agencies line management structure without delay to a Head of Service or equivalent.

Stage 3:
If the issue cannot be resolved at Head of Service (or equivalent) level then consideration should be given to progressing the dispute through the further layers of more senior management up to, for example, Strategic Head of Service or Director level.

In situations where such senior officers have become involved in resolving disagreements between agencies and those disputes relate to the safeguarding needs of individual Adults at Risk, the BSAB Team must be made aware of this. The purpose of such notification is to help monitor interagency safeguarding activity, and to identify issues which may benefit from BSAB scrutiny. The agency which found it necessary to escalate an issue to such a high level in another organisation should advise the other organisation of their intention to do so.

It is acknowledged that some organisations have flat management structures. Where this is the case, the same individual manager may have involvement in more than one of the above stages.

Each stage (1, 2 or 3) should be completed within 5 working days (15 working days maximum).

Where there is a need for intervention to prevent a life threatening episode (for example risk of suicide) immediate action to reduce the risk of harm will be required by all relevant parties whilst the dispute is ongoing. In such circumstances, where certain agencies maintain a position of non-involvement and other agencies disagree with this position, the BSAB Team should be informed at the earliest opportunity.

Written records of all these discussions must be kept.

10.2.2. What happens when disagreements need to be resolved very quickly in order to safeguard an adult at risk's welfare?

Professional judgement should always be used and the protection of the individual must take precedence. For a variety of reasons there may be a delay in managers at levels 1 and 2 responding to telephone calls or emails. When this occurs careful consideration should be given to involving managers at the next level of the management structure by letting them know there is a disagreement, that a speedy response is required to safeguard the adult at risk and that in the absence of such a response, they will be contacted to help progress the disagreement further.

10.2.3. Complaints to single agencies about their activities within the safeguarding process

Complaints received from any source about the safeguarding adults practice and arising from the safeguarding adults process should be handled by the relevant complaints procedures of the agency about which the complaint has been made.

If more than one agency has been named or is implicated in the complaint, the complaints officers from the named agencies must reach joint agreement with the complainant about how the complaint investigation will be taken forward.

If the complaint results from the experience of the adult safeguarding process by the adult at risk, their carer, family member or personal representative and/or from a breakdown of inter-agency

working, the relevant BSAB team and the chair of Blackpool Safeguarding Adults Board must be notified of the complaint and the findings.

If the complaint is upheld, a decision should be made by the Safeguarding Adults Board, in consultation with relevant members, about whether a case review or a safeguarding adults review should be conducted to enable lessons to be learnt.

This process does not apply to:

- Complaints or representations relating to services that are delivered by individual agencies as a result of strategy/case conference decisions – although these may form part of a protection plan review;

- Complaints about an individual professional.

These complaints will be dealt with by means of the internal complaints procedures of the relevant agency.

If differences or disputes arise from a complaint which involves different local authorities or health authorities, for example, between a host and commissioning authority, reference should be to senior managers within the respective agencies up to directorate level if disagreements cannot be resolved.

10.2.4. Safeguarding Adult Review (previously referred to as Serious Case Reviews)

Where practice gives rise to concerns about how agencies have worked together when the death or serious injury of an adult at risk has occurred, the BSAB will consider requests to conduct a Safeguarding Adults Review (SAR).

The purpose of having a case review is to:

- Identify learning from a case.
- To review the effectiveness of procedures (both multi-agency and those of individual organisations)
- To inform and improve local inter-agency practice
- To improve practice by acting on learning (developing best practice)

If at any point throughout the safeguarding process it is felt that the criteria for undertaking a Safeguarding Adults Review is met, the referral form should be completed (see appendix B**)** and returned to the Business Development Manager for the BSAB.

For further information see BSAB Safeguarding Adults Review Protocol.

11. Part Three - Safeguarding Adults Guidance

11.1. Roles & Responsibilities

In its broadest terms, safeguarding is everybody's business. Adult abuse can happen to anyone, anywhere, and responsibility for dealing with it lies with us all as members of the public, volunteers and professionals.

11.1.1. Everyone – all staff and volunteers

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

Anyone can witness or become aware of information suggesting that abuse and neglect is occurring. The matter may, for example, be raised by a worried neighbour, a concerned bank cashier, a GP, a welfare benefits officer, a housing support worker or a nurse on a ward. Primary care staff may be particularly well-placed to spot abuse and neglect, as in many cases they may be the only professionals with whom the adult has contact. The adult may say or do things that hint that all is not well. It may come in the form of a complaint, a call for a police response, an expression of concern, or come to light during a needs assessment. Regardless of how the safeguarding concern is identified, everyone should understand what to do, and where to go locally to get help and advice. It is vital that professionals, other staff and members of the public are vigilant on behalf of those unable to protect themselves. This will include:

- knowing about different types of abuse and neglect and their signs;
- supporting adults to keep safe;
- knowing who to tell about suspected abuse or neglect; and
- supporting adults to think and weigh up the risks and benefits of different options when exercising choice and control.

Operational front line staff are responsible for identifying and responding to allegations of abuse and substandard practice. Staff at operational level need to share a common view of what types of behaviour may be abuse or neglect (see appendix F for guidance), and what to do as an initial response to a suspicion or allegation that it is or has occurred (see section 5 for guidance). This includes GPs. It is employers' and commissioners' duty to set these out clearly and reinforce regularly.

It is not for front line staff to second-guess the outcome of an enquiry in deciding whether or not to share their concerns. They should utilise their internal safeguarding procedures (if applicable) to escalate concerns to their line manager. Where immediate line managers do not take action in response to the concern being raised, they should escalate the alert in line with organisational procedures, and if necessary (including where the response to an escalated concern is not

appropriate in the view of the person raising the alert) raise an alert with the Local Authority (**See section 5).**

The first priority should always be to ensure the safety and protection of the adult at risk.
All staff and volunteers have a duty to act in a timely manner on any concern or suspicion that an adult who is vulnerable is being or is at risk of being abused, neglected or exploited and to ensure that the situation is assessed and investigated.

Staff or volunteers should:

- be aware that they must call the police and/or an ambulance where appropriate in situations where the abuse of the adult indicates an urgent need for medical treatment, or where there is immediate risk of harm indicating urgent action is needed to protect the person;

- be authorised to make a report to the police, and if a crime has been committed, ensure action is taken to preserve evidence. This could be where there has been a physical or sexual assault, especially if the suspect is still at the scene;

- share their concern with colleagues and seek advice and support;

- know they must inform their line manager. If their line manager is implicated in the abuse then they should inform a more senior manager;

- know what services are available and how to access help and advice for the adult at risk;

- know how and where to make an alert to the Local Authority, where speaking to a manager would cause delay;

- know that they must make a clear factual record of their concern and the action taken.

Concerns about abuse or neglect **must** be reported whatever the source of harm is. It is imperative that poor or neglectful care is brought to the immediate attention of managers and responded to swiftly, including ensuring immediate safety and well-being of the adult. Where the source of abuse or neglect is a member of staff it is for the employer to take immediate action and record what they have done and why (similarly for volunteers or students).

11.1.2. Managers in all organisations

Skilled and knowledgeable supervision focused on outcomes for adults is critical in safeguarding work. Managers have a central role in ensuring high standards of practice and that practitioners are properly equipped and supported. It is important to recognise that dealing with situations involving abuse and neglect can be stressful and distressing for staff and workplace support should be available.

Managers need to develop good working relationships with their counterparts in other agencies to improve cooperation locally and swiftly address any differences or difficulties that arise between front line staff or managers.

They should have access to legal advice on when proposed interventions, such as the proposed stopping of contact between family members, require applications to the Court of Protection.

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;

- meet their responsibilities under the Health and Social Care Act 2008 and the Care Standards Act 2009 and ensure compliance with registration and outcomes and guidance on compliance, on quality and 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 an support staff who raise concerns.

The role and responsibility of the manager is:

- to ensure that steps have been taken so that the alleged victim is made safe (and take further action if required);

- to ensure that any staff or volunteer who may have caused harm is not in contact with service users and others who may be at risk, for example, 'whistleblowers';

- to ensure that appropriate information is provided in a timely way.

Managers in health settings should report concerns as a serious incidents (SI) in line with clinical governance procedures, and a decision must be made whether the circumstances require an alert to the Initial Contact Team (see section 5.1.4 for contact details) in line with the policy, procedure and guidance.

11.1.3. All Organisations

Any organisation that provides care and support to adults at risk has responsibilities to safeguard adults at risk within these procedures. To ensure effective partnership working, each organisation must recognise and accept its role and functions in relation to adult safeguarding.
This involves:

- actively developing service provision so as to minimise the risk of abuse occurring
- working with partner agencies to support adults at risk who have experienced abuse
- working with partner agencies to end any abuse that is occurring

- ensuring they have internal safeguarding adults procedures (in line with this document)
- having an appropriate safeguarding lead at a senior manager level and be aware of their other associated responsibilities

All organisations that work with adults at risk must ensure that they respond to issues of abuse and neglect in accordance with these policy and procedures. This includes the responsibility to ensure that:

- all staff (and volunteers) report concerns/allegations or suspicions of abuse to managers and make alerts into the safeguarding adults procedures in accordance with these procedures;

- appropriate senior representatives of the organisation attend and actively contribute to safeguarding strategy meetings (or discussions);

- staff (and volunteers) actively contribute and participate within safeguarding enquiries carried out under the Blackpool Multi-Agency Safeguarding Adults Policy and Procedures;

- appropriate senior representatives of the organisation attend and actively contribute to strategy and reporting meetings;

- the organisation and its staff (and volunteers) work in partnership with other agencies to ensure the protection planning needs of the adult at risk are met;

- information is shared between agencies in accordance with information sharing policies and protocols;

- the organisation keeps its own records in relation to safeguarding concerns, alerts, and their outcome;

- the organisation participates in Safeguarding Adults Reviews (SARs) where requested by the BSAB (see section 11.1.9 for further details relating to the BSAB);

- the organisation supports and empowers adults at risk to make decisions about their own lives within these procedures;

- the staff teams (and volunteers) adhere to the Mental Capacity Act and Code of Practice where an adult at risk lacks mental capacity in relation to decisions required within these procedures;

- the organisation supports adults at risk to end abuse and to access support that enables them to cope with the impact of what has happened.

11.1.4. Senior Managers in all Organisations

Each agency should:

- identify a senior manager to take a lead role in the organisational and in inter agency arrangements, including the Safeguarding Adults Board (SAB);

- In order for the Board to be an effective decision-making body providing leadership and accountability, members need to be sufficiently senior and have the authority to commit resources and make strategic decisions;

- To achieve effective working relationships, based on trust and transparency, the members will need to understand the contexts and restraints within which their counterparts work.

11.1.5. Chief Officers in all Organisations

All officers, including the Chief Executive of the local authority, NHS and police chief officers and executives should:

- lead and promote the development of initiatives to improve the prevention, identification and response to abuse and neglect;
- They need to be aware of and able to respond to national developments;

- ask searching questions within their own organisations to assure themselves that their systems and practices are effective in recognising and preventing abuse and neglect;

- The Chief Officers must sign off their organisation's contributions to the Strategic Plan and Annual Reports;

- Chief Officers should also receive regular briefings of case law from the Court of Protection and the High Courts.

11.1.6. Commissioners

Commissioners from the local authority, NHS and CCGs are all vital to promoting adult safeguarding.

- Commissioners have a responsibility to assure themselves of the quality and safety of the organisations they place contracts with and

- ensure that those contracts have explicit clauses that holds the providers to account for preventing and dealing promptly and appropriately with any example of abuse and neglect.

11.1.7. Regulated Professionals

Staff governed by professional regulation (for example, social workers, doctors, allied health professionals and nurses) should understand how their professional standards and requirements underpin their organisational roles to prevent, recognise and respond to abuse and neglect.

11.1.8. Designated Adult Safeguarding Managers

Each member of the Safeguarding Adults Board (SAB) should have a Designated Adult Safeguarding Manager (DASM) responsible for:

- the management and oversight of individual complex cases;
- responding to allegations and issues of concern that are raised about a person who may have harmed or who may pose a risk to adults;
- co-ordination, where allegations are made or concerns raised about a person, whether an employee, volunteer or student, paid or unpaid.;
- keeping in regular contact with their counterparts in partner organisations;
- Highlighting the extent to which their own organisation prevents abuse or neglect taking place;
- providing advice and guidance within their organisation, liaising with other agencies as necessary;
- monitoring the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process;
- ensuring that systems are in place to provide the employee with support and regular updates in respect of the adult safeguarding enquiry. Particular care must be taken to not breach the right to a fair trial in Article Six of the European Convention on Human Rights as incorporated by the Human Rights Act 1998;
- working closely with the children's services Local Authority Designated Officer (LADO) and other DASMs and LADOs for both adults and children in the region or nationally to ensure sharing of information and development of best practice.

11.1.9. Blackpool Safeguarding Adults Board (BSAB)

The BSAB is a multi-agency board which is established in each local authority area to help and protect adults in its area. These adults have needs for care and support (whether or not the authority is meeting any of those needs), and are experiencing, or is at risk of, abuse or neglect, and as a result of their needs are unable to protect themselves.

The Board has a terms of reference and comprises key statutory (Local Authority, Clinical Commissioning Group and local police) and non-statutory agencies. The role of the Board will help and protect adults at risk of abuse or neglect by co-ordinating and ensuring the effectiveness of what each of its members does. The member agencies work in partnership to ensure that organisations individually and collectively prioritise the prevention of abuse and develop effective systems and practices to respond to abuse, promote awareness, develop workforce training initiatives and achieve continual learning and improved practice. The Boards also work to ensure

adult safeguarding is integrated into other community initiatives and services and has links with other relevant inter-agency partnerships.

The BSAB is chaired by an independent chair person. Board members from partner organisations have a lead role within their organisation with regard to safeguarding adult's arrangements and represent their organisation with authority, make multi-agency agreements and take issues back to their organisation for action.

BSABs must also arrange for there to be a review of a case (known as Safeguarding Adults Reviews, SARs), involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult has either died or is still alive but suspect that the death (or serious harm) has been caused by abuse or neglect. Each member of the BSAB must co-operate in and contribute to the carrying out of a review under this section with a view to both identifying the lessons to be learnt from the adult's case, and applying those lessons to future cases.

11.1.10. Local Authority

Lead Coordinating Agency

The local authority **must** make (or require another agency to do so), whatever enquiries it thinks necessary so that it can decide if any action should be taken when it has reasonable cause to suspect that an adult at risk is experiencing or at risk of experiencing abuse or neglect.

Local authorities must cooperate with each of their relevant partners, and those partners must cooperate with the local authority, in order to protect adults with care and support needs experiencing or at risk of abuse or neglect.

Relevant partners of a local authority include any other local authority with which they agree it would be appropriate to co-operate (e.g. neighbouring councils with who they provide joint shared services) and the following agencies or bodies who operate within the local authority's area including:

- NHS England;
- Clinical Commissioning Groups;
- NHS trusts and NHS Foundation Trusts;
- job centres;
- the Police;
- prisons;
- probation services.

As a part of the role as lead coordinating agency the local authority should:

- ensure that any safeguarding adults concern is acted on in line with this policy, procedure and guidance;

- coordinate the actions that relevant organisations take in accordance with their own duties and responsibilities. This does not mean that the 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 their wishes, giving 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 enquiry 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;

- facilitate learning the lessons from practice and communicate these to the BSAB.

11.1.11. Lead Councillor (portfolio holder) for Adult Social Care and Local Authority Members

The portfolio holder for adult social care has a responsibility to:

- make sure the Director of Adult Social Services and the BSAB are effectively discharging their responsibilities in relation to adults at risk;

- have a good understanding of the range of abuse and neglect issues that can affect adults and of the importance of balancing safeguarding with empowerment;

- understand prevention, proportionate interventions, and the dangers of risk adverse practice and the importance of upholding human rights. Managers must ensure that members are aware of any critical local issues, whether of an individual nature, matters affecting a service or a particular part of the community.

In addition, Local Authority Health Scrutiny Functions, such as the Council's Health Overview and Scrutiny Committee, Health and Wellbeing Boards (HWBs) and Community Safety Partnerships can play a valuable role in assuring local safeguarding measures, and ensuring that SABs are accountable to local communities. Similarly, local Health and Wellbeing Boards provide leadership to the local health and wellbeing system; ensure strong partnership working between local government and the local NHS; and ensure that the needs and views of local communities are represented. HWBs can therefore play a key role in assurance and accountability of SABs and local safeguarding measures. Equally SABs may on occasion challenge the decisions of HWBs from that perspective.

11.1.12. Director of Adult Social Services

As chief officer for the leading adult safeguarding agency, the Director of Adult Social Services (DASS) has a particularly important leadership and challenge role to play in adult safeguarding.

- Responsible for promoting prevention, early intervention and partnership working is a key part of a DASS's role and also critical in the development of effective safeguarding;
- Taking a personalised approach to adult safeguarding requires a DASS promoting a culture that is person-centred, supports choice and control and aims to tackle inequalities.

11.1.13. Complaints Officers

Local authorities have statutory complaints procedures in relation to service user or carer complaints. If one of these complaints is received which indicates an adult is at risk of abuse or neglect, they will need to consider the need to make a safeguarding alerts.

If a complaint is made to the local authority that leads to a safeguarding adult's enquiry, the local authority will need to decide the relative timelines of both the safeguarding adult's enquiry and the complaints process – and whether it is possible to run both simultaneously.

11.1.14. NHS Funded Services

The majority of adults in receipt of healthcare are able to safeguard their own interests and to protect themselves from harm. However, within healthcare settings, patients may be at an increased risk of harm as the nature of a health condition gives rise to higher dependency on others. Such patients may need additional support to safeguard themselves from harm.

Safeguarding Adults: The Role of Health Services (DoH 2011) states that safeguarding adults is an integral part of patient care, and a core responsibility of Health Service Managers and their Boards, Health Service Practitioners, NHS Commissioners.

Clinical Governance and Adult Safeguarding: An Integrated Process (DoH Feb 2010) highlights the need for the multi-agency safeguarding adults procedures to be an integral part of Clinical Governance, and to be followed alongside internal NHS processes.

11.1.15. Clinical Commissioning Group (CCG)

The role of clinical commissioning groups is:

- to provide strategic leadership to ensure NHS and the wider safeguarding partnership work effectively together to both prevent and respond to issues of adult abuse and neglect;

- active contribution to safeguarding boards ;

- ensuring the wider NHS network has established systems and processes to safeguard adults effectively;

- promoting safeguarding adults as a core element of local clinical governance arrangements, establishing local standards, monitoring the effectiveness of local systems, promoting and embedding joint working, delivering key messages and supporting the NHS network to promote and deliver effective safeguarding systems and practice.

11.1.16. Safeguarding role of Health Service Managers and Boards

The government's commitment to patient choice, control and accountability includes support and protection for those in the most vulnerable situations. Managers of health services have responsibilities for the safety and well-being of all their patients. However, they have particular duties for those patients less able to protect themselves from abuse or neglect. The Department of Health guidance places a responsibility on health service managers and boards to:

- use the safeguarding principles to shape strategic and operational safeguarding arrangements;
- set safeguarding adults within the services strategic objectives;
- use integrated governance systems and processes to prevent abuse occurring and
- respond effectively where harm does occur;
- work with local safeguarding adults boards, patients and community partners to create safeguards for patients;
- provide leadership to safeguard adults;
- ensure accountability and use learning within the service and the partnership to bring about improvement.

11.1.17. Health Service Practitioners

The "Role of Health Service Practitioners" (DoH 2011), highlighted the responsibilities of all staff to address concerns of abuse or neglect through safeguarding adults procedures and alongside other governance arrangements.

11.1.18. Complaints Departments

- Complaints departments provided by acute, specialist and community health trusts have been established to provide confidential advice and support to patients, families and carers. This includes providing confidential assistance in resolving problems and concerns;

- Where concerns raised indicate that a person is at risk of abuse or neglect, a safeguarding alert may need to be made alongside informing relevant NHS managers, in accordance with their internal procedures;

- If a complaint is received that indicates an adult is at risk of abuse or neglect, they will need to consider the need to make a safeguarding alert;

- If a complaint is made that leads to a safeguarding adult's enquiry, the multi-agency partnership will need to decide the relative timelines of both the safeguarding adult's enquiry and the complaints process – and whether it is possible to run both simultaneously.

11.1.19. North West Ambulance Service (NWAS)

- In the course of providing medical assistance NWAS staff may receive information or make observations that suggest an adult at risk has been abused or is at risk of abuse;

- Where a person has been physically harmed, NWAS staff may be the first to provide assistance and their actions and recording of information may be crucial to subsequent enquiries;

- If the patient is conveyed to hospital, the staff should inform a senior member of the Accident and Emergency (A&E) department staff, or nursing staff if conveying to another department, of their concerns about possible abuse. NWAS staff should also follow the procedures for making a safeguarding alert.

11.1.20. Lancashire Police

- Lancashire Police may have crimes reported to them that indicate that an adult at risk is being abused or is at risk of abuse, requiring an alert into the safeguarding adults procedures. Similarly a safeguarding alert may be received indicating that a crime has occurred, requiring reporting to Lancashire Police;

- Close liaison will be required between Lancashire Police, safeguarding leads and other parties to ensure that actions are coordinated in a timely and effective manner;

- Where a police investigation is required, it should be afforded priority over all other investigation processes. This however should not prevent protection planning arrangements being undertaken. Close consultation with the police should take place wherever possible, especially in circumstances where the protection planning arrangements may potentially impact on their investigation, for example, where implementing the protection plan may in itself forewarn the person alleged to have caused harm of an impending investigation;

- It may also be appropriate to consider whether police investigations can be undertaken concurrently or jointly or information shared with the safeguarding investigation, so as to limit the potential distress caused by the need to re-interview victims and other individuals;

- Where a criminal investigation is required and these safeguarding adults procedures are being followed, the police should be included within strategy discussions/meetings.

11.1.21. Lancashire Fire & Rescue Service (LFRS)

- LFRS visit adults at risk in various settings, including their own homes when responding to incidents or when carrying out home fire safety checks;

- Where staff have a concern about an adult at risk they will need to inform their line manager who may need to consider undertaking a safeguarding alert;

- Staff from other agencies are not expected to be fire safety experts. However, they should be aware of the potential risk and work alongside LFRS to assess and manage risk with the consent of the occupier.

11.1.22. Housing and Housing Related Support Organisations

- Housing organisation staff are in a position to identify tenants who are at risk of abuse, neglect and exploitation;

- Housing related support organisations provide housing and support services for adults with a wide range of needs. The quality of their service is regulated through the Quality Assessment Framework, which includes standards that they must meet with regard to safeguarding adults from abuse;

- In addition to recognising the risks of abuse and making alerts, housing organisations will often have an important role within protection planning arrangements.

11.1.23. Crown Prosecution Service (CPS)

The CPS is the principal public prosecuting authority for England and Wales and is headed by the Director of Public Prosecutions.

- The CPS has produced a policy on prosecuting crimes against older people which is equally applicable to adults at risk, who may also be vulnerable witnesses;

- Support is available within the judicial system to support adults at risk to enable them to bring cases to court and to give best evidence. If a person has been the victim of abuse that is also a crime, their support needs will need to 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 in making sure that special measures are put in place to support vulnerable or intimidated witnesses to give their best evidence. They are available both in the Crown and Magistrate Courts. These include the use of trained intermediaries to help with communication, screens and arrangements for evidence and cross-examination to be given by video link (Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, and guidance on using special measures, Ministry of Justice, March 2011).

11.1.24. HM Coroner

Coroners are independent judicial officers who are responsible for investigating violent or unnatural or 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);
- or deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions are identified by the Coroner or his or her officers.

For the list of deaths which **MUST** be reported to HM Coroner Blackpool & the Fylde please see Appendix E.

In the above situations the BSAB may also need to consider whether the criteria for a Safeguarding Adults Review has been met.

11.1.25. The Probation Service (CRCs & NPS)

In June 2014, Probation Trusts ceased to exist and were replaced by 21 Community Rehabilitation Companies (CRCs) and the National probation Service (NPS). The work previously carried out by the Probation Trusts has been divided as follows:

CRCs – Responsibility for managing low and medium risk offenders subject to Court Orders or post release licenses. Delivery of accredited offending behaviour and specialist domestic abuse programmes, delivery of unpaid work.

NPS – Delivery of all court services including writing pre-sentence reports, providing advice to the Parole Board and presenting breach and recall paperwork. Management of all high risk cases subject to community supervision or post release licence. Management of all MAPPA offenders, which includes all offenders convicted of sexual offences and all serious violent offenders. Working with victims of serious crime. Delivery of sex offender treatment programmes. Responsibility for probation staff managing high risk prisoners in custody.

- However, safeguarding adults spans all of these areas of responsibility and both agencies continue to engage in multi-agency working to identify offender or victims who may be at risk of abuse, or assess and manage offenders to may pose a risk to vulnerable members of the community;

- Both agencies are represented at the BSAB and contribute to MARAC and MAPPA process to ensure a multi-agency perspective is maintained and develop awareness of the issues surrounding adults at risk and what action needs to be taken to prevent and protect.

11.1.26. Care Quality Commission (CQC)

The Care Quality Commission (CQC) is the independent regulator of all health and adult social care in England, including those provided by the NHS, local authorities, private companies and voluntary organisations. Specifically this includes:

- medical and clinical treatment given to people of all ages, including treatment given in hospitals, ambulance services, and mental health services;
- care provided in residential and nursing homes;
- care provided in the community or in people's own homes;
- services for people whose rights are restricted under the Mental Health Act;
- care provided either by the NHS or by independent organisations.

Health and adult social care providers who are required by law to be registered with CQC must show that they are meeting the essential standards. Registration is combined with continuous monitoring of essential standards as part of a system of regulation. Failure to make an alert to the safeguarding adults process when one should have been raised is an automatic barrier to CQC "good" judgement. The CQC publication "Our Safeguarding Protocol" states that they will attend safeguarding strategy meetings where:

- a person or people registered with CQC to provide services are directly implicated;
- urgent or complex regulatory action is indicated;
- any form of enforcement action has started, or is under consideration, in relation to the service or location involved and which relates to risks to people using the service or the quality of their care.

However, regardless of attendance, the CQC should receive copies of any strategy and case conference meeting minutes in relation to services they regulate.

CQC will provide relevant information to the chairs of all strategy meetings convened in relation to regulated services as requested. For example, information from CQC about the quality of service and regulatory track record of the provider may be useful to the chair of the meeting in determining the service provider's level of involvement in the process.

11.1.27. Trading Standards Service

The Trading Standards Service can help support and protect adults at risk from doorstep crime and other abusive sales practices that exploit adults at risk. Doorstep crime describes situations where rogue traders, doorstep criminals and uninvited sales people persuade vulnerable people to let them

into their homes, with the intention of carrying out a theft or to carry out unnecessarily or substandard work and then pressurise consumers to part with large sums of money.

Trading Standards Services can take a range of actions, including the investigation of complaints against traders, provide people with information on their consumer rights and work with partners to develop cold calling control zones. Trading Standards staff will also identify situations that require a safeguarding adult alert and be able to work with partner organisations within the safeguarding adults procedures to safeguard adults at risk.

11.1.28. Department of Work and Pensions

The Department for Work and Pensions is responsible for welfare and pension policy.
People who are incapable of managing their own financial affairs may have an appointee. An appointee is fully responsible for acting on the customer's behalf in all the customer's dealings with the Department. This includes the claiming of benefits. Misuse of appointeeship will be investigated and potentially revoked by the Department of Work and Pensions. Strategy discussions/meetings will need to consider whether and how issues of suspected financial abuse should be reported to the Department of Work and Pensions.

11.1.29. The Health & Safety Executive (HSE)

In relation to safeguarding adults at risk from abuse, HSE is responsible for enforcing work- related health and safety legislation in hospitals, nursing homes and day care centres.

Local Authorities enforce the Health and Safety at Work Act in respect of certain non-domestic premises, including residential care homes (unless the care home is owned or substantially operated by the local authority, in which case enforcement is undertaken by HSE).

In the event that a care home has dual registration for residential and nursing, a judgement is required by the Local Authority and HSE according to the main activity of the service. The allocation of enforcement responsibility under the Health and Safety (Enforcing Authority) Regulations 1998 is described within its "A-Z guide to allocation".

The supporting role of the HSE (and Local Authority Health and Safety Departments) should be considered in all investigations of abuse that occur within health and care service settings. Health and safety offences are usually prosecuted by HSE, the Local Authority or other enforcing authority in accordance with current enforcement policy. The Crown Prosecution Service (CPS) may also prosecute health and safety offences, but usually does so only when prosecuting other serious criminal offences, such as manslaughter, arising out of the same circumstances.

11.1.30. Community, Voluntary and Private Sector Providers (and all other providers)

Community, voluntary and private sector organisations will need to work closely with statutory agencies, such as the police, NHS and Adult Social Care, in the interests of adults at risk and to achieve the objectives of these procedures.

The role of community, voluntary and private sector organisations will be dependent on the nature of the service provided, however each of the responsibilities as set out in “All Organisations” section also apply.

All service providers should have clear operational policies and procedures that reflect the framework set by the SABs in consultation with them. This should include what circumstances would lead to the need to report outside their own chain of line management, including outside their organisation to the local authority. They need to share information with relevant partners such as the local authority even where they are taking action themselves. Providers should be informed of any allegation against them or their staff and treated with courtesy and openness at all times. It is of critical importance that allegations are handled sensitively and in a timely way both to stop any abuse and neglect but also to ensure a fair and transparent process. It is in no-one’s interests to unnecessarily prolong enquiries. However some complex issues may take time to resolve.

Voluntary organisations need to work with commissioners and the SAB to agree how their role fits alongside the statutory agencies and how they should work together. This will be of particular importance where they are offering information and advice, independent advocacy, and support or counselling services in safeguarding situations. This will include telephone or on-line services.

Additionally, many voluntary organisations also provide care and support services, including personal care. All voluntary organisations that work with adults need to have safeguarding procedures and lead officers.

12. Specialist Support Services & Linked Agendas

12.1. Specialist Support Services

12.1.1. Court of Protection

The Court of Protection deals with decisions and orders affecting people who lack mental capacity.

The court can make major decisions about health and welfare, as well as property and financial affairs, that the person lacks the mental capacity to make. 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 mental capacity to make such decisions;
- appoint deputies to make decisions for people lacking mental capacity to make those decisions;
- decide whether a lasting power of attorney or an enduring power of attorney is valid;
- remove deputies or attorneys who fail to carry out their duties.

In most cases decisions about personal welfare can be made legally without making an application to the court, as long as there is agreement reached about the decisions and they are made in

accordance with the core principles set out in the Mental Capacity Act 2005 and the Code of Practice.

However, it may be necessary to make an application to the court in a safeguarding situation where there are:

- particularly difficult decisions to be made;
- disagreements that cannot be resolved by any other means;
- ongoing decisions needed about the personal welfare of a person who lacks mental capacity to make such decisions for themselves;
- matters relating to property and/or financial issues to be resolved;
- serious healthcare and treatment decisions, for example, withdrawal of artificial nutrition or hydration;
- concerns that a person should be moved from a place where they are believed to be at risk;
- concerns or a desire to place restrictions on contact with named individuals because of risk or where proposed safeguarding adults actions may amount to a deprivation of liberty outside of a care home or hospital;

The Court of Protection and the Office of the Public Guardian (OPG) complement each other. The Court of Protection provides the decision making functions and the OPG provides regulation and supervision.

12.1.2. Office of the Public Guardian (OPG)

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

- setting up and managing separate registers of lasting powers of attorney, of enduring powers of attorney and of court-appointed deputies;
- supervising deputies;
- sending Court of Protection visitors to visit people who lack mental capacity and also those for whom it has formal powers to act on their behalf;
- receiving reports from attorneys acting under lasting powers of attorney and deputies;
- providing reports to the Court of Protection;
- dealing with complaints about the way in which attorneys or deputies carry out their duties.

The OPG undertakes to notify local authorities, the police and other appropriate agencies where abuse is identified.

The OPG can carry out an investigation into the actions of a deputy, of a registered attorney (lasting powers of attorney or enduring powers of attorney) or someone authorised by the Court of Protection to carry out a transaction for someone who lacks mental capacity, and report to the Public Guardian or the court.

The OPG may be involved in safeguarding adults at risk in a number of ways, including:

- promoting and raising awareness of legal safeguards and remedies, for example, lasting powers of attorney and the services of the OPG and the Court of Protection;
- receiving reports of abuse relating to adults at risk;
- responding to requests to search the register of deputies and attorneys (provided free of charge to local authorities and registered health bodies);

- investigating reported concerns, on behalf of the Public Guardian, about the actions of a deputy or registered attorney, or someone acting under a single order from the court;
- working in partnership with other agencies, including Adult Social Care services and the police.

12.1.3. Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DOLS) , are a legal safeguard for people who cannot make decisions about their care and treatment when they need to be cared for in away that may restrict their freedom and liberty. They set out a process that hospitals and care homes should follow if they think it will be necessary to deprive a person of their liberty, in order to deliver a particular care plan in the person's best interests.

What amounts to a deprivation of liberty occurring depends on the specific circumstances of each individual case. As a result, there is no single definition or a standard checklist that can be used.

In March 2014, the Supreme Court handed down its judgment in the case of "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council".

The Supreme Court has clarified that there is a deprivation of liberty for the purposes of Article 5 of the European Convention on Human Rights in the following circumstances:

- The person is under continuous supervision and control;
- *and* is not free to leave;
- *and* the person lacks capacity to consent to these arrangements.

The Supreme Court held that factors which are NOT relevant to determining whether there is a deprivation of liberty include the person's compliance or lack of objection and the reason or purpose behind a particular placement1. It was also held that the relative normality of the placement, given the person's needs, was not relevant. This means that the person should not be compared with anyone else in determining whether there is a deprivation of liberty.

The Supreme Court has held that a deprivation of liberty can occur in domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement in the community. Hence, where there is, or is likely to be, a deprivation of liberty in such placements that must be authorised by the Court of Protection.

Where a deprivation of liberty is required, the hospital or care home (known as the managing authority), should refer immediately to the relevant local authority procedures relating to DoLS. In the event that someone is being deprived of the liberty in a setting other than a hospital or care home, then an application to the Court of Protection would be required to legally authorise the deprivation of liberty.

Deprivation of liberty must be undertaken in accordance with the Deprivation of Liberty Safeguards Code of Practice (http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476) . In the event that a person is deprived of their liberty without a DoLS being authorised, consideration should also be given to the need for implementing the safeguarding adults procedures.

An application to the Court of Protection should also be made when there is an un-resolvable dispute with the family regarding whether the person should be in a particular placement. Legal

advice will be required. The Deprivation of Liberty Safeguards process should not be used to prevent removal from placement in such cases.

12.2. Linked Agendas

12.2.1. Hate Crime

Hate crimes happen because of hostility, prejudice or hatred of:

- disability
- gender identity
- race, ethnicity or nationality
- religion or belief sexual orientation

"Hate crime is taken to mean any crime where the perpetrator's prejudice against any identifiable group of people is a factor in determining who is victimised" (ACPO: Guide to Identifying and Combating Hate Crime 2000).

It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence.

Apart from individually charged offences under the Crime and Disorder Act 1998, local crime reduction partnerships can prioritise action where there is persistent anti-social behaviour that amounts to hate crime where appropriate. The police and other organisations should work together to intervene within the safeguarding adults procedures to ensure a robust, coordinated and timely response to situations where adults at risk become a target for hate crime. Coordinated action will aim to ensure that victims are offered support and protection and action is taken to identify and prosecute those responsible.

12.2.2. Forced Marriage

Forced marriage occurs when, one or both spouses do not consent to a marriage and some element of duress is involved. Duress might include both physical and/or emotional/psychological pressure. Forced marriage is recognised as an abuse against human rights and will also constitute abuse within the context of these procedures if the person is also an adult at risk.

The Forced Marriage Unit (www.fco.gov.uk/forcedmarriage) is a joint initiative between the Home Office and the Foreign and Commonwealth Office providing specialist advice and guidance. The Forced Marriage Unit provides comprehensive resources and information, including the following guidance:

- Multi-Agency Practice Guidelines: Handling Cases of Forced Marriage (June 2009)
- Forced Marriage and Learning Disabilities: Multi-Agency Practice Guidelines (Dec 2010)

The guidance recommends forced marriage of an adult at risk, should be dealt with within the safeguarding adults procedures. The One Chance Rule is that sometimes there will only be one

chance to help a person facing forced marriage, hence reference should be made with urgency to the Multi-Agency Practice Guidelines listed above.

The police should always be contacted for advice in relation to suspicions or concerns about forced marriage.

In addition, the Forced Marriage Unit provides a confidential advice and assistance for:

- those who have been forced into marriage
- those at risk of being forced into marriage
- people worried about friends or relatives
- professionals working with actual or potential victims of forced marriage

12.2.3. Honour-based violence

Honour-based violence is a crime and concerns must always be reported to the police. It has or may have been committed when violence has occurred in situations where families feel that dishonour has been brought to the family. Women are predominantly (but not exclusively) the victims and the violence is often committed with a degree of collusion from family members and/or the community. Many of these victims will contact the police or other organisations. Many are so isolated and controlled that they feel unable to contact the police.

Alerts that may indicate honour-based violence include domestic abuse concerns, concerns about forced marriage or enforced house detention and missing person reports. If a concern is raised through a safeguarding adults alert, and there is a suspicion that the adult is the victim of honour-based violence, the police, who have the necessary expertise to manage risks of this nature, must always be notified.

12.2.4. Human trafficking

'Human trafficking' is defined as:

"the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or a position of vulnerability, or the giving or receiving payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude or the removal of organs."

(United Nations 2000)

If an identified victim of human trafficking is also an adult at risk, the response will be coordinated under the safeguarding adults procedures. This will include organisations that have a role to play in dealing with victims of human trafficking, such as the police, health trusts, immigrations officials and other relevant support services including those in the voluntary sector. The adult at risk should receive the support and advice they need and be safely repatriated if this is the future plan. The early identification of victims of human trafficking is key to ending the abuse.

There is a national framework to assist in the formal identification and help to coordinate the referral of victims to appropriate services; this is called the National Referral Mechanism. The UK Human Trafficking Centre takes referrals of adults and children identified as being the victims of trafficking. Local authorities can provide a range of assistance on a discretionary basis. The Centre now comes under the Serious and Organised Crime Agency (SOCA).

The police are the lead agency in managing responses to adults who are the victims of human trafficking and must always be notified where such concerns are identified.

12.2.5. Prevent Agenda: exploitation by radicalisers who promote violence

Individuals may be susceptible to exploitation 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 and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause.

There are a number of factors that may make the individual susceptible to exploitation by violent extremists, such as identity or personal crisis, particular personal circumstances, unemployment or underemployment and criminality. None of these factors should be considered in isolation but in conjunction with the particular circumstances of the individual.

The Home Office leads on the anti-terrorism strategy, CONTEST, and PREVENT is part of the overall CONTEST strategy, aiming to stop people becoming terrorists or supporting violent extremism. The police should be the initial point of contact in relation to such concerns. A safeguarding adult alert will also be required where the person is an adult at risk.

12.2.6. Anti-social behaviour

Anti-social behaviour teams bring together experienced staff from the local authority, Lancashire Police, housing and other organisations to prevent and resolve anti-social behaviour when concerns are raised (including those from members of the community). Anti-social behaviour teams will manage incidents referred, working with the private or social housing agency concerned in addressing incidents of anti-social behaviour. Anti-social behaviour is any aggressive, intimidating or destructive activity that damages or destroys another person's quality of life. This might, for example, include:

- persistent verbal abuse or threats;
- assault or physical harassment;
- racial or homophobic harassment;
- graffiti, vandalism or damage to property.

Persistent anti-social behaviour can cause significant alarm, harassment and stress. The anti-social behaviour team may assist by a range of actions, including:

- setting up mediation sessions;

- referring those committing anti-social behaviour to diversionary activities and support using acceptable behaviour contracts to deter the person or group from persisting with their action;
- securing injunctions against individuals;
- use of housing legislation to address persistent incidents within a local neighbourhood;
- use of anti-social behaviour orders to prevent the person or group from persisting with their activities.

12.2.7. Multi-Agency Public Protection Arrangements (MAPPA)

The police, probation and prison service (MAPPA Responsible Authorities) are required to ensure that there is a risk management plan in place for the most serious offenders.

The purpose of MAPPA is to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public, including previous victims, from serious harm. It aims to do this by ensuring that all relevant agencies work together effectively to:

- identify all relevant offenders;
- complete comprehensive risk assessments that take advantage of coordinated information sharing across the agencies;
- devise, implement and review robust risk management plans; and
- focus the available resources to best protect the public from serious harm.

The police, probation and prison service are the responsible authorities required to ensure the effective management of offenders, however NHS, social services, education and housing all have a duty to cooperate under the Criminal Justice Act (2003).

12.2.8. Safeguarding Children & Young People

The Children Act 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.

It is essential that those working to safeguard adults at risk are also aware of their responsibilities to safeguard and promote the welfare of children and young people. There will be occasions when those working with adults at risk identify risks to children and young people, and occasions when safeguarding adults and safeguarding children procedures need to operate side by side. Reference should be made to the local child protection procedures if there are concerns about abuse or neglect of children and young people under the age of 18.

Sometimes allegations of abuse will occur with regard to a person who is approaching the age of 18. If an allegation of abuse is made before a young person turns 18, the process of safeguarding the young person would be managed under child protection procedures. The investigation, once started, should be completed under these procedures.

Where a young person may remain at risk after the age of 18 and they would meet the criteria of an adult at risk at that age, representatives from adult services may need to be invited to strategy meetings in order to contribute to the development of protective measures and plan for the young person's future. Once a young person turns the age of 18, protection arrangements would then be reviewed by adult services.

If an allegation of abuse is with regard to an adult at risk who has turned 18 years of age, an alert should be undertaken as detailed in these procedures. If children services have previously been involved in relation to related issues of support or concern, it may be appropriate to invite representatives from children services to attend strategy meetings in order to advise on relevant issues.

12.3. Involving the Adult at Risk

Adults at risk need to be able to make informed decisions about situations in their own lives. This includes having the safeguarding adults procedures explained to them so that they know what to expect and how they would wish to be involved. In order to be fully involved they may need support in a variety of ways such as the help of a family member or friend, an advocate or IMCA (see below), a personal assistant, a language interpreter or other communication assistance. Due regard should be given to issues equality and diversity, and accessibility issues, such as venues.

The Care Act requires that each local authority must arrange for an independent advocate to represent and support an adult who is the:

- subject of a safeguarding enquiry **or;**
- Safeguarding Adult Review **and;**
- where the adult has 'substantial difficulty' in being involved in the process **and;**
- there is no other suitable person to represent and support them

This duty to provide an independent advocate is separate from the power of the local authority to provide an Independent Mental Capacity Advocate (IMCA) in safeguarding enquiries where someone lacks capacity to fully participate. Both these provisions are in recognition of the importance of providing support and representation for people who have experienced abuse and neglect. The IMCA can support and represent an adult at risk of abuse and neglect, where necessary and appropriate. The local authority is not required to provide two different advocates. It is not likely to be in the adult's interest to do this.

Advocates have two roles. They need to provide support to the adult to assist them in understanding the safeguarding process. The second role is representation, particularly in ensuring that the individual's voice is heard and the safeguarding process takes account of their views wherever appropriate.

Effective safeguarding is about seeking to promote an adult's rights, rather than merely their physical safety and taking action to prevent similar situations occurring again. There is increasing case law on safeguarding from the Court of Protection of which advocates and safeguarding leads should be aware.

However, if an enquiry needs to start urgently, then it can begin before an advocate is appointed but one must be appointed as soon as possible. In such cases, all agencies should set out how the services of advocates can be accessed, and the role they should take.

The Care Act sets out four areas where a substantial difficulty might be found such that an independent advocate should be made available.

1. Whether or not the individual understands relevant information. Many people can be supported to understand information, if it is presented appropriately and if time is taken to explain it. Some people however may not be able to understand it, for example if they have advanced dementia, or substantial learning difficulties but nevertheless should be involved in all decisions that they do have capacity to make.

2. Whether or not the individual can retain information. If the adult is unable to retain information long enough to be able to weigh up options within the decision making, then they are likely to have substantial difficulty in understanding the options open to them.

3. Does the adult have substantial difficulty using or weighing information? An adult must be able to weigh up information, in order to participate fully and choose between options. For example they need to be able to weigh up the advantages and disadvantages of changing where they live or who they live with. If they are unable to do this, they will have substantial difficulty in coming to a decision.

4. Can the adult communicate their views, wishes and feelings whether by talking, writing, signing or any other means? It is critical in this particularly sensitive area that people are supported in what may feel a daunting process which may lead to some very hard and difficult decisions.

An adult with dementia, significant learning disabilities, a brain injury or mental ill health may need an advocate to participate in a safeguarding enquiry. That is usually likely to be an IMCA.

It is also possible that the person or people that would normally be considered as appropriate to support or represent the views of the individual, such as family or friends, do not themselves have the capacity to support the individual. This is one of the circumstances where an Independent Mental Capacity Advocate should be instructed by the local authority if the individual lacks capacity that would result in them having substantial difficulty in participating.

But equally an individual who is thought to have been abused or neglected may be so demoralised, frightened, embarrassed or upset that independent support provided under the Care Act to help them to be involved will be crucial.

The Care Act requires local authorities to consider whether there is an appropriate person who can facilitate an adult's involvement in the safeguarding process. The legislation contains three requirements.

1. This cannot be someone who is already providing care and treatment in a professional capacity or on a paid basis (regardless of who employs or pays them). That means it cannot be, for example, a GP, or a nurse, a key worker or a care and support worker involved in the adult's care or support.

2. The adult who is the subject of the safeguarding enquiry or Safeguarding Adults Review (SAR) has to agree to the person supporting them, if the adult has the capacity to make this decision. Where an adult with capacity does not wish to be supported by a relative, for example, perhaps because they do not wish to discuss the nature of the abuse with them, then the local authority cannot consider the relative to be an appropriate person to act as the adult's advocate. The adult who is the subject of the enquiry or of the SAR has to agree to the appropriateness of the supporter. If the adult in question does not have the capacity

to consent to being represented or supported by a particular person, then the local authority has to be satisfied that it is in the adult's best interests to be supported and represented by the proposed person.

3. The person is able to support and represent the adult and to help their involvement in the processes. In some circumstances it is unlikely that they will be able to fulfil this role easily; for example, a family member who lives at a distance and who only has occasional contact with the adult; a spouse who also finds it difficult to understand the local authority processes, or a friend who expresses strong opinions of their own, prior to finding out those of the individual concerned. It is not sufficient to know the adult well; the role is to actively support the adult's participation in the process.

Sometimes the local authority will not know at the point of first contact or at an early stage of the enquiry or SAR whether there is someone appropriate to assist the adult in being involved. They may need to arrange initially for an advocate, and find later that there is a more appropriate person in the adult's own network to act. The advocate can at that stage 'hand over' to the appropriate person. Alternatively the local authority may agree with the adult, the appropriate person and the advocate that it would be beneficial and in the adult's best interest for the advocate to continue their role.

Equally it is possible that the local authority will consider someone appropriate who may then turn out to have difficulties in supporting the adult's involvement. The local authority must at that point arrange for another independent advocate.

There is nothing to prevent an appropriate family member or friend also offering support to an adult subject of an enquiry or SAR even where a safeguarding advocate has been appointed. There may also be some cases where the local authority considers that an adult needs the support of both a family member and an advocate; perhaps because the family member can provide a lot of information but not enough support, or because while there is a close relationship, there may be a conflict of interest with the relative, for example in relation to differences in what each want as the final outcome.

The local authority may be carrying out two enquiries or a SAR focusing on more than one individual, in the same household or setting. If both people agree, and it is in both their best interests where they lack capacity, to have the same advocate, and if the advocate and the local authority both consider there is no conflict of interest, then the same advocate may support and represent both of them.

For example if the adults who are subjects of the enquiries have had similar experiences and want similar outcomes then it may make sense for one advocate to support both. But where for example one wishes for quite a different outcome or resolution, there may be a conflict of interest and two advocates will be needed. If any of the people – the people who are the subjects of the concern, the local authority or the independent advocate – consider that it would be better to have different advocates, then separate advocates should be provided.

Some enquiries will be very short. This may be because there is actually no abuse or neglect, or because there is no ongoing risk of harm through abuse or neglect (e.g. one-off incidents), or because the adult has the capacity to make the decision not to take the matter further. In some cases where a crime is identified it is not always for the adult to decide whether or not an enquiry proceeds. It is a factor but the police are under wider duties to investigate crime and to protect the public at large.

It may also be appropriate to suggest an "instructed" advocate to support the adult at risk. 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.

Advocates will ordinarily be invited to strategy meetings and reporting meetings, 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.

12.3.1. Independent Mental Capacity Advocates (IMCAs)

IMCAs provide a form of non-instructed advocacy. Their role was established by the Mental Capacity Act 2005. There is a legal requirement to consider instructing an IMCA in the event that an adult at risk lacks mental capacity in relation to protective measures required within the safeguarding adults procedures.

Protective measures may include (but are not limited to):

- restrictions on contact with certain people
- temporary or permanent moves of accommodation
- increased support or supervision
- an application to the Court of Protection
- restrictions on accessing specific services and/or places
- access to counselling or psychology with the aim of reducing the risk of further abuse

The Local Authority or NHS body may instruct an IMCA to represent the person concerned if it is satisfied that it would be of benefit for the person to do so.
In safeguarding adults cases access to IMCAs is not restricted to people who have no one else to support or represent them. Therefore, people who lack mental capacity who have family and friends can still have an IMCA to support them through the safeguarding adults procedures.
Where they apply, refer to local policies/procedures in relation to the use of Independent Mental Capacity Advocates (IMCAs).

12.3.2. Witness support and special measures

If there is a police investigation, the police will ensure that interviews with a vulnerable or intimidated witness are conducted in accordance with "Achieving Best Evidence in Criminal Proceedings".

Special measures are those specified in the Youth Justice and Criminal Evidence Act 1999 and will 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, 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 achieve their best evidence for the police and the courts.

The Witness Service provides practical and emotional support to victims and witnesses (either for the defence or for the prosecution). The support is available before, during and after a court case to

enable them and their family and friends to have information about the court proceedings, and could include arrangements to visit the court in advance of the trial.

12.3.3. 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, which includes information, emotional support and practical help. Help can be accessed either directly from local branches or through the Victim Support helpline.

12.3.4. Keeping families and others concerned informed and supported

When the adult at risk wishes, it is important that relatives and friends are involved within the safeguarding adults procedures. This will help them to feel fully supported when dealing with difficult or distressing issues.

If the adult at risk gives their consent, it will be possible to share with them concerns for their welfare or safety. It will also be possible to involve relatives/friends in meetings about how concerns or allegations are being addressed and how they are being supported to be safe in the future.

If the adult at risk decides that they do not wish for a relative or friend to be informed or involved, professionals will need to respect this decision. If they do not have the mental capacity to decide this themselves, a decision will need to be made in their "best interests" under the Mental Capacity Act.

If relatives/friends are implicated in the allegations or concerns, this will impact on the decisions as to whether, when and how information is shared and/or how they are included within the safeguarding adults procedures.

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

12.4. Responsibilities to those who are alleged to have caused harm

People and organisations who are alleged to have caused harm to an adult at risk have the right to be treated fairly and have their confidentiality respected throughout the safeguarding adults procedures.

Only in exceptional circumstances, such as in the examples below, will it be inappropriate for a person or organisation to not be informed of allegations about themselves:

- the police advise that to do so may result in further harm to the adult at risk of that vital evidence may be compromised or lost
- lawyers acting on behalf of an employer of the person alleged to cause harm advise otherwise
- it is not in an adult at risk's best interests as determined under the Mental Capacity Act
- where an adult at risk with mental capacity refuses permission for them to be informed of the allegations (and there are no other persons at risk)

If the above points do not apply then the person or organisation alleged to have caused harm should:

- know that they are the subject of a safeguarding allegation (irrespective of any other investigation, such as disciplinary investigation and with agreement from the police, criminal proceedings);

- be informed in a timely manner consistent with the needs of the safeguarding enquiry;

- be informed of the nature and content of the allegation;

- have an opportunity to respond to allegations concerning their practice or conduct within the safeguarding enquiry (for example through an interview) prior to the completion of the enquiry report;

- have an opportunity to read the safeguarding report and respond to the findings of the enquiry. This should include the opportunity to make written comments if they so choose, so that their response can contribute to the process of reaching a case conclusion;

- know if a reporting meeting is due to be held to establish, on the balance of probabilities, whether the allegation is substantiated or not;

- know the case conclusion reached within the reporting meeting.

The strategy discussion or meeting will need to establish whether and when the person or organisation is informed and when they are informed so as to not undermine the safeguarding enquiry. Such decisions will need to be made on a case-by-case basis.

The most appropriate way of informing the person or organisation of the allegations should be considered. A person alleged to have caused harm should be provided with appropriate support throughout the process to participate and enable their views to be recognised.

Where the person who is alleged to have carried out the abuse themselves has care and support needs and are unable to understand the significance of questions put to them or their replies, they should be assured of their right to the support of an 'appropriate' adult if they are questioned by the police under the Police and Criminal Evidence Act 1984 (PACE). Victims of crime and witnesses may also require the support of an 'appropriate' adult.

Under the Mental Capacity Act, people who lack capacity and are alleged to be responsible for abuse, should be entitled to the help of an Independent Mental Capacity Advocate (IMCA), to support and represent them in the enquiries that are taking place (see section 12.3.1). This safeguard was introduced to ensure that people in this situation have support and help. This is separate from the decision whether or not to provide the victim of abuse with an independent advocate under the Care Act.

A person alleged to have caused harm should be enabled to respond to allegations made about them and be invited to the reporting meeting. Invitation to the reporting meeting, however should only be with the permission of the adult at risk and following careful consideration of the likely impact. If this is not possible, their views must be represented. The safeguarding lead will decide if the person alleged to have caused harm should attend the reporting meeting. The adult at risk's wish to attend must always override the wishes of the person alleged to have caused harm.

12.4.1. Abuse by another adult at risk

It is the nature of the incident and its impact, rather than the nature of the relationship between those concerned that are the important factors in determining the need for the safeguarding adults

procedures to be followed. Where such an incident occurs within a service, for example where both people are living in a care setting, the risk of harm may be compounded by the emotional distress of living with an abusive person.

The safety of the adult at risk will be of primary importance. However, where the person causing harm is also an adult at risk, there may also be ongoing responsibilities for their welfare. Consideration may be required as to how their care and support needs are being provided for, and whether the incident reveals unmet needs. Such an assessment should be undertaken separately from the person experiencing abuse.

The fact that the person alleged to have caused harm has a particular diagnosis or condition does not preclude the safeguarding adult procedures from being the appropriate response. However, where this is the case, additional support or care planning actions may be required in order to address *their* support needs, alongside the protection needs of the adult at risk.

It will be necessary for such an assessment to consider:

- The extent to which the person causing the harm is able to understand his/her actions
- The extent to which the abuse or neglect reflects the needs of the person causing the harm
- The likelihood that the person causing the harm will further abuse the victim or others
- The support/care needs of that individual

The primary focus of the reporting meeting is the safety of the adult at risk. If the person causing abuse or neglect is also an adult at risk, it may be necessary to hold a separate meeting to address the needs of the person causing the harm and the risks that they may present. It may be appropriate for a separate care manager/care coordinator to be involved in order to respond to these issues.

In all cases, the care manager, care coordinator or link/key worker representing the adult at risk and the relevant staff working with the person causing harm must be involved/ kept informed throughout the safeguarding adults procedures.

12.4.2. Abuse by carers who are relatives or friends

There is a difference between unintentional harm caused inadvertently by a carer and a deliberate act of either harm or neglect.

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

In such circumstances, a carer's assessment where required, should take into account the following factors:

- whether carer demands exceed the carer's ability or capacity;
- the emotional and/or social isolation of the carer and the adult at risk;
- communication difficulties between the adult at risk and the carer;
- whether the carer is in receipt of any practical and/or emotional support from other family members or professionals;

- financial difficulties;
- whether the carer has a lasting power of attorney or appointeeship;
- a personal or family history of violent behaviour, alcoholism, substance misuse or mental illness;
- the physical and mental health and well-being of the carer.

Circumstances in which a carer (for example, a family member or friend) could be involved in a situation that may require a safeguarding response include:

- a carer may witness or speak up about abuse or neglect;
- a carer may experience intentional or unintentional harm from the adult they are trying to support or from professionals and organisations they are in contact with; or,
- a carer may unintentionally or intentionally harm or neglect the adult they support on their own or with others.

Assessment of both the carer and the adult they care for must include consideration of the wellbeing of them both. Section 1 of the Care Act includes protection from abuse and neglect as part of the definition of wellbeing. As such, a needs or carer's assessment is an important opportunity to explore the individuals' circumstances and consider whether it would be possible to provide information, or support that prevents abuse or neglect from occurring, for example, by providing training to the carer about the condition that the adult they care for has or to support them to care more safely. Where that is necessary the local authority should make arrangements for providing it.

If a carer speaks up about abuse or neglect, it is essential that they are listened to and that where appropriate a safeguarding enquiry is undertaken and other agencies are involved as appropriate.

If a carer experiences intentional or unintentional harm from the adult they are supporting, or if a carer unintentionally or intentionally harms or neglects the adult they support, consideration should be given to:

- whether, as part of the assessment and support planning process for the carer and, or, the adult they care for, support can be provided that removes or mitigates the risk of abuse. For example, the provision of training or information or other support that minimises the stress experienced by the carer. In some circumstances the carer may need to have independent representation or advocacy; in others, a carer may benefit from having such support if they are under great stress or similar; and

- whether other agencies should be involved; in some circumstances where a criminal offence is suspected this will include alerting the police, or in others the primary healthcare services may need to be involved in monitoring.

Other key considerations in relation to carers should include:

- involving carers in safeguarding enquiries relating to the adult they care for, as appropriate;
- whether or not joint assessment is appropriate in each individual circumstance;
- the risk factors that may increase the likelihood of abuse or neglect occurring; and
- whether a change in circumstance changes the risk of abuse or neglect occurring .A change in circumstance should also trigger the review of the care and support plan and, or, support plan.

Further information about these considerations can be found in an ADASS paper on carers and safeguarding below:

12.4.3. Abuse of trust

See also Section 6.1.7 – Responding to abuse in a Care Setting

A position of trust is one in which one person is in a position of power or influence over the other person because of their work or the nature of their activity.

Where the person who is alleged to have caused harm is in a position of trust, the adult at risk may be reluctant to make a complaint or take action out of a sense of loyalty, fear, of abandonment or other repercussions.

Where the person who is alleged to have caused the abuse or neglect has a position of trust with the adult at risk because they are a member of staff, a paid employee, a paid carer, a volunteer or a manager or proprietor of an establishment, the organisation will need to invoke its in-house disciplinary procedures (which should make provision for when the person alleged to have caused harm is a proprietor or manager), as well as taking action under these multi-agency safeguarding procedures. Discussion should also take place with the organisation's Designated Adults Safeguarding Manager (DASM) – for further information on this role, see section 11.1.8**.** The Local Authority Designated Officer (LADO) may also need to be involved and local procedures will be developed to clarify LADO responses and pathways which are compliant with the Care Act Guidance 2014.

A referral must also be made to professional bodies (where applicable) and the Disclosure and Barring Service if the employee or volunteer has been found to have harmed or put at risk of harm an adult at risk and the relevant criteria has been met.

If the person who is alleged to have caused harm is a member of a recognised professional group the organisation will need to take actions under the relevant code of conduct for the profession as well as taking action under these policy and procedures.

In all cases regard should be given to issues of confidentiality and information sharing, ensuring the rights of employees accused of abuse are protected and any actions taken against them are proportionate and lawful.

12.4.4. Allegations against Professionals

When a complaint or allegation has been made against a member of staff, including people employed by the adult at risk, they should be made aware of their rights under employment legislation and any internal disciplinary procedures.

The Police and Crown Prosecution Service (CPS) should agree procedures with the local authority, care providers, housing providers, and the NHS/CCG to cover the following situations:

- action pending the outcome of the police and the employer's investigations;
- action following a decision to prosecute an individual;

- action following a decision not to prosecute;
- action pending trial; and
- responses to both acquittal and conviction.

Employers who are also providers or commissioners of care and support have, not only a duty to the adult who has been abused, but also a responsibility to take action in relation to the employee when allegations of abuse are made against them. Employers should ensure that their disciplinary procedures are compatible with the responsibility to protect adults at risk of abuse or neglect.

With regard to abuse, neglect and misconduct within a professional relationship, codes of professional conduct and/or employment contracts should be followed and should determine the action that can be taken. Robust employment practices, with checkable references and recent DBS checks are important. Reports of abuse, neglect and misconduct should be investigated and evidence collected.

Where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation such as the Health and Care Professionals Council, General Medical Council and the Nursing and Midwifery Council. If someone is removed from their role providing regulated activity following a safeguarding incident the regulated activity provider (or if the person has been provided by an agency or personnel supplier, the legal duty sits with them) has a legal duty to refer to the Disclosure and Barring Service. The legal duty to refer to the Disclosure and Barring Service also applies where a person leaves their role to avoid a disciplinary hearing following a safeguarding incident and the employer/volunteer organisation feels they would have dismissed the person based on the information they hold.

If someone is removed by being either dismissed or redeployed to a non-regulated activity, from their role providing regulated activity following a safeguarding incident, or a person leaves their role (resignation, retirement) to avoid a disciplinary hearing following a safeguarding incident and the employer/ volunteer organisation feels they would have dismissed the person based on the information they hold, the regulated activity provider has a legal duty to refer to the Disclosure and Barring Service. If an agency or personnel supplier has provided the person, then the legal duty sits with that agency. In circumstances where these actions are not undertaken then the local authority can make such a referral.

The standard of proof for prosecution is ‘beyond reasonable doubt’. The standard of proof for internal disciplinary procedures and for discretionary barring consideration by the Disclosure and Barring Service (DBS) and the Vetting and Barring Board is usually the civil standard of ‘on the balance of probabilities’. This means that when criminal procedures are concluded without action being taken this does not automatically mean that regulatory or disciplinary procedures should cease or not be considered. In any event there is a legal duty to make a safeguarding referral to DBS if a person is dismissed or removed from their role due to harm to a child or a vulnerable adult.

Jobs that involve carrying out certain activities for children and adults may require an enhanced DBS check with a check of the barred lists.

This will check whether someone’s included in the 2 DBS ‘barred lists’ (previously called ISA barred lists) of individuals who are unsuitable for working with children and adults. People on the barred lists can’t do certain types of work. There are specific rules for working with children - known as working in a regulated activity with children. These are different than the rules for regulated activities for adults.

It's against the law for employers to employ someone or allow them to volunteer for this kind of work if they know they're on one of the barred lists.

Employers **must** refer someone to DBS if they:

- sacked them because they harmed someone;
- sacked them or removed them from working in regulated activity because they might have harmed someone;
- were planning to sack them for either of these reasons, but they resigned first

You're breaking the law if you don't refer someone to DBS when you should.

For further information about the DBS service please see https://www.gov.uk/disclosure-barring-service-check/overview

If you require any advice or would like to speak to someone at the DBS, please use the contacts below:

Disclosure customer services
customerservices@dbs.gsi.gov.uk
Telephone: 0870 909 0811

12.4.5. Abuse by children

If an adult at risk is being abused by a child (including their own child), the response should involve the local authority children's services as appropriate, in order to respond to the risks of harm related to the child.

12.5. Mental Capacity and Consent

People have the right to make decisions about their own lives. They may choose to live with risk or make decisions that others believe to be unwise. This means adults at risk are entitled to accept or decline support in relation to their own safety and well-being, including actions within these procedures. People should be supported to make an informed decision.

Mental capacity should be presumed. It is time and decision specific. If the adult at risk is assessed as not having mental capacity to make decisions about their own safety the decision will need to be made in their best interests (Mental Capacity Act 2005).

The two stage test of mental capacity is:

- Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?
- If so, is the impairment or disturbance sufficient that the person lacks the mental capacity to make that decision?

A person is unable to make that decision if he/she is unable to:

- understand the information relevant to the decision;

- retain that information (for as long as required to make the decision);
- use or weigh that information as part of the process of making the decision;
- communicate their decision (whether by talking, using sign language or any other means).

Where a person with mental capacity is subject to undue influence or coercion they may, lack the ability to make the decision alone and require additional support to do so. In deciding whether the adult at risk has mental capacity to consent to an alert, consider if the adult at risk has mental capacity to make informed decisions:

- about other people being informed?
- about actions which may be taken under multi-agency policy and procedures?
- about their own safety, including an understanding of longer-term harm as well as immediate effects? and
- how to take action to protect themselves from future harm?

If the adult at risk has mental capacity to decide about a safeguarding alert, referral or actions taken as a part of the safeguarding process, their consent should be sought, unless to do so may place a person at risk or it is not possible to seek that person's consent.

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, a "best interests" decision will need to be made in line with the Mental Capacity Act 2005.

12.5.1. Undertaking activities without the consent of the adult at risk

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

Any actions taken without the adult at risk's consent should be proportional to the risk of harm. The following are examples of when a decision to make an alert without consent will be required:

- It is in the public interest, for example:
    - there is a risk to other "adults at risk", or
    - the concern is about institutional or systemic abuse, or
    - the concern or allegation of abuse relates to the conduct of an employee or volunteer within an organisation providing services to adults at risk, or
    - the abuse or neglect has occurred on property owned or managed by an organisation with a responsibility to provide care
- the person lacks mental capacity to consent and the activity is in the person's "best interests" (Mental Capacity Act 2005);
- a person is being unduly influenced or intimidated, to the extent that they are unable to give consent;
- it is in the person's vital interests (to prevent serious harm or distress or in life- threatening situations);
- it is necessary to prevent crime.

Public interest considerations involve balancing the rights of the individual to privacy with the rights of others to protection. It may be necessary to act contrary to the person's expressed wishes in order to safeguard others, for example:

- other adults are at risk from the person or organisation alleged to be causing harm;

- the concern is about institutional abuse;

- the allegation or concern relates to the conduct of an employee or volunteer within an organisation providing services to adults at risk. Where a person with mental capacity declines support within these procedures, and thereby places themselves at risk of serious harm, the safeguarding lead may need to inform their line manager, and should always do so if the risk is life threatening. Legal advice may also be required. It may be appropriate to explore an alternative process to provide support.

No person has the right to place another at risk. Therefore consent is not required to take actions that safeguard the safety and well-being of others. However, it would be good practice to inform the person of actions being taken, unless to do so would place any person at further risk.

12.5.2. Deciding whether to report an incident to the police

If a crime has been or may have been committed, seek the person's consent to report the matter immediately to the police.

If the person has mental capacity in relation to the decision and does not want a report made, this should be respected unless there are justifiable reasons to act contrary to their wishes, such as:

- the person is unduly influenced or intimidated, to the extent that they are unable to give consent, or
- there is an overriding public interest, such as where there is a risk to other people, or
- it is in the person's vital interests (to prevent serious harm or distress or in life- threatening situations)

There should be clear reasons for overriding the wishes of a person with the mental capacity to decide for themselves. A judgement will be needed that takes into account the particular circumstances.

If the person does not have mental capacity in relation to this decision, a "best interests" decision will need to be made and recorded in line with the Mental Capacity Act.

The police may be contacted at any time throughout the safeguarding adults process if more information becomes available and it becomes apparent that a crime has been committed.

It is important **when a situation is reported to the police**, that wherever possible the adult at risk, potential witnesses or the person or organisation alleged to have caused harm are not questioned by anyone, so as not to undermine any police investigation required.

For these reasons it is important that forensic and other evidence is not contaminated:

- try not to disturb the scene, clothing or victim if at all possible;
- secure the scene, for example, lock the door;
- preserve all containers, documents, locations, etc;
- evidence may be present even if you cannot actually see anything.

If in doubt contact the police and ask for advice.

12.6. Risk assessment and protection planning

Risk assessment, protection planning, and the provision of support to enable the adult at risk to be in control of decisions about their own life, are core elements of every stage of the safeguarding adults process.

12.6.1. Risk Assessment

Risk assessments in relation to 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 personal budget arrangements.

Assessment of risk is a dynamic and ongoing process. It should be kept under continual review so that adjustments can be made in response to changes in the level and nature of the risk. The primary aim of a safeguarding adults risk assessment is to assess:

- current risks;
- potential risks.

A safeguarding adults risk assessment will determine:

- what the actual risks are – the harm that has, or may be caused;
- the level of severity of that harm and the views and wishes of the adult at risk;
- the person's ability to protect themselves;
- who or what is causing the harm;
- factors that contribute to the risk, for example, personal, environmental or relationships that result in increased or decreased risk;
- the risk of future harm from the same source.

The risk assessment should identify other risks which may be evident in the person's home, seeking advice from partner agencies as appropriate.

Organisations will have a range of risk assessment tools in paper and IT formats to assist staff in risk assessment.

Risk assessments throughout the process (including as a part of the enquiry) should:

- establish the facts of the abuse or neglect and inform the initial and subsequent protection plans;
- assess what service provision may be needed by the adult at risk and/or where indicated, their carer;
- gain information to help inform decisions about what legal powers may be relevant to a protection plan;

- ensure that forensic and other evidence is collected and preserved, and relevant files and documents are secured, using the appropriate powers of partner organisations where necessary;
- ensure that any other assessments required are carried out;
- establish if there is a need to protect other adults at risk and find out what is needed to protect them;
- identify the person causing the harm if their identity is not known and establish where they are;
- find out if the person causing the harm is also a service user;
- decide if domestic abuse is indicated and the need for referral to a MARAC;
- identify people causing harm who should be referred to MAPPA;
- identify whether a child (under 18 years) is at risk.

12.6.2. Protection Planning

The protection plan records the agreed arrangements to manage the assessed risk. It should be drawn up in partnership with the adult at risk and their desired outcomes - initially to ensure their immediate safety and longer term to ensure that the risk is reduced or eradicated. It should include consideration of the following issues:

- what support the adult at risk would like to receive;
- what action can be provided to protect the adult at risk;
- what, if any, action must be taken to protect other parties;
- what contingency arrangements can be put in place if required arrangements for review.

Where a person with mental capacity declines the protection plan, all reasonable efforts should be undertaken to understand the person's reason for declining support, and to consider how the plan could be amended in light of their concerns and wishes. If a person initially declines support, they should be provided with the opportunity to change their mind, at any time. If a person lacks the mental capacity in relation to the protection plan, a "best interests" decision will be required in line with the Mental Capacity Act.

Organisations must avoid safeguarding arrangements that do not put people in control of their own lives, or that revert to a paternalistic and interventionist way of working. People have complex lives and being safe is only one of the things they want for themselves. Professionals and other staff should not be advocating "safety" measures that do not take account of individual well-being, as set out in section one of the Care Act.

In deciding what action to take, there should be the presumption that the majority of people can make choices which involve taking risks. Of course their capacity to make decisions about arrangements for enquiries or managing the abusive situation should be taken into account.

In order to make sound decisions, the adult's emotional, physical, intellectual and mental capacity in relation to self-determination and consent and any intimidation, misuse of authority or undue influence will have to be assessed.

Where a person is without mental capacity to make decisions about their safety, decisions about protective arrangements should be made in their best interests taking into account their wishes, feelings, beliefs and values (Mental Capacity Act 2005).

The safeguarding lead will need to ensure that agreed protection arrangements are implemented. Any party that is unable to complete an agreed action should notify the safeguarding lead at the earliest opportunity.

12.6.3. Specific considerations for risk assessment and protection planning at referral stage

The safeguarding lead will need to evaluate the nature and extent of the presenting risk and the need for urgent protective measures. Alongside the risk to the individual named within the safeguarding alert, any risks to other people should also be considered. Protective measures already put in place by the alerter (or where relevant a current service provider) will need to be evaluated and additional protective measures put in place where required.

These actions will sometimes be urgent and will need to be taken before there is opportunity for a strategy discussion/meeting to be held. The strategy discussion/meeting process can further evaluate and review these actions. Actions taken that impact on the welfare of the adult at risk should be taken in consultation with them.

12.6.4. Specific considerations for risk assessment and protection planning at strategy stage

The strategy discussion/meeting must assess the risk and work with the adult at risk to devise an initial or interim protection plan that safeguards them from future harm.

The assessment of risk and the interim protection plan will need to be kept under continual review during the safeguarding enquiry. New information or changes in circumstances may cause the assessment of risk and protection plan to be re-evaluated. The strategy discussion/meeting should include details of how the protection plan is to be monitored and by whom and this should be recorded on the protection plan. A further meeting may be required in some circumstances to ensure the protection planning arrangements are effective, proportionate, and reflect the adult at risk's wishes and the safety of others.

12.7. Domestic Abuse

In 2013, the Home Office announced changes to the definition of domestic abuse:

- Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse... by someone who is or has been an intimate partner or family member regardless of gender or sexuality;

- Includes: psychological, physical, sexual, financial, emotional abuse; so called 'honour' based violence; Female Genital Mutilation; forced marriage;

- Age range extended down to 16.

Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and much safeguarding work (that meets the criteria set out in section 5.1.2) that occurs at home is, in fact is concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.

12.7.1. Making the links between safeguarding and domestic abuse

Multi-agency working is fundamental to safeguarding adults and domestic abuse work. Multi-agency strategy meetings and conferences take place as part of the safeguarding adults procedures Multi-Agency Risk Assessment conferences (MARAC) address high risk domestic abuse. It is important that all professionals develop their understanding of how adult safeguarding and domestic abuse work interlink when a person with care and support needs is experiencing domestic abuse.

A person, with care and support needs that prevent them from safeguarding themselves, who is "at risk" of abuse from current or ex-partner or from a family member is experiencing domestic abuse.

A person experiencing domestic abuse, who has care and support needs that prevent them from safeguarding themselves, is an "adult at risk"

Both the local domestic abuse and safeguarding adults' protocols will apply to these situations.

Safeguarding work in such a situation should include best practice in relation to domestic abuse and should ensure that the person experiencing abuse has choice and support to access to specialist domestic abuse services. There are some specific legal measures that can be taken to protect people experiencing domestic abuse; For example, "Domestic Violence Protection Orders" (DVPO's) can stop an abuser having contact with the person at risk for 14-28 days. These should be considered as part of multi-agency efforts to decrease risk of abuse/help safeguard an adult at risk from domestic abuse.

Best practice is for the person at risk to be at the centre of "Making Safeguarding Personal"(LGA 2014), and using "Safe Enquiry" (see page 38), being supported and empowered to address the risk they face. Local Domestic Abuse risk assessment tools and protocols should be used. This is a useful tool for working with a person to assess and recognise the level of risk they are experiencing. If the risk of serious harm or homicide is high a referral MUST be made to your local Multi-Agency Risk Assessment Conference (MARAC).

As the multi-agency safeguarding strategy meeting duplicates part of the MARAC process there needs to be clarity about how multi-agency intervention in each case is being managed. Some of this will depend on timing. Seek advice from your manager or safeguarding lead if the dual processes are duplicating or allowing key issues to go unaddressed.

Services that meet care and support needs may also play an important role in protecting someone from domestic abuse; for example, tele-care monitoring systems, regular visits by care workers. If services are being used as part of a protection plan this must be specified and those co-ordinating and delivering the services MUST be made aware of the risk of abuse and what to do if the risk increases, for example, a perpetrator tries to gain information about the victims whereabouts.

Domestic abuse includes sexual assault. If someone has been raped or sexually assaulted forensic evidence is key to potential conviction. If the situation is already known to the Police then it is likely the victim will have attended the local Sexual Assault Referral Centre (SARC) and/or have been contacted by an Independent sexual violence Advocate (ISVA). If the victim is not sure about

contacting the police/giving evidence they can self-refer to the SARC. Evidence will be collected and stored but will only be used to take a case forward with the victim's informed consent.

Studies have shown that professionals can find it hard to focus on the level and source of primary risk, for example, pursuing issues of drug and alcohol dependency or "poor parenting" and "forgetting" the context of domestic abuse. Not paying sufficient attention to the level of risk from domestic abuse can mean opportunities to prevent serious harm or death are missed.
When a person who appears to have mental capacity is choosing to stay in a high risk abusive relationship, or where children or other dependent adults are at risk, then professionals should refer to their local multi-agency domestic abuse procedures.

12.7.2. Research that has mainly been carried out with women has shown that:

- Being disabled strongly affects the nature, extent and impact of abuse.
- Sexual abuse appears to be proportionately more common for disabled than for non-disabled women.
- People's impairments are frequently used in the abuse. Humiliation and belittling were an integral part of this and were particularly prevalent
- Perpetrators often use forms of abuse that exploit, or contribute to, the abused person's impairment; for example not recharging hearing aid or wheel chair batteries
- Perpetrators may deprive the person of necessary medication or over medicate them
- Many abusers deliberately emphasise and reinforce dependency as a way of asserting and maintaining control
- The impact of domestic abuse is often especially acute where the abusive partner is also the carer, the carer has considerable power and control and the victim relies on them.

("Making the Links" Women's Aid 2008)

12.7.3. Key practice messages – links between domestic abuse and safeguarding adults

- Remember that older and disabled adults experience domestic abuse;
- Look out for patterns of coercive or controlling behaviour, as well as incidents of abuse;
- Listen to and communicate respect towards the adult at risk/person experiencing domestic abuse;
- Ensure they are at the centre of decision making about actions that could be taken to stop or decrease the abuse they are facing;
- Always take action to safeguard children who are living with or witnessing domestic abuse;
- Always take action to safeguard adults without capacity to protect themselves;
- Always take action to safeguard adults who are at high risk – informing them if you are acting against their wishes.

12.7.4. Additional impacts of domestic abuse on people with care and support needs

- Increased physical and/or mental disability;
- Reluctance to use essential routine medical services or to attend services outside the home where personal care is provided for fear of physical signs of domestic abuse being recognised;
- Increased powerlessness, dependency and isolation;
- Feeling that their impairments are to blame;
- Increased shame about their impairments; for example in relation to needs for personal care.

12.7.5. Additional barriers to seeking help from people with care and support needs

Research of disabled women's experiences has shown that the barriers to accessing services can include:

- Lack of accessible information and domestic abuse services;
- Fear that interpreters (e.g. BSL) may not keep confidentiality;
- Assumptions that physical and sensory impairments prevent people making their own decisions;
- Having become accustomed to being dependent and being treated without respect and dignity – assuming abuse is normal and minimising its impact ;
- Lack of accessible information about abuse and legal rights;
- Lack of accessible domestic abuse services;
- Fear of having to live in a care home;
- Reliance on the abuser for care and support;
- Lack of accessible information about services to meet their care and support needs and about options such as direct payments;
- The expectation that disabled people should be grateful for support and not complain;
- The adult at risk may be the carer of the abuser, and feel a sense of obligation to carry on and put up with the abuse;
- Older and disabled adults may be more physically vulnerable, more socially isolated and less able to escape, and the abuser may be constantly present;
- Shame and stigma; for example older adults who have put up with a lifetime of abuse may experience shame for having put up with it for so long;
- Not being asked. Although women with disabilities may have been in close contact with professionals, professionals rarely ask about abuse, and women were reluctant to disclose if not asked;
- Being more easily identified visibly and traceable through attendance for specialised care/services or benefits – it is less easy to remain protected from stalking or continued abuse after leaving an abusive relationship.

12.7.6. Give opportunities and develop trust to disclose abuse:

Building up trust in you/your organisations approach to domestic abuse will help people feel able to disclose. For example:

- Demonstrate you understand domestic abuse for example by talking about the plot of soap operas or celebrities who have survived domestic abuse;
- Be non-judgemental about the victim and the perpetrator;
- Be clear that the abuse should stop;
- Never blame a victim for the abuse ;
- Display posters about Domestic abuse and sources of help and support.

12.7.7. Create opportunities to seek help

Research shows that women experiencing domestic abuse will not usually voluntarily disclose domestic abuse to a professional unless they are directly asked. However, whilst victims may be reluctant to disclose what is happening to them, many report that they hope that someone will ask them. Being asked makes an important difference. Repeated enquiry on a number of occasions also increases the likelihood of disclosure.

It is **crucial** that such enquiries are made when the person **is safe to disclose** and in a situation which will not increase risk to them – for example, because the abuser becomes worried that their behaviour is being challenged.

You should also **explain the limits of your confidentiality,** before asking any questions: for example: **"**The only time I would tell anyone anything you told me would be if a child was in danger, or if you or another adult was in serious danger. Even then, I would tell you what I was doing first if I could and do everything I could to support you."

Work with women attending hospital accident and emergency units and using midwifery services has shown that it is effective to ask every woman using the service a question that can enable disclosure of domestic abuse to take place. For example:

- Has anyone close to you made you feel frightened?
- Does anyone close to you bully you, control you or force you into things?
- Do you feel safe at home?/when you are with (……)
- Has anyone close to you ever hurt you physically, such as hit you, pushed you, slapped you, choked you, or threatened you in any way?
- Have you been upset because someone talked to you in a way that made you feel ashamed or threatened?

Additional direct questions relevant to **adults with care and support needs i**nclude:

- Has anyone prevented you from getting the things you need such as food, clothes, medication, glasses, hearing aids or medical care?
- Does anyone with-hold care and support you need?

- Has anyone prevented you from being with the people you want to be with?
- Has anyone tried to force you to sign papers against your will?
- Has anyone taken money or things belonging to you?
- Has anyone made fun of you or made you feel ashamed because of your disability?

In a similar way information about domestic abuse can be routinely offered to all service users/patients, for example in information packs. Those who are experiencing abuse may then go on to use it. They will also know that you and/or your organisation take domestic abuse seriously, giving them confident to disclose at a later date. Those who are not experiencing abuse themselves may become better informed and may pass the information on to others or become advocates for their friends and family.

12.7.8. Working with people with care and support needs who are experiencing domestic abuse

Research shows us that practitioners should keep a range of issues relevant to people **with care and support needs,** at the front of their mind, when identifying potential abuse; when trying to enable and encourage people to disclose abuse; when making assessments; and when planning any interventions.

Among the key areas to consider are:

12.7.9. Accommodation and support packages

Accommodation and physical accessibility can be significant barriers for those seeking help. According to research many women believe they could not be accommodated according to their needs if they left a violent relationship. However, some areas of the country do have facilities for disabled women and professionals should make themselves aware of what is available in their area. Disabled women were also reluctant to leave their own housing if it had been adapted for them. They may also fear that institutional care could be forced upon them if they leave an adapted home and abusive carer.

All possible accommodation options should be explored. This might include staying in the current home with support to make this safe (see Sanctuary schemes). If moving to a place of safety is the best option then all options should be explored. These can include providing a support plan in a refuge or other specialist domestic abuse housing scheme, re-housing with a support plan floating support from a domestic abuse service, supported living or care home with floating support from a domestic abuse service.

The Care Act has clarified the responsibility of local authorities in case where a person moves into another local authority. If an adult has an existing support plan this should be continued by the new local authority until they have carried out an assessment. Where the second local authority has been notified that an adult at risk intend to move to their area they must provide information and start an assessment of needs. The local authority where the person currently lives is responsible for co-ordinating the transfer and keeping the adult informed.

12.7.10. Independence and self-esteem

Loss of independence and low self-esteem affects most people who suffer domestic abuse and internalising the messages given by abusers is a common psychological response – e.g. “It is my fault that he gets angry” “I need to wait to see what he wants before I decide what I want”. Accounts of people with care and support needs suggest that people who are dependent on their abuser for care may be more likely to blame themselves or their care needs for the abuse; People with life-long disabilities may be used to having to tolerate widespread disrespectful attitudes and behaviours towards them and may find it harder to name what is happening to them as abuse.

Some people fear loss of pride and fear of failure to manage their condition. People may also fear losing hard won independence and those reliant on care packages that have taken a lot to arrange, or personal assistants (PAs) that work well with them, may feel that their options are severely limited; for example, fearing that it will be impossible to take services with them if they leave a relationship and move area.

12.7.11. Confidence in services

Whilst some people will have good and trusting relationships with professionals who can support them to report and deal with domestic abuse, others will not trust agencies to respond effectively or will fear further loss of independence. People with these concerns may need more time and to build trust and confidence, and a positive indication that they will be supported before they disclose to professionals, and move on to consider their options.

Women who have experienced abuse from personal assistants reported the pervasive and continual nature of the abuse they experienced and some described collusion between the PA and professionals resulting in their marginalisation and their experience of abuse not being taken seriously.

Independent and voluntary sector organisations with expertise in domestic abuse may be better placed to gain the confidence of and offer support to those who mistrust statutory agencies.

12.7.12. Parenting

Parents with their own care and support needs may be particularly fearful of losing their children as a result of reporting domestic abuse. Their partner may have told them they will lose the children if they leave.

They may rely on a partner or other family member to support them with childcare, or they may feel that their capacity as a parent will be judged negatively due to their disability, addiction or mental health problem, for example.

Identifying and working effectively with domestic abuse within adult safeguarding work can, therefore, also become critical to the protection of children. Where children are linked to an abusive adult relationship, **local children's safeguarding policies and procedures must be followed** without delay. Workers must not collude with the abused persons fears that s/he will lose contact with the children if the domestic abuse is reported.

12.7.13. Substance misuse

Victims of domestic abuse may use alcohol or drugs in order to cope with, or 'block out' what is happening to them. Some victims of domestic abuse are forced into drug or alcohol misuse by their abuser in order to intensify control. They may be drawn into sex working or other high-risk activity to pay for access to drugs or alcohol.

There is also potential for a perpetrator to exercise control over a victim who is dependent upon substances, including prescription medication, by controlling access to drugs or alcohol or to treatment. Perpetrators may also steal prescription medication for personal use or to sell to others. Research shows that victims of domestic abuse who misuse substances felt they were consistently judged and stigmatised by agencies and that false assumptions were frequently made by workers. This demonstrates the need for professionals to emphasise that their role is to support the person and to encourage the victim to disclose if they are struggling as a result of drug or alcohol misuse. Good practice where either a perpetrator or victim is misusing substances could include the following:

- Recognise the relationship between domestic abuse and substance misuse and implement safe enquiry (see page 38) into both of these areas as part of a holistic assessment of need;

- Respect that a victim may wish to address the effects of domestic abuse before tackling their substance misuse and may therefore need support to minimise any harm posed to themselves or others as a result of substance misuse;

- Be mindful that substance misuse by the victim may make it difficult for them to accurately assess risk posed to them - it may 'dull' their perception;

- Remember that if the perpetrator goes through detox the risk to the victim can increase as episodes of violence and increased control can escalate;

- Be aware that 1 in 4 suicide attempts by women are thought to be domestic abuse-related

See the Stella Project at www.avaproject.org.uk .

12.7.14. Older age

Some older women can and do make active choices to leave situations of domestic abuse. However, some older people may feel less able to access services; they may be less aware than younger people of the services and options available to them, particularly if they have been isolated due to abuse. They may believe that services are only for younger people, or people with children or have experience of domestic abuse support services that are focused on the needs of younger women and their children which are not “older woman” friendly.

Older women with no formal education, experience of work outside the home or economic resources such as a pension of their own or being named as a home owner or tenants are more

financially dependent on abusive partners than many younger women. Older women may have suffered abuse for many years in a long-standing relationship and may fear living alone and unable to make decisions for themselves, or they may feel shame or embarrassment from years of accepting abuse without apparent complaint.

It can be extremely difficult for some older people to accept help. The 'self-help' model familiar to younger people, and the possibility of calling a stranger to discuss personal or family problems may also be unfamiliar to them. They may need more time, more reassurance and more confidence in what might happen and the services available, before they disclose abuse and accept help to move forward. In other situations older women report “leaping” at the opportunity to be safe once they discover they are believed and that help is available.

Assumptions about age can mean that when older people are seen to be injured, unhappy, depressed or have other difficulties, these are presumed to be the result of health or social care needs. This can mean that signs of domestic abuse are missed. Professionals should take great care to assess older people in a person centred way, asking open questions and enabling the person to identify their needs and the reasons for them. It is important to avoid judgements based on stereotypical expectations of the needs of older people and the services they require.

12.7.15. Mental ill-health

Domestic abuse can have an enormous effect on mental health. It is now well accepted that abuse (both in childhood and in adult life) is often the main factor in the development of depression, anxiety and other mental health disorders, and may lead to sleep disturbances, self-harm, suicide and attempted suicide, eating disorders and substance misuse.

- Abused women are at least three times more likely to experience depression or anxiety disorders than other women;

- One-third of all female suicide attempts and half of those by Black and ethnic minority women can be attributed to past or current experiences of domestic abuse;

- Women who use mental health services are much more likely to have experienced domestic abuse than women in the general population;

- 70% of women psychiatric in-patients and 80% of those in secure settings have histories of physical or sexual abuse.

Perpetrators may use mental ill-health against their victim for example, by:

- Saying the victim couldn't cope without them;
- Saying the victim is 'mad', and is “making it up”;
- Not allowing them to go anywhere alone because they are the 'carer';
- Speaking for the person: "You know you get confused/you're not very confident/you don't understand the issues";
- Telling them they're a bad mother and cannot look after the children properly;

- Forcing a woman to have an abortion because 'she couldn't cope';
- Threatening to take the children away;
- Threatening to "tell Social Services" - the implication being they will take the children away;
- Telling the children "Mummy can't look after you";
- Deliberately misleading or confusing the person;
- Withholding medication;
- Undermining you when you disclose the abuse or ask for help: "You can't believe her - she's mad".

These behaviours will almost certainly add to emotional distress and exacerbate any existing mental health issues

See Women's Aid http://www.womensaid.org.uk/domestic-violence-survivors-handbook

12.7.16. Carers who are at risk of abuse

The Care Act defines a carer as someone who:
'... provides or intends to provide care for another adult' (but not as a volunteer or contacted worker)

The local authority has a duty to assess a carers needs for support to maintain their well-being - **including protection from abuse.** Support to address domestic abuse should be offered if the carers if the abuse is causing their physical or mental health to deteriorate, or preventing them from caring for another adult.

Perpetrators of domestic abuse towards people who care for dependent adults may harm or threaten to harm the dependent adult as a way of controlling their victim. The carer may feel unable to leave or seek help for themselves due to fear of leaving the person they care for with the perpetrator or fear of being unable to care for them on their own.

Some people with care and support needs are intentionally abusive to their carers. However, others may not have capacity to choose not to be abusive e.g. if their disability causes abusive behaviour. For example; this happens to some people with dementia.

Support should be offered to carers if their health or safety is at risk whilst they are providing care to another adult and the full range of domestic abuse services offered including contact with the police. If the carer is at high risk the MARAC and local safeguarding procedures should be followed.

12.7.17. Exposure to an abusive environment

Disabled adults who live in a household where domestic abuse is taking place may be directly harmed and may experience distress and mental health issues as a result of witnessing abuse of their carer or other family members that they are unable to prevent; for example, adults with a learning disability living in the family home where another family member is the primary victim. It is important to recognise that such exposure to abuse can present serious short- and long-term harm.

12.7.18. Forced marriage

Forced marriage is a crime. It is a form of domestic abuse and where it affects people with disabilities it is an abuse of an adult at risk.

There is a clear distinction between a forced marriage and an arranged marriage. In arranged marriages, the family of both spouses take a leading role in arranging the marriage but the decision to accept the arrangement or not remains with the prospective spouses. In forced marriage, one or both spouses do not, or through lack of mental capacity cannot, consent to the marriage. This is the case if a person's disability prevents them from giving informed consent to a marriage.
In 2013 97 of the 1013 (9.6%) of cases known to the Forced marriage Unit concerned a disabled person.

It is important to recognise that Forced marriage situations can involve the person being at risk from a number of people in the family/community. So called "Honour based violence"

For example, serious injury or death may be threatened or perpetrated against someone who does not co-operate with the marriage or their family. Disclosures of potential forced marriage must be taken seriously. Advice on safety planning and practice guidance can be gained from the Home Office's Forced Marriage Unit www.gov.uk/stop-forced-marriage The Home Office also publishes "Forced Marriage and Learning Disabilities: Multi-agency Practice Guidelines"

12.7.19. Other domestic abuse within families

Physical and sexual abuse towards parents and other relatives (e.g. grandparents, aunts, uncles) can be carried out by adults and by young people and children, some of which can cause serious harm or death. The UK prevalence study on elder abuse identified younger adults (rather than the person's partner) as the main perpetrators of financial abuse.

In some situations abuse and neglect may be unintentional or as a result of "carers stress". However, the assumption should be that any form of abuse can cause serious harm. A person centred approach to the adult at risk/victim will enable professionals to identify when abuse is unintentional and therefore when it may be stopped through, for example, support to the perpetrator (see working with perpetrators below)

Abuse within families reflects a diverse range of relationships and power dynamics which may affect the causes and impact of abuse. These can challenge professionals to work across multi-disciplinary boundaries in order to protect all those at risk.

Adults with the capacity to do so are expected to report situations where a child or a vulnerable adult is experiencing serious abuse or harm. Not to do so is a crime.

12.7.20. Mental capacity, adult safeguarding and domestic abuse

12.7.21. Mental capacity to take decisions

Some victims of domestic abuse may lack capacity to take certain decisions for themselves, and will need additional help to support and empower them to take decisions within a legal framework, using the provisions of the Mental Capacity Act 2005. (see **section 3.3.2, 3.3.3 and 12.5** on Mental Capacity).

Decisions taken with and on behalf of adults who need safeguarding because of domestic abuse may be serious and have far-reaching consequences; for example, leaving a family home or being restricted from contact with the perpetrator and other family members. People must be involved to the maximum degree possible in making plans about their own well-being, including their protection from abuse or neglect. The Care Act (2014) says that an independent advocate **must** be engaged if a person's needs mean they may have difficulty taking part in such decisions.

12.7.22. An unwise decision or a decision taken under duress?

Assessing capacity can be particularly challenging in domestic abuse situations, where the person is cared for by, or lives with a family member or intimate partner and is seen to be making decisions which put/keep themselves in danger.

Skilled assessment and intervention is required to judge whether such decisions should be described as 'unwise decisions' which the person has capacity to make, or decisions that are not made freely, due to coercion and control. For example, a decision to continue to live with an abusive partner might be a free and informed decision based on a full appreciation of the risks and the alternative courses of action, including support available. However, a victim may also be caught in the "Stockholm syndrome", a psychological defence mechanism that creates attachment to a perpetrator as a cognitive strategy for staying safe. A decision not to leave may also be based on a realistic fear of the behaviour the perpetrator has threatened if the victim were to disclose abuse or try to leave the relationship. Research shows that women are at most risk of serious harm from the perpetrator when they are leaving the abusive relationship.

Recent case law has clarified that there is scope for councils (using the principle of inherent jurisdiction) to commence proceedings in the High Court to safeguard people who do not lack capacity but whose ability to make decisions has been compromised because of constraints in their circumstances, coercion or undue influence.(seewww.bailii.org/ew/cases/EWCA/Civ/2012/253.html)

It is also important to remember that a principle of the Mental Capacity act is that a person only has full capacity **IF** they have access to all the relevant information about the decision they are making – in this case the decision/s about what, if anything, to do about the risk of abuse they are facing. . This means that the person at risk must be given and have time to understand accessible information about the options open to them. This should include specialist domestic abuse services such as Sanctuary schemes and places of safety as well as legal options such as restraining orders and knowledge of actions that the police can take such as Domestic Violence Protection Orders.

Creating a relationship within which a victim feels safe to discuss the detail of the coercion they face can take time. Advocates are an additional resource that can be used to support people faced with such decisions. Specialist advocates (IDVA's) are available to support people at high risk from domestic abuse. The Care Act (2014) mandates the use of advocates for anyone who has difficulty making decisions about how their health and care needs should be met.

If a professionals decide on limited information and time spent with someone that the person is making a "free", capacitated, unwise decision to stay in an abusive situation when this is not the case the victim may feel blamed for the abuse.

It is important that all victims are given information about their options whether or not they appear to want to use them at this time or not. People may also return to an abusive situation even after they have chosen to leave. The barriers that prevent people leaving abusive situations are also important in deciding to return. Staying or returning to abusive situations should be understood in that context. In such a situation the person is an adult at risk and a safeguarding plan should include safety planning with them to minimise risks and ensure they have clear options for leaving again if that is their choice. A new DASH risk assessment should be carried out a referral made to MARAC if the risk is high.

12.7.23. People who lack capacity

When a person is assessed as lacking capacity to make decisions about keeping themselves safe from domestic abuse then any decision made by professionals for, or on behalf of, that person must be made in their best interests.

The involvement of an independent mental capacity advocate (IMCA) should be considered in all circumstances where a person does not have mental capacity to make decisions about their protection, especially where this could involve a permanent change of accommodation. Consideration should also be given to whether the proposed changes mean that the person is likely to be deprived of their liberty and an application for a Deprivation of Liberty Safeguard (DoLs) made if that is the case.

Independent mental capacity advocates (IMCAs) are a statutory safeguard for people who lack capacity to make important decisions, and who do not have friends and family to represent them. However, in safeguarding adults cases, access to IMCAs is not restricted. People who lack capacity and who do have family and friends are still entitled to have an IMCA to support them in adult protection procedures if the decision-maker is satisfied that having an IMCA will benefit the person. IMCAs can represent the person in discussions about important decisions which may arise during safeguarding and domestic abuse interventions, such as where they should live, who they should live with and what treatment they should receive.

It is important that IMCAs themselves should be able to feel safe, confident and well-supported when dealing with the complexities of domestic abuse, so that they can give the best support to their client in a challenging situation. As not all IMCAs have had training around domestic abuse, the use of an IMCA does not preclude joint working with another specialist advocate such as an Independent Domestic Violence Advisor (IDVA).

For more guidance about mental capacity see:

www.scie.org.uk/publications/mca/index.asp for SCIE practice guides and links to other sources of information.

The Code of Practice together with comprehensive advice on the Act can be found at: www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

12.7.24. Making safe enquiries, safety planning and making defensible decisions

The Care Act (2014) creates **a duty on adult social care** to ensure that enquiries are made in any circumstance where an adult with health and are needs may be at risk from abuse (safeguarding enquires).

A "Safe enquiry" means making sure the potential perpetrator is not and will not easily become aware of your enquiry.

Safe enquiry has been developed as a corner stone of best practice in relation to Domestic Abuse. The practice has been developed following circumstances in which women and their children have been placed at risk of serious harm (and homicide) due to perpetrators becoming aware that professionals knew about their behaviour.

Research has shown that incidence of violence and levels of harm increase when a perpetrators control is being challenged. It is very important that the perpetrator does not learn about any disclosure or plans being made by the person at risk by accident or without the knowledge of the person at risk, unless there are very exceptional circumstances.

Safe enquiry is vital if the person at risk is to feel safe enough to disclose information about their experiences. They hold the knowledge of the perpetrator and patterns of their abusive behaviour. They play a crucial role in enabling the risk they face being accurately assessed and safety planning being detailed and effective.

It is vital that practitioners working with adults with health and social care needs facing domestic abuse adopt this practice when carrying out any safeguarding enquiry. Safe enquiry should be the default practice until any time a risk assessment carried out with the person who may be at risk, establishes that it is not needed.

12.7.25. Making Safe Enquiries

- **Ensure privacy for the person at risk** before enquiring into possible abuse - never assume that any other person is "safe": never ask in front of a partner, friend or child;
- Make sure that you can't be interrupted, and that you - and the person - have sufficient time;
- Only use professional interpreters and advocates;

- Document the person's response and use your organisations systems that alert others with a need to know about the risk;
- Ensure that **records** about domestic abuse are s**ecure and confidential**; for example, not in client / patient held records or organisational systems to which the perpetrator may have access;
- Ensure that every-one who has access to information about the person at risk knows to keep it confidential.

Risk assessment and safety planning

Safe enquiry must be supported by attention to risk and safety planning. People at risk will have limited confidence in a service where they can disclose risk but which does not help them to make decisions about their future safety.

Any risk of **serious harm or homicide or risk to a dependent adult or a child must be acted on**.

12.7.26. When abuse is disclosed or identified

- **Deal with any immediate need** for medical attention e.g. by calling an ambulance.
  If the person is taken to hospital follow through to ensure safety planning takes place during their admission and on discharge
- **Deal with any immediate need** for protection e.g. contact the police or specialist domestic abuse services. Use a council office or health centre as a place of safety if the person is willing to do so whilst other arrangements are made.
- **Establish the level of risk** posed to the individual, child or family from the information you have, using locally agreed processes including your own risk assessment and the CAADA-DASH (see chapter 8).

  - If there is a risk to a child follow your local safeguarding children
  - **If the risk is high take action** to alert the appropriate professionals and multi-agency pathways referring to MARAC and IDVA for all adult victims;
  - Follow your local safeguarding adults procedures
  - If you are making a referral explain the children/adult safeguarding procedures and the MARAC in a way that the person can understand (there may be helpful local leaflets or websites)
  - Involve an advocate if the person needs support to make their views and decisions known
  - Keep good records – they may be useful in legal action to help protect the person at risk and will support you in your professional decision making and in making referrals.

If the person is going to stay at/or return home support them to make **a safety plan**. Safety planning is supporting the person to plan how they are going to keep as safe as possible. It may include staying away from rooms when domestic abuse is likely to take place such as the kitchen. Safety planning also includes supporting the person (who may be adamant that they do not want to leave) to consider how they would they leave home if that becomes necessary to prevent serious harm to themselves or children/other adults at risk; this can include keeping important documents and some

clothing with a friend/in a secure location.

If you do not have the experience to do this get advice and help from a specialist domestic abuse agency, (see also 'The Survivors Handbook' www.womensaid.org.uk and www.mensadviceline.org.uk)

Ensure that if it is within your role you work actively with the person at risk to:

- Enable them to gain access to information about the options open to them to stop the abuse. For example, in relation to and specialist services and legal remedies;

- Enable them to understand the options available for care and support, housing, money and support planning;

- **Continue to review needs and risks**, remembering that the situation can escalate quickly.

If it is not within your role assure yourself that someone else has taken over this work before you complete your involvement.

Take care not to collude with or reinforce the thought patterns created by the abuse:

- Do not collude with the sense of responsibility that many victims of abuse have internalised about the abuse ('it's my fault because….')

- Where the perpetrator has capacity emphasise that most people who perpetrate abuse are able to take responsibility to choose to stop their abusive behaviour

12.7.27. Ensure that any decision that you make to refer or not to refer are defensible

Deciding to act, how to act or not to act in response to issues of risk is very challenging and is an area where professionals can be swayed by common cognitive errors such as "the garden path" (failure to give critical attention to new evidence) or "the rule of optimism" (minimisation of risks).

It is therefore important to continually test assumptions about risk and to test your decision making process. Professionals may not have all the information they need to make good decisions about the form and levels of risk in a situation and mistakes can be made. However, your practice can be upheld if your decisions are defensible. A defensible decision is one that balances considerations and professional judgements and which is made on the basis of seeking advice and support and:

- All reasonable steps have been taken to avoid harm;
- Reliable assessment methods have been used;
- Information has been collected and thoroughly evaluated;

- Decisions are recorded and subsequently carried out;
- Policies and procedures have been followed;
- Practitioners and their managers adopt an investigative approach and are proactive.

Your decisions must also:

- be **recorded** contemporaneously in a legible and approved system and format;
- specify the **rationale** behind the decision in relation to the circumstances, including references to relevant legislation and guidance;
- be **retained** with other records relating to the individual/organisation subject of the decision;
- be **'signed' and dated** by the person making the record; and
- the information is **shared appropriately** when others need to know.

12.7.28. Assessing and managing the risks of domestic abuse in safeguarding circumstances

An assessment of risk should take place in all situations where a person is an adult at risk because of domestic abuse.
Comprehensive, accurate and well-informed risk assessments are fundamental to good practice and good outcomes for people who need both adult safeguarding and domestic abuse services.

A thorough risk assessment enables practitioners to be confident about the interventions they are making and decisions to share information with other professionals as part of a multi-agency strategy. A risk assessment carried out with the person at risk is a useful tool for supporting them to recognise the risk they are facing.

In making professional judgements, practitioners should be mindful that there may be more than one person at risk, including any children, who may need to be referred to children's safeguarding services.

12.7.29. Involving the person at risk of Domestic Abuse

Involving the person at risk, and/or a professional advocate or IMCA (if the person lacks capacity), in the risk assessment, is the best and most effective way forward. An assessment carried out in this way is more likely to:

- end up with a much more accurate, comprehensive and better-evidenced risk assessment;

- give the person an opportunity and support to identify, describe and understand the risks for themselves keeping them central to the safeguarding process.

Professional skill and judgement is needed to engage anyone at risk from domestic abuse. Trust and confidence need to be built in order to counteract factors such as shame and coping mechanisms.

For example, victims may initially say that injuries were 'accidental' when they are not or minimise the impact of their injuries, e.g. "oh I'm used to it". If you lack experience in this area ask to work alongside an experienced worker such as an Independent Domestic Violence Advisor (IDVA).

If your professional judgement is that a person is at high risk, even if the person does not think/recognise they are then the "rule of safety" should prevail. In these circumstances make a "defensible decision" (see below) as to whether or not to refer the case to MARAC and/or the safeguarding adults' procedures.

Any risk assessment will benefit from information from other agencies. Where the adult has capacity to consent ask them if you can collect information from other agencies and use a consent for to record their decision. If the adult does not have capacity to consent then you can make a "best interest" decision as to whether or not to collect information relevant to the risk . Where the person is at **high risk information should be shared**/a referral made to MARAC **what-ever the views** of the person at risk.

Under 'Clare's Law', or the Domestic Violence Disclosure Scheme, a person who is experiencing domestic abuse has a 'right to ask' - this enables them to ask the police about a partner's previous history of domestic abuse or violent acts. Police can proactively disclose information about a previous perpetrator of domestic abuse to a current partner in prescribed circumstances.
See http://www.endthefear.co.uk/wp-content/uploads/2011/09/DVDS-leaflet.pdf?563068

12.7.30. Using risk assessment tools and exercising professional judgement

Risk indicator tools are associated with many safeguarding adults procedures and all areas have risk indicator tools to assess the level of risk in domestic abuse situations. Tools can aid judgement and decision-making about the level of risk to individuals and families, how they might be reduced or managed, how any identified needs should be met, and who by. Risk assessments, properly used, should lead to robust risk management that aims to protect and promote the safety and well-being of the people affected by the abuse.

The focus of the risk assessment process should be safety planning and supporting the person at risk, not on completing a form, or a "tick box exercise". It should draw on multiple forms of information and evidence about the perpetrators background and any antecedent incidents of domestic abuse and take into account of the woman's evidence, her level of fear, any coercive control and psychological abuse and any evidence collected.

It is important to remember that risk can be fluid and circumstance can change sometimes suddenly. Ensure that the safety plan includes a way of the person at risk letting professionals know if they think the risk level has increased.

Most areas now use the Domestic Abuse, Stalking and Honour Based Violence Risk Identification Check-list, known as the **DASH,** or a similar system, embedded in and referenced to their local procedures and protocols. As well as being used as a tool to identify and discuss risk, this tool is also used for professionals from any agency to refer high risk cases to the local **MARAC** (Multi Agency

Risk Assessment Conference). A MARAC referral should be made for any adult at serious risk of injury or death from domestic abuse.

The CAADA DASH-RIC is an evidence-based list of 24 questions about what factors are present in a domestic abuse situation, which is usually carried out with the victim; for example "Are you very frightened?", "Has (……) ever attempted to strangle/choke/suffocate/drown you?". CAADA state that an answer of yes to 14 or more of the questions indicates a serious risk of injury or harm. However, a score that is lower than that may reflect a situation where a victim is too scared to disclose some aspects of the abuse.

The exercise of professional judgement is essential when considering the points score from the DASH RIC (or similar systems), especially where it has resulted in a lower score than expected. Some practitioners have found this to be the case where the person experiencing domestic abuse is also an adult at risk. The DASH risk assessment is predisposed to assess risks for women with children and is known to have limitations for identification of the risk factors experienced by disabled and older people.

If the victim and professionals judgement is that the person is at high risk even though the DASH score is low then a referral to MARAC can still be made. Any risk factors identified that are not on the risk assessment tool can be added to the form at the end. For example; the abuse may cause greater harm due to the person's frailty or ill-health. A professional should always use their judgement to refer a case that they believe is high risk. However, CAADA also advise that even if the professional believes the person is not at high risk a MARAC referral should still be made if the risk tool indicate high risk. When a case is referred to MARAC the judgement of one professional can be tested against information held by other agencies

12.7.31. Multi-agency Risk Assessment Conferences (MARACs)

MARACs are regular meetings which take place in each local area, usually chaired by the Police, where statutory and voluntary sector partners work together to share and discuss the information known about the risks faced by high risk victims of domestic abuse.

MARAC meetings consider cases identified as 'high risk' by use of the DASH , and develop a coordinated safety plan to protect each victim. This can include recording the actions which are agreed for any children and adults at risk and perpetrators.

Membership of the MARAC is fixed and all members attend for all case discussions. Several (e.g. 15-20) cases may be considered at each MARAC. Case referral information is shared with all attendees prior to the meeting and each agency brings any information they have about the person at risk, any children at risk, the alleged perpetrator and other relevant information about the household. Agencies such as Fire and Rescue who collate information on a household basis are also able to contribute any relevant information.

The referral to MARAC is usually carried out with the consent of the victim. However, if that is not forthcoming or impossible to obtain then the MARAC will still consider cases of high risk without consent, with the justification of preventing serious harm.

12.7.32. MARAC and safeguarding procedures

When an adult with care and support needs is at **high risk** due to domestic abuse a referral must be made to both the safeguarding adults procedures and the MARAC, as both apply.

As safeguarding activity has the potential to duplicate that of the it is important that local protocols indicate how to operate the safeguarding procedures side by side with the MARAC.

Some of the advantages and disadvantages of each process that need to be taken into account in resolving these issues for local procedures or – in the absence of local agreement - for individual cases are:

- The MARAC addresses high risk case only. Referrals can be made to the safeguarding adults procedures from the MARAC meeting and/or if the referral is found not to be "high risk" (e.g. after at IDVA has visited);

- Safeguarding adults procedures apply to all levels of risk and can refer to the MARAC if the risk is found to be high;

- Referral to MARAC results in a referral to an Independent Domestic Violence Advisor (see below);

- MARAC is not usually an effective mechanism for immediate response to a crisis, but some areas have a mechanism for calling an emergency meeting to discuss a particular case;

- The MARAC information sharing protocol ensures that all MARAC agencies are contacted and share any relevant information. There is no need to have prior knowledge of their involvement in the case. The outcome is a more informed safeguarding plan;

- Safeguarding adult's strategy discussions/ meetings – which include agreeing an immediate protection plans take place on a case by case basis;

- Safeguarding adult's strategy discussions/ meetings often involve only the agencies that are known to have contact with the adult plus the police. Some of the key partner agencies (e.g. private care agencies) may not be partners to the MARAC;

- Safeguarding plan meetings/case conferences discuss the safeguarding plan in detail and designate a professional to co-ordinate multi-agency working. There is a mechanism for reviewing the plan;

- MARAC meetings can discuss 15-20 cases in a day long meeting. Each situation is discussed for a short period of time and it is assumed that agencies will carry out any actions they agree. The IDVA often co-ordinates multi-agency working through advocating for actions a greed to be carried out;

- The person at risk is not present at the MARAC meeting and MARAC's do not monitor the detailed implementation of the protection/safeguarding plan. The adult at risk from

domestic abuse (or their representative if they do not have mental capacity to take part in the meeting) should always invited to the present at Safeguarding adults meetings;

- **Children's safeguarding procedures** should also be initiated if those are appropriate.

12.7.33. Common barriers and pitfalls that prevent effective risk assessment and management

All agencies should be mindful of these barriers to professionals providing effective protection to those experiencing domestic abuse. Some of the most common barriers to effective risk management and therefore to the prevention of serious harm are:

1. Myths, stereotypes and flawed beliefs that are held true by professionals about the nature of domestic abuse, why it occurs and why victims remain in abusive relationships.

   Domestic Homicide reviews illustrate that this is often the biggest barrier to effective risk assessment and management. This needs to be tackled as a priority for any service, through effective staff supervision and training,.

2. Not involving the victim/adult at risk in all stages of risk assessment and management:

   - The principles of person centred working and empowerment are central to accurate identification of the nature of the abuse they are experiencing and the risks they face.

   - The victim will have detailed knowledge of the abusive behaviour and risk factors

   - Research demonstrates that risk assessment and management is consistently more effective when undertaken collaboratively with the person experiencing the abuse.

3. Unintended collusion with the perpetrator. This can take many forms but common examples include:
   - The victim is not seen as credible and their account of their circumstances are seen as inaccurate or embellished, for example due to the extreme (and “unbelievable”) nature of the abuse or the appearance/ behaviour of the victim, or because they do not give a logical and ordered account of what has happened;

   - Professionals / agencies view the victim as being responsible for the abuse. This can happen where the victim presents as angry with professionals rather than as a passive “victim”, misuses substances or has mental health problems; especially if the perpetrator presents as rational and appears to co-operate with professionals;

   - Agencies place all the responsibility for protecting others in the household e.g. children and dependent adults on the victim and not on the perpetrator;

- Apparent/carer's ability to protect children, or adults with care and support needs, is seriously impaired by the effects of abuse. Supporting a parent/carer to increase their ability to protect others must involve measures to stop the abuser as well as support to the parent/carer to decrease the risk to themselves;

- The perpetrator makes counter allegations of abuse. Professionals should work to ensure that everyone is safe. Safe Enquiry should be used with each/every potential victim and risk assessments made without breach of confidentiality to the other adult , involving other professionals such as Domestic abuse specialist agencies and the Police if appropriate;

- Perpetrators use their professional status, vulnerability, manipulation or 'charm' to avoid detection or being held to account.

4. Not asking children or adults with care and support needs about how the abuse is affecting them.
    - Serious Case Reviews into death or serious injury indicate that professionals have sometimes failed to establish the perspective of the children or of any adults with care and support needs, on the situation. This limits information about what is happening which would inform the risk assessment and also prevents recognition of the impact of the abuse on those children/adults;

    - Always consider "What is life like for this child or adult?" and – where safe – seek their perspective.

5. Not using or inappropriate use of assessment, referral and risk assessment forms:

    - It can be important for prosecution of the perpetrator that accurate records are kept in the locally agreed format at all stages of the case;

    - Used as tools these forms can help to inform the overall assessment of the level of risk posed and ensure that the case is managed effectively;

    - Using risk assessments forms as "paper work"/"administrative check lists" rather than as a tool to engage with the person at risk about what is happening to them.

    Used as the record of a focused conversation about risk DASH forms collated detailed information about the level of risk and its source and can also enable the victim to see what factors are placing them at high risk.

6. Not undertaking in-depth assessments that take full account of static risk factors (where this is part of your professional role):

- Advice from research highlights the importance of anchoring estimates of long-term likelihood of abuse reoccurring in a detailed consideration of static risk factors

Professionals required to undertake in-depth and on-going risk assessments, e.g. social workers, probation, CAFCASS officers, must recognise that risk indicator tools are no substitute for a thorough examination of static risk factors – including previous incidents, past behaviour, background and personal circumstances.

- Dynamic factors should be used to make moderate adjustments to risk assessments and aid intervention/treatment planning.– for example current attitudes and statements of the perpetrator, current drug or alcohol use, stress levels etc.

7. Not increasing support and protection at times of increased risk :

    - Research and Domestic Homicide reviews all indicate that separation (of the victim and perpetrator) is a key time of high risk to women and their children.

8. Challenging perpetrators on their behaviour or implementing zero tolerance policies **without fully gauging** how this can increase risks to the victim.

    Perpetrators should not be challenged except on the basis of a defensible decision making process in consultation with specialist domestic abuse professionals

9. Not ensuring safe contact arrangements are in place for children (whether mandated by court or informal)

10. Not recognising, or responding to, additional key risks posed to BME domestic abuse victims.

    - always use a professional interpreter
    - assess the social care needs of asylum seekers and refugees who are experiencing domestic abuse See http://www.scie.org.uk/publications/guides/guide37
    - support victims with insecure immigration status through their entitlement to health care, protection from the police and recourse to apply for a court order (injunction) to protect them from their abuser
    - seek help from specialist BME services for victims.

12.7.34. Domestic abuse support services and legal remedies

When an adult in need of safeguarding support is experiencing domestic abuse there are specialist support and protection services that they may want to use. Any victim of domestic abuse should be signposted to specialist domestic abuse support services regardless of their assessed level of risk but adults needing care and support may need assistance to do so and/or an intermediary .

Follow up from a risk assessment process should be supporting adults at risk to access specialist support services and ensuring their immediate and on-going safety as a key outcome.

Practitioners need to develop knowledge about the resources that are available for people locally. All councils and their partners should have a comprehensive and regularly updated directory of local and national resources available to their population. For good examples (although there are many others across the UK) go to: www.endthefear.co.uk (covers Greater Manchester and national resources).
Nationally, www.womensaid.org.uk has a directory of local services and professionals can call the National Domestic Violence Helpline (0808 2000 247, run in partnership by Women's Aid and Refuge) for advice or to make a referral to a local service.

Action on Elder Abuse's confidential Freephone helpline, provides information, advice and support to victims and others who are concerned about or have witnessed abuse. www.elderabuse.org.uk Practitioners should ensure they are aware of this information so that they are able to support adults at risk to access appropriate services.

12.7.35. Domestic Abuse Support Services

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12.7.36. Legal remedies

Social workers and other practitioners need:

- to be aware of the range of legal remedies and sanctions which may be available;
- to be able to provide accessible information about the options an adult at risk may have;
- know to involve the person / victim in getting good legal advice;
- know where to get expert advice, from the police or legal services with knowledge of safeguarding and domestic abuse.

For more detailed information about legal remedies for domestic abuse go to:

- www.womensaid.org.uk and look at the sections on criminal law and civil law; and
- www.ncdv.org.uk for legal advice and support

A useful reference point for practitioners, who need more information about legal sanctions and remedies in the context of adult safeguarding, is:

SCIE Report number 50 "*Safeguarding adults at risk of harm: A legal guide for practitioners"*, by Michael Mandelstam. (www.scie.org.uk/publications/reports/report50.pdf)

12.7.37. Working with perpetrators of domestic abuse

Research has demonstrated that the majority of perpetrators of domestic abuse are men and that men are more likely to inflict serious injury including homicide. However, some women can and do perpetrate domestic abuse.

Little is known about disabled men's experience of domestic abuse by men or women, or about disabled women's experience of abuse from other women e.g. partners or carers.

The interventions that are most successful in stopping domestic abuse work from the assumption that abusive men intentionally use their behaviour to control intimate partners and family members. Research has also demonstrated that arrest can work in reducing some repeat offending for some men. Injunctions or restraining orders can prevent some perpetrators from continuing harassment or abuse.

Risk can be decreased by professionally run specialist group programmes that support perpetrators to understand and choose to change their behaviour. Probation intervention programmes are available to men who have been sentenced in a criminal court. Voluntary programmes may also be available to men who do not have a court sentence but who wish to address their behaviour. Such interventions include assessment and group work on factors directly linked to domestic abuse. They require the perpetrator to engage in the program and be honest about the abuse they perpetrate.

Domestic Homicide reviews and Serious case reviews about children killed by men perpetrating domestic abuse to their mothers often demonstrate the vital importance of accurate risk assessment using objective criteria and of **ALWAYS** checking that decreases in violence reported by the man is born out in reality by his partner and that he has not replaced physical aggression with more subtle means of coercion and control.

Specialist training should be undertaken before assessing perpetrators of domestic abuse or providing interventions to address abusive behaviour. Practitioners without that skill base should focus their interventions on the safety of adult victims and children, and signpost perpetrators to specialist services.

It is important to note that perpetrators of domestic abuse should not be offered or referred to anger management or generic counselling to address their behaviour. Community or family conferencing and mediation between partners are also never appropriate where domestic abuse is a factor as these interventions can increase the risks to the victims of domestic abuse.
More information about research and working with perpetrators can be found by going to:

www.respect.uk.net and looking at the 'research' pages; and
www.avaproject.org.uk and looking at their projects, especially the Stella project.

12.7.38. Perpetrators with care and support needs

It is important to recognise that some adults with care and support needs can themselves be perpetrators of domestic abuse and that this can often be hidden or go unrecognised by family members or professionals. The abuse may have been present for many years and an abuser's disability, mental health, drug or alcohol misuse and/or vulnerability may have been used as an excuse for their behaviour, even in situations where they have capacity to choose to control their actions.

It is still crucial that the safety of the victim and any other family members is prioritised at all times.

Whether the abuse is deliberately perpetrated or not, carers and family members should not have to tolerate the impact of violence on their own well-being. Professionals should make it clear to the victim (as in all cases of abuse) that the abuse is not their fault and that they have a right to be protected and consider what their options.

The principles of safe enquiry and victim centred risk assessment are the same what-ever the cause or motivation for the abuse. Any situation with an adult at risk must be managed in line with local multi-agency safeguarding and MARAC procedures. It is crucial to identify and manage the risks posed to the victim and to any others exposed to the abuse and to ensure that any interventions made to prevent further harm have the intended outcome.

Professionals should respond to any disclosure by a person about their own abusive behaviour with clear statements that the behaviour is not acceptable and needs to change. This information should either trigger or add to the risk assessment and safety planning.

Where the perpetrator has care and support needs it is best practice for these to be assessed and provided for **separately** to services for the adult at risk – for example the person's carer or partner. However, professionals working with an abusive person MUST share information relevant to the safety of others with those co-ordinating the safety plan for the victim/s.

As with other perpetrators, only specialists in the field of domestic abuse should attempt any behavioural work.

12.7.39. Mental ill health

Most people with mental ill-health do not behave abusively. If someone is random or unpredictable in whom they are abusive to, for example, members of the public and people at work or in the community, then their poor mental health may be causing their behaviour. However, if the abuse is directed towards one person, in a careful and planned way that leaves the victim feeling controlled and powerless then we should reasonably conclude that the person is making a choice to behave in that way (Manchester Working Together).

12.7.40. Drug and alcohol misuse

It is important to recognise that alcohol and / or drug use do not cause domestic abuse. The vast majority of people who misuse substances are not perpetrators of domestic abuse. However, for those that are, the incidence or severity of abuse, particularly physical abuse, may increase with substance misuse. However, in other instances drugs and alcohol use may debilitate the abuser, decreasing the risk of abuse.

Perpetrators who misuse substances will often evade taking any responsibility for their behaviour and it is crucial that professionals do not collude by accepting their substance misuse as a valid excuse. Interventions often work best when substance misuse and abusive behaviour are both addressed.

It is important, however, to remember that in some cases risk to the victim can increase and episodes of violence and increased control may escalate when a perpetrator goes through detox.

12.7.41. Abuse from carers

Perpetrators of domestic abuse towards people with care and support needs will often have the same motivations for control as in other domestic abuse situations. Effective interventions with them to stop their abusive behaviour will therefore be the same as those described above.

The crime of wilful neglect covers the deliberate neglect by a carer of a mentally incapacitated adult. The Domestic Violence Crime and Victims Act (2004)includes the crime of causing or allowing the death of a child or vulnerable adult and this may be relevant to carers who do not ensure that a person in their household gets help to prevent serious harm .

However, some safeguarding and/or domestic abuse referrals are judged to be a result of carer stress and may arise from lack of coping skills or unmet needs. Where that is the case effective intervention to reduce the stress may prevent further harm. In these situations Adult Social Care has a duty to assess the needs of the adult and the carer. This does not exclude action from other agencies, including police or MARAC action.

ADASS (2011) draws a distinction between **intentional harm and unintentional harm.**

Whatever the motivation the key concern is the impact of the abuse or neglect on the adult at risk and safeguarding work must focus on preventing harm to that person. A person centred approach to safeguarding, involving the person at risk in planning and assessing the outcomes of interventions aimed at securing their safety is key to maintaining that focus.

In general families and carers make an invaluable contribution to society and support of carers is integral to the Care Act (2014). However, practitioners should be aware of and vigilant against the potential of 'the rule of optimism', when professionals may place undue confidence in the capacity of families to care effectively and safely, affecting professional perceptions and recognition of risk of harm, abuse or neglect.

This may arise from:

- generalised assumptions about “carers”;
- uncritical efforts to see the best;
- concerns about consequences of intervention;
- minimising concerns;
- not seeing emerging patterns;
- not ensuring a consistent focus on the person at risk.

If the 'rule of optimism' prevails, situations where there is harmful intent on the part of the carer or where unintentional harm is having a serious impact on the person’s well-being may not be recognised. Agencies that could protect the victim may then not be involved and serious harm can result. Such cases are the exception but they exist and have been identified through serious case reviews. If deliberate /reckless acts of harm or omission leading to neglect are suspected, safeguarding procedures and police referral must always follow.

Routine use of the DASH-RIC, or similar, tool to assess the level of risk (with the person at risk if it is safe to do so) in all domestic abuse situations helps prevent the rule of optimism prevailing.

ADASS (Advice Note 2011) suggests that the risk of harmful behaviour, whether intended or not, tend to be greater where the carer’s well-being is at risk because they:

- have unmet or unrecognised needs of their own;
- are themselves vulnerable;
- have little insight or understanding of the person’s care and support needs;
- have unwillingly had to change his or her lifestyle;
- are not receiving practical and/or emotional support from other family members;
- are feeling emotionally and socially isolated, undervalued or stigmatised;
- have other responsibilities such as family or work;
- have no personal or private space or life outside the caring environment;
- have frequently requested help but problems have not been solved;
- are being abused by the person they are caring for;
- feel unappreciated by the person they are caring for or that they are being exploited by relatives or services.

Potential signposts to situations where abuse of carers is more likely, include those situations where relationships and/or communication are unsatisfactory and the person being cared for:

- has health and care needs that exceed the carer’s ability to meet them, especially where of some duration;
- does not consider the needs of the carer or family members;
- treats the carer with a lack of respect or courtesy;
- rejects help and support from outside; including breaks;
- refuses to be left alone by day or by night;
- has control over financial resources, property and living arrangements;
- engages in abusive, aggressive or frightening behaviours;
- has a history of substance misuse, unusual or offensive behaviours;
- does not understand their actions and their impact on the carer;

- is angry about their situation and seeks to punish others for it;
- has sought help or support but did not meet thresholds for this; and
- the caring situation is compounded by the impact of the nature and extent of emotional and/or social isolation of the carer or supported person.

(ADASS 2011)

12.8. Self-Neglect - Vulnerable Adults Risk Management Model (VARMM)

12.8.1. Introduction & Principles

This model provides a framework to support adults at risk, as defined by Care Act 2014.

It should be applied when an adult at risk with mental capacity makes choices that could result in serious harm injury or death.

The VARMM Risk Assessment and Management Tool is intended for use in the following circumstances (VARMM):

- Where an adult has capacity[3] to make the decision(s) that is creating significant concern for agencies about the adults safety and/or wellbeing (risk of serious injury/death) and the adult is making that decision of their own free will;

And

- Where there is no perpetrator – the risk arises from the individual's refusal to engage with services and/or self neglect in one or more areas of their lives;

And

- Where existing care management and health and social care involvement has failed to resolve the issues;

And

- Where the Risk Management Assessment Matrix score is 10 or above**;**

Or

- Where the Risk Management Assessment Matrix score is less than 10, but there is no coordinated multiagency response to the case and how risk is monitored (see exemplar).

1. There could be times when a person comes under the Mental Capacity Act whilst in VARMM. Their capacity may vary: for example due to excessive use of alcohol. At such times, when a person lacks capacity they come under the Mental Capacity Act and any decision involving risk of harm that cannot wait until they have regained capacity, must be taken immediately and be in their best interests.

12.8.2. Where the case meets the above criteria the VARMM strategy meeting should be held

12.8.3. Process

It is always best practice to inform the adult at risk that the VARMM process is being initiated; however the adult's refusal to engage with service may be a cause of concern. Referral into the VARMM safeguarding process should not therefore be delayed because it is impossible to engage with the individual. The adults consent should be sought, but a decision to initiate the process without consent may be justified if there are concerns that the adult is at risk of significant harm.

If at all possible the adult should be invited to VARMM meetings.

VARMM is a multi-agency process and can not be undertaken by one service in isolation. These complex cases can sometimes divide agencies, a multi agency approach will promote better understanding of each others roles and help to prevent any misunderstandings or conflicts.

The initial VARMM meeting (strategy discussion / meeting under safeguarding adults processes) should consider including individuals from:

- **Mental Health Services**
- **Drugs and Alcohol Services**
- **Adult Social Care**
- **Health Community or/and Hospital**
- **Police**
- **Housing Services**

*****This list is not exhaustive*****

12.8.4. Information Sharing

There is a duty placed on public agencies under the Human Rights Act (1998) to intervene to protect the rights of citizens. The organisation that you work for will also have a Code of Conduct that places a duty of care to service users upon you.

Individuals being considered within the VARMM process will have a pressing social need and as such any intervention, including information sharing must be either with their consent or under a duty of care, acting in their best interests or undertaken to secure a legitimate aim i.e. to prevent a crime or protect the public.

The information exchanged under this procedure will only be used for the purpose of protecting the individual from significant harm.

Wherever possible consent will be requested from the individual regarding the sharing of information, however, if this is not possible e.g. because of a refusal to engage, or if there is a refusal to give consent to information being shared, you will need to consider the possible implications for the individual and others of not sharing the information. The need to protect the individual or the wider public may outweigh an individual's right to confidentiality. Decisions to share information

about an individual under this procedure should be taken by the organisation and not a member of staff acting on their own. This should not however create a delay in the information being shared.

Wherever possible the individual should be informed of the need to share their information unless this would increase their risk of harm.

12.8.5. The initial VARMM meeting (strategy discussion / meeting)

The Initial VARMM Meeting should collate information from all agencies to ensure that all risk factors are considered and their consequences explored. The VARMM risk assessment and management tool must be completed in the meeting by the agency that initiated the process, and the meeting must agree a risk matrix score.

Scoring the risk
Using the risk matrix below a risk score can be calculated.

Service user risk
Low = harm that would be unlikely to require medical or criminal intervention (without a statement to the police) (1)

Medium = harm that would require medical or criminal intervention that may be substantiated without a complaint from the person (2)

High = harm that may result in permanent harm or death (3).

Likelihood of risk

Low	**Medium**	**High**
History of refusing services/interventions, will sometimes accept services on a short term basis. Does engage with some agencies for specific purposes – e.g. GP, housing etc **(Score - 3)**	History of refusing services and often refuses to talk to services about situation. Currently refusing to engage with key services relating to health or social care **(Score - 4)**	History of refusing services and interventions, currently refusing to engage with any services unless under duress –e.g court proceedings for rent arrears etc **(Score - 5)**

At this Initial VARMM Meeting the risk matrix score will be agreed.
Risk Matrix Score = Risk to service user x the Likelihood of the risk.
Where the matrix score is **10 or above, the VARMM process must be initiated**

Where the matrix score **is below 10**, **the following should be considered** to determine if VARMM is appropriate:

- Are agencies working together in a coordinated way with a shared understanding of each others roles and responsibilities to the vulnerable adult?

- Are agencies clear about the factors that would indicate that the risk is escalating and know what to do if this is the case?

If the answer is' No' to either of the above questions, the VARMM process should be initiated.

If the score is 9 or below, then entering the VARMM process is a multi-agency decision made at the initial meeting.

If the case enters the VARMM process **the safeguarding lead** will coordinate the multi-agency plan and ensure that the VARMM review timescale is adhered to.

If the case is not progressed within VARMM, the meeting must agree multi-agency complex case management and monitoring arrangements, and identify a clear pathway back into VARMM should the situation deteriorate as well as clarifying what factors would constitute deterioration/increase in risk.

12.8.6. Reporting and recording

It is essential that all agencies involved once a case enters the VARMM process, should notify their Senior Managers within 24 hours of this decision being made.

This will ensure that senior managers are aware and can support workers with high risk cases that may result in attendance in coroner's court, challenges in the press etc. and assess any organisational risks.

The decision to enter the VARMM process should be recorded on the VARMM Notification Form (see attached) and uploaded to Framworki and shared with strategy discussion / meeting minutes for multi-agency partners.

Senior managers must be informed when a case leaves the VARMM process.

12.8.7. Using the Risk Assessment and Management Tool

It is essential in VARMM cases to:

- Show evidence of a decision specific capacity assessment involving the individual, demonstrating that the individual has capacity to make the decision giving rise to the concern;
- Demonstrate evidence of a robust risk assessment and risk management strategy;
- Maintain clear communication strategies between relevant workers, managers, organisations etc;
- Evidence clear recording mechanisms for each case;

The Risk Assessment and Management Tool will not replace professional judgment but aims to provide guidance around the issues and processes that will need to be considered in managing risk. An exemplar is available which identifies the type of case that would benefit from the VARMM process.

Managing risks

Once a VARMM Risk Management Plan (safeguarding protection plan) has been agreed at the Initial VARMM Meeting, a core group identified and safeguarding lead identified appointed to oversee it, multi-agency reviews should be held within the timescales below:

Total Matrix Score

3 - 9 – review within 50 working days of agreeing the Risk Management Plan
10 -15 – review within 25 working days of agreeing the Risk Management Plan.

12.8.8. Review process

The review should involve an actual meeting (under the reporting meeting for safeguarding) with all of the agencies involved with the VARMM Risk Management Plan to assess if:

- they have had any contact with the individual in the review period – if not, what attempts have been made to engage with the individual?
- the person has accepted any elements of the VARMM plan. If yes, what elements and how frequently?
- the risks have increased – detail what has changed and rescore matrix
- the risks have decreased – detail what has changed and rescore matrix

If the risks have increased and the contact decreased an actual meeting may be necessary.

The Reporting Meeting will revise the Risk Management Plan and set the next review date.

12.8.9. Exiting the VARMM process

- If/when the risk reduces and the VARMM Matrix score drops below 10, the VARMM process should be exited.

- **Unless** there are ongoing issues with multi-agency working.

At the point of exiting there should be:

- A clear record of how the situation is to be monitored when and by whom and

- A clear pathway back into VARMM should the situation deteriorate & clarity about what factors would constitute deterioration/ increase in risk (Exit Plan).

13. Appendices

Appendix A: Information required when making a safeguarding alert

Where possible, the alerter should 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 concern if different;
- name of organisation, if an 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(s), 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, that is, disability or illness;
- funding authority, if relevant;
- ethnic origin and religion;
- gender (including transgender and sexuality);
- communication needs of the adult at risk 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 referral and, if not, on what grounds the decision was made to refer;
- what is known of the person's mental capacity and their views about the abuse or neglect and 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 or neglect:

- 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 (or organisation) alleged to be causing 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 personal budget?
- 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?
- what details of any immediate plans have 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 at risk?

Appendix B: Safeguarding Adults Review (SAR) Referral Form

Referral for Case Review Sub Group
This form to be returned to safeguarding.adultsboard@blackpool.gov.uk Address: BSAB, PO Box 4, Blackpool, FY1 1NA (01253) 476931 All sections should be completed using the information held by the agency. This will be collated and presented to the Serious Case Review Sub- Group.

1. Adult's details			
Name		DOB	
DOD (if applicable)		Date of incident	
Gender		Age	
Ethnicity		Religion	
Relevant family - name, DOB, relationship		Relevant Family - name, DOB, relationship	
Address of Adult			
Address of death or incident			

2. Referral details

Date of referral	
Name of referrer	
Agency	
Address	
Telephone No	
Email	

3. Agencies you know to be involved

Agency/Professional	Name, address & telephone number	Date of first contact	Date of most recent contact

4. Your agency involvement with the adult

5. Please outline circumstances of the incident (also include if any other review is being undertaken as a result of this incident)

6. Please indicate whether you feel the grounds for a Safeguarding Adults Review have been met: 1) A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if— (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and (b) condition 1 or 2 is met. (2) Condition 1 is met if— (a) the adult has died, and (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died). (3) Condition 2 is met if— • (a) the adult is still alive, and • (b) the SAB knows or suspects that the adult has experienced serious abuse • or neglect. (4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

For completion by Case Review Subgroup Chair	
Date to be heard at Case Review Subgroup	
Further information required from	

Appendix C:VARMM Risk Assessment Tool

VARMM
Risk Management Tool
High Risk VARMM cases (Section 1 completed at the initial VARMM meeting, Section 2 at each review meeting, attendance sheet at EVERY VARMM meeting)

Section 1		
1. Name of Service user		
2. Frameworki/ NHS Number		
3. Date of Assessment		
4. Name(s) of workers/individuals involved in the risk assessment		
5. Current Risk factors	6. Relevant previous risk factors	Source of risk data – service user, workers, files etc

		Information verified as current and accurate?
7. Scoring the risk		
Service user risk – Low, Medium or High X Likelihood of Risk Calculation =		
Matrix Risk Score		
Is the case entering the VARMM Process	YES/ NO	
Rationale for the decision:		
Timescale for VARMM review/ meetings	Score 3-9 review within 50 working days Score 10-15 review within 25 working days	
Date of next Review Meeting		
Risk Management plan – please detail what actions will be taken, when, by whom, and what contingency plans have been agreed.		

Membership of core group	Contact details

End of section 1

Section 2
(Review)

To be completed at each review meeting (Virtual or Actual)	
Review Record – Detail below how the Risk Management Plan has been implemented.	
Contact with the individual? By whom, when, if not what attempts have	Have any elements of the VARMM Risk Management Plan been

been made?	implemented – detail
Have the risks increased – what has changed? What can be done to address this? At this point rescore risk	Have the risks decreased – what has changed? At this point rescore risk. **Can this now exit the VARMM process? Yes/ No**

Revised VARMM Risk Management Plan or Exit Plan: What actions have been agreed and who will carry them out?		
Action	Name of workers	Timescales

Date of next review	**Venue – if meeting**	
Organisational Risk score – high/medium/low. Who will notify the relevant service manager -		
Name of Service manager notified of the risks,	Contact details/ Telephone Number:	
Date Notified		

Attendance register

To be completed at the end of each VARMM meeting (Actual or Virtual)

Name	Contact Details	Signature

Appendix D: Carers & Adult Safeguarding (ADASS document)

This short review considers issues around carers and safeguarding adults.

http://static.carers.org/files/carers-and-safeguarding-document-june-2011-5730.p**df**

Appendix E Reportable Deaths – HM Coroner Blackpool & the Fylde

Reportable deaths: a death should be referred to HM Coroner if either:

- the cause of death is unknown
- it cannot readily be certified as being due to natural causes
- the deceased was not attended by the doctor during the last 14 days or viewed after death
- there are any suspicious circumstances or history of violence
- the death may be linked to an accident [whenever it occurred]
- there is any question of self-neglect or neglect by others which may have caused or contributed to the death
- the death occurred abroad [including Scotland and Northern Ireland]
- A Public Authority has been involved in the care of the deceased, particularly if :

  - the death has occurred or the illness arose during or shortly after detention in police or prison custody (including voluntary attendance at a police station and remand to a Bail Hostel)

  - the deceased was detained or was a voluntary patient under the Mental Health Act

- The death has occurred at a time when the Deceased was subject to a Deprivation of Liberty Order
- the death is linked with child birth or an abortion [but not a still born child]
- death of a Mother within 1 year of Child Birth (including stillbirth or spontaneous abortion)
- the death might have been contributed to by the actions of the deceased [such as a history of drug or solvent abuse, self injury or overdose]
- the death could be due to an industrial disease or related in any way to the deceased's current or previous employment
- the death of a child including a child

  - whose name is on the Child Protection Register of a Local Authority

  - who is being looked after by a Local Authority

  - who is subject to a Care Order

- to death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic

- the death may be related to a medical procedure or treatment whether invasive or not
- there is an actual or potential expression of concern about a patient's treatment, care or management
- the death occurs at a GP surgery
- there are any other unusual or disturbing features to the case the death
- the death occurs within 24 hours of admission to hospital [unless the admission was purely for terminal care]

[HM Coroner for Blackpool & Fylde, October 2014]

Appendix F: Considerations for referral into safeguarding adults process

Some of the examples to think about in each section could be categorised under a different type of abuse – they should still be considered, whatever category of abuse they are eventually recorded as.

Distinguishing between poor practice and abuse requires a level of analysis / thinking by those involved. Consider the implications of the harmful act for the adult at risk and the impact on that person; consider also whether you feel that the involvement of more than one organisation or agency is required to work with the individual to help them feel safer**.** Where it is agreed with the adult at risk or their representative and within your organisation that the practice has resulted in harm, a response using the safeguarding adults procedures will be indicated.

THINK*!*

Does it need more than my agency ***alone*** *to work with the service user around this issue or not?*

In coming to an answer, you consider the information below (this list is not exhaustive), where you identify numbers 3 or 4 on one occasion or more immediate action must be taken (safeguarding alert and other actions, depending on the circumstances of the incident). If you identify 4 or more numbers 1 or 2 a safeguarding alert would usually be indicated.

- Whether the abuse was a 'one off' event, or part of a longstanding relationship or pattern. Was it:
    1. An isolated incident
    2. recent abuse in an ongoing relationship
    3. repeated abuse

- The impact of the abuse on the alleged victim.
    1. short term (can be take in their stride) - does the individual understand why it happened and what they want to do about it?
    2. lasting distress or physical or emotional injury
    3. Had the potential to be life threatening or to create additional harm

- The impact of the abuse on other vulnerable adults or children.
    1. no-one else involved or witnessing abuse
    2. where it was witnessed are other service users disturbed or distressed about the abuse
    3. others are seriously intimidated or their environment affected

- The intent of the person allegedly responsible for the abuse.
    1. inadvertent or ill informed
    2. violent or serious unprofessional response to difficulties in caring
    3. planned and deliberately malicious
    4. resulting from a lack of training

- The illegality of the person alleged to have caused harm's actions.
    1. poor or bad practice but not illegal
    2. maybe against the law
    3. clearly a criminal offence

- The risk of the abuse being repeated against this alleged victim.
    1. very unlikely
    2. not if significant changes are made – for example training, supervision, respite or support
    3. very likely even if changes are made or more support provided

- The risk of the abuse being repeated against other vulnerable adults or children.
    1. no, very unlikely- you must also consider and document why you believe this to be the case.
    2. this person alleged to have caused harm or setting may change, but supervision or training needed
    3. this person alleged to have caused harm setting represents a threat to other vulnerable adults or children

The things to think about indicated below DO NOT represent a strict "threshold" they should give those making alerts and those considering referrals into the safeguarding adults process some prompt questions for more ambiguous cases.

Physical abuse

- *Assault*
- *hitting*
- *slapping*
- *pushing*
- *misuse of medication*
- *restraint*
- *female genital mutilation (FGM)*
- *inappropriate physical sanctions*

This could be in a care home or other provider, for example hospital trust, by an unpaid carer in the community, family member, spouse/partner, volunteer, neighbours, local residents, strangers or other adults at risk.

Things to think about which may be categorised as physical abuse:

Does the adult at risk have Inexplicable marks or lesions, fractures/injuries, cuts or grip marks found on more than one occasion?

Are there marks lesions, cuts caused by one person but to several service user?

Has inappropriate restraint been used?

Have food, drinks or aids to independence been withheld from one or more adult at risk?

Misuse of medication

Has the adult at risk not received prescribed medication as in the care plan (missed/wrong dose) on one occasion or multiple occasions?
What was the impact of this missed dose on the adult at risk? Even if no immediate harm has occurred, does this missed dose impact on them in other ways, does it affect their treatment plan or require additional tests or assessments to be undertaken?

If there are recurring missed medications or errors that affect one or more adult **and/or** result in harm this may be physical abuse of one individual or organisational abuse (dependent on the setting).

Is medication being used inappropriately, which is not consistent with the person's needs?

Has medication been deliberately administered incorrectly?
Is medication administered covertly and routinely without evidence or recording that it is in their best interests?

Is the delivery method unsafe i.e. insoluble tablets being secreted in solid foods

Repeated medication errors, **even if they result in no significant harm**, are a strong indicator of poor systems, staff supervision or training – this *may* be categorised as organisational abuse.

Moving and handling

Are moving and handling procedures not followed or staff not trained and competent to use the required equipment? Has a person been injured, or repeated incidents where safe moving and handling equipment and procedures are not used (correctly or at all), and (making this very likely to happen)?

If this a practice which is evident throughout a care home, hospital or by a specific care agency (rather than by just one member of staff), this *may* be categorised as organisational abuse.

Physical abuse between service users

The fact that the person alleged to have caused harm has a particular diagnosis or condition does not preclude the safeguarding adult procedures from being the appropriate response. If there are repeated incidents of physical abuse between (for example residents of a care home), consideration should be given to organisational factors which are making this repeated physical abuse more likely.

Domestic abuse

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional abuse,*
- *forced marriage*
- *honour based violence*

- Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse, by someone who is or has been an intimate partner or family member regardless of gender or sexuality;

- Age range for domestic abuse extends down to 16 years

Someone with care and support needs and is subject to domestic abuse may be experiencing:

- Someone preventing them from getting the things they need such as food, clothes, medication, glasses, hearing aids or medical care?

- Is care and support needed being with held?

- Is anyone preventing them from being with the people they want to be with?

- Is someone trying to force them to sign papers against their will?

- Is someone taking money or things belonging to them?

- Has someone fun of them or made them feel ashamed because of their disability?

- Has the adult at risk become accustomed to being dependent and being treated without respect and dignity – assuming abuse is normal and minimising its impact ;

- The adult at risk may be the carer of the abuser, and feel a sense of obligation to carry on and put up with the abuse;

- Older and disabled adults may be more physically vulnerable, more socially isolated and less able to escape, and the abuser may be constantly present;

- Shame and stigma; for example older adults who have put up with a lifetime of abuse may experience shame for having put up with it for so long;

Sexual abuse

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

Things to think about in relation to sexual abuse:

Sexual abuse between service users

> The fact that the person alleged to have caused harm has a particular diagnosis or condition does not preclude the safeguarding adult procedures from being the appropriate response. If there are repeated incidents of sexual abuse between (for example residents of a care home), consideration should be given to organisational factors which are making this repeated physical abuse more likely.

Someone in a position of trust may be engaging in an intimate or sexual relationship with an adult at risk – this may be a paid carer, personal assistant, housing officer.

Serial abusing in which the perpetrator seeks out and 'grooms' individuals.

Sexual abuse is usually thought of as the involvement of a person in a sexual activity to which they have not consented or which they do not truly comprehend. However, it must be remembered that to prevent a person from expressing their chosen sexuality may also threaten their human rights and may be considered to be a form of abuse.

Capacity and consent should be carefully considered in cases of sexual abuse, an individual's capacity to consent to a sexual act should be carefully explored.

Psychological abuse

- *emotional abuse*
- *threats of harm or abandonment*
- *deprivation of contact*
- *humiliation*
- *harassment*
- *cyber bullying*
- *blaming*
- *controlling,*
- *intimidation*
- *coercion*
- *verbal abuse*
- *isolation or unreasonable and unjustified withdrawal of services or supportive networks*

Things to think about relating to psychological abuse

Are residents in a setting feeling intimidated or bullied by members of staff and feeling frightened to talk about why? (This could be in a care home, sheltered housing or any other provider setting.

Is the treatment of an individual undermining dignity and damaging their esteem?

Is the adult's choice or opinion denied or left unrecognised?

Is the adult experiencing antisocial behaviour or bullying by friends, neighbours r strangers?

Is bullying occurring by one person, but with multiple victims?

Is the adult at risk being humiliated?

Is the adult at risk experiencing emotional blackmail?

Are there frequent or frightening verbal outbursts in the presence of or directed at the adult at risk?

It is also important to note that psychological abuse may also be linked to all other types of abuse – for example someone experiencing physical abuse may also be experiencing psychological abuse.

Financial or material abuse

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

Some of the indicators below can be explained by other causes or factors, however patterns or clusters of indicators may suggest that there is a problem.

Potential indicators of financial abuse include:

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

Has there been a failure to meet agreed contribution to cost of residential care by family member or attorney results in a failure to provide personal allowance and/or jeopardises placement. Concern can be evidenced that the family member is using the person money and resources for their own purposes.

There may be serial abusing in which the perpetrator seeks out and 'grooms' individuals.

Are there legal documents, such as powers of attorney which the adult didn't understand at the time he or she signed them?

Is there any evidence to suggest that the adult is being targeted by scammers, for example excessive post addressed to the individual?

An adult may be at increased risk of financial abuse or scams if they are experiencing:

- Isolation
- Loneliness
- Recent losses
- Lack of familiarity with financial matters

Modern slavery

- *slavery*
- *human trafficking*
- *forced labour and domestic servitude*

Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

Forced labour/debt bondage: Victims are forced to work to pay off debts that realistically they never will be able to. Low wages and increased debts mean not only that they cannot ever hope to pay off the loan, but the debt may be passed down to their children

Forced labour: Victims are forced to work against their will, often working very long hours for little or no pay in dire conditions under verbal or physical threats of violence to them or their families.

Sexual exploitation: Victims are forced to perform non-consensual or abusive sexual acts against their will, such as prostitution, escort work and pornography. Whilst women and children make up the majority of victims, men can also be affected. Adults are coerced often under the threat of force, or another penalty.

Criminal exploitation: Often controlled and maltreated, victims are forced into crimes such as cannabis cultivation or pick pocketing against their will.

Domestic servitude: Victims are forced to carry out housework and domestic chores in private households with little or no pay, restricted movement, very limited or no free time and minimal privacy often sleeping where they work.

Possible indicators of modern slavery include:

- **PHYSICAL APPEARANCE:** Victims may show signs of physical or psychological abuse, look malnourished or unkempt, or appear withdrawn
- **ISOLATION:** Victims may rarely be allowed to travel on their own, seem under the control, influence of others, rarely interact or appear unfamiliar with their neighbourhood or where they work
- **POOR LIVING CONDITIONS:** Victims may be living in dirty, cramped or overcrowded accommodation, and / or living and working at the same address
- **FEW OR NO PERSONAL EFFECTS:** Victims may have no identification documents, have few personal possessions and always wear the same clothes day in day out. What clothes they do wear may not be suitable for their work
- **RESTRICTED FREEDOM OF MOVEMENT:** Victims have little opportunity to move freely and may have had their travel documents retained, e.g. passports
- **UNUSUAL TRAVEL TIMES:** They may be dropped off / collected for work on a regular basis either very early or late at night.
- **RELUCTANT TO SEEK HELP:** Victims may avoid eye contact, appear frightened or hesitant to talk to strangers and fear law enforcers for many reasons, such as not knowing who to trust or where to get help, fear of deportation, fear of violence to them or their family.

Discriminatory abuse

- *forms of harassment, slurs or similar treatment; because of race, gender and gender identity, age, disability, sexual orientation or religion.*

Indicators of discriminatory abuse may include:

- There may be poor quality of care to certain groups of patients/clients
- A patient/client may prefer not to be cared for by certain member(s) of staff
- A member of staff/volunteer may seem to avoid caring for certain groups of patients/clients.
- Inappropriate remarks or comments
- Staff member/volunteer may seem to avoid caring for certain groups of patients/clients
- Inappropriate social contact or activity offered
- Lack of choice of appropriate food
- Minimal or no contact with relevant groups or organisations, etc.
- No individualised care plan or no reference in care plan to specialised needs

Organisational abuse

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

The prevalence of any types of abuse (or persistent and/or unaddressed) within an institutional setting may be characteristic of institutional abuse.

The adult at risk, in an institutional setting, may display any of the indicators mentioned in all forms of abuse described above and the formal setting displays signs such as :

- Collective failure of an organisation to provide appropriate and professional service despite the input of external professional agencies.
- Discrimination through wilful or unwitting prejudice, ignorance, thoughtlessness and stereotyping of individuals or groups
- Failure to ensure necessary safeguards to protect vulnerable adults and maintain good standards of care in accordance with individual needs, Failure to specify in a persons' plan how a significant need must be met. Inappropriate action or inaction related to these results in harm such as injury, choking etc.
- Staff positively arranging the care regime to satisfy their own needs rather than those of the residents or patients.
- Or there is a failure to address a need specified in the person's plan which has the potential to cause harm, including if it is a recurring event or is happening to more than one adult. If this practice is evident throughout the care home/hospital/care agency, and not just being perpetrated by one member of staff
- Inadequately trained, poorly supervised and unsupported staff
- An environment lacking clear communication pathways, accountability and a systematic approach to safe working practices where dignity and respect are viewed as paramount
- The wilful badness and mistreatment of residents by one or more key staff members goes unchallenged.
- no policies/protocols in place regarding assistance with continence needs
- Continual medication errors, even if they result in no significant harm, are a strong indicator of poor systems, staff compliance or training.
- Person does not receive recommended assistance to maintain mobility, or the person has a fall as a recurring event, or is happening to more than one adult.
- Person is injured, or common non use of moving and handling procedures make this very likely to happen.

- A person is locked in their room and the buzzer is disconnected. They are told they cannot leave and that their requests to leave will be declined or ignored. Unlawful Restraint/possible Deprivation of Liberty is occurring (e.g. cot sides, locked doors, medication, complete and effective control and supervision) and person has not been referred for a Deprivation of Liberty Safeguard assessment although this had been recommended. Best interest decisions have not been taken for a person or persons lacking mental capacity or recommendations have been ignored.

- Recurring event, or is happening to more than one person. Insults contain discriminatory, e.g. racist, homophobic abuse. The staff member has used digital technology to record torment or abuse.

- A significant level of violent incidents between adults living in care or health settings can be an indicator of poor staff attitude, training, risk assessment and risk management, or poor supervision and management of the service.

Neglect and acts of omission

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

A person may be suffering from neglect when their general wellbeing or development is impaired due to the negligence of another.

- Adult at risk is provided with an evidently inferior medical service or no service, and this is likely to be because of neglect on the part of the provider
- Person has not been formally assessed/advice not sought with respect to pressure area management, or plan not followed.
- Person does not receive, when they request it, the necessary help to get to the toilet to maintain continence, or have appropriate assistance such as changed incontinence pads - Recurring event, or is happening to more than one adult.
- The care home institutes a blanket policy of only allowing all residents two changes of incontinence pads per person per day.
- Person does not receive necessary help to have a drink/meal, person misses one dose of medication - If this is a common occurrence in the setting, or there are no policies/protocols in place regarding medication, assistance with eating or drinking
- Person does not receive scheduled domiciliary care visit(s) and no other contact is made to check on their well-being or calls are being missed to more than one adult at risk.
- Hospital discharge without adequate planning and harm occurs
- Partner, carer or family member refusing to access or provide medical, emotional or physical care, or are withholding the necessities of life, such as medication, adequate nutrition and heating

Self-neglect

- *neglecting to care for one's personal hygiene, health or surroundings*
- *behaviour such as hoarding*

It may be that the adult is self-harming or refusing services to the point of serious harm or risk of death.

Safeguarding adults (VARMM Model) in relation to self-neglect should be applied**:**

- Where an adult has capacity to make the decision(s) that is creating significant concern for agencies about the adults safety and/or wellbeing (risk of serious injury/death) and the adult is making that decision of their own free will; and
- Where there is no perpetrator – the risk arises from the individual's refusal to engage with services and/or self neglect in one or more areas of their lives; and
- Where existing care management and health and social care involvement has failed to resolve the issues, and
- Where the risk management matrix indicates it (see section 12.8 guidance).