

Multi-Agency Safeguarding Adults Policy and Procedures



Bournemouth, Dorset and Poole Adult Social Services

Dorset, Bournemouth and Poole NHS Trusts

Dorset Police

July 2011

If you suspect an adult at risk is being abused or neglected contact the following numbers:

Bournemouth Borough Council: 01202 454 979

The Borough of Poole: 01202 633 902

Dorset County Council: 01305 221 016

If you wish to discuss your concerns outside normal office hours you may contact the Out-of-Hours Service:
01202 657 279

If you think an adult may be at immediate risk or harm,
contact the Police: 999

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Foreword

Safeguarding Adults is everybody's business

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

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

The Local Authorities of Bournemouth, Dorset and Poole, the Dorset Police and NHS, together with partner agencies are committed to working together, both to promote safer communities, to prevent harm and abuse and also to deal well with suspected or actual incidents. It is our firm belief that adults at risk are best protected when procedures between statutory agencies are consistent across agencies and boundaries.

All employees and volunteers, in whatever setting or role, are in the frontline in preventing harm occurring and in taking action where concerns arise. The Policy & Procedures set out here are designed to explain simply and clearly how agencies and individuals must work together to protect adults at risk. The target audience is qualified and unqualified employees, volunteers, members of the public and anyone in contact with or caring for an adult who may be at risk of harm.

Much progress has already been made if we are to prevent and minimise the risk of harm to adults in need of community care or health support. However, more remains to be achieved. The aim is to consolidate experience and to improve the safeguarding of adults at risk throughout Bournemouth, Dorset & Poole. This should therefore be seen as a 'living' document, which will be reviewed annually, initially in September 2012.

jane Ashman

Jane Ashman, Independent Chair of the Dorset and Bournemouth & Poole Safeguarding Adults Board.

1. Policy

Aims

The Multi-Agency Safeguarding Adults Policy and Procedures represents the commitment of organisations in Bournemouth, Dorset & Poole to work together to safeguard adults at risk of harm.

The Policy & Procedures are for different agencies and individuals involved in safeguarding adults, including all employees and volunteers working in public, voluntary and private sector organisations, members of the public and anyone in contact with an adult who may be at risk of harm.

The procedures aim to make sure that:

- The needs and interests of adults at risk of harm are always respected and upheld.
- The human rights of adults at risk of harm are respected and upheld.
- The primary aim for all agencies shall be to prevent harm.
- A proportionate, timely, professional and ethical response is made to any adult at risk of harm.
- All decisions and actions are taken in line with the Mental Capacity Act 2005.

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

- Choice and control.
- Safety.
- Health.
- Quality of life.
- Dignity and respect.
- Rights and access to justice.

'Adult at risk of harm' or 'Adults at Risk' means the same as and replaces the term 'Vulnerable Adult' used in 'No Secrets' 2000. Either of these will be used through this document.

Statement of Government Policy on Adult Safeguarding issued 16 May 2011

The Government believes that Safeguarding is everybody's business with communities playing a part in preventing, detecting and reporting neglect and abuse.

According to the 'No Secrets' Government Guidance (DH, 2000), Local Authorities have the lead role in co-ordinating work to safeguard adults. However, the guidance recognizes that successful responses need multi-agency and multi-disciplinary working. Department of Health Statement of Government Policy 16/05/2011 confirms 'No Secrets' will remain as statutory guidance until at least 2013.

Principles and Values

The following statement of principles is for use by all agencies engaged in safeguarding adults work:

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

The work of the Safeguarding Adults Boards is also underpinned by other general sets of principles, standards or legislation to which all agencies agree to follow:

- Caldicott guidelines
- Human Rights Act 1998
- Data Protection Act 1998
- Safeguarding Adults: National Framework of Standards for good practice and outcomes in Adult Protection (ADASS 2005).

Commitment of all agencies working together

All agencies who are members of the Bournemouth, Dorset and Poole Safeguarding Adults Boards and other partner agencies who are signatories, have agreed to work to these policies and procedures, so that there is consistency in how adults at risk of harm are safeguarded from harm.

Individual organisations may have their own guidance. However, those which provide services under contract to the partner agencies are required to comply with these Policy & Procedures. These Procedures must also be used in conjunction with related procedures such as domestic abuse/violence, disciplinary procedures, health and safety and whistle-blowing etc.

Those who work as personal assistants to adults who may be at risk are advised to make themselves familiar with these Policy & Procedures

The Policy & Procedures commit organisations to:

- Work together to prevent and protect adults at risk of harm.
- Empower and support people to make their own choices.
- Respect confidentiality except where there is risk of serious harm to others.
- Accept the right to self-determination can involve risk and ensure that such risk is assessed, recognized and understood by all concerned.

- Seek to minimize risks through open discussion between the individual and agencies about the risks involved and offer appropriate help.
- Investigate actual or suspected harm and neglect.
- Support adults and provide a service to adults at risk who are experiencing harm, neglect and exploitation.

The responsibilities of organisations working together to safeguard adults are:

- Each partner agency has a clear, well publicised policy of Zero Tolerance of harm within the organisation.
- Everyone to whom this document applies needs to be aware that doing nothing is not an option. Employees have a duty to report in a timely way any concerns or suspicions that an adult at risk is being or is at risk of being harmed.
- Employees have a responsibility to ensure they understand their role and responsibilities in regard to these Policy & Procedures.
- All organisations to whom these Procedures apply are responsible for ensuring their employees and volunteers are appropriately trained in this policy and procedure.
- Actions taken under these Procedures do not affect the obligations on partner organisations to comply with statutory responsibilities, such as notification to regulatory authorities under the Health & Social Care Act 2008 or to comply with employment legislation.
- Organisations continue to have a duty of care to adults who purchase their own care independently or who have a personal budget.
- Partner organisations are required to comply with the Dorset Over-Arching Information-Sharing Protocol.
- All agencies and providers are required to co-operate with any investigation relating to an adult deemed to be at risk or where there are safeguarding concerns brought to the attention of the Local Authority or Police, regardless of whether the Local Authority or Health have a contract for the individual or individuals.

Please contact Bournemouth & Poole Safeguarding Adults Board Management Support Officer on 01202 261015 for:

Dorset Overarching Information Sharing Protocol Data Sharing Policy

Dorset Inter-Agency Policy on the Management of Service User Information (Confidentiality)

Working with Adults at Risk

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

Equalities Impact Assessment

Consideration has been given to the overall equality impact of changes to policy and procedure in respect of the 6 equality strands:

- people from different age groups
- disabled people
- people of different faiths or beliefs
- gender and trans-gender people
- black and minority ethnic people
- lesbian, gay or bi-sexual people

The impact of the changes to policy is not specific to any one group, the overall changes are expected to reduce the risk of harm to all adults at risk.

Structure of the Policy & Procedures

The priority of the organisations involved in developing this report is taking action to safeguard adults who are or maybe at risk of harm. This document is therefore in four main parts:

The **first part** outlines the policy underpinning the procedures.

The **second part** includes detailed definitions and information on related processes.

The **third part** outlines the procedures to identify and respond to suspected or actual harm of an adult at risk.

The **fourth part** contains roles and responsibilities, practice guidance and other information.

The **fifth part** contains glossary, acronyms and acknowledgements

2. Definitions

2.1 Definition of an adult at risk

The term 'adult at risk' has been used to replace 'vulnerable adult' and 'harm' will replace 'abuse,' as used throughout 'No Secrets'. However, this section gives some more detail as to what these terms can mean in practice.

An Adult at Risk is: an adult aged 18 years or over 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself from significant harm or exploitation' (No Secrets, DH, 2000). This definition is taken from the current Department of Health guidance to local Safeguarding partnerships. This Policy covers and applies to people who fund their own care and support and people who are funded by Continuing Health Care.

An adult at risk *may* therefore be a person who:

- Is frail due to age, ill health, physical disability or cognitive impairment.
 - Has a learning disability.
 - Has a physical disability and/ or a sensory impairment.
 - Has mental health needs including dementia or a personality disorder.
 - Has a long-term illness/ condition.
 - Misuses substances or alcohol.
 - Is a victim of domestic violence or abuse
 - Is a carer such as a paid or unpaid family member/ friend who provides personal assistance and care to adults and is subject to harm.
 - Is unable to demonstrate the capacity to make a decision and is in need of care and support.
 - Is aged 18+ and is continuing within the Special Education system.
- (This list is not exhaustive).

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

Wrongful application of the Local Authority eligibility criteria can confuse the decision about whether to pass an alert onto the referral stage for threshold decision making. FACS eligibility criteria for adult care services should not be used in making decisions in Safeguarding; the essential factor is whether the person meets the criteria for being an adult at risk.

This definition includes people who purchase all or part of their care services, as well as those who are publicly funded. It includes those who are eligible for assessment but have chosen not to apply, use or purchase services.

An adult at risk's vulnerability is determined by a range of interconnected factors including personal characteristics, factors associated with their situation or environment or social factors. Some of these are described below in **Table 2.1**:

Robust joint working arrangements and systems need to exist between Children and Adult Services for those young people where there are safeguarding issues, to ensure the transition is properly managed. This may apply to child protection, children in care, children with mental health issues or children who are disabled. Please see Section 4.20 & 4.21 for additional information and refer to the transition guidance in your agency.

The Policy & Procedures have also taken account of the South West Association of Directors of Adult Social Services (ADASS) Safeguarding Adults Threshold Guidance, 2011 and the Law Commission.

Table 2.1: Factors determining vulnerability

| | |
|---|---|
| Personal characteristics of the adult at risk that <u>increase</u> vulnerability may include: | Personal characteristics of the adult at risk that <u>decrease</u> vulnerability may include: |
| <ul style="list-style-type: none"> • Not having mental capacity to make own decisions about their own safety including fluctuating mental capacity associated with mental illness. • Communication difficulties. • Physical dependency – being dependent on others for personal care and activities of daily life. • Low self-esteem. • Experience of harm. • Childhood experience of abuse. | <ul style="list-style-type: none"> • Having mental capacity to make decisions about their own safety. • Good physical and mental health. • Having no communication difficulties or if so, having the right equipment/ support. • No physical dependency or if needing help, able to self-direct care. • Positive former life experiences. • Self-confidence and high self-esteem. |
| Social/ situational factors that increase the risk of harm may include: | Social/ situational factors that decrease the risk of harm may include: |
| <ul style="list-style-type: none"> • Being cared for in a care setting that is more or less dependent on others. • Not getting the right amount or the right kind of care that they need. • Isolation and social exclusion. • Stigma and discrimination. • Lack of access to information and support. • Being the focus of anti-social behaviour. • Being a victim of domestic violence or abuse | <ul style="list-style-type: none"> • Supportive family relationships. • Active social life and a circle of friends. • Able to participate in the wider community. • Good knowledge and access to the range of community facilities. • Remaining independent and active. • Access to sources of relevant information. • Ability to contact assistance if needed. |

2.2 Mental Capacity

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

This includes their ability:

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

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

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

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

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

Mental capacity is time–and–decision specific. This means that a person may be able to make some decisions but not others at a particular point in time. For example, a person may have the capacity to consent to a simple medical examination but not to major surgery. A person must receive all appropriate help and support to communicate their decision. Their ability to make a decision may also fluctuate over time. Record all Best Interest decisions.

See Section 4.24 for more information on the Mental Capacity Act.

2.2.1 Ill treatment and wilful neglect of an adult at risk who lacks capacity

An allegation of harm or neglect of an adult at risk who does not have the capacity to consent on issues about their own safety will always give rise to action under the Safeguarding Adults process and subsequent decisions made in their best interests in line with the Mental Capacity Act and Mental Capacity Act Code as outlined above. Section 44 of the Act makes it a specific criminal offence to wilfully ill treat or neglect a

person who lacks capacity by anyone who has responsibility for the care of that person (Code of Practice).

<http://webarchive.nationalarchives.gov.uk/http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf>

2.2.2 Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) 2007 are an amendment to the Mental Capacity Act (MCA) 2005 and the DoLS Code of Practice is a supplement to the overarching MCA Code of Practice. They provide a legal framework to protect those who may lack the capacity to consent to arrangements for their treatment and/or care and where levels of restriction or restraint used in delivering that treatment and /or care are so extensive as to be depriving the person of their liberty. The safeguards apply where that person's treatment and /or care is being delivered in a registered care home or hospital and has not been authorised under the Mental Health Act 1983.

A deprivation of liberty can be authorised by supervisory bodies, these are the Local Authority and the PCT. To obtain authorisation to deprive someone of their liberty, managing authorities (Registered Care Homes and Hospitals) have to apply for an authorisation if the managing authority believes it is in the individual's best interest.

The Care Quality Commission (CQC) has also issued guidance for providers of registered services on the Mental Capacity Act and DoLS. Reference should be made to the relevant local authority and health trust for procedures relating to DoLS.

See also section 4.24

2.2.3 Restraint

Unlawful or inappropriate use of restraint or physical interventions and/or deprivation of liberty is physical harm. There is a distinction to be drawn between restraint, restriction and deprivation of liberty. An assessment as to whether a person is being deprived of liberty will depend on the particular circumstances of the case, taking into account the degree of intensity, type of restriction, duration, the effect and the manner of the implementation of the measure in question. In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence. Someone is using restraint if they use force, or threaten to use force, to make someone do something they are resisting, or where a person's freedom of movement is restricted, whether they are resisting or not.

Restraint covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned does something, or does not do something they want to do, for example, the use of key pads to prevent people from going where they want from a closed environment. Appropriate use of restraint can be justified to prevent harm to a person who lacks capacity as long as it is a proportionate response to the likelihood and seriousness of the harm.

Providers of Health and social care must have in place internal operational procedures covering the use of physical interventions and restraint incorporating best practice guidance and the Mental Capacity Act Code and the Deprivation of Liberty Safeguards (DoLS) (see below).

2.2.4 Information Sharing

Safeguarding adult enquiries, investigations and conferences can only be successful in protecting adults at risk if professional employees share and exchange all relevant information. That information must be treated as confidential at all times between those who need to know it to safeguard adults. Employees will be bound by the ethical and statutory codes that cover confidentiality and data protection.

All agencies and providers are required to co-operate with any investigation relating to an adult deemed to be at risk or where there are safeguarding concerns brought to the attention of the Local Authority regardless of whether the Local Authority or Health have a contract for the individual or individuals.

All those providing information should take care to distinguish between fact, observation, allegation and opinion. It is important that, should any information exchange be challenged in respect of a breach of confidentiality or, for example, as a breach of the Human Rights Act, the information can be supported by evidence.

Concerns may arise within an agency as information comes to light about a person with whom the service is already in contact. Whilst professionals should seek in general to discuss any concerns with the individual and their carers and seek agreement to share the knowledge with other relevant agencies, this should not be done where such discussion and agreement-seeking will jeopardise the safety of the individual.

Information must be adequate, relevant and not excessive in relation to the purpose for which it is held and must be held no longer than is necessary for that purpose. For further guidance on Information Sharing, see Section 4.9 and Dorset Overarching Information Sharing Protocol.

Please contact Bournemouth & Poole Safeguarding Adults Board Management Support Officer on 01202 261015 for: Dorset Overarching Information Sharing Protocol – Data Sharing Policy

2.2.5 Consent

It is always essential in safeguarding to consider whether the adult at risk is capable of giving informed consent. Their views should be sought and recorded on each occasion.

This may be in relation to whether they give consent to:

- an activity that may be harmful – if consent to harm or neglect was given under duress, for example, as a result of exploitation, pressure, fear or intimidation, this apparent consent should be disregarded.
- a Safeguarding Adults investigation going ahead in response to a concern that has been raised. Where an adult at risk with capacity has made a decision that they do not want action to be taken and there are no public interest or vital interest

considerations, their wishes must be respected, provided that a risk assessment has been undertaken and recorded to demonstrate how the decision was reached. The person must be given information and have the opportunity to consider all the risks and fully understand the likely consequences of that decision over the short and long-term.

- the recommendations of an individual Safeguarding plan being put in place.
- a medical examination.
- an interview.
- certain decisions and actions taken during the Safeguarding Adults process with the person or with people who know about the harm caused and its impact on the adult at risk.

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

- There is a public interest, for example, not acting will put others or children at risk.
- There is a duty of care to intervene, for example, a crime has been or may be committed.
- *See also Section 4.23 and 4.23.1 for more information on responding when an adult is deemed to be at serious risk but declines support and services.*

Vital interest.

- If the adult at risk 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 under Safeguarding Adults procedures with relevant professional colleagues. This is to enable professionals to assess the risk of harm and to be confident that the adult at risk is not being unduly influenced 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 at risk that this action is being taken unless doing so would increase the risk of harm.

Best interest.

- If an adult at risk lacks capacity to make informed decisions about maintaining their safety and they do not want any action to be taken, professionals have a duty to act in their best interests under the Mental Capacity Act 2005. This would automatically trigger a Safeguarding Adults referral.

Public interest

- If the adult at risk has the mental capacity to make informed decisions about maintaining their safety and they do not want any action to be taken, practitioners have a duty to share the information with relevant professionals to prevent harm to others. This will automatically trigger a Safeguarding Adults referral.

Personal decisions

- The adult at risk will have views about what is an acceptable level of risk to them and about balancing the risks in order to maintain the lifestyle or contacts they wish. There may be a balance to be struck between the benefits of achieving safety and the loss of contact with someone whom they value.

- A person with mental capacity may choose to live in a situation which is seen as unsafe by professionals, if the alternatives they are being offered are unacceptable to them. They do not, however, have a right to make decisions about the protection other people may need where they may also be at risk from the same person, service or setting.
- Adults at risk need to be able to make informed choices from the information they are given. In order to do this they may need support in a variety of ways such as the help of a family member or friend (as long as they are not the person alleged to have caused the harm), an advocate or IMCA, a language interpreter or other communication assistance or aid.

2.3 Harm

For the purpose of the Multi-Agency Safeguarding Adults Policy & Procedures, the term harm is defined as:

...a violation of an individual's human and civil rights by any other person or persons, which results in significant harm (DH, 2000).

Harm may be:

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

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

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

Harm can take place anywhere in settings such as the person's own home, day or residential centres, supported housing, educational establishments, the workplace or in nursing homes, clinics or hospitals.

A number of harmful acts are crimes and informing the Police must be a key consideration.

2.3.1 Significant harm

In determining what justifies intervention and what sort of intervention is required, No Secrets uses the concept of 'significant harm' taken from the Law Commission, Who Decides? 1997. Harm should be taken to include:

- Ill treatment (including sexual harm and forms of ill treatment which are not physical).
- The impairment of, or an avoidable deterioration in physical or mental health and/ or

- The impairment of physical, intellectual, emotional, social or behavioural development.

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

Seriousness of harm or the extent of the harm is not always clear at the point of the alert or referral. All reports of suspicions or concerns should be approached with an open mind and could give rise to action under the Multi-Agency Safeguarding Adults Policy & Procedures.

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

- Vulnerability of the person.
- Nature and extent of the harm or neglect.
- Length of time the harm or neglect has been occurring.
- Impact of the alleged harm on the adult at risk.
- Risk of repeated or increasingly serious acts of harm or neglect.
- Risk that serious harm could result if no action was taken.
- Illegality of the act or acts.

Harm can be viewed in terms of the following categories:

(See *Table 2.2*)

- Physical
- Sexual
- Psychological/ emotional
- Financial and material
- Neglect and acts of omission
- Discriminatory
- Institutional

Any of the above, with the possible exception of Institutional Harm, may include domestic violence or abuse.

The definition of domestic violence adopted by the Bournemouth and Poole and Dorset domestic violence strategic groups is the Association of Chief Police Officers (ACPO) and Home Office definition 2004:

“any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 and over, who are or have been intimate partners or family members, regardless of gender and sexuality” (family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family)

It should be noted that domestic violence is defined by there being a close family or intimate relationship between the victim and the perpetrator not by where the abuse occurs. Domestic violence or abuse is typified by one person having power and control over another. The abuse generally increases in severity over time.

Please see Section 4.11 and 4.12 for more information on domestic violence and abuse and MARAC.

Many harmful behaviours may constitute a criminal offence. All suspected harm must receive a response and where appropriate a multi-agency investigation.

Who can be an abuser?

Anyone can be an abuser.

The following examples are not exclusive:

- Family members and relatives
- Neighbours, friends and associates
- Paid carers or volunteers
- Professional staff
- Strangers
- Other service users
- May be adult at risk if abuse is towards carer
- Self

Where could abuse happen?

It could happen anywhere.

The following examples are not exclusive:

- Adult at risk's own home
- Relative or friends home
- Residential or nursing home
- Day centre or support services
- Hospitals
- Public place
- Supported living scheme
- Educational establishment
- Person's place of employment

2.3.2 Abuse of Trust

This may apply in any of the categories.

A relationship of trust is one in which one person is in a position of *power or influence* over the other person because of their work or the nature of their activity. There is a particular concern when harm is caused by the actions or omissions of someone who is in a position of power or authority and who uses their position to the detriment of the health and well-being of a person at risk, who in many cases could be dependent on their care.

Where the person who is alleged to have caused harm is in a position of trust with the adult at risk, the adult at risk may be deterred from making a complaint or taking action out of a sense of loyalty, fear of abandonment or other repercussions.

Where the person who is alleged to have caused the harm or neglect has a position of trust with the adult at risk because they are a paid employee, a paid carer, a volunteer or a manager or proprietor of an establishment, the organisation will invoke its disciplinary procedures, as well as taking action under the Multi-Agency Safeguarding

Adults policy and procedures. If a crime is suspected a report must always be made to the police and referral must be made to the Independent Safeguarding Authority (ISA) if they have been found to have harmed or put at risk of harm an adult at risk.

If the person who is alleged to have caused the harm is a member of a recognized professional group, the organisation responsible for the employment will act under the relevant code of conduct for the profession, as well as taking action under this policy and procedures.

Where the person alleged to have caused the harm or neglect is a volunteer or a member of a community group, adult social care services will work with the relevant group to take action under these policy and procedures.

Where the person alleged to have caused the harm is a neighbour, a member of the public, a stranger or a person who deliberately targets adults at risk, in many cases the policy and procedures will be used to ensure that the adult at risk receives the services and support that they may need.

In all cases regard should be given to issues of consent, confidentiality and information sharing.

2.3.3 Self Neglect and Self Harm

Self-neglect and Self Harm do not generally come under the scope of these procedures. Practitioners should refer to other legislation and guidance (for example: Environmental Health, Mental Health Services, National Assistance Act 1948, Section 47 etc). Refer also to Part 4.23 for guidance on responding to cases of self neglect in certain cases where the adult is reluctant to engage with services.

Please see paragraphs:

4.13 Hate Crime

4.14 Honour based violence

4.15 Forced marriage

4.17 Human trafficking

4.18 Exploitation by radicalisers

4.19 Allegations against carers who are relatives or friends

4.20 Harm by children

4.21 Child protection

4.22 Transitions

Table 2.2 TYPES OF HARM, INDICATORS AND EXAMPLES

These should be combined with the definition of Significant Harm paragraph 2.3.1

| | TYPE OF HARM (all may apply to carers and those who self-fund) | DEFINITION | EXAMPLES (not exhaustive) | What are the signs of harm? (not exclusive) |
|---|--|---|---|--|
| 1 | Physical | <p>Non-accidental harm to the body. Can range from careless rough handling to direct physical violence.</p> <p>Unlawful or inappropriate use of restraint or physical interventions and/or deprivation of liberty is also physical harm. See paragraph 2.2.2</p> | <p>Hitting, slapping, pinching, shaking, pushing, scalding, burning, dragging, kicking, physical restraint, locking an individual in a room or a car, harassment, enforced sedation, inappropriate use of medication, catheterization of a patient for management ease, inappropriate sanctions, exposure to heat or cold, not giving adequate food or drink.</p> | <ul style="list-style-type: none"> • History of unexplained falls or minor injuries • Bruising which is characteristic of non-accidental injury – hand slap marks, pinch marks, grip marks • Black eyes/injuries to the face • Marks made by implements • Bruising to buttocks, lower abdomen, thighs • Bite marks • Burns/scalds • Individual flinches at physical contact • Reluctant to undress or uncover body • Loss of weight |
| 2 | Sexual | <p>Direct or indirect involvement in sexual activity without capacity and/or consent. Individual did not fully understand or was pressured into consenting.</p> <p>Consent is defined as not given when a person has mental capacity but does not want to give consent, a person lacks mental capacity and is therefore unable to give consent, a person feels coerced into activity because the other person is in a position of trust, power of authority or the other party is a close relative and the action would be classed as incestuous.</p> | <p><i>Non contact:</i></p> <p>Inappropriate looking, pornography, photography, indecent exposure, harassment, serious teasing or innuendo, coercion to watch sexual activity.</p> <p><i>Contact:</i></p> <p>Coercion to touch e.g. of breasts, genitals, anus, mouth, masturbation of either self or others, penetration or attempted penetration of vagina, anus, mouth with or by penis, fingers and or other objects</p> | <p>Physical signs may apply to male or female and may include</p> <ul style="list-style-type: none"> • Urinary tract infections, vaginal, penial or anal infection, sexually transmitted disease • Pregnancy in a women unable to give consent • Difficulty in walking or sitting with no apparent explanation • Torn, stained or bloody underclothes or bedding • Bleeding, bruising, torn tissue or injury to the rectal, anal and/or vaginal area • Bruising to thighs and/or upper arms <p>Behavioural changes</p> <ul style="list-style-type: none"> • Uncharacteristic sexually explicit/seductive behaviour • Promiscuity • Use of explicit language • Self harm • Obsession with washing • Fear of pregnancy may be exaggerated <p>Remember individuals may partially disclose using repeating phases like “it’s a secret” or “shut up” or “I’ll hurt you”</p> |

| | TYPE OF HARM (all may apply to carers and those who self-fund) | DEFINITION | EXAMPLES (not exhaustive) | What are the signs of harm? (not exclusive) 21 |
|---|--|---|--|---|
| 3 | Psychological/emotional | <p>Behaviour which has a harmful effect on an individual's emotional well being, causing mental distress undermining their self-esteem and affecting individual's quality of life.</p> <p>Wilful infliction of mental suffering by a person in a position of trust and power.</p> <p>Psychological harm may present with other forms of harm.</p> <p>Behaviour which deliberately causes serious psychological and emotional harm may constitute a criminal offence.</p> | <p>Shouting, controlling, coercion, bullying, blaming, swearing, insulting, ignoring, threats of harm or abandonment, intimidation, harassment, humiliation, depriving an individual of the right to choice and their privacy, dignity, self-expression, deprivation of contact, undermining self-esteem, isolation and over-dependence.</p> <p>Treating a person in a way which is inappropriate to their age and/or cultural background.</p> | <p>Indicators may include one or more of the following:</p> <ul style="list-style-type: none"> • Loss of interest, withdrawn, anxious or depressed • Appear to be frightened, fearful or avoiding eye contact • Irritable, aggressive or challenging behaviour, unexplained sleep disturbance • Poor concentration • Self harm, refusing to eat, deliberate soiling • Eating problems, unusual weight gain or loss |
| 4 | Neglect/acts of omission | <p>Failure of any person who has responsibility for the charge, care or custody of an adult at risk to provide the amount and type of care or treatment that a responsible person could be expected to provide.</p> <p>reference to s44 MCA</p> <p>Neglect can be intentional or unintentional.</p> <p>It is intentional if the neglectful individual is aware of the consequences and potential for harm resulting from lack of actions.</p> <p>Unintentional may result from failure to understand the needs, not knowing about available services or possible effect of lack of action or because their own needs prevent giving the care needed to the adult at risk.</p> | <p>Failure to provide</p> <ul style="list-style-type: none"> • Appropriate and adequate food and drink • Shelter • Heating • Clothing • Medical care • Educational services • Hygiene • Personal care • Inappropriate use or withholding of medication/over medication • Repeated deprivation of medical or physical or social care • Failure to intervene in behaviour which is dangerous/failure to report harm • Being prevented from receiving visitors or interacting with others • Not meet basic standards of care | <p>This form of harm may be identified within a person's accommodation, their physical presentation or in the standard and care provided.</p> <p>Indicators may include</p> <ul style="list-style-type: none"> • Inadequate heating and lighting • Neglect of accommodation • Poor physical condition (e.g. leg ulcers or ulcerated bed sores) • Clothing or bedding in poor condition including being wet or soiled • Failure to ensure access to health or social care • Weight loss or gain through inadequate or unsuitable food • Medication not given as prescribed • Failure to ensure appropriate privacy and dignity |

| | TYPE OF HARM (all may apply to carers and those who self-fund) | DEFINITION | EXAMPLES (not exhaustive) | What are the signs of harm? (not exclusive) 22 |
|---|--|--|---|---|
| 5 | Financial & Material | <p>The unauthorized taking (theft) or misuse of any money, income, assets, personal belongings or property or any resources of an adult at risk without their informed consent or authorization.</p> <p>Factors that may increase vulnerability</p> <ul style="list-style-type: none"> • Person unable to manage own money • Person isolated in community • Person is dependent on others to handle finances • Person has no independent advocates <p>Financial abuse is a crime.</p> | <ul style="list-style-type: none"> • Misuse of enduring power of attorney, lasting power of attorney or appointeeship. • Money and possessions stolen • Misappropriating money, valuables or property • Forcing changes to will • Denying the adult at risk the right to access personal funds, property possessions or inheritance • Unauthorized disposal of property or possessions • Being asked to part with money on false pretences • Stealing • Misuse of funds • Fraud | <p>The following situations or observations may indicate financial abuse</p> <ul style="list-style-type: none"> • Unexplained or sudden inability to pay bills • Power of Attorney obtained and misused when a person lacks or does not lack mental capacity to understand • Unexplained withdrawal of money with no benefits • Person lacking goods or services that they can afford • Extortionate demands for payments for services |
| 6 | Institutional/ Corporate | <p>Involves the collective failure of an organisation to provide safe, appropriate and acceptable standards of service to adults at risk.</p> <p>Occurs when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of adults at risk.</p> <p>Can occur in any setting providing health and social care.</p> <p>It is most likely to occur when employees:</p> <ul style="list-style-type: none"> • Receive little or no support from management. • Are inadequately trained. | <ul style="list-style-type: none"> • Lack of individualized care • Inappropriate confinement or restriction • Sensory deprivation • Inappropriate use of rules • Custom and practice • No flexibility on bedtimes or waking times • Dirty clothing or bed linen • Lack of personal possessions or clothing • Deprived environment or lack of stimulation • Misuse of medical Procedures • Medication errors • Dietary needs not met • Poor moving and handling | <ul style="list-style-type: none"> • Unacceptable practice encouraged, tolerated or left unchanged • Organisational standards not meeting those laid down by regulatory bodies • Service users not treated with dignity and respect • Diverse needs not recognized and valued in terms of age, gender, disability, ethnic origin, race or sexual orientation • Services not flexible • Organisation do not promote choice and individual focus • Communication discouraged • Whistle blowing policy not in place and accessible • Insufficient employees training and development. |

| | TYPE OF HARM (all may apply to carers and those who self-fund) | DEFINITION | EXAMPLES (not exhaustive) | What are the signs of harm? (not exclusive) |
|---|---|--|---|---|
| | | <ul style="list-style-type: none"> • Are poorly supervised and poorly supported in their work. • Receive inadequate guidance. <p>The risk of harm is also greater in institutions:</p> <ul style="list-style-type: none"> • With poor management. • With too few employees. • Which use rigid routines and inflexible practices. • Which do not use person-centred care plans. • Where there is a closed culture. <p>The behaviour is cultural to the Institution and not specific to particular members of employees</p> <p>See also Abuse of Trust relating to individual misuse of power paragraph 2.3.2</p> | | |
| 7 | Discriminatory harm Includes "hate crimes" (See Section 4.13) | <p>Exists when values, beliefs or culture result in a misuse of power that denies opportunity to some groups or individuals.</p> <p>Principles of discriminatory harm are provided by legislation, includes Race Relations Act 1976, Disability Discrimination Act 1995, Sex Discrimination Act 1975, Equality Act 2010 and Human Rights Act 1998.</p> <p>Consists of harmful or derisive attitudes or behaviour based on a persons gender, sexuality, ethnic origin, race, culture, age, disability, faith or belief or any other</p> | <ul style="list-style-type: none"> • Verbal abuse • Harassment or similar treatment • Unequal treatment • Deliberate exclusion from services such as education, health, justice and access to services and protection • Harmful or derisive attitudes • Inappropriate use of language | <ul style="list-style-type: none"> • Lack of respect for an individuals beliefs and cultural background • Unable to eat culturally acceptable foods • Religious observances not encouraged or anticipated • Isolation due to language barriers • Signs of sub-standard service offered to minority groups or individuals • Repeated exclusion from rights afforded to citizens such as health, education, employment and criminal justice |

| | TYPE OF HARM (all may apply to carers and those who self-fund) | DEFINITION | EXAMPLES (not exhaustive) | What are the signs of harm? (not exclusive) 24 |
|----|---|--|--|---|
| | | <p>discriminatory harm, includes hate crimes</p> <p>Hate crime is any criminal offence committed against a person or property that is motivated by an offender's hatred of someone because of one or more of the above.</p> <p>Forced marriages are an abuse of an individuals human rights</p> | | |
| 8. | <p>Domestic violence or abuse Any of the above categories may include domestic abuse/violence.</p> <p>See also paragraphs 4.11 & 4.12</p> | <p>A wide range of behaviours involved beyond physical violence.</p> <p>“Any incident of threatening behaviour, violence or harm (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality”</p> <p>It is rarely a one-off incident and should be seen as a pattern of harmful and controlling behaviour through which the abuser seeks power over the victim.</p> | <p>See individual examples under psychological and emotional, physical, sexual, neglect, financial and material.</p> | <p>See indicators under psychological, physical, sexual, financial or emotional harm</p> <ul style="list-style-type: none"> • Appears to be afraid of partner / of making own choices • Behaves as though she/he deserves to be hurt or mistreated • May have low self-esteem or appear to be withdrawn • Appears unable or unwilling to leave perpetrator • Leaves perpetrator and returns • Makes excuses for or condones the behaviour of the abuser • Blames abuse on themselves • Minimises or denies abuse or seriousness of harm • Perpetrator always with the victim and won't let victim speak for themselves eg at GP visits |

3. Procedures

3.1 Introduction

The seven key stages of the Safeguarding Adults process for employees and volunteers are as follows:

- **Stage One:** Raising an alert/concern.
- **Stage Two:** Response to an alert/concern and deciding which Pathway to follow.
- **Stage Three:** Strategy discussion or meeting.
- **Stage Four:** Investigation.
- **Stage Five:** Case conference and Safeguarding plan.
- **Stage Six:** First Review of the Safeguarding plan.
- **Stage Seven:** Subsequent reviews and closing the Safeguarding Adults process.

During these stages, key considerations are:

- Taking action to protect and support the adult.
- Assessing and addressing risk.
- Supporting and enabling the adult at risk to achieve outcomes that they see as the best for them, where possible.
- The need for the person at risk to be represented by an advocate, eg: an Independent Mental Capacity Advocate (IMCA). *See section 4.8 & 4.24.*
- Deciding whether a mental capacity assessment is needed to clarify issues of consent.
- Taking appropriate action for the person causing harm.
- Taking appropriate action with a service and/or its management if they have been culpable, ineffective or negligent.
- Identifying any lessons to be learnt for the future, including recommendations for any changes to the organisation and service delivery.
- Asking the adult at risk if they feel safer as a result of the intervention.
- Considering whether a person is being deprived of their liberty and whether the Deprivation of Liberty safeguards apply.
- Considering whether Human Rights legislation, especially whether Articles 3 and 8 apply.

Table 3.1 summarizes what is involved in the seven key stages. If, at any stage, an Investigating Manager (IM) feels that the issue is no longer appropriate for the Safeguarding

Adults process, it can be closed down. The seventh stage – closing the Safeguarding Adults process – is only for those investigations that go through all of the stages, including review.

The IM has a responsibility to ensure that the person who raised the alert, is informed that appropriate action has been taken.

It is important that this process runs to time; however, the interests of the adult at risk are paramount and divergence from the timescales may be justified on grounds of good practice where:

- Adherence to the timescales would jeopardize achieving the most appropriate outcome for the adult at risk.
- It would not be in the best interests of the adult at risk.
- The complexity of the investigation is such that a longer timescale is unavoidable.

Reasons for divergence from timescales must be recorded. Where this divergence concerns the strategy meeting, investigation and case conference, the agreement of the IM must be sought and an alternative timescale agreed to avoid the process becoming open ended.

Other processes, including police investigations, can continue alongside the Safeguarding Adults process, but should not delay it; for example, a decision that on the balance of probabilities harm took place, can be taken even if the police have not concluded their enquiries.

Table 3.1: seven key stages of the Safeguarding Adults process

| Stage | Activity | Responsibility | Timescale |
|---|---|---|--|
| <u>Stage 1</u> Raising a Concern/ Alert (paragraph 3.3) | <ul style="list-style-type: none"> Act to protect adult at risk. Deal with immediate needs. Report to line manager or another appropriate manager immediately if line manager unavailable. Report to the Police, if a crime is suspected. Do not question the victim Record facts. Refer to Safeguarding Adults contact point. | Any concerned person. Employees or volunteer. Any concerned person. | Immediately, if emergency <i>or</i> within same working day (this should be within 4 hours). |
| <i>Decision</i> | <ul style="list-style-type: none"> Take any immediate action to identify and address the risk. Decide whether to raise the concern/alert with the safeguarding contact point. If NHS, consider reporting as serious incident (SI). | Any Manager or employee, as appropriate. | Immediately <i>or</i> within 24 hours. |
| <u>Stage 2</u> Response to a Concern/ Alert. This is the responsibility of the LA Social Services (paragraph 3.4) | <ul style="list-style-type: none"> Gather initial information. Clarify facts. Determine whether to accept the alert/concern as a referral. Notify other funding LAs and agree any actions required. Advise referrer of decision. Notify CQC if required. Communicate with other funding LAs and agree any actions required. | LA Safeguarding contact points. Designated Safeguarding Adults Manager Registered service provider. | |
| <i>Decision</i> (Pathways, paragraph 3.4.5) | <ul style="list-style-type: none"> Evaluate risk. Consider any links with other processes eg: safeguarding children or complaints, disciplinary etc). Undertake cross checks with MARAC ,Computer Databases, Cautionary Contacts Lists, Probation etc Decide if Safeguarding Adults procedures apply and criteria met for a referral and which Pathway to follow. Agree an interim safeguarding plan. (Police investigation may have begun). Decide if a strategy meeting or discussion is needed. | Relevant Local Authority Managers (ie: Safeguarding Leads, Locality Manager, Contract Monitoring) and Police, as appropriate. | Within 24 hours of receipt of alert. |

| <i>Stage</i> | <i>Activity</i> | <i>Responsibility</i> | <i>Timescale</i> |
|---|--|---|--|
| <p><u>Stage 3</u></p> <p>Strategy discussion or multi- agency meeting.</p> <p>This stage applies to Pathways 3&4 paragraph 3.5</p> | <ul style="list-style-type: none"> • Evaluate risk. • Agree further actions and activities in relation to the Investigation. • Agree people responsible and timescales. | IM, Police and relevant partner organisations, as appropriate. | Within a maximum of 7 calendar days from receipt of the Safeguarding Adults alert. |
| <i>Decision</i> | <ul style="list-style-type: none"> • Decide if investigation needed. • Agree investigation plan. • If not Safeguarding Adults agree appropriate action and consider changes to care or support plan. • If not Safeguarding Adults, close process at this point. • Advise referrer and consult with adult at risk. | IM and relevant partner organisations. | |
| <p><u>Stage 4</u></p> <p>Investigation (paragraph 3.6)</p> | <ul style="list-style-type: none"> • Conduct investigation • Re-evaluate risk. • Collate evidence and share with involved organisations. • Produce and distribute report. | <p>Allocated Investigator</p> <p>IM and other relevant agencies</p> | |
| <p><u>Stage 5</u></p> <p>Case Conference and Safeguarding Plan (paragraph 3.7)</p> | <ul style="list-style-type: none"> • Receive investigation evidence. • Evaluate risk. • Consult with adult at risk and/or their representative. • Formulate a Safeguarding Plan if required. • Close Safeguarding Adults process and consider changes to care or support plan, if appropriate. • Finalize and distribute detailed actions required in Safeguarding Plan and ensure consistency between this and care plan. • Inform relevant agencies of the outcome e.g CQC • Keep under review. • Complete Monitoring Form where used | Co-ordinated by IM with relevant partner organisations. | <p>Within 21 calendar days of strategy meeting.</p> <p>Within 2 weeks of Safeguarding Adults Conference.</p> |
| <i>Decision</i> | <ul style="list-style-type: none"> • Agree outcome. • Agree review. | | |

| | | | |
|---|---|--|---|
| <p><u>Stage 6</u></p> <p>First review of the Safeguarding Plan</p> <p>(paragraph 3.8)</p> | <ul style="list-style-type: none"> • Review the Safeguarding Plan. • Re-assess and re-evaluate risk. | <p>Co-ordinated by IM with relevant partner organisations.</p> | <p>Within 3 months of case conference or as agreed at case conference.</p> |
| <p><u>Stage 7</u></p> <p>Subsequent Reviews and closing the Safeguarding Adults process</p> <p>(paragraph 3.9)</p> | <ul style="list-style-type: none"> • Complete Safeguarding Adults process. • Sign off Safeguarding Adults process. • Review process continues. • Consider and update effectiveness of Safeguarding Plan. If risk removed and Safeguarding Plan no longer required, it will be closed and Care/Support Plan continued. Ongoing preventative actions should be included in Care/Support Plan. • Decide if a referral to a serious case review panel is required. • Dissemination of lessons learnt. • Process may also be closed pending outcome of prosecution. • Ensure referrer, members of safeguarding conference, adult at risk are informed of closure of safeguarding process. • Obtain views from the adult at risk or their representative on their experience of the safeguarding process and whether they felt safer as a result. • Support for employees | <p>Signed off by IM.</p> | <p>On agreement with other organisations and adults at risk.</p> <p>Up to 6 months from first review.</p> |

3.2 Risk assessment and management

Risk assessment and risk management are central to the Safeguarding Adults process. A risk assessment must be undertaken when an alert is raised. This should clarify the degree of risk to the adult at risk, other adults and/or children. Risk should be constantly re-evaluated throughout the process to ensure adults at risk and all others involved are appropriately protected.

Risk assessment is integral to the whole process of safeguarding and is specifically concerned with the identification of specific risks to a person covered by the Safeguarding Adults policy and procedures.

3.2.1 The primary aim of a Safeguarding Adults risk assessment is to assess:

- Current risks that people face.
- Potential risks they and other adults may face.

3.2.2 Risk assessment will specify:

- What the actual risks are – the harm that has been caused, the level of severity of the harm and the views and wishes of the adult at risk and any advantages or disadvantages to them.
- The person's ability to protect themselves and ability to minimize and manage the risk themselves. This will be particularly important to those in receipt of a personal budget or self funding
- Who or what is causing the harm.
- Factors that contribute to the risk, for example, personal, environmental, relationships, resulting in an increase or decrease to the risk.
- The risk of future harm from the same source.

The risk assessment should also take into account wider risk factors, such as the risk of fire in the person's home.

The Safeguarding Plan is the risk management plan that is put in place aimed at removing or minimizing risk to the person and others who may be affected if it is not possible to remove the risk altogether. It will need to be monitored, reviewed and amended/revised as circumstances arise and develop.

A formal risk assessment can take place at any point. However, the most likely point at which a formal assessment will take place is after the strategy discussion or meeting.

3.2.3 The risk assessment should:

- Establish the facts of the harm or neglect and inform the safeguarding plan.
- 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 Safeguarding 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. (*Refer to paragraph 3.3.2 to paragraph 3.3.4*)
- 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 violence or abuse is indicated. Where domestic violence or abuse is indicated the CAADA DASH risk assessment checklist (RIC) should be completed. This will indicate whether the individual is at high risk of harm from the

perpetrator and if there is a need for referral to a Multi-Agency Risk Assessment Conference (MARAC) (see www.dorsetforyou.com/marac for the CAADA DASH RIC, MARAC referral process and MARAC referral form). See Section 4.11 and 4.12.

- Identify people causing harm who should be referred to Multi-Agency Public Protection Arrangements (MAPPA). See Section 4.16.
- Identify whether a child (under 18 years) is at risk and if so, refer to Safeguarding Children contact point.

A plan to manage the identified risk and to put in place Safeguarding measures will include:

- What action must be taken immediately to protect the person at risk.
- What needs to be in place to reduce any immediate risks, including ways to enable the individual to increase their own protection against risk of harm.
- When and how quickly a strategy meeting or discussion needs to take place.
- A proportionate response to the particular situation to manage the risk posed to the person who has been harmed and others who may be at risk from the person alleged to have caused the harm.
- What measures need to be taken to address risks that are caused by the setting which is providing care to the person at risk.
- What needs to be put in place to meet the ongoing support needs of the person at risk.

(see also Risk Management Guidance in section 4.25)

3.3 Stage One: Raising an alert/ concern

This section covers:

- Responsibilities of the person raising the alert/ concern.
- Preserving evidence and record keeping.
- Responsibilities of the alerting manager.

Alerts/concerns may be made to Safeguarding Adults contact points by any person concerned about an adult at risk of harm.

Raising an alert/ concern refers to the duty of all employees of any service involved with adults at risk immediately to inform the relevant manager and the Safeguarding Adult contact point of a concern that an adult at risk:

- Has been harmed or neglected or
- Is being harmed or neglected or
- Is at risk of being harmed or neglected.
- Is suspected of being harmed or neglected.

An alert/concern may be:

- A direct disclosure by the adult at risk.

- Raised by employees or volunteers, others using the service, a carer or a member of the public.
- An observation of the behaviour of the adult at risk, of the behaviour of another person(s) towards the adult at risk or of one service user towards another.

3.3.1 Responsibilities of the person raising the alert

3.3.1.1 Taking immediate action

- Make an immediate evaluation of the risk and take reasonable and practical steps to ensure that the adult is in no immediate danger.
- Inform the manager immediately.
- If it is not possible to inform the manager, and the matter is urgent, inform the Safeguarding Adults Contact Point in the Local Authority immediately.
- Do not try to question the alleged victim, except in relation to immediate needs.
- Where appropriate, dial 999 for an ambulance if there is need for emergency medical treatment, in line with information-sharing considerations. *See paragraphs 2.2.4 and 4.9.*
- Contact the Police if a crime has been or may have been committed.
- Do not disturb or move articles that could be used in evidence, and secure the scene, for example, by locking the door to a room. *See paragraph 3.3.2 to 3.3.4 for more detail on preserving evidence.*
- Contact Children's Social Care if a child is also at risk.
- If possible, make sure that other service users are not at risk.

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

- Assure them they are being taken seriously.
- Listen carefully to what they are saying, stay calm, get as clear a picture possible but avoid asking questions at this stage. It could compromise any future investigation.
- Do not give promises of complete confidentiality.
- Explain there is a duty to tell the manager or other designated person and that their concerns may be shared with others who could have a part to play in protecting them.
- Reassure them that they will be involved in decisions about what will happen.
- Explain that everything possible will be done to protect them from further harm or neglect.
- If they have specific communication needs, provide support and information in a way that is most appropriate to them.
- Do not be judgemental or jump to conclusions.
- Do not discuss the allegation / incident with the person alleged to have caused

harm.

- Do not discuss the disclosure with other employees.

3.3.2 Preserving evidence

The first concern must be to ensure the safety and well-being of the adult at risk. However, in situations where there has been or may have been a crime and the police have been called it is important that forensic and other evidence is collected and preserved. The police will attend the scene and agencies and individuals can play an important part in ensuring that evidence is not contaminated or lost.

- 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 it cannot actually be seen
- If in doubt contact the police and ask for advice.

3.3.2.1 Evidence gathering and victim care

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

3.3.2.2 Incidents of Physical and/or Sexual Assault

- The most important priority is to ensure that the urgent medical and welfare requirements of the adult at risk are met.
- Preserve any potential forensic opportunities, and record verbatim the disclosure made by the adult at risk.
- Any sexual activity that is not freely consented to is criminal and must be reported immediately to the police via 999, before any internal investigation/ interview.

Following allegations of physical and/or sexual assault, consideration will be given to organizing, with the adult's consent, a medical examination. The Police have specialised units that investigate rape and serious sexual assaults. A specially trained officer will be responsible for arranging a forensic examination. This will normally be conducted at a sexual assault referral centre. However, if it is not appropriate for a client to be taken by police to a sexual assault referral unit, the officer will make arrangements for the examination to be facilitated elsewhere. Any examination will ideally be carried out by a Forensic Medical Examiner.

If the assaulted person has a physical injury and it is appropriate for the person on the scene to examine it, always obtain their consent first.

- Only touch what is essential. Wherever possible, leave things as they are.

- Strongly advise the assaulted person not to wash or remove clothing.
- Preserve the assaulted person's clothing and footwear, do not wash or wipe them. Handle them as little as possible.
- Preserve anything that is used to comfort the assaulted person, for example, a blanket.
- Do not clean up, do not wash anything or in any way remove fibres, blood and the like.
- Try not to touch items/weapons. If necessary, as before keep handling to a minimum. Put them in a clean dry place until the Police collect them.
- The room should be secured and no-one allowed to enter, unless necessary to support the person present, the assaulted person and/or the person alleged to have caused the harm, until the Police arrive.
- If the person alleged to have caused the harm is also a service user, a separate employee needs to be assigned to them.
- Sexual relationships or inappropriate sexual behaviour between an employee and a service user are always harmful and will lead to disciplinary proceedings. This is additional to any criminal action that has been taken.
- A sexual relationship between the service user and a care worker is a criminal offence under Sections 38–42 of the Sexual Offences Act 2003.

There may be Safeguarding Adults referrals that involve sexual innuendo or remarks that will not result in a criminal investigation; however, all Safeguarding Adults referrals that indicate any form of sexual assault require a risk assessment, intelligence gathering and appropriate information sharing with relevant partners.

3.3.2.3 Incidents of Theft/ Financial Abuse

With the person's consent, secure all receipts, bankbooks, bank statements, benefit books and the like.

3.3.2.4 Methods of Preservation

- For most items use clean paper, a clean paper bag or a clean envelope. Do not lick the envelope to seal it.
- For liquids, use a clean glass.
- Do not handle items unless really necessary to move and make safe.

3.3.3 Considering the person alleged to have caused harm

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

3.3.4 Making a record

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

Make an accurate record at the time, including:

- Date and time of the incident.
- Exactly what the adult at risk said, using their own words (their account) about the harm and how it occurred or exactly what has been reported.
- Appearance and behaviour of the adult at risk.
- The views of the adult at risk.
- Any injuries observed.
- What the person alleged to have caused the harm said or did, if present.
- Details of the person alleged to have caused harm.
- Likely movements of the adult at risk and the alleged harmer within the next 24 hours.
- Any actions and decisions taken.
- Name and signature of the person making the record.
- If the incident was witnessed, write down exactly what was seen.
- Police officers should complete VA 112.

The record should be factual. However, if the record does contain an opinion or an assessment, it should be clearly stated as such and be backed up by factual evidence. Information from another person should be clearly attributed to them. *See also paragraph 4.28.*

3.3.5 Informing a manager

- Inform the manager immediately.
- If there are concerns that an employee has harmed an adult at risk, there is a duty to report these concerns to a manager.
- If there are concerns that the manager has harmed an adult at risk, inform a senior manager in the organisation, or another designated manager for Safeguarding Adults.
- If there are concerns that an adult at risk may have harmed another adult at risk, inform the manager.

3.3.5.1 Who should the Manager inform?

If the alerting manager agrees that harm or neglect has taken or may take place and the following has not already been done, he or she should inform:

- The Safeguarding Adults Contact Point in the Local Authority.
- The police, if a crime has been or may be committed. Discuss risk management and any potential forensic considerations.
- The unit or service manager responsible for the management of the service.

- CQC if the adult is receiving care from a registered health or social care provider. Calls should be made to the National Contact Centre on 03000 616161 (registered Manager).
- Children's Social Care if children are also perceived as being at risk from harm.

And also:

- If there is a need for an immediate Safeguarding plan, refer to the relevant adult social care team or the relevant adult social care out-of-hours services if out of normal office hours e.g: weekends evenings and Bank Holidays.
- If the person causing the harm is also an adult at risk, arrange an employee to attend to their needs but do not discuss the alleged harm or question them.
- In line with the organisation's disciplinary procedures, take appropriate action in relation to an employee suspected of harming an adult or adults at risk.

3.3.6 Making a decision to raise an alert/ concern without consent

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

- Other people or children could be at risk from the person causing harm.
- It is necessary to prevent crime.
- Where there is a high risk to the health and safety of the adult at risk.
- The person lacks capacity to consent.

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

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

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

If the alerting manager is unsure whether to raise an alert, they should contact the relevant Local Authority Safeguarding Adults contact point for advice. If in doubt make the alert and discuss with the local Social Services or the Police.

See also paragraphs: 2.2.5 and 4.24.

3.3.7 Supporting employees

Managers are responsible for:

- Supporting any employee or volunteer who raised the concern.
- Enabling and supporting relevant employees to play an active part in the

Safeguarding Adults process.

- Ensuring that any employees delivering a service to the adult at risk are kept up to date on a need-to-know basis and do not take actions that may prejudice the investigation.

3.3.8 Whistle-Blowing

If the Line Manager or his or her Manager is alleged to be causing harm or is colluding in the harm, the Alerter must raise an alert to social services and/or the Police and refer to their organisations own Whistle-Blowing policy.

The service user's interest is paramount and the common law "duty of care" requires that each employee has a responsibility to:

- Draw attention to any matter they consider to be damaging to the interests of a service user, carer or colleague.
- Report any identified omissions.
- Put forward proposals that may improve a service.
- Prevent malpractice

Anonymous alerters will always be

- Treated seriously.
- Treated with a fair and equitable manner.
- Kept informed of action taken and its outcome.

Confidential alerters should be aware of the 'whistle-blowing' policy in their own workplace, or can contact Public Concern at Work.

Support for Alerters – The Public Interest Disclosure Act 1998

People have in the past been put off from disclosing their concerns about possible neglect or abuse because of having worries about their duty of confidentiality and/or the consequences of speaking out.

The Public Interest Disclosure Act 1998 seeks to protect genuine disclosures of such acts.

No confidentiality clause in an employment contract can be used to prevent anyone from disclosing genuine concerns about harm or harmful practice to an appropriate person.

Additionally, any person being treated detrimentally at work because of making an appropriate disclosure may be able to claim compensation at an Employment Tribunal.

For further information see:

The Public Interest Disclosure Act (PIDA) www.informationcommissioner.gov.uk

Public Concern at Work is an independent authority on whistle blowing and can offer advice and support.

Contact them by:

Phone: 0207 4046609

E-mail: whistle@pcaw.co.uk

Website: www.pcaw.co.uk

Post: PCAW

Suite 301

16 Baldwin Gardens

London

EC1N 7RJ

Figure 3.1: Alerting action to be taken after becoming aware

Alerters guide – What to do if harm is suspected

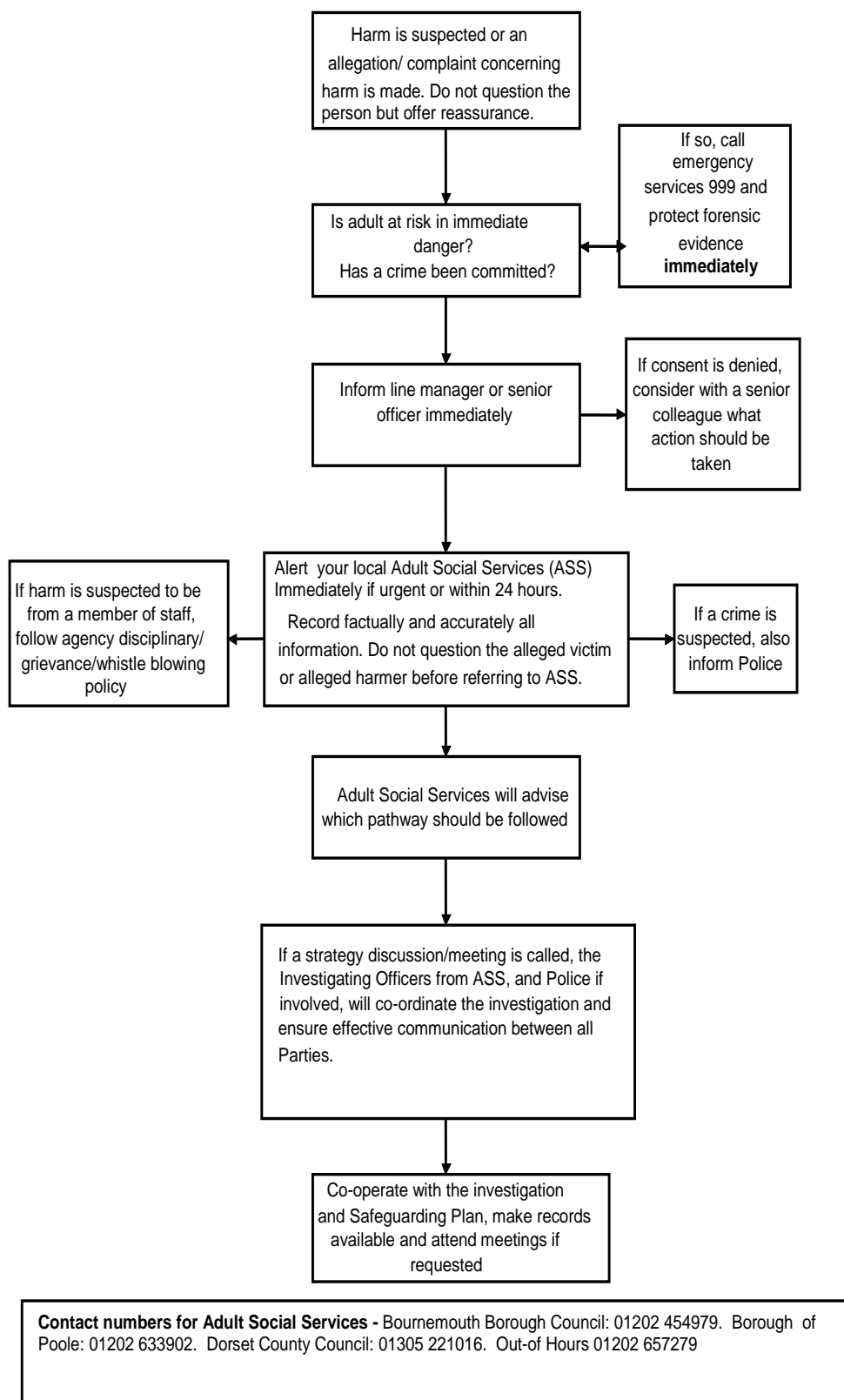


Figure: 3.2 Safeguarding Adults Timescales and Process

| | Timescale | Total time |
|--|---|-------------|
| Stage 1 Alert/Initial action Abuse suspected by anyone working with or in contact with adults at risk. Inform line manager and Social Services. If a crime is suspected, contact Police Confirm in writing. | Immediate if urgent or within 24 hours | 1 day |
| Stage 2 Responding to an alert by Social Services/Police (SRU) Does alert meet Safeguarding criteria? Initial information gathering and safeguarding decision. Ensure initial action taken to safeguard individual and others and follow appropriate pathway. <i>See para 3.4.5.</i> | 24 hours | 2 days |
| Stage 3 Strategy discussion or meeting Appoint Safeguarding Adult investigator and convene strategy discussion or meeting in a timescale commensurate with the degree of risk, to plan investigation | within 7 calendar of alert, depending on pathway or level of risk | 9 days |
| Stage 4 Investigation Process Undertake investigation | Urgent will be same day | |
| Stage 5 Safeguarding Adult Conference Multi-agency meeting evaluates information, level of risk, formulates initial Safeguarding Plan, and identifies key workers/care co-ordinators who will finalise detailed actions in Safeguarding Plan. Agree closure of investigation stage | Within 21 calendar days of Strategy meeting | 30 days |
| Finalise Safeguarding Plan Finalise detailed actions required in Safeguarding Plan and ensure consistency between this and care plan. | Within 2 weeks of safeguarding adult conference | 44 days |
| Stage 6 First Review Meeting To consider and update effectiveness of Safeguarding Plan. If it is not working and risk remains, convene a new conference | within 3 months of initial conference | 4.5 months |
| Stage 7 Subsequent Reviews Consider and update effectiveness of Safeguarding Plan as above. If risk removed and SP no longer required it will be closed and Care Plan continued. Ongoing preventative actions should be included in the Care plan. | Up to 6 months from 1 st review | 10.5 months |

3.4 Stage Two: Responding to an Alert

This section is the responsibility of the local authority Social Services and covers:

- Receiving or responding to an alert and gathering the facts.
- Pathways for responding to alerts.

An alert is the direct reporting of an allegation, concern or disclosure to a Safeguarding Adults contact point. All alerts, including those from integrated Community Learning Disability and Mental Health teams, concerning the alleged harm of an adult at risk should be passed immediately to the appropriate Adult Social Service Safeguarding contact point.

The Alert will be logged on the local authorities' data base as a Safeguarding Adult alert.

Checks will be made to identify whether or not the adult at risk or the person alleged to have caused harm is known to any relevant services including Children's Services, Domestic Abuse Services, CMHT, Drug and Alcohol Services, etc.

If the adult at risk is in a placement funded by another LA, ensure that the LA is notified and agree any actions required.

An alert begins a process of gathering information, assessment of the allegation, assessment of the adult at risk's needs and a risk assessment to decide whether the Safeguarding Adults policy applies. This should be done in consultation with the person raising the alert and relevant informed professionals to help determine proper interpretation of the concerns. The decision on whether or not to convene a strategy meeting/discussion must be made within 7 calendar days of the alert reaching the appropriate team.

3.4.1 Guidance on responding to and recording an alert.

Alerts to the relevant Safeguarding Adults contact point will be taken from *anyone* who has a concern that an adult is at risk.

3.4.2 Information to be obtained when receiving the alert

Where possible, include as much information under the following headings. It is understood that this may not be immediately available.

3.4.2.1 Details of the person raising the alert

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

3.4.2.2 Details of the adult at risk

- Name(s), address and telephone number.
- Date of birth, or age.
- GP.
- 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 alert.
- Whether the adult at risk has consented to the alert being raised 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.

3.4.2.3 Information about the harm or neglect or physical harm

- How and when did the concern come to light?
- When did the alleged harm occur?
- Where did the alleged harm take place?
- What are the details of the alleged harm?
- What impact is this having on the adult at risk?
- What is the adult at risk saying about the harm?
- What do they want to happen?
- 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) or another adult at risk?

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

- Name, age and gender
- What is their relationship to the adult at risk?
- Are they the adult at risk's main carer?
- Are they living with the adult at risk?
- Are they an employee, paid or unpaid carer or volunteer?
- What is their role?
- Are they employed through a personal budget or self-funding?
- Which organisation are they employed by?
- Are there other people (adults and/or children) at risk from the person alleged to be causing the harm?

3.4.2.5 Any immediate actions that have been taken

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

3.4.3 Alerts to the Police

Dorset Police is resolute in its commitment to tackling all forms of crime against adults at risk. Every member of the community deserves protection from exploitation and harm by those entrusted with their care and the people they should be able to rely on to keep them safe.

Alerters must make it clear whether they are reporting a crime or suspected crime, or seeking advice. Referral must also be made to the relevant local authority. **In an emergency call the Police on 999.**

Partner agencies should contact the Safeguarding Referral Unit via email SRU@dorset.pnn.police.uk. This office is staffed 0800 to 1700 Monday to Friday. Once the referral is sent then a telephone discussion can take place by phoning 01202 222777. The Safeguarding Referral Unit will facilitate early strategy discussions which will decide if the referral is suitable for joint Adult Social Services and Police investigation or single agency action.

A specially trained police officer will be responsible for arranging any forensic examination that is required. Where sexual assault is suspected, this will normally be conducted at a Sexual Assault Referral Centre (SARC). However, if it is not appropriate for a client to be taken by police to a sexual assault referral unit, the officer will make arrangements for the examination to be facilitated elsewhere.

The Police will always determine whether a criminal investigation is required and decide which is the most appropriate department to undertake the investigation. It is likely that offences against the person which are complex and serious will be investigated by the Criminal Investigation Department and lesser offences but of concern to a local area will be dealt with by the Safer Neighbourhood Team (SNT). Criminal investigation by the Police will take priority over all other lines of enquiry. However, safeguarding the adult at risk is of prime importance throughout the investigation.

3.4.4 Referrals to a Multi-Agency Risk Assessment Conference (MARAC)

If the concern indicates high-risk domestic violence and this is confirmed by completion of the CAADA DASH risk assessment, a referral should be made to MARAC. If the referrer does not have authority to refer to MARAC, this can be done by the Investigating Manager. See 3.2.3

3.4.5 Pathways for responding to Alerts

The following framework has been developed to assist Local Authorities Safeguarding Teams to determine the most appropriate and least restrictive response to allegations and concerns about an adult at risk who may have been harmed. Decisions will have regard to the level of seriousness and risk.

The decision on which Pathway to follow is the responsibility of the Local Authority Safeguarding Adult Teams.

3.4.5.1 Pathway 1: Provider Services Action

This pathway may be followed when the individual is in the care of a registered provider.

If all the following circumstances apply, consideration may be given to a manager in provider services who has received training in Pathway 1, taking action to address quality of care issues and reporting back to the Investigating Manager:

- One-off, isolated incident which had no or minimal impact on the physical, psychological, financial or emotional well-being of the adult at risk.
- Not part of a pattern of harm related to either the victim or perpetrator for example:
 - No or minimal level of impact from similar incidents previously recorded for the adult at risk.
 - No or minimal level of impact from previous harm by the alleged perpetrator.
 - No or minimal level of impact from any incidents previously recorded for the service provider.
- Low level concerns about poor practice or the quality of a Care Service.
- Low level repeated incidents involving another service user/ patient where there is minimal impact on the victim and a safeguarding plan is in place to address concerns regarding the same person alleged to have caused harm.
- No criminal investigation is likely.
- No clear intention to harm or exploit the adult at risk.
- Remains in overall compliance with Health and Social Care Act 2008.
- There has been no breach of contract conditions or block or caution placed upon the service.
- Consideration has been given to disciplinary procedures when relevant.

3.4.5.2 Pathway 2: Community Services Action

This pathway may be the most appropriate and effective where the individual is cared for in the community by family, or a provider who is not regulated, or receives no additional social services care. An assessment or review of the individual service needs is carried out by social care or health employees who feed back to the designated manager and the safeguarding service.

- The incident may have minimal impact on the physical, financial, psychological or emotional well-being of the adult at risk but on the information available would not appear to amount to significant harm as described in the safeguarding policy.
- Concerns have been raised about difficulties and tensions within informal support networks e.g. family and friends which may be perceived as harm but have minimal impact on the adult and on the information available would not appear to amount to significant harm.
- Concerns can be resolved by offering an assessment under the NHS and Community Care Act 1990.
- Low impact concerns have occurred in the past, but at lengthy and infrequent intervals.
- No criminal investigation is likely.
- No breach of professional codes of conduct.
- There are no ongoing/ unmanaged risks for other adults or children.

3.4.5.3 Pathway 3: Full Safeguarding Adults Investigation

A full Safeguarding Adults Investigation will be undertaken in one or more of the following circumstances.

- The physical, psychological, financial or emotional well-being of the adult at risk, appears to have been adversely affected by the incident.
- A criminal offence has been suspected.
- Possible breach of Health and Social Care Act 2008.
- Possible breach of professional code of conduct.
- There is actual or potential harm or exploitation of other adults at risk or children.
- There is deliberate intent to exploit or harm an adult at risk.
- There is significant breach in a duty of care.
- The referral forms part of a pattern of harm either by an individual or service provider.

This level of response would require a formal Strategy Meeting to begin the investigation process.

3.4.5.4 Pathway 4: Large Scale Investigations

This level of response would apply to complex Alerts raised in respect of 4 or more adults at risk in the following circumstances:

- Institutional harm.
- Serious allegations of harm.
- A number of criminal offences may have been committed.
- Multiple breaches of the Health and Social Care Act 2008 may have occurred.

For more detail see Section 4.26

The roles and responsibilities of 'Investigators' and Investigating Managers are detailed in stages 3.5, 3.6, 3.7 and 3.8.

3.5 Stage Three: Strategy discussion or meeting

This section covers:

- Purpose of the strategy discussion or meeting.
- Who should attend.
- Recording and sharing information.
- Roles and responsibilities.
- Possible outcomes.

The relevant IM will ensure that a multi-agency strategy discussion or meeting is convened and chaired, and minutes taken and circulated.

This is a professional planning meeting. Its purpose is to address immediate risks, evaluate the information received and decide if an investigation should be undertaken and the process to be followed. If so, it will agree the terms of reference for the investigation.

It is convened by the Investigating Manager within maximum 7 calendar days of the alert. The timescale must be commensurate with the degree of risk.

The strategy stage could be a discussion by telephone if holding a meeting would involve a delay and place the person at greater risk or where few organisations are involved and a meeting is not necessary. If a strategy discussion is held, it may still be necessary to hold a follow-up strategy meeting, and more than one strategy meeting or discussion may be necessary.

Invitations and replies should be confirmed by email where possible, requesting all those invited to provide a report, even if not able to attend.

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

Information shared at the strategy stage is strictly confidential. The information should not be shared for any purpose other than the protection and care of the adult(s) at risk of harm and/or neglect. Permission must be obtained from the organisation that gave the information if another organisation wishes to use it for any other purpose. *See paragraphs 2.2.4 & 4.9.*

Every effort should be made prior to the meeting to explain its purpose to the adult at risk to find out their concerns, what they want to happen and how they want to be involved in what is decided. The strategy meeting must decide who will feed back the decisions of the meeting to the adult at risk and/or their representative and agree the most appropriate method for that feedback.

3.5.1 Purpose of the strategy discussion or meeting

The purpose of the strategy discussion or meeting is:

- To agree a multi-agency plan to investigate the allegations and assess the risk to the person who is being harmed and address any immediate needs.
- To co-ordinate the collection of information about the harm or neglect.
- To identify roles and responsibilities.
- Agree timescales.

3.5.1.1 The strategy discussion or meeting must:

- Consider whether immediate action has been taken to safeguard the adult at risk.
- Establish if consent has been gained from the adult at risk.
- Consider the wishes of the adult at risk and the outcomes they are seeking.
- Ensure the adult at risk has been offered an advocate (where appropriate).
- Ensure an assessment has been made of the adult at risk's mental capacity.
- Consider whether a court appointed deputy is required.
- Consider how the adult at risk's family or carers be involved if the adult at risk wishes this.
- Agree whether an investigation will take place, and if so, how it should be conducted and by whom.
- Agree to interview the person alleged to have caused harm, bearing in mind if he/she is an employee, then the lead responsibility for this will be with the employer. If a criminal action is suspected, then the Police will lead this process.
- Undertake risk assessment (*see paragraphs 3.2 & 4.25 for further guidance*)
- Agree an interim safeguarding plan.
- Make a clear record of the decisions.
- Record what information is shared.
- Agree an investigation plan with timescales.
- Agree a communication strategy.
- Consider whether a child (under 18 years) or other adults may be at risk. Refer to Children's Social Care, if necessary.
- Circulate decisions to all invitees within five days using the appropriate pro forma.
- Ensure the person raising the alert is kept informed of the current position and planned way forward, unless it is inappropriate to do so.

The strategy discussion or meeting should take place before any investigation. The commencement of a police investigation is an exception to this when vital evidence gathering is required.

3.5.1.2 Deciding whether to hold a face-to-face multi-agency strategy meeting

A decision to hold a face-to-face strategy meeting will be based on the following factors:

- The potential risk to the person being harmed.
- The risks to others from the person causing harm.
- Whether several organisations have concerns and need to share information.
- Whether there may be a number of investigations by different organisations.
- Whether there may be legal or regulatory actions.
- Whether the allegation involves a member of employees/volunteer or the safety of a service.
- Whether the situation could attract media attention.

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

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

3.5.1.3 Who should attend

Attendance at the strategy meeting should be limited to those who need to know and who can contribute to the investigation and the decision-making process. This should be employees of any organisation who have a role in investigating the allegation of harm or neglect, or in the assessment of the risk to the adult at risk, or for taking action in relation to the person causing the harm. They should be of sufficient seniority to make decisions within the meeting concerning the organisation's role and the resources they may contribute to the agreed safeguarding plan. They may include:

- The manager of the Safeguarding Adults Investigator.
- The social services care manager or key worker if the case is known to them.
- The police, if there are concerns that a crime has been committed.
- The person raising the alert, if they are a relevant professional.
- The CQC Compliance Inspector for that service.
- A GP.
- Relevant health professional.

- The IMCA or other advocate (if an IMCA has not been instructed a decision must be made as to whether to do so. An organisation which does not have authority to appoint an IMCA should discuss this with the IM, who can ensure that one is instructed as necessary).
- Other employees from adult social care who have a role to play/relevant involvement.
- The manager of a provider service unless they are named in the allegation, in which case advice should be sought from the Compliance Inspector for that service regarding who should attend.
- A representative of the council legal department or client affairs officer.
- A representative of any other organisation which has a role to play.
- A child protection co-ordinator, if there are also child protection concerns.
- The Safeguarding Adults lead for health.
- A manager from a *Supporting People* housing organisation.

If the allegation involves an employee or paid carer, the strategy meeting will be attended, where appropriate, by:

- The authorized officer for contracts.
- The commissioning manager.
- The human resources (HR) officer.
- The line manager of the employee.
- A senior manager of the employing organisation.

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

In cases where a crime has been reported and is being investigated by police, all subsequent action by other organisations must be co-ordinated by the joint strategy discussion led by the Police and Social Care. The officer in charge (OIC) of the Police part of the investigation will therefore jointly lead strategy meetings or discussions with the investigating manager from Social Care. The outcome will be noted on the Police Crime Recording System as applicable. The police investigation could take some time and other organisations could have duties to take action. Agreement must be reached at the strategy stage, either in a strategy discussion or meeting between the police and other involved organisations about what actions they can take and when.

Any IM who experiences difficulty in obtaining a response from any key organisation to an alert or to an informal request for advice or who has any other concerns regarding a Safeguarding Adults investigation should refer their concerns to the relevant Safeguarding Adults lead and/or member of the Safeguarding Adults Board.

3.5.2 Recording and Sharing Information:

A record should be made of the decisions and actions required. The record should be distributed to all relevant individuals and organisations and take account of data protection issues. The record should include:

- Name of the adult at risk.
- Date and time of the meeting.
- Name and contact details of the IM.
- Names and contact details of attendees.
- Details of the incident or the concern, with time, location and relevant details.
- Type(s) of harm suspected.
- An assessment of the seriousness/severity of harm.
- Consideration of the wishes/ desired outcomes of the person at risk.
- Record any involvement of an advocate.
- Documented consent of adult at risk.
- Name of the person causing harm (or alleged to have caused harm).
- Whether there were any witnesses.
- Decisions made, including timescales and names and tasks of responsible people.
- Name(s) and contact details of the organisation(s) conducting the investigation.
- Name of the person(s) who will conduct the investigation.
- Name of the organisation that is contributing to the interim safeguarding plan and what that contribution is.
- Details about any disagreements and how these will be resolved.
- Date for a strategy meeting review, if one is to take place.
- Date for the case conference.

Decisions of the meeting or discussion should be made available to participants at the meeting within 24 hours and minutes of the meeting should be distributed within agreed timescales. Regard should be had to confidentiality and data protection issues. It is the responsibility of professionals to note their own actions and not wait for the minutes.

3.5.3. Decisions about supporting and interviewing of the adult at risk

Whether or not the person at risk has mental capacity, they should be the first person to be interviewed to establish what has occurred and what they want to happen.

- Clarify that whether or not the adult at risk consents to the process and if not, what actions need to be taken.
- Clarify the key issues of risk faced by the adult at risk.
- Identify and address any communication needs of the adult at risk.
- Identify and take into account any equality issues that need to be addressed.
- Decide who will interview and record the account of the adult at risk.
- Decide who will ensure the adult at risk is involved in the process to the maximum of their willingness and ability, and how this will be achieved.
- Decide who will support the adult at risk in a formal investigation and ensure that their needs for support and protection are met.

3.5.4 Decisions about supporting and interviewing of the person allegedly causing harm

- Decide who will interview the person allegedly causing harm and/or give them information about the allegations (and when this should happen). If the allegation is being dealt with as a crime, the interview will be conducted by the Police under caution with the involvement of an Appropriate Adult. If the person allegedly causing harm is an employee, and the matter is not being dealt with as a crime, the employer will need to be involved as their employment disciplinary processes will need to be followed. Agreement should be made in the strategy meeting. CQC will need to be informed if the individual is employed in a regulated service. If there is a lack of clarity about whose role it is to conduct the interview, legal advice should be sought.
- If the person allegedly causing harm is an employee or a volunteer, confirm that the relevant regulatory authority has been informed. It is important to preserve the confidentiality at all times of all concerned including employees under the Safeguarding Adults information-sharing protocols.
- The primary concern must be the safety of the adult at risk but the person allegedly causing harm has a right to have information about any accusations and the process that will be followed.
- Decisions about notifying the person allegedly causing harm need to be made at the strategy meeting, weighing up potential repercussions or further risk of harm.
- If the person allegedly causing harm is also an adult at risk, a decision must be made about how their needs are to be met during the investigation. For example, if they lack capacity, they will also need someone who can represent them, possibly an IMCA.
- Identify if the person needs advice, support, assistance or services under community care legislation.
- Throughout the Safeguarding Adults process, people alleged to have caused harm must be treated and spoken of without prejudice.
- Cases where the person alleged to have caused harm is a family member, friend or carer need to be treated with particular sensitivity. For example, work may need to be done to make sure the person alleged to have caused harm understands what harm is. A carer may also need a carer's assessment.

3.5.5 Action to be taken if the person causing harm is also an adult at risk

Adults at risk may also cause harm to another adult at risk. The identification of indicators that such a person (for example, another service user, resident or a carer) may be a potential harmer should be included as part of any risk assessment. If a criminal offence is disclosed the police must be informed.

Assessment of the risk posed by an adult at risk who has allegedly caused harm should include an assessment of the nature of the risk. This assessment may result in the provision of community care services to the person who is alleged to have caused the harm and/or signposting to appropriate mainstream services as part of the Safeguarding Adults plan for the adult at risk.

If a person who is an adult at risk is identified as a potential harmer this should be addressed as part of their care plan, including:

- Undertaking a risk assessment.
- Devising a safeguarding plan.
- Devising a treatment plan.
- Having in place a contingency safeguarding plan.
- Making arrangements for monitoring and reviewing plans.

Plans should involve all relevant professionals as well as family and carers where appropriate.

An allegation of harm or neglect perpetrated by an adult who is at risk to another adult at risk will *always* give rise to decisions under the Safeguarding Adults process and should be responded to (in terms of an initial response) within 24 hours to enable a risk assessment to be undertaken.

Immediate action should be taken to protect others at risk from harm where this is necessary.

3.5.5.1 Specific decisions to be taken at the strategy meeting when the person alleged to have caused harm is also an adult at risk

The primary focus of the strategy meeting or discussion is the adult at risk who has been harmed. It may be necessary to hold a separate multi-agency meeting to meet the needs and address the behaviour of the person causing the harm. However, decisions that will need to be taken at the strategy meeting in relation to the person causing the harm will include:

- How to co-ordinate action in relation to the adult at risk causing the harm.
- Identification and allocation of a separate care manager/care co-ordinator in order to ensure that their needs are met and that a care plan is devised to ensure that other adults at risk are not also put at risk from the person's actions.
- Identification of who should be involved in the investigation and development of the interim safeguarding plan.
- Whether there is likely to be a criminal prosecution (if known at this point).
- What information needs to be shared, and with whom.

The IM will maintain communication with those concerned with the care of the adult at risk who is also alleged to be the person causing harm.

In all cases, the care manager, care co-ordinator or link/key worker representing the adult at risk and the relevant employees working with the person causing the harm must be informed immediately and be closely involved at all stages.

3.5.6 Roles and responsibilities

Safeguarding investigations can involve more than one line of enquiry that needs to be co-ordinated. In fact many investigations may run concurrently, for example, disciplinary processes or a criminal investigation. However, all such processes need to be discussed, agreed and co-ordinated at the strategy meeting.

The organisation responsible for undertaking their part of the investigation should have regard to their other responsibilities or the legal powers, for example, employment law, criminal law and clinical governance.

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

- Identify any possible personal safety issues for the person who will conduct the investigation and plan to address these.
- In cases where a potential or actual crime has been reported and is being investigated by police, invite the OIC to the strategy meeting. If the OIC is unavailable to attend, hold a strategy discussion on the telephone and note the crime incident number.
- Action that may lead to legal proceedings should take precedence over other proceedings and there should be discussion and co-ordination of those processes to avoid prejudicing such investigations.
- If there is going to be a police investigation that could lead to criminal proceedings, there should be early identification of the likely need for witness support and special measures to be made available to them.
- If there are going to be a number of investigations, the meeting or discussion will decide in what order the various investigations, assessments and enquiries should take place.
- Where joint investigations or assessments are planned, there should be clear agreement between the organisations concerned as to their respective roles and responsibilities.
- Agree how communication will be maintained during the investigation.
- Identify who will be the responsible person within each participating organisation for any agreed actions.
- Decide who else needs to be informed.
- Identify whether there are children at risk, agree a referral to the children's social care team and who will make the referral.

- If the situation indicates that the adult at risk is being subjected to domestic violence and the risks are high (as indicated by completion of the CAADA DASH risk assessment), agree a referral for a MARAC. Designate the organisation and the person who will complete the CAADA DASH risk assessment and make the referral. This can be done by the worker identifying the concern in conjunction with the agency's MARAC representative. The CAADA DASH process does not replace the Safeguarding Adults process, but adds benefit to any risk assessment and allows specific issues relating to high risk domestic violence or abuse to be identified and managed.
- If the alert was made by a service user or a member of the public about harm or neglect within an organisation, the organisation's complaints procedure could form part of the investigation and risk assessment. A decision will be made on a case-by-case basis as to whether the complaints process is suspended pending the outcome of another investigation.

3.5.7 Possible outcomes

3.5.7.1 Continuing the Safeguarding Adults process

The Safeguarding Adults process will continue and an investigation/ joint investigation and risk assessment will take place.

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

- Whether the strategy will need to be reviewed during the investigation and risk assessment and make a date for that to happen.
- The timescale in which the investigation should take place. The investigation should begin as soon as possible after the strategy meeting or discussion and be completed within 21 calendar days of the Strategy meeting.
- If, due to the complexity of the investigation, it is clear from the outset that a longer timescale will be required, this must be agreed at the strategy meeting or discussion by all relevant organisations and a record made of the decision.
- In the above situation it may be necessary to hold a further strategy meeting to ensure that a review is made of protection arrangements
- A date for a Safeguarding conference.

3.5.7.2 Investigations and processes that could be triggered by an alert

An alert can trigger various processes that amount to a formal investigation, for example, a criminal investigation, or disciplinary procedures, action under Serious Incident (SI) policies in health, or less formal investigative processes. Such investigations might include:

- A police investigation if a crime might have been committed.
- A review by CQC, if the concern arose in a regulated service.
- Consider which Pathway to follow. *See paragraph 3.4.5.*

- An assessment of a carer's needs.
- Action by employers such as suspension and an investigation under disciplinary procedures if the concern indicates that the harm or neglect was caused by an employee or paid carer.
- Investigation of a complaint by the complaints department of an organisation.
- An investigation by the Public Guardian's Office (PGO) if the concern is about an attorney created under a lasting or enduring power of attorney or a court-appointed deputy.
- Referral to the Court of Protection for a decision, declaration order or the appointment of a deputy.
- An investigation by the Department for Work and Pensions if the concern is about the misuse of appointeeship or fraud in relation to benefits.
- Action for breach of contract terms.
- A referral to MARAC where the allegation indicates a high risk domestic violence victim.
- An investigation into a situation where forced marriage or honour based violence could be indicated. In these instances links should be made to the MARAC.
- Arrangements for the care and treatment of the person who is alleged to have caused the harm if they are also an adult at risk.

Table 3.2: Type of investigation or risk assessment and agency responsible

| Type of investigation/ risk assessment | Agency responsible |
|--|---|
| Criminal (including assault, theft, fraud, hate crime, domestic violence and abuse or wilful neglect of a person lacking capacity). | Police. |
| Domestic violence or abuse – serious risk of harm. | Relevant organisation carries out a CAADA DASH risk assessment and referral to MARAC. |
| Fitness of registered service provider. | CQC |
| Unresolved serious complaint in healthcare setting. | CQC |
| Breach of rights of person detained under the Mental Capacity Act 2007 Deprivation of Liberty Safeguards (DoLS). | CQC Supervisory body eg: LA or PCT |
| 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) Environmental Health Dept. |
| Complaint regarding failure of service provision (including Neglect of provision of care and failure to protect one service user from the actions of another). | Manager/ proprietor of service/ complaints department. Ombudsman (if unresolved through complaints procedure). |
| Breach of contract to provide care and support. | Service commissioner (eg: social services, PCT, Supporting People). |
| Assessment of need for health and social care provision (service users and carers). | Social Services, NHS/ CMHT/ care trust. |
| Access to health and social care services to reduce risk of harm/ neglect. | Social Services, NHS/ CMHT/ care trust. |
| Misuse of enduring or lasting power of attorney or misconduct of a court-appointed deputy. | PGO/ 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. | PGO/ Court of Protection. |
| Misuse of appointeeship or agency. | Department of Work and Pensions. |
| Anti-social behaviour (eg: harassment and nuisance by neighbours). | Police Community Safety Team. Local Authority |
| Breach of tenancy agreement (eg: harassment and nuisance by neighbours). | Landlord/ registered social landlord/ Housing Trust/ Community Safety Team. |
| Bogus callers or rogue traders. | Police and Trading Standards officers. |

3.5.7.3 Continuing action through other processes

There maybe no need to conduct a Safeguarding Adults investigation but there maybe a need for action through other processes (for example, care management).

3.5.7.3.1 No further action under the Safeguarding Adults procedures

There are Safeguarding Adults concerns but the adult at risk has mental capacity, is living at home and they are confident that they can protect themselves from further harm and they do not wish any action to be taken under the procedures. Practitioners must be confident that the adult at risk is making this decision without undue influence, threats and intimidation. If there are no other people at risk from the person causing the harm, there will be no more action under the procedures at this time. In this situation there should be express agreement with the adult at risk that there will be no more action under the procedures. They should be given information about harm and neglect, 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.

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

A decision to discontinue the Safeguarding Adults process must be agreed by all relevant organisations and recorded and signed off by the IM. The reasons for closing the Safeguarding Adults process should be recorded and a copy sent to strategy meeting attendees. The person raising the alert should be informed unless inappropriate to do so. The adult at risk should have a copy of the decisions that takes into account issues of confidentiality and the need for protection of personally identifiable information.

3.5.8 Resolution of disagreements

Where there are disagreements that cannot be resolved by discussions between front-line workers or attendees at meetings, the issue should be brought to the attention of line managers or lead managers and Safeguarding Adults leads, who will hold discussions to try to resolve differences.

If disagreements still cannot be resolved, the IM will refer to a more senior manager within his/her organisation (for example, the Safeguarding Adults lead). This senior manager should then decide whether to address the disagreement with another senior manager in the organisation where the delay is occurring or take another course of action. At all times participating agencies should avoid delay resulting from inter-agency disagreement and ensure that the well-being of the person at risk takes priority.

3.6 Stage Four: Investigation

This section covers:

- Purpose of the investigation.
- Roles and responsibilities.
- Undertaking the investigation.
- The investigator's report.

3.6.1 The Purpose of the investigation is:

- To establish the facts and contributing factors leading to the referral.
- To identify and manage risk to ensure the safety of the individual and others.
- To assist them to recover from any trauma.
- To clarify the views of the adult at risk, enable a mental capacity assessment to be carried out if required and instruct an IMCA if that is indicated.
- To determine who was responsible and/or culpable and what action should be recommended in relation to them.
- To review the management of the setting/service and any improvements required or sanctions to be recommended.

3.6.1.1 Investigation/Assessment Checklist

- Complete, as necessary, the alert form and ensure that it has been put onto the appropriate database.
- Liaise with the relevant manager if emergency action is required to protect the adult(s) at risk or children.
- Keep a complete record of contacts, meetings, interviews, phone calls and any decisions taken and issues considered to be placed in the closed section of the client's file.
- Record decisions taken as a result of meetings or consultations with other professionals or service providers.
- Carry out an assessment/investigation with other agencies, where appropriate, and write a summary of the findings that will support decision making.
- Inform the Alerter's Manager/referrer about actions & progress, unless to do so would jeopardize the investigation.

3.6.1.2 Map out the investigation

- What needs to be found out?
- Who might have this information?
- What legal powers are needed?
- Check out all necessary documentation.
- Is a psychological, psychiatric or speech therapy assessment of any of the adults at risk needed, prior to carrying out any interviews?
- Interview people, in the appropriate environment, taking into account any need for an independent advocate and/or any language, communication, gender or race issues.

- Plan interviews with colleagues prior to commencing the interview.
- Take statements and record interviews; (training in conducting interviews is essential).
- Collate the evidence.

3.6.1.3 Evaluate the evidence obtained from:

- Medical or forensic evidence.
- Background reports, service records and previous histories.
- Witness statements from formal/joint interviews.
- Assessment of individuals' capacity and witness skills.
- Circumstantial evidence.
- Assessment of the extent and seriousness of the harm and the effect it has had on the adult at risk and others in their network.

3.6.1.4 Contributing to other lines of enquiry

The investigation may also contribute to:

- A police prosecution.
- Identifying powers to protect the adult at risk, for example, a restraining order
- Actions under civil law, for example, an injunction.
- Employees disciplinary proceedings.
- Referrals to:
 - > the ISA
 - > the CQC in relation to a registered provider
 - > commissioners of the service in relation to breach of contracts
 - > a landlord in relation to a breach of a tenancy agreement.
- A community care assessment or assessment under CPA.
- A healthcare assessment.

3.6.1.5 Standard of proof

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

3.6.2 Roles and responsibilities

3.6.2.1 The investigator

The manager in Social Services who has responsibility to undertake an investigation is called the Investigating Manager and will identify an employee to be the designated 'investigator' for the investigation.

The investigator should be a suitably qualified and experienced employee who has received specific training in safeguarding adults investigations and will work under the supervision of the Investigating Manager. The Investigator and Investigating Manager must not have line manager responsibilities for the person alleged to have caused harm, or work

in the same department. If there is a criminal investigation, the Police will be the lead organisation and any other investigations must be co-ordinated with them.

3.6.2.2 Specific responsibilities of Investigating Managers (IM)

- Effective supervision and ongoing support are essential for the Investigator (the practitioner who is undertaking the investigation).
- The manager of the investigator must confirm the accuracy of all records relating to a Safeguarding Adults investigation, including:
 - > records of the initial investigation and assessment.
 - > records of any decisions taken at strategy meetings or Safeguarding Conferences.
 - > records of the investigation and interview(s) and
 - > a record of any decision taken to close the investigation.
- The manager of the investigator should take all reasonable steps to ensure the health and safety of employees involved in a Safeguarding Adults investigation.
- A risk assessment of the situation should include consideration of the risks to the employees involved in the Safeguarding Adults investigation. Where the risk is assessed as being high, employees should not normally undertake a visit unaccompanied.
- The manager of the investigation must preserve the confidentiality at all times of all concerned including employees under the Safeguarding Adults information-sharing protocols.

3.6.2.3 Responsibility of all organisations taking part in the investigation

Each organisation must designate a suitably trained and experienced employee to ensure that the organisation carries out its role and responsibilities in the plan agreed at the strategy meeting stage. This will include ensuring that the organisation carries out agreed actions including implementing their part of the interim safeguarding plan.

3.6.2.4 In addition, the manager of the organisation will ensure that:

- Actions to safeguard adults at risk are given top priority and they are supported throughout the process.
- Clear records are kept of any contact with, or actions taken to support or care for, the adult at risk.
- There is support and supervision for employees carrying out this work.
- The organisation actively co-operates with other organisations taking part in the investigation, risk assessment and Safeguarding Adults enquiry.
- The IM is kept up to date and informed of any new information or changes in the situation or the plan as soon as possible.
- Any agreed enquiries are conducted without delay .

- Clear records are kept of any enquiries or investigation findings which emerge about the circumstances of the Safeguarding Adults concerns.
- A written report of the findings is prepared and sent to the IM, which will form the basis of the organisation's input into the safeguarding plan.

3.6.3 Undertaking the investigation

3.6.3.1 Timescales

Unless the situation was regarded as so urgent that it was decided to conduct an immediate investigation, the investigating officer will make contact with the adult at risk and begin the investigation immediately following the strategy meeting.

The investigation should be implemented without any reasonable delay and should be completed within 21 calendar days of the strategy meeting.

The investigating officer must keep the IM informed of the progress of the investigations and any change to the timescales. If for any reason the investigation cannot be completed within the timescales, a revised agreement about timescales and any necessary action(s) to be taken must be reached with the IM and other relevant organisations and recorded.

3.6.3.2 Interviewing the Adult at Risk

See also link for more detailed guidance in section 4.27.

- Agree an interim safeguarding plan with the adult at risk and ensure they know what it is and how they will be supported and kept informed during the investigation, including having an appropriate independent advocate if they wish.
- Clarify the mental capacity of the adult at risk to make decisions about their own safety
- Arrange for an assessment by the most appropriate person, if required.
- Carry out a risk assessment with the adult at risk if they have mental capacity.
- Discuss issues of confidentiality and information sharing with the adult at risk and if there are no others at risk, get permission to share information with other organisations as required. If there are others at risk, inform the adult at risk of the duty to share information to protect others.
- If the person at risk has mental capacity, reassure them that no decisions or plans which have an impact on their daily living arrangements will be made without their agreement to that decision.
- Identify who will keep the adult at risk informed and what information can be shared with them.
- Where the adult has capacity, ensure their wishes are respected as to sharing of information with relatives and/or carers (unless there is a duty to override their decision).
- If the police are the lead investigating organisation, they will conduct interviews in a

way to achieve best evidence under the provisions of the Youth Justice and Criminal Evidence Act 1999.

- If there are grounds for prosecution, the CPS should consider the need for an application to be made to the court for special measures under the above legislation.
- If during the investigation it becomes clear that the situation indicates domestic violence or abuse, the CAADA DASH risk assessment should be completed and if this indicates that there is a high risk of harm, a referral should be made to the MARAC. If the organisation conducting the investigation cannot make such a referral they should refer to the IM, who will complete the CAADA/DASH risk assessment and refer.
- If the person at risk does not have mental capacity to make decisions about their safety, the investigator must continue to involve them. They must also consult with their personal representative, a court-appointed deputy or attorney, if they are not implicated in the allegation and/or an IMCA if one has been instructed.
- Identify if the person needs advice, support, assistance or services under community care legislation.
- During the investigation the investigator should keep the relevant IM informed of the progress of the investigation and of any information that could impact on the continued safety of the person at risk or others who may be at risk and indicate changes that are needed to the interim safeguarding plan.
- If the investigation is likely to be prolonged, another strategy meeting must be held to ensure that the interim safeguarding plan is providing adequate safeguards for the adult at risk (and other individuals at risk if necessary).
- If the investigation reveals that a child or young person is living in the same household or is in regular contact with the person alleged to have caused harm and could be at risk, referral should be made immediately to the relevant children's social services team.

3.6.4 The Investigators report

The Investigator should:

- Send the report of the investigation to the IM. The report will form the basis of the discussion at the Safeguarding conference.
- Keep personally identifiable information concerning the adult at risk, the person causing the harm and any third parties to a minimum.
- Share relevant information from the report only with organisations who have a need to know in order to safeguard the adult at risk, to inform the Safeguarding plan and to inform what action will be taken against the person causing the harm if the allegation is substantiated.

The IM will ensure a Safeguarding conference is convened normally within 21 calendar days of the strategy meeting to bring together the findings. All reports from the investigation should be sent to the Chair of the conference 3 days beforehand and shared with the adult at risk if appropriate.

3.7 Stage Five: Safeguarding conference and Safeguarding plan

This section covers:

- Purpose of the Safeguarding conference.
- Who should attend.
- Responsibilities and tasks of the Safeguarding Conference.
- Developing the Safeguarding plan.
- Other possible outcomes of the Safeguarding conference.
- Recording and feedback.

3.7.1 Purpose of the Safeguarding conference

The aim of a Safeguarding conference is to enable inter-agency, multi-disciplinary discussions to:

- Consider the details of the case and the information contained in the investigator's report(s).
- Consider the evidence and, if substantiated, plan what action is indicated.
- Consider the outcomes the adult at risk wishes to achieve.
- Make a decision about the levels of current risks and a judgement about any likely future risks.
- Plan further action if the allegation is not substantiated.
- Plan further action if the investigation is inconclusive.
- Consider what legal or statutory action or redress is indicated.
- Agree a safeguarding plan.
- Agree individual responsibilities for taking actions and timescales.
- Agree how the safeguarding plan will be reviewed and monitored.

To help support the attendance and effective participation of the adult at risk. The Safeguarding conference may be divided into two parts:

- Part 1, for professionals to receive the investigator's report and to make decisions on the findings.
- Part 2, concerned with agreeing the safeguarding plan. This part could be attended by the adult at risk. The agenda should be set out so that the adult at risk may actively participate in the meeting (if appropriate).

Alternatively, if it is necessary in order to meet the adult at risk's access and communication needs (if specialist facilities are needed), a separate safeguarding plan meeting could be held in a different venue. If this proves to be necessary, such a meeting should be held as close in time to the first part of the meeting as possible.

3.7.1.1 Planning the Safeguarding Conference

The Safeguarding conference should take place within 21 calendar days from the strategy meeting but this may depend upon decisions taken at the strategy meeting. Some investigations and outcomes or processes may not be completed within this time frame, for

example, a criminal prosecution but the Safeguarding conference should not be delayed because it is essential that a Safeguarding plan is put in place as appropriate.

The IM is responsible for ensuring that a Safeguarding conference is convened in an appropriate location, chaired and minutes taken. The chair of the Safeguarding conference may be the IM, another IM or a more senior manager if the nature of the enquiry indicates that this would be appropriate, for example, in the case of a large-scale enquiry or where an allegation concerns an employee or a paid carer.

The IM must ensure:

- Communication needs of all those attending are met.
- The adult at risk's needs are met, for example, an interpreter, transport or an advocate.
- Ensure all agencies provide reports for the meeting and make these available to chair beforehand.
- The Investigator who carried out the investigation and risk assessment attends the conference and submits a report summarizing the findings. This should be sent to the IM and Chair before the meeting and copied to all attendees to Part 1.

3.7.2 Who should attend

3.7.2.1 Attendance of the adult at risk in the second part of the Safeguarding Conference

The adult at risk should be:

- Supported to take the lead in deciding what should be in the safeguarding plan.
- Invited, supported and enabled to attend the Safeguarding conference or equivalent part of the meeting as appropriate where it is safe for them to do so.
- Supported to have an active part in the decisions about what measures can be taken to protect them and reduce the risk to their safety. This will include being given information about the purpose of the meeting and who will be there.

If the person at risk has capacity to make decisions about their own safety, their views should be taken into account about who should attend the meeting. This could include choosing a representative to attend on their behalf.

If, for reasons of confidentiality or any other reason, the adult at risk who has mental capacity does not attend the Safeguarding conference, they should be consulted beforehand as to their views. Their views should be represented at the meeting by a representative, advocate (including IMCAs) or a key worker.

If the person at risk does not have capacity to make decisions about their safety, they should be represented by someone already closely connected with them, a family member (if they are not implicated), a welfare attorney or, if one has been instructed, an IMCA, who will advise on what is in the person's best interests unless there are issues of confidentiality which exclude them from the meeting or relevant part of it. In this case they should be consulted beforehand so that the views of the adult at risk can be represented at the

meeting and they must be informed of the outcome of the meeting.

The meeting should decide who will feed back the decisions about the Safeguarding plan to the adult at risk if they do not attend the meeting and they must know who they can contact if they do not agree with or wish to comment on the plan.

A record should be made if the adult at risk does not attend the meeting, including reasons why this has occurred.

Information to the Adult at Risk and Other Relevant People

Inform the adult at risk:

- Exactly what the meeting is about.
- Who is going to be at the meeting?
- What will be discussed -the agenda.
- They have a right to speak.
- They can sit where they choose.
- They can have a break at any time.
- They can have support and legal advice.
- They can bring an advocate.
- They can send an advocate on their behalf if they do not want to attend the meeting.

3.7.2.2 Others attending the meeting

- Carers should only be invited to the meeting on the express wish of the person at risk. If the adult does not have the mental capacity to make that discussion, it may be made in their best interests, or with the consent of an attorney or deputy.
- The person causing the harm should not attend the meeting unless the Chair has agreed before the meeting, it is part of the safeguarding plan to change their behaviour and reduce harm or neglect and the adult at risk has given explicit consent. He/she should not attend if there are ongoing criminal processes or he/she is an employee or volunteer. If the meeting decides there are actions to be taken with regard to the person causing the harm, the meeting must decide who will inform him/her of the actions and the reasons why this decision was taken.
- Each organisation involved in the investigation should send a suitably qualified and experienced manager to the Safeguarding conference. This will usually be the person who undertook the investigation in the organisation and may be the manager or the Safeguarding Adults lead.
- The manager of the organisation who conducted the investigation and risk assessment.
- The investigator(s) – Social Care and Police, if a joint investigation.
- Adult Social Services Manager.
- The manager of any other organisation who can contribute to the safeguarding plan.
- The care manager or care co-ordinator or key worker for the adult at risk.

- GP.
- Other relevant professionals, for example, the police, psychiatrist or other healthcare involved with the adult at risk.
 - Local Authority solicitor (may be invited if appropriate to advise on points of law and would need the investigator's report in advance).
 - Any other appropriate or useful agencies who are relevant to the individual or case or who can help in formulating the safeguarding or care plan. e.g. specialist domestic or sexual violence agencies.

The case conference is not a legal process, therefore it is not a forum for legal representatives of service providers to attend. A separate meeting may be convened for legal representatives to meet and discuss issues relevant to them.

If a professional is unable to attend, they must provide relevant written information to the meeting. The Chair will need to reach a view whether there are a sufficient number of relevant attendees for the meeting to be held.

People attending the meeting should have the delegated authority to agree to provide services to contribute to the safeguarding plan if their organisation has a role to play.

3.7.3 Responsibilities and Tasks of the Safeguarding Conference

The meeting will:

- Agree agenda and confidentiality and respect notices.
- Everyone attending states his or her name, agency and what their involvement is in the case.
- The investigator(s) must give a report outlining the details of the case previous, current and future risk and the action taken to date.
- Representatives from other agencies will inform the conference of their previous involvement with the individual or case and of any action being undertaken or planned.
- Evaluate the information and make a decision about current levels of risk and make decisions about the reduction of future risks.
- Availability of statutory powers of intervention must be discussed.
- A safeguarding action plan should be agreed with timescales stating the responsibility of each agency and Contingency plan.
- The safeguarding plan should be completed (if possible) at the conference, signed by all involved and a photocopy given to all those attending.
- Identify key worker/care co-ordinator to work with key agencies and finalise the safeguarding plan within 2 weeks, if not previously completed.
- Where an adult at risk is under the care of secondary Mental Health Care Services (CMHT) the safeguarding adults plan should be incorporated into their Care Plan.
- Arrangements for review of progress within 3 months must be made.
- Decide what action is appropriate when the allegation was not proved or was

unfounded but concerns remain about standards of care.

- If it is decided that a safeguarding plan is not necessary, or that no further action is to be taken, the reasons why must be detailed in the minutes and consideration is given to referral or support from other agencies.
- Decide who will feed back to referrer.
- Determine how the adult at risk will remain central to the Safeguarding plan.

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

3.7.3.1 Deciding the outcome

The purpose of the Safeguarding conference is to evaluate the evidence and to determine the outcome on balance of probability. It is also to ensure the safeguarding plan is still relevant and appropriate.

3.7.3.2 Possible outcomes for the adult at risk

- Identifying areas and actions to continue to monitor.
- Removal from property/support, advice, services.
- Community Care Assessment/services.
- Civil Action.
- Application to Court of Protection.
- Application to change appointeeship.
- Referral to advocacy service.
- Referral to counselling services.
- Management of Access to Finances.
- Guardianship/use of Mental Health Act 2007.
- Review of self-directed support.
- Restriction/management of access to alleged perpetrator.
- Referral to specialist domestic or sexual violence services e.g. outreach, refuge, Rape Crisis, ISVA, SARC
- Referral to MARAC.
- Declaratory Relief.
- DoLS authorization.
- Referred to Complaints Procedures.
- No further action.
- Other.

3.7.3.3 Possible outcomes for the person alleged to have caused harm

- Criminal prosecution/formal caution.
- Police action.
- Community Care Assessment/services.
- Removal from property/support, advice, services.
- Management of access to adult at risk.

- Referral to *ISA*.
- Referral to professional regulatory body eg: GSCC.
- Disciplinary action.
- Action by CQC.
- Identify areas and actions to continue to monitor.
- Counselling/training.
- Referral to court-mandated treatment.
- Referral to MAPPA.
- Action under Mental Health Act 2007.
- Action by contract compliance.
- Carer's Assessment.
- Exoneration.
- No further action.
- Other.

3.7.4 Developing the Safeguarding plan

The meeting will:

- Agree a safeguarding plan with the adult at risk (or the person representing them or their best interests) and decide which employees will monitor and co-ordinate the plan.
The plan should begin in the conference and the details finalized no later than 2 weeks after the conference.
- Agree contingency actions if the safeguarding plan does not work.
- Designate a safeguarding plan key worker, who could be from any relevant agency.
- This person can be from any of the agencies engaged in the Safeguarding of the individual and they will be the primary contact for all contributors about developing or changing risks between reviews.
- Agree a core group who will work with the key worker to implement the safeguarding plan.
- This safeguarding plan is a multi-agency document and all parties have a responsibility to take the actions agreed to reduce identified risks. It should include action points, responsibilities and timescales.
- Agree how the safeguarding plan will be shared with partners, taking into account information-sharing considerations.
- Provide support and services to meet the needs of the adult at risk and of a carer, if that is indicated.
- Determine what additional information needs to be shared and with whom.
- Where potential exists for risks to arise outside of normal office hours, then the Investigating Manager must ensure that the out-of-hours team are made aware of the content and context of the safeguarding plan. They will be responsible for ensuring immediate safety out of office hours.
- Set a date within 3 months for a review unless all organisations agree that a review can take place as part of the care management/CPA or health and social care process. If this is the decision reached, the reporting mechanism for the outcome of the review needs to be established and agreed (for example, information sent to the chair or the IM following the review).

- Between formal reviews the key workers may become aware of or may be informed by other parties of developing and changing risks. It is for the Key Worker to liaise and inform the Investigating Manager, who will, if necessary call for an urgent unscheduled review.
- Ensure the Safeguarding Plan is cross-referenced in the MARAC and MAPPA when taking place.
- Subsequent reviews should be no more than 6 monthly.

3.7.5 Other possible outcomes of the Safeguarding conference

Other possible outcomes of the Safeguarding conference may include the following:

- Implementation of changes following an organisational review, for example, employees, recruitment, policies, procedures, training, working practice and culture. This may include planned changes (training etc) relating to the individual employees.
- Implementation of requirements made in recommendations from a complaints process (including an action plan/timetable for implementation).
- Review of personal budget arrangements for someone who directs their own care.
- Improvement of risk monitoring and quality assurance measures.
- Referral to the ISA. A referral to the ISA must be made by the regulated activity provider:
 - If they have withdrawn permission for the person (an employee or volunteer) to engage in regulated or controlled activity, or would have done so if the person had not resigned, retired, been made redundant or been transferred to a position which is not a regulated or controlled activity and
 - If they think the person has:
 - engaged in relevant conduct or
 - satisfied the harm test (that is, they have harmed or put at risk of harm the adult at risk).

3.7.5.1 Information that may be shared with other local authorities where concerns have been identified about the quality of care of a particular provider

Following the investigation:

- CQC should be informed if a local authority or a health organisation had concerns about the standards of care within a registered health or social care service.
- Factual information regarding concerns about standards of care can be shared with local authorities on a need-to-know basis.
- If an investigation has not been completed and there has been no decision about whether the concerns have been proven, the information can be shared with local authorities to enable them to ascertain whether there are concerns about service users that they are responsible for and whether any action needs to be taken.
- If, following an investigation, allegations have been proved, then that factual information can be shared on a need-to-know basis with respect for the right to confidentiality of the person causing the harm.
- The organisations must seek legal advice with regard to restraint of trade issues.

3.7.6 Recording and feedback

3.7.6.1 Safeguarding Conference minutes

- A detailed set of minutes must be taken at the Safeguarding Conference. The Chair will be responsible for ensuring a dedicated minute taker is present.
- The minutes will record decisions of the Safeguarding conference and evidence of how the decisions were made. Should no further action be required the rationale for this should be clearly recorded within the minutes.
- Details of the Safeguarding plan with actions agreed at the meeting, timescales and responsible person.
- The Chair, will ensure that minutes are sent to all those who were invited to attend the conference within 10 working days, including:
 - All attendees and invitees to the whole meeting.
 - All those contributing to the safeguarding plan.
 - The CQC where the Safeguarding conference relates to a regulated service.
 - All other relevant regulatory bodies, as appropriate.
- Any questions or clarification about the content of the minutes must be made to the Chair of the meeting within five working days of receipt. Only the Chair can agree any changes to the content of the minutes.
- The minutes of the Safeguarding Conference are confidential and should only be distributed to those agency members who attended or were invited to attend the conference. They must not be reproduced without permission of the Chair.
- The Chair should ensure the minutes are produced in a manner that makes them understandable to the service user or nominated person for example Braille, large print, total communication and so on.
- Unless it would increase the levels of risk, a copy should be sent to the adult at risk or, with their permission, to another person. If the adult at risk does not have mental capacity, a decision should be made in their best interests about who to send the minutes to.

Information that cannot be shared must be deleted from versions of documents sent out. Data Protection Act 1998 principles must be adhered to.

- Where information is sent to a carer, with permission of the adult at risk or in their best interests, the IM will decide what information can be shared about the person causing the harm.
- The IM will decide who is the best person to feedback the outcome of the meeting to the adult at risk as soon as possible after the meeting. The adult at risk should be enabled to raise any issues they may have about the decisions taken and the Safeguarding plan that has been developed/agreed on. It will also be important to establish with the adult at risk if they feel safer as a result of the Safeguarding plan.

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

3.7.6.2 If a referral or complaint is received after an adult at risk has died

The referral or complaint could contain an allegation or suspicion that harm or neglect could have been a contributory factor in the person's death. The allegation may be made by a family member or friend, a concerned member of employees who is 'whistle blowing', or as a result of a report from the coroner. Such a referral will give rise to action under the Safeguarding Adults policy and procedures. Further concern will be to ensure that no other adults are at risk from the same source and, if they are, to take steps to ensure their safety. Decisions may also be taken about whether a serious case review will be undertaken.

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

The Safeguarding Adults process will continue and an immediate review must take place to decide whether the death was as a result of the inadequacy of the safeguarding plan or whether poor inter-agency working was a contributory factor. In either of these situations the police may be involved where there is evidence or suspicion:

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

The Coroner will be informed by the police of the death as soon as possible (and before burial or cremation) if harm or neglect is suspected to be a contributory factor.

If the incident occurred in a health or social care setting and involved unsafe equipment or systems of work a referral may be made to the Health and Safety Executive (HSE). The HSE will make a decision as to whether they will investigate.

A strategy meeting of relevant organisations should be convened to review the allegation or complaint and to agree a co-ordinated investigation. If there is to be a police investigation, that investigation will take primacy. All organisations will be expected to co-operate in the agreed process.

Consideration should be given to whether there should be an independent manager's review or a serious case review (SCR) to examine the circumstances involved.

Please contact Bournemouth & Poole Safeguarding Adults Board Management Support Officer on 01202 261015 for: Serious Case Review Protocol

If the adult at risk was a victim of domestic violence and was murdered, a statutory duty to undertake a Domestic Homicide Review (DHR) exists. This duty can be met through the safeguarding adults Serious Case Review process but the Home Office must be informed of any learning outcomes from the review through the Chair of the relevant Community Safety Partnership (CSP). (<http://www.homeoffice.gov.uk/publications/crime/DHR-guidance>)

3.8 Stage Six: Review of the Safeguarding plan

This section covers:

- Purpose of the review.
- Who should attend
- Actions.
- Recording and feedback.

3.8.1 Purpose of the review

If a date for a review of the safeguarding plan has not been fixed at the case conference, a review will always take place within 3 months from the date it was produced.

In practice a review tends to happen much sooner than this and may be more than one meeting.

The purpose of the review is to ensure that the actions agreed in the safeguarding plan have been implemented and to decide whether further action is needed, including any service improvements. The Review should be managed in the same way as Strategy Meetings and Safeguarding Conferences, by the Investigating Manager.

3.8.2 Who should attend

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

The adult at risk should be enabled to participate in the review on the same basis as for the Safeguarding conference with their advocate or personal representative to support them or represent them as required.

3.8.3 Actions

The review should:

- Review risk assessment and current and future level of risk.
- Decide about ongoing responsibility for the safeguarding plan.
- Decide in consultation will the adult at risk or their personal representative what changes, if any, need to be made to the safeguarding plan to decrease the risk or to make the plan fit more closely with their wishes.
- Record the feedback of the adult at risk or their personal representative about the safeguarding plan and/or other matters of importance to them.
- Make decisions about what changes/additions are needed to the care plan.
- Decide whether there is need for a further review and, if so, set a date.
- Decide whether to close the Safeguarding Adults enquiry/processes.
- Whether the case can return to normal procedures (e.g. standard care, CPA, care plan, care management, primary health or social care).
- All participating agencies will be consulted and written reports may be requested.
- The views and wishes of the adult at risk will always be sought and they or their representative or advocate should be able to attend if they wish.
- The Investigating Manager will ensure a full record of the meeting is made and shared with the participants.

The Review outcome will be one or more of the following:

- A revised safeguarding plan.
- Agreed monitoring and reporting arrangements.

- The identification of any weaknesses in the process and recommendations for improvement sent to the Safeguarding Adults Co-ordinator.
- The identification of any strategic policy issues.
- No further action under Safeguarding Adults procedures.
- The Responsible manager will ensure that the appropriate paperwork in relation to the outcome is completed in a timely manner.

A new concern of harm or neglect would be considered as a new alert/referral.

3.8.4 Recording and feedback

- Record any decisions and actions with the names of those organisations and individuals who have a role to play in the safeguarding plan and who have been undertaking actions agreed during the review.
- Ensure that 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.
- Reach agreement about feedback arrangements during the review in accordance with the adult at risk's 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.

3.9 Stage Seven: Closing the Safeguarding Adults process following review

This section covers:

- When to close the Safeguarding Adults process.
- Actions on closing.
- Evaluation and learning.
- Record keeping and confidentiality.
- Monitoring.

3.9.1 When to close the Safeguarding Adults process

The Safeguarding Adults process may be closed at any stage if it is agreed that an ongoing investigation is not needed or if the investigation has been completed and a safeguarding plan is agreed and put in place and a review has agreed there are no ongoing risks.

In most cases a decision to close the Safeguarding Adults process is taken at the Safeguarding conference or at a safeguarding plan review.

The IM must reach agreement to close the process with all organisations that have been involved in the review process or who might have relevant information. The closing process must be signed off by the IM and/or a senior manager in the case of a serious/complex Safeguarding Adults situation.

3.9.2 Actions on closing

The IM should ensure that, on conclusion of the process:

- All actions are completed or are in progress.
- All records are completed.
- Case records contain all relevant information and satisfactorily completed forms.
- The person at risk knows that the process is concluded and where/who to contact if they have any future concerns about harm.
- All those involved with the person know how to re-refer if there are renewed or additional concerns.
- If proven, action taken to remove a member of employees from a professional register or refer to the ISA.
- All evidence and decisions are adequately recorded.
- Referral is made to appropriate professional bodies where necessary.
- Notifiable occupation schemes are informed.
- The referrer is notified of completion.
- All relevant partner organisations are informed about the closure, including original attendees to the Safeguarding conference.
- The necessary monitoring forms and all data monitoring systems are completed.

Feedback must routinely be sought from the adult at risk about their experience of the process and whether they are satisfied with the measures that have been put in place and if they feel safer.

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

Through the Safeguarding Adults Board (SAB), any partner agency can request that a case review, serious case review or independent management review is undertaken if there was a near-miss or a fatality and procedures do not appear to have been followed or agencies did not work together effectively. Please see Serious Case Review (SCR) protocol for how to do this.

Please contact Bournemouth & Poole Safeguarding Adults Board Management Support Officer on 01202 261015 for: Serious Case Review Protocol

3.9.2.1 When other processes continue

The Safeguarding Adults process may be closed but other processes may continue, for example, a disciplinary or professional body investigation. These processes may take some time. Consideration may need to be given to the impact of these on the person at risk.

3.9.3 Evaluation and learning

The IM will ensure that:

- An evaluation or a quality assurance audit of the Safeguarding Adults process is considered by organisations involved through the Quality Assurance process and informed by feedback from the adult at risk.
- A record is made of any lessons learnt and actions planned to address key issues.
- Feedback is collated and integrated and cascaded into organisational learning in a variety of ways, including training and case discussions at appropriate levels within organisations.

Feedback from the process will be included as appropriate in the annual reports compiled for the SAB to inform future development and training and learning plans.

3.9.4 Large-scale investigations and serious case reviews

For Large-Scale Investigation, see also section on Pathway 4, paragraph 3.4.5.4 and in Section 4.26.

Please contact Bournemouth & Poole Safeguarding Adults Board Management Support Officer on 01202 261015 for: Serious Case Review Protocol

Most local partnerships will have in place local procedures to determine action to be taken in a serious case review.

The following procedure is for large-scale investigations and service-level concerns.

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

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

Such situations will involve a wide range of organisations and a number of individual Safeguarding Adults processes and investigations. There will be an overarching strategy meeting or discussion and case conference. However, each situation will require an outcome, that is, a potential Safeguarding Adults plan for each individual.

It is important that all aspects of the investigation are planned and the organisations and

individual professionals are clear about their respective roles and responsibilities.

In receiving information about individual cases of suspected or actual harm or neglect, it is important to consider possibilities that other adults may also be at risk, including whether past service users could have been harmed. Data checks should be made and consultation held with other organisations who have a responsibility for a person receiving a service.

Where the need for a large-scale investigation becomes apparent, senior managers in the local authority should identify a senior manager to take responsibility for coordinating the overall investigation with all other relevant organisations. If a crime is thought to have been committed, the usual principles and responsibilities for reporting to police apply.

If the concern is with a health setting, the concerned party will contact the executive lead for Safeguarding Adults in that organisation and the NHS. Together they will determine the next steps.

CQC will be alerted where the investigation relates to a regulated health or social care provider.

The Safeguarding Adults co-ordinator of the local authority should also be informed.

Part 4 APPENDICES

4A. Roles and Responsibilities

4.1 Safeguarding Adults Boards (SABs)

These are multi-agency boards established in each local authority to promote, inform and support Safeguarding Adults work. They ensure that priority is given to the prevention of harm and that adult safeguarding is integrated into other community initiatives and services and has links with other relevant inter-agency and community partnerships.

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

<http://www.dorsetforyou.com/safeguardingadults>

<http://www.boroughofpoole.com/go.php?structureID=U4640524f74b47&ref=S4D05E438C0227>

4.2 Safeguarding Adults Structures

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

4.2.1 Everyone – All Employees and Volunteers

The first priority should always be to ensure the safety and protection of the adult at risk. All employees and volunteers from any service or setting should know about this policy and procedures. All employees and volunteers from any service or setting who have contact with adults at risk have a responsibility to be aware of issues of harm, neglect or exploitation. This includes personal assistants paid for from direct payments or personal budgets. All employees 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 harmed, neglected or exploited and to ensure that the situation is assessed and investigated.

Employees or volunteers should:

- Be aware that they must call the police and/or an ambulance where appropriate in situations where the harm 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 authorized 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 harm then they should inform a more senior manager or Adult Social Services direct.
- Know what services are available and how to access help and advice for the adult at risk.
- Know how and where to make a direct referral, where speaking to a manager would cause delay.
- Know that they must make a clear factual record of their concern and the action taken.

4.2.2 Role and responsibility of managers in all organisations

The role and responsibility of the manager is:

- To ensure the alleged victim is made safe.
- To ensure that any employee or volunteer who may have caused harm is not in contact with service users and others who may be at risk.. To ensure that appropriate information is provided in a timely way.
- To ensure that access is given to the investigator (Police or Social Service Staff) to records and information relating to the adult at risk, regardless of whether they are funding their own care or support.

The primary responsibility for co-ordinating information in response to a Safeguarding Adult concern is vested in the Investigating Manager (IM) working with the Police if a crime is suspected. If this is the case, the Police will lead the investigation. All managers in all organisations have a key role to play.

Managers should ensure that they:

- Make employees aware of their duty to report any allegations or suspicions of harm to their line manager, or if the line manager is implicated, to another responsible person or to the local authority.
- Meet their responsibilities and ensure compliance with the Health and Social Care Act 2008.
- Operate safe recruitment practices and routinely take up and check references.
- Adhere to and operate within their own organisation's 'whistle-blowing' policy and support employees who raise concerns.

Managers of regulated activity providers must fulfil their legal obligations under the Vulnerable Groups Act 2006 and the Vetting and Barring Scheme as administered by the

Independent Safeguarding Authority (ISA). Managers have responsibility for making checks on and referring employees and volunteers who have been found to have harmed an adult at risk or put an adult at risk from harm.

Managers in health settings should report concerns as a serious incident (SI) in line with clinical governance procedures and a decision must be made whether the circumstances meet the criteria for referral to the Safeguarding Adults process in line with the policy and procedures.

4.2.3 Human Resource & Disciplinary Actions

When a safeguarding allegation has been made in relation to an employee the alerter must follow the safeguarding procedures and inform their line manager and social services.

The line manager will inform their Human Resource department and follow the disciplinary procedures.

If their line manager is the alleged abuser, they must inform the line manager above or social services direct, who will advise. They may need to follow their 'whistle blowing' procedure.

It is likely that the employee will be suspended as a "neutral act" pending further enquiries.

The safeguarding strategy discussion will determine how to proceed, and involve Human Resources in this. Both sets of procedures will need to be followed but precedence must always be given to safeguarding the adult at risk and if criminal investigation is taking place pursuing forensic evidence.

4.3 Local Authorities

4.3.1 Lead co-ordinating agency

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

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

The local authority must:

- Ensure that any Safeguarding Adults concern is acted on in line with this policy and procedures.
- Co-ordinate 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 due consideration to other adults

or children.

- Ensure that key decisions are made to an agreed timescale.
- Ensure that an interim and a final safeguarding plan are put in place with adequate arrangements for review and monitoring.
- Ensure that actions leading from investigation are proportionate to the level of risk and enable the adult at risk to be in control, unless there are clear recorded reasons why this should not be the case.
- Ensure independent scrutiny of circumstances leading to the concern and to Safeguarding Adults work.
- Facilitate learning the lessons from practice and communicate these to SABs.

4.3.2 Lead Councillor for Safeguarding Adults

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

4.3.3 Director of adult social services

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

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

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

4.3.4 Safeguarding Investigating Manager (IM)

The lead co-ordinating role in relation to individual cases is taken by senior employees of the local authority adult social care, the integrated/joint health and social care team, centralized Safeguarding Adults team or CMHTs who are designated IMs. An IM must be informed of any safeguarding concern arising in any organisation and has overall responsibility for coordinating the Safeguarding Adults process.

The IM has overall responsibility to ensure that:

- The action being taken by organisations is co-ordinated and monitored.
- The adult at risk is involved in all decisions that affect their daily life.
- Those who need to know are kept informed.
- A decision is made in consultation with other relevant organisations to instigate the Safeguarding Adults process.

- A multi-agency strategy meeting or discussion is held to determine how the Safeguarding Adults process will be conducted, who will conduct an investigation and to ensure decisions are recorded and copied to relevant organisations.
- The response of the organisations involved in the Safeguarding Adults process is co-ordinated. The aim is to agree that where indicated a multi-agency investigation will take place with agreement to share information in line with the information-sharing protocol.
- A multi-agency case conference is convened and chaired and a record made of the decisions and circulated to all relevant organisations.
- A safeguarding plan is agreed with the adult at risk if they have mental capacity to participate in this, or in the best interests of the person if they have been assessed not to have mental capacity.
- Any safeguarding documentation is completed including monitoring information or any statistical data which is required.

4.3.5 Out-of-Hours services

Local 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 Out-of-Hours services, 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.

Out-of-Hours Officers must also be aware that, if responding to an emergency, other adults may also be at risk.

An Out-of-Hours Officer would not be responsible for a Safeguarding Adults investigation but it may be necessary to interview the alleged victim where:

- The allegation is serious, that is, life-threatening or likely to result in serious injury (in which case action would be co-ordinated with the police to ensure that any evidence is preserved).
- The referral is unclear.
- There is a need to interview the adult at risk to ensure they can be safeguarded against further harm if necessary.

Whether or not any immediate action is necessary the Out-of-Hours Officer (OoHO) will record the facts concerning the alleged harm or neglect and pass all relevant information to the appropriate duty team in adult social care or to a CMHT on the next working day. If the case is already allocated, the Out-of-Hours Officer will notify the allocated worker.

In a situation where employees who work for other organisations including health services and those who work out of hours become aware that an adult at risk is being harmed or neglected, they should call emergency services if the adult is at serious risk of immediate harm and the local authority Out-of-Hours or emergency Out-of-Hours service if an immediate safeguarding plan needs to be put in place. If this action has been taken, the

Out-of-Hours service deal with the referral as above.

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

4.3.6 Complaints officers

Health & Social Care organisations have statutory complaints procedures. If a complaint received by a complaints officer could indicate that an adult is at risk, the complaints officer will bring this to the attention of the relevant Safeguarding Adults lead immediately.

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

4.4 Police

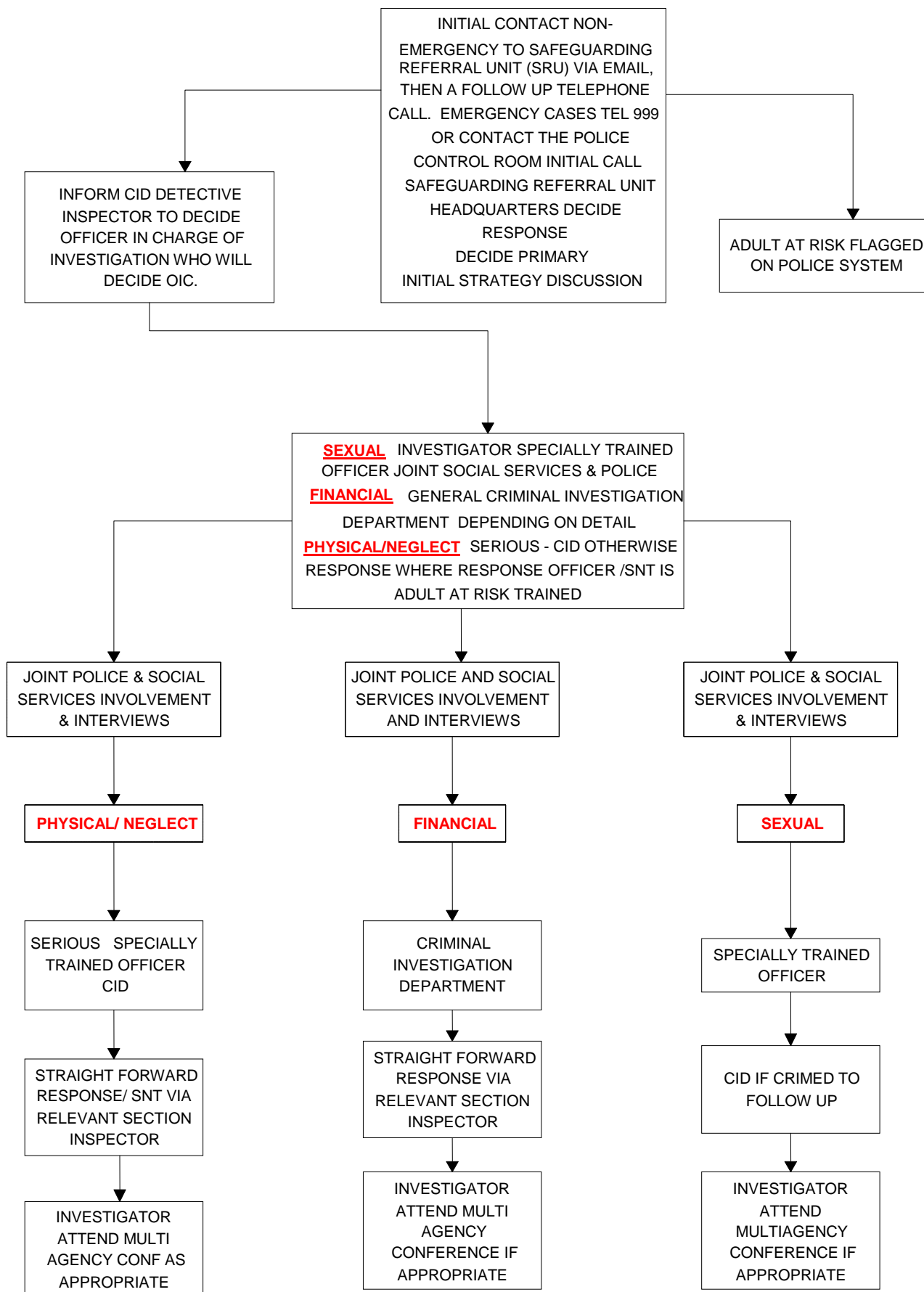
The Police Service is resolute in its commitment to tackling all forms of crimes against 'adults at risk'. Every member of the community deserves protection from exploitation and harm by those entrusted with their care and the people they should be able to rely on to keep them safe.

4.4.1 Aims of the Police Safeguarding Adults at Risk Policy

- To hold people causing harm accountable for their actions. Where criminal proceedings are deemed inappropriate, to work with partnership agencies and to identify courses of action.
- To work in effective partnership with other agencies to safeguard adults at risk.
- Where a criminal offence appears to have been committed, the police will be the lead investigating agency and will direct investigations in line with legal and other procedural protocols. They will facilitate early strategy discussions with Social Services. A police investigation will be initiated at the outset and a comprehensive initial risk assessment undertaken.

It is the responsibility of the police to investigate allegations of crime by preserving and gathering evidence. The police will interview the alleged victim, wherever possible and appropriate in a joint interview with the Social Services trained investigator. The police will also interview the alleged person causing harm and any witnesses. Where the police are the lead investigating agency they will work with the local authority and other partner agencies in line with the Safeguarding Adults policy and procedures to ensure that identified risks are acted on and a risk management or safeguarding plan is agreed at an early stage.

Figure 4: Dorset Police Flow Chart



4.4.2 Barriers to reporting crimes

Many adults at risk who are victims fear that they will not be believed and that reporting a crime will be detrimental to their care needs or family needs. Some will have had poor experiences with statutory agencies in the past or they may not wish to get an employee into trouble.

The following are some reasons why some adults at risk do not report the crimes and harm they have experienced:

- Fear that reporting will lead to the loss of care.
- Fear of retaliation from the person causing harm.
- A belief that nothing will be done if the crime or harm is reported.
- A lack of understanding of the true nature of what is happening to them and whether it amounts to crime or harm, or a lack of knowledge about how to report crimes or harm.
- A belief that the police will be insensitive and/or dismissive of the report.
- A belief that the criminal justice system is unsupportive of people with disabilities and other adults at risk.
- A belief that a prosecution will not be pursued because they will be deemed to be an unreliable witness.
- Embarrassment/feelings of shame.

There may also be practical barriers deterring the adult at risk, for example, someone with hearing difficulties may need a British Sign Language interpreter to be present. Cases where there may be issues and barriers to reporting in addition to those outlined above. They may include fear of being identified as being vulnerable to family/friends, losing their home, carer or financial and emotional support. There may also be cultural matters that keep them isolated from services. An example of this is where a member of the extended family is the carer of an adult at risk where the person may have to accept what has happened, as they do not recognise the particular behaviour as being harmful.

4.5 NHS-funded services, Clinical Governance and Safeguarding

The policy and procedures apply to all health services within Dorset, Bournemouth and Poole. The government White Paper, *Liberating the NHS* (DH, 2010a), makes clear that patients must be at the heart of the NHS. Services will be accountable to patients for the quality of care, shared decision making will become the norm and patient safety is put above all else.

Achieving this vision is most keenly tested by how well services meet the needs of those patients who are least able to protect themselves from harm or hold services to account, that is, how well we safeguard adults.

4.5.1 Why is safeguarding Adults relevant to the NHS?

The NHS is accountable to patients for their safety and well-being through delivering high-quality care. This duty is underpinned by the NHS constitution of which all providers of NHS services are legally obliged to take account. Quality is defined as providing care that is effective and safe and which results in a positive patient experience.

Some patients may be unable to uphold their rights and protect themselves from harm. They may have the greatest dependency and yet be unable to hold the service to account for the quality of care they receive. The NHS has particular responsibilities to ensure that those patients receive high-quality care and that their rights are upheld, including their right to be safe.

Safeguarding Adults: A national framework of standards for good practice and outcomes in adult protection work (ADSS, 2005) describes a range of activities that focus on those patients who are least able to protect themselves from harm. It covers a spectrum of activity aimed at:

- Preventing safeguarding concerns arising, through provision of high-quality care.
- Providing effective responses where harm occurs, supporting the patient's choices through multi-agency Safeguarding Adults procedures.

Figure 4.1: Safeguarding as a continuum

Liberating the NHS (DH, 2010a) foresees a better NHS that:

- Is genuinely centred on patients and carers.
- Achieves quality and outcomes that are among the best in the world.
- Refuses to tolerate unsafe and substandard care.
- Eliminates discrimination and reduces inequalities in care.
- Is transparent with clearer accountabilities for quality and results.
- Gives citizens a greater say in how the NHS is run.
- Is less insular and fragmented, works much better across boundaries with Local Authorities and between Hospitals and practices.
- However, learning from the No Secrets review (DH, 2000) and investigations into NHS failures identifies that we have some way to go to achieve this vision of Safeguarding Adults.



Recurrent themes are that:

- Neglect and harm arise in the absence of effective prevention and early warning systems.
- Neglect and harm are not always recognised.
- Where neglect or harm is recognised within services, there is lack of transparency and openness in investigation – incidents are not managed through multi-agency Safeguarding Adults procedures.

- Safeguarding Adults is often seen as the responsibility of others such as the local authority.
- The patient's voice is not heard.
- Patients are not empowered to make choices about their care and protection.

Safeguarding Adults is embodied within key policy drivers for quality, but too often connections are not made and safeguarding becomes an adjunct rather than a core part of service delivery.

Quality, innovation, prevention and productivity (QIPP) are essential to achieving the NHS vision within this challenging economic climate. Safeguarding Adults is highly relevant to QIPP:

- Quality: clinical risk and poor patient experience arise from poor care, neglect or harm.
- Innovation: Safeguarding Adults involves working collaboratively and creatively with patients, public and partner agencies to address health, well-being and safety.
- Prevention: preventing harm must be the primary aim for the patients' wellbeing and efficiency of services.

Productivity: failures of care are costly for the service as well as the patient. The ultimate risk to productivity is through deregistration in the event of noncompliance with CQC's 'Essential Standards of Quality and Safety'. Health services may be involved in Safeguarding Adults concerns arising in:

- Community: caring for a patient who has experienced poor care, neglect or harm from within their community, for example, a family member or neighbour.
- Services: this may be harm caused by their own service or another care service. Harm may be caused by the healthcare intervention or by omission (neglect) or from their environment.

4.5.2 Who may require support in Safeguarding Adults?

The majority of adults in receipt of healthcare are able to safeguard their own interests and to protect themselves from harm. For some patients, their personal circumstances and the environment they are in impair their ability to protect themselves. Such patients may need additional support to safeguard themselves from harm. Within healthcare settings, patients may be at increased risk of harm as the nature of a health condition gives rise to higher dependency on others.

Figure 4.2: Healthcare services response to safeguarding Adults



Safeguarding Adults describes a range of activities focused on adults who are at risk of harm as they are less able to protect themselves. It is core to delivering the NHS quality agenda and highly relevant to providing the quality, innovative, preventative and productive service required by a modern NHS.

It is complex and diverse in its nature and appropriate responses to Safeguarding Adults concerns will be equally complex and diverse, taking into account:

- The nature and degree of the Safeguarding Adults concern.
- The cause of the harm.
- Most significantly, the wishes of the patient and the outcome that they seek to achieve.

4.5.3 GPs' role in Safeguarding Adults

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

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

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

4.5.4 Patient-led safeguarding

Patients must have control of their care, having the information and support to make choices and be in control of their treatment.

The following defines a positive patient experience:

Getting good treatment in a comfortable, caring and safe environment, delivered in a calm and reassuring way; having information to make choices, to feel confident and feel in control; being talked to and listened to as an equal; and being treated with honesty, respect and dignity.

4.5.5 Role of all Health Employees

Health services will:

- Ensure that employees and volunteers recognise poor practice and respond accordingly.
- Have clear operational procedures for all employees and volunteers.
- Provide access to training appropriate to level of responsibility.
- Ensure employees receive clinical and managerial supervision which allows them to reflect on their practice and the impact of their actions on others.
- Ensure appropriate risk assessments to support timely and appropriate action.
- Work collaboratively with service users and carers, support witnesses and support people causing harm who are also adults at risk.
- Ensure information is shared according to agreed information-sharing protocols.
- Ensure accessible information is available to adults and carers that explains what harm is and how they can raise a concern.
- Designate a safeguarding manager at a senior level to lead on the implementation, monitoring and development of Safeguarding Adults activities within the organisation.

4.5.6 Ownership and strategic leadership

The NHS has an executive lead who is responsible for the overall monitoring of progress of Safeguarding Adults best practice. The role of Strategic Health Authorities (SHAs) is to support the development of adult safeguarding within the local region. South West SHA has produced guidance on the development of safeguarding across the NHS, focusing on promoting and embedding joint working processes.

NHS will develop and roll out a performance framework to measure the effectiveness of local systems. They will set up a local health network which will provide support and advice, deliver key messages, enhance communication within the region, set the behaviours and promote the implementation of new policy and guidance.

They will work with local health partners to determine the best way to bring the local NHS organisations together to develop the network. They will provide three functions:

- Development of a database of local Safeguarding Adults leads across NHS organisations and maintenance of regular network communications.
- Facilitation of network meetings between the SHA and the local health network.
- Development of local engagement by ensuring local representation to the health network.

In addition, NHS will share responsibility for improving Safeguarding Adults performance across health and social care by developing their partnership role with local directors of adult social care with their deputy regional directors of public health.

4.5.7 Safeguarding role of the NHS trust boards

NHS trust boards should ensure that the health contribution to safeguarding and promoting the welfare of adults at risk is implemented effectively across the whole local health economy, both through the PCT's commissioning arrangements and through the responsibilities of the provider boards and committees.

All health services must allocate a board member with lead responsibility for Safeguarding Adults, who will act as a champion in the organisation's vision and responses, and who will provide high-level support for employees in leadership positions related to Safeguarding Adults issues.

The Safeguarding Adults lead board member should ensure strategic ownership of Safeguarding Adults at trust board level, ensuring that appropriate training is available for all employees, including the board and that attendance is monitored. In addition, the trust board member will provide regular feedback to the board on all Safeguarding Adults activity in the organisation, including SI reporting, root cause analysis and lessons learnt from events.

The trust board member will also contribute to the annual report produced by the local multi-agency SAB.

4.5.8 Inter-relation of NHS safety systems and procedures with Safeguarding Adults procedures

Concerns regarding harm and neglect that arise within a health service will be dealt with in line with the local Safeguarding Adults policy and procedures and may require action under organisations' Incidents Requiring Reporting Procedures, clinical governance processes and/or complaints procedures.

Health services must produce clear guidance to managers and employees that sets out who is responsible for the decision-making processes and for initiating action under the above processes and to support clarity about what constitutes a Safeguarding Adults incident.

Organisations must also provide information to employees of how they can raise concerns of poor practice and the support and protection they are entitled to under the Public Interest Disclosure Act 1998.

4.5.9 Membership of Multi-Agency SABs

Members of SABs are of sufficient seniority that they can represent their organisation with authority and make decisions on its behalf.

They will contribute to the annual report of the SAB, setting out a summary of Safeguarding Adults incidents, responses and initiatives within their agency. The report will contribute to an annual audit of Safeguarding Adults activity by the local SAB on which to base the annual development and training plans.

4.5.10 South Western Ambulance Service Trust

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

AS will not investigate suspicions and, if there is someone else present, will avoid letting the person know they are suspicious. If the patient is conveyed to hospital, the employees should inform a senior member of the A&E staff, or nursing staff if conveying to another department, of their concerns about possible harm. They will complete a patient report form and give a copy to the employees at A&E or other location where clinical responsibility is being handed over. AS employees should also follow local procedures for contacting the local authority, which in Bournemouth, Dorset and Poole is to contact the Adult Social Care Safeguarding contact point as soon as possible within 24 hours of identifying the concern.

4.5.11 Patient Advice and Liaison services (PALs) and complaints departments

PALS and complaints departments provided by acute, specialist and community health trusts have been established to provide confidential advice and support to patients, families and carers, including providing confidential assistance in resolving problems and concerns. PALS act as a focal point for feedback from patients to inform service developments and as such can act as an early warning system about concerns including quality of care for NHS trusts and PCTs.

PALS employees are in a position to recognise that a concern which is raised with them either by a patient or a carer or friend could indicate that the person is at risk of harm or neglect. They should raise that concern with their own health trust via senior managers and Safeguarding Adults leads and make a referral to the relevant local authority Adult Social Care Safeguarding contact point as soon as possible within 24 hours, to ensure that appropriate action is taken under the multi-agency policy and procedures.

4.6 All organisations providing services to adults at risk

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

- Safeguarding Adults is taken into account in all appropriate HR strategies, systems, policies and procedures.
- National safe recruitment and employment practices are adhered to, including the ISA.
- Employees and volunteers in contact with adults at risk have regular supervision and support to help them identify and respond to possible harm and neglect.

4.6.1 Other organisations' safeguarding Adults responsibilities

4.6.2 Care Quality Commission (CQC)

The CQC regulates health and social care services and ensures that the powers of the Mental Health Act 1983 are properly used.

Where CQC receives information about a possible Safeguarding concern, that information must be immediately brought to the attention of the Compliance Inspector for the service, or their line manager. If, on a review of the information, there appears to be a Safeguarding Adults concern, CQC should pass the information to the local authority through the locally determined Safeguarding contact point within 24 hours. If there is an indication of potential criminal activity, a referral must also be made to the Police.

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

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

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

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

Where registered persons are implicated in the alleged harm, CQC will assist the IM in determining whether those registered persons should be included as full partners in the strategy discussion.

Whether relevant CQC employees attend or not they must be sent copies of minutes of the agreed strategy. If they have any concern about the proposed safeguarding plan, they will discuss this with the IM.

Where the allegation suggests breaches of regulation CQC may complete a review of the service, in which case they will inform the relevant IM. This activity may take place as well as other investigations being undertaken by another organisation. If the police are conducting an investigation CQC will coordinate their action with them.

The outcome of any assessment or investigation must also be shared with the CQC if it is related to a regulated service.

If the allegation is substantiated and indicates a breach of regulations, CQC will consider whether any further regulatory activity is required and will inform the relevant IM of their decision.

4.6.3 Court of Protection

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

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

In most cases decisions about personal welfare will be able to be made legally without making an application to the court, as long as the decisions are made in accordance with the core principles set out in the Mental Capacity Act 2005 and the best interests checklist and any disagreements can be resolved informally.

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

- Particularly difficult decisions to be made.
- Disagreements that cannot be resolved by any other means.
- Ongoing decisions needed about the personal welfare of a person who lacks 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.

4.6.3.1 Court-appointed deputies

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

4.6.3.2 Public Guardian Office (PGO)

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

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

The PGO Safeguarding Adults at Risk Policy states that the organisation will strive to ensure that adults at risk receive their entitlement to safeguards that:

- Prevent harm from occurring and/or continuing, where possible.
- Identify harm promptly.
- Ensure the harm ceases and the person causing harm is dealt with, wherever possible.

The PGO also undertakes to notify Local Authorities, the Police and other appropriate agencies when harm is identified.

The PGO's Safeguarding Adults at Risk Policy covers any person:

- Who has a deputy appointed by the Court of Protection or
- Is the donor of a registered enduring power of attorney or lasting power of attorney or
- Is someone for whom the court authorized a person to carry out a transaction on their behalf under Section 16(2) of the Mental Capacity Act (single orders). This includes young people aged 16 or over who are defined as adults under the Mental Capacity Act. The PGO may be involved in Safeguarding Vulnerable Adults 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 PGO and the Court of Protection.
 - Receiving reports of harm relating to adults at risk ('whistle-blowing').
 - 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 care social services and the police.

4.6.3.3 Investigations undertaken by the PGO

The PGO 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 authorized by the Court of Protection to carry out a transaction for someone who lacks capacity and report to the Public Guardian or the court.

How the investigation is carried out will depend on the particular circumstances but will typically involve contact with people and agencies that have contact with the person.

Local authorities can use the PGO protocol to refer concerns to the PGO relating to anyone who falls within the PGO definition of an adult at risk, as given above.

The PGO will refer all concerns and allegations relating to people not covered by the PGO Safeguarding Adults at Risk Policy to the relevant adult social care service.

Where it is considered that a crime has or may have been committed, a report will be made to the Police.

4.6.4 Housing organisations

Employees of housing organisations are in a position to identify tenants who are at risk of harm, neglect and exploitation and will refer them to the local authority Safeguarding Adults contact point in line with the Policy & Procedures. *Supporting People* housing has become a major provider of housing and support services for adults with a wide range of needs. The quality of their services is regulated through the Quality Assessment Framework, which includes standards that they must meet with regard to safeguarding adults from harm. In addition to recognising the risks of harm of adults to whom they provide accommodation and in many cases care, employees of housing organisations have an important part to play in establishing protection plans.

4.6.5 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 harm that is also a crime, their support needs can be identified by the police, the CPS and others who have contact with the adult at risk. Witness Care Units exist in all judicial areas and are run jointly by the CPS and the Police.

The CPS has a key role to play in making sure that special measures are put in place to support vulnerable or intimidated witnesses to give their best evidence. Special measures were introduced by the Youth Justice and Criminal Evidence Act 1999 and are available both in the Crown Court and in the magistrates' 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.

4.6.6 The Coroner

Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause and deaths in custody, which must be reported to them. 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.
- In the above situations the local SAB should give serious consideration to instigating a serious case review.

4.6.7 Dorset Fire and Rescue

Dorset Fire and Rescue personnel visit people in their homes when carrying out a Home Safety Checks. Personnel carry out the visit in accordance with Dorset Fire and Rescue guidance and policy, providing fire safety advice and installing, where appropriate, one or more smoke alarms. Where personnel have a concern about an adult at risk they follow internal procedure and contact a trained Safeguarding Officer who then takes action, which, where appropriate, will involve contacting the Safeguarding Adults contact point in the Local Authority as soon as possible within 24 hours.

Staff undertaking Fire Safety (Protection) visits in residential, institutional settings are also trained to recognise a concern and raise through the Service procedure.

Where other agencies visit people in their homes, the Dorset Fire and Rescue advises those employees to look for any indication of fire risk. This may include: burn marks made by carelessly discarded smoking materials; evidence of hoarding, where access or egress may be impeded or could be fuel for a potential fire; and a build-up of grease on cooking equipment (chip pans in particular). The use of oxygen is also noteworthy, particularly where the user is also a smoker. This situation would trigger an immediate Home Safety Check. Employees from other agencies are not expected to become fire safety experts or to deal with risks they may observe but they should be aware of the potential risk and make a referral through the DFRS website or contacting Service Headquarters. so that we may contact the occupier to arrange for a Home Safety Check.

4.6.8 The Dorset Probation Service

Dorset Probation Trust is the agency that manages all offenders in the community on statutory supervision. This includes those people made subject to Community Orders and Suspended Sentence Orders. It provides advice and guidance to Magistrates and Crown courts in regard to sentencing by means of Pre-Sentence reports. DPT also supervises

those offenders subject to post-custody Licences. For dangerous offenders it provides advice to the Parole Board to inform release decisions.

DPT has the power to breach community orders and recall licensees to prison if offenders fail to comply with supervision or re-offend.

The fundamental purpose of supervision is to protect the public by working with offenders to reduce re-offending and harm. The basis of this role is the use of the Offender Assessment System (OASys) to assess risk and identify factors that have contributed to offending. (Other risk assessment tools are also used). Risk assessment informs risk management plans that are shared and informed by other public and voluntary services.

Information sharing and partnership working with other agencies within the MAPPA are the core of effective public protection work. These principles also apply in partnership arrangements in safeguarding adults and children. Employees who identify adults at risk of harm are expected to follow these Policy & Procedures, inform their manager and refer to the Local Authority Safeguarding Adults contact point as soon as possible within 24 hours.

DPT also has a requirement to inform victims of serious sexual and other violent crimes of release plans and allow victims to have their views expressed to Parole Boards.

4.7 Commissioning

4.7.1 Commissioning Governance

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

- Ensure that agencies from whom services are commissioned know about and adhere to relevant registration requirements and guidance.
- Ensure that all documents such as service specifications, invitations to tender, service contracts and service-level agreements adhere to the multi-agency Safeguarding Adults policy and procedures.
- Ensure that managers are clear about their leadership role in Safeguarding Adults in ensuring the quality of the service, the supervision and support of employees, and responding to and investigating a concern about an adult at risk.
- Commission a workforce with the right skills to understand and implement Safeguarding Adults principles.
- Ensure employees have received induction and training, including Safeguarding training, appropriate to their levels of responsibility.
- Liaise with the local SAB and regulatory bodies and make regular assessments of the ability of service providers to effectively safeguard service users.
- Ensure that services routinely provide service users with information in an accessible form about how to make a complaint and how complaints will be dealt with.
- Ensure that service providers give information to service users about harm, how to

recognise it and how and to whom they can raise a concern.

- Ensure Safeguarding Adults are always included in the monitoring arrangements for contracts and service-level agreements.
- Ensure that commissioners (and regulators) regularly audit reports of risk of harm and require providers to address any issues identified.

4.7.2 Personal budgets and self-directed care

People who direct their own care have a responsibility to consider, through their support plan, how to manage any risks to their safety and work to address these. In particular, they need to consider their responsibility to use safe recruitment and employment practices. They may need support to do this.

Commissioners have a responsibility to:

- Ensure that people who commission their own care are given the right information and support to do so from providers who engage with Safeguarding Adults principles and protocols.
- Ensure that the commissioning of services such as brokerage services includes information on safeguarding and dignity.
- Ensure that services are commissioned in a way that raises service users' and carers' expectations in relation to quality of services.
- Ensure that commissioners develop links with front-line employees to review performance of providers in relation to complaints, standards of care and safeguarding.

In the event of safeguarding concerns, the authorized officer for the contract should attend any strategy or planning meetings, if required to do so, and carry out any actions agreed at the meetings. They will monitor and review to ensure that any changes required in the management, staffing or practice of the service, are undertaken.

4.7.3 Commissioned services

All commissioned service provider organisations should produce their own guidelines that are consistent with the multi-agency Safeguarding Adults policy and procedures. These should set out the responsibilities of employees, clear internal reporting procedures and clear procedures for reporting to the local Safeguarding Adults process.

In addition, provider organisations' internal guidelines should cover:

- A 'whistle-blowing' policy which sets out assurances and protection for employees 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 .
- How to fulfil their legal obligations under the Vulnerable Groups Act 2006 and the Vetting and Barring Scheme as administered by the ISA.

- Robust recruitment arrangements.
- Training and supervision for employees.

Provider organisations should routinely provide users of their service with information about how to make a complaint and about the Safeguarding Adults process.

Part 4B PRACTICE GUIDANCE

4.8 Support for those involved in the Safeguarding Adults process

4.8.1 Supporting the adult at risk

The adult about whom there is a concern should be supported in a way which does not jeopardise any investigation or criminal prosecution. The IM is responsible for ensuring that arrangements are made to meet these needs. Decisions about how this will be achieved will be taken at the multi-agency strategy meeting informed by what the adult is saying they need and what would be acceptable to them.

4.8.2 Advocates

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

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

Advocates should be invited to the strategy meeting or case conference, either accompanying the adult at risk or attending on their behalf, to represent the person's views and wishes. Instructed advocates would attend only with the permission of the adult at risk.

4.8.3 Independent mental capacity advocates (IMCAs)

IMCAs provide one type of non-instructed advocacy. Their role was established by the Mental Capacity Act 2005 to provide a statutory safeguard mainly for people who lack capacity to make important decisions and who do not have family or friends who can represent them to do so. IMCAs have a statutory role in the Safeguarding Adults process.

There is a legal requirement to make a decision about instructing an IMCA for an adult at risk who is the focus of Safeguarding Adults processes where they lack capacity to make decisions about their safety. IMCA instruction may be unnecessary if the adult at risk has adequate alternative independent representation. This could be from another advocate, or from family or friends.

It is good practice for the IM to make a decision about the need for IMCA instruction and, if required, to make the instruction to the local IMCA provider.

Before making an instruction to an IMCA for Safeguarding Adults, it is necessary to assess the person as lacking capacity for consenting to at least one protective measure which is either being considered or has been put in place. (See Section 4.24). Examples of protective measures may include (but are not limited to):

- Restrictions on contact with certain people
- Temporary or permanent moves of accommodation
- The police interviewing the person or collecting forensic evidence which may support a prosecution
- 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 harm.

4.8.4 Support for vulnerable witnesses

4.8.5 Witness support and special measures

If there is a police investigation, the Police will ensure that interviews with the adult at risk who is a vulnerable or intimidated witness are conducted in accordance with 'Achieving Best Evidence in Criminal Proceedings'.

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.

4.8.6 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.

4.8.7 Keeping families and others concerned informed and supported

Family and friends and other relevant people who are not implicated in the allegation of harm often have an important part to play in the Safeguarding Adults process and provide valuable support to the individual and to manage the risk.

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

If the adult does not have mental capacity, family and friends must be consulted under the Mental Capacity Act 2005.

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

4.8.8 Responsibilities to those who are alleged to have caused the harm

Adults who are alleged to have harmed an adult at risk have the right to be assumed innocent until the allegations against them are found to be substantiated. Whether they are an employee, a volunteer, a relative or a carer they also have the right to be treated fairly and their confidentiality respected.

What information is shared with them and when should be decided at the strategy discussion or meeting. They have a right to know in broad terms what the allegations are that have been made against them, unless the police advise otherwise, or it would jeopardise the investigation. It is not the responsibility of Social Care Safeguarding Investigators to interview those alleged to have caused harm. A risk assessment should be made. They should be provided with appropriate support throughout the process. The IM and Strategy meeting will decide whether this is needed, what is needed and who will provide it.

If the person causing harm is also an adult at risk, they should be provided with appropriate support. If the person causing harm is a young person or has a mental disorder, including a learning disability and they are interviewed at the police station, they are entitled to the support of an appropriate adult under the provisions of the Police and Criminal Evidence Act 1984 Code of Practice. (Refer to local Police and Criminal Evidence Act procedures and agreements.)

4.9 Information sharing

An information-sharing protocol has been agreed by all statutory partner organisations. Please contact Bournemouth & Poole Safeguarding Adults Board Management Support Officer on 01202 261015 for: Dorset Overarching Information Sharing Protocol – Data Sharing Policy. This protocol recognises that information sharing between organisations is essential to safeguard adults at risk of harm, neglect and exploitation. This includes people who fund their own care and support.

In this context organisations could include not only statutory organisations but also voluntary and independent sector organisations, housing authorities, the police and CPS and organisations which provide advocacy and support where these organisations are involved in Safeguarding Adults enquiries, including raising an alert and participating in an investigation and/or making a contribution to safeguarding plans.

Information will be shared within and between organisations in line with the principles set out below.

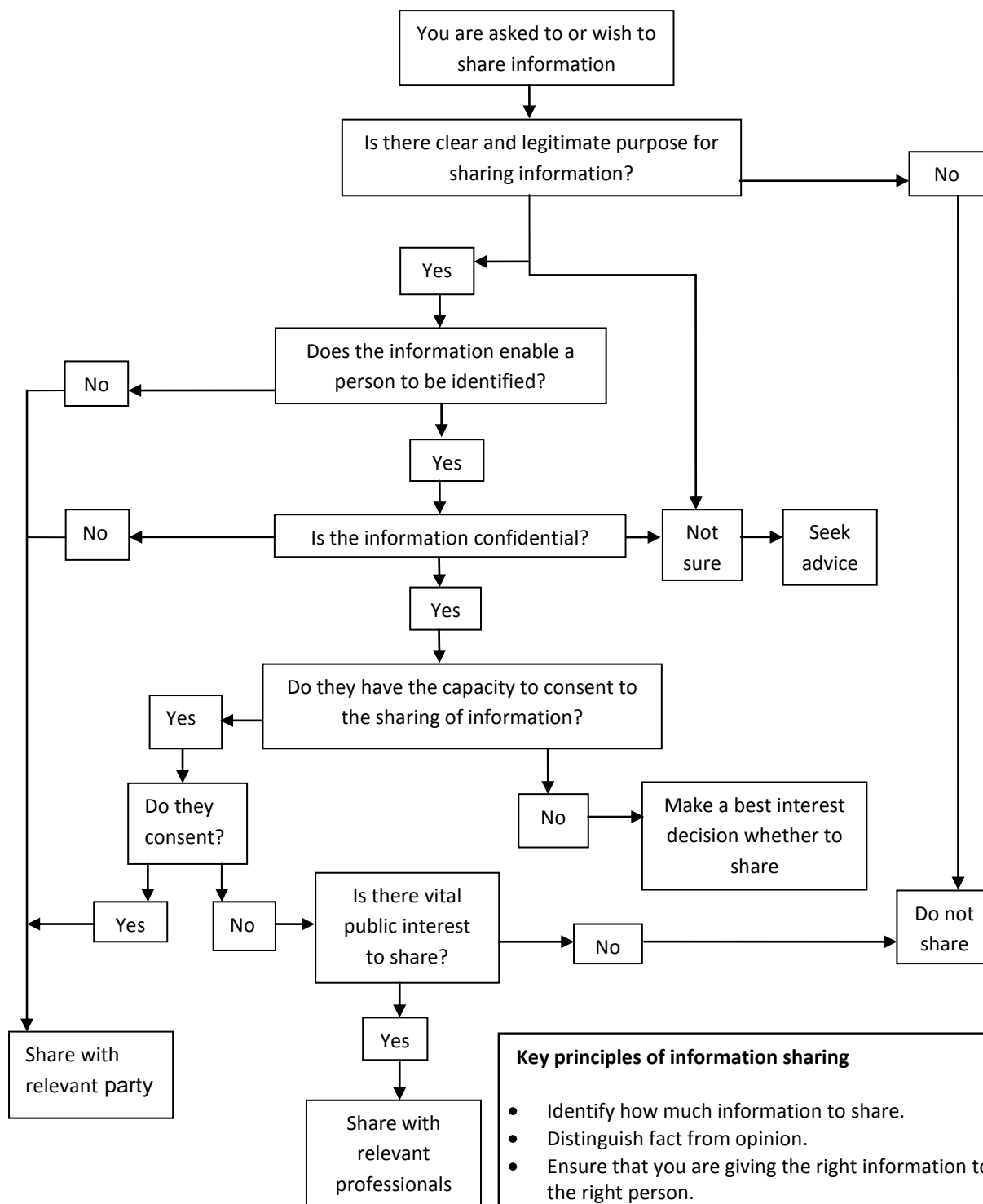
- Adults have a right to independence, choice and self-determination. This right extends to them being able to have control over information about themselves and to determine what information is shared. Even in situations where there is no legal requirement to obtain written consent before sharing information, it is good practice to do so:
- The person's wishes should always be considered, however, safeguarding adults at risk establishes a general principle that an incident of suspected or actual harm can be reported more widely and that in so doing, some information may need to be shared among those involved.
- Information given to an individual employee 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 obtain the adult at risk's written consent to share information and should routinely explain what information may be shared with other people or organisations.
- 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 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.

Employees reporting concerns at work ('whistle-blowing') are entitled to protection under the Public Interest Disclosure Act 1998. Decisions about what information is shared and with whom will be taken on a case-by-case basis. Whether information is shared with or without the adult at risk's consent, the information shared should be:

- Necessary for the purpose for which it is being shared.
- Shared only with those who have a need for it.

- Be accurate and up to date.
- Be shared in a timely fashion.
- Be shared accurately.
- Be shared securely.
- The information-sharing protocol sets out the following guidance for sharing information:
 - Sharing information with consent.
 - Sharing information without consent.
 - Information sharing when the person does not have capacity to consent.
 - Sharing information between adults and children's services.
 - Sharing information with the Police.

Fig: 4.3 Flowchart of key questions for Information Sharing



Record the information sharing decision and your reasons, in line with your agency's or local procedures.

Key principles of information sharing

- Identify how much information to share.
- Distinguish fact from opinion.
- Ensure that you are giving the right information to the right person.
- Ensure you are sharing the information securely.
- Inform the person that the information has been shared, if they were not aware of this and it would not create or increase risk of harm.

If there are concerns that a child may be at risk of significant harm or any adult may be at risk of serious harm, then follow the relevant procedures without delay.

4.10 Complaints

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 organisation about which the complaint has been made. If more than one organisation has been named or is implicated in the complaint, the complaints officers from the named organisations 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 IM and the chair of the multi-agency SAB must be notified of the complaint and the findings.

If the complaint is upheld a decision should be made by the chair of the SAB, in consultation with relevant members, about whether a case review or a serious case review should be conducted to enable lessons to be learnt.

This procedure does not apply to:

- Complaints or representations relating to services that are delivered by individual organisations as a result of strategy/case conference decisions – although these may form part of a safeguarding 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 organisations up to directorate level if disagreements cannot be resolved.

The Court of Protection offers a potential route for the resolution of complaints or disagreements about the Safeguarding Adults process, for example, where decisions have been made on behalf of people who have capacity or there has been a failure to act in the best interests of an adult who does not have mental capacity.

4.11 Domestic Violence & Abuse

Domestic violence/abuse is defined as ‘any incident of threatening behaviour, violence or harm (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members regardless of gender or sexuality’. (Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family; see ACPO, 2004.)

Whatever form it takes, domestic violence/abuse is rarely a one-off incident and should instead be seen as a pattern of harmful and controlling behaviour through which the abuser seeks power and control over the victim. Domestic violence/abuse occurs across society,

regardless of age, gender, 'race', sexuality, wealth and geography. Domestic violence is predominantly committed by men against women but men can be abused by women and domestic violence can also occur in same sex relationships. Children are also affected both directly and indirectly and there is also a strong correlation between domestic violence/abuse and child abuse.

Domestic violence/abuse can occur with any members of the family. It is important that all agencies are as robust in their interventions with interfamilial domestic violence/abuse as they are with intimate/ex-partner relationships and appropriate support services are sought to meet the needs of the adult who is experiencing domestic violence/abuse.

Effective safeguarding is achieved when agencies share information to obtain an accurate picture of the risk and then work together to ensure the safety of the adult at risk is prioritised. While the adult at risk should always remain at the centre of the Safeguarding Adults process and be involved in their own safety planning, this does not preclude the sharing of information without their consent, particularly where the risks are considered to be high. This approach is supported by legislation including the Data Protection Act 1998 (Schedules 2 and 3), the Crime and Disorder Act 1998 and the Human Rights Act 1998. The abusive partner should not be informed of any disclosures. Consideration should be made to contacting relevant agencies who may hold information on the adult at risk in domestic circumstances which might include the police, children's social care, health and provider organisations. Where the case has met the MARAC threshold information can and should be shared as part of the MARAC process which is underpinned by an information sharing protocol. (This list is not exhaustive).

Please contact Bournemouth & Poole Safeguarding Adults Board Management Support Officer on 01202 261015 for: Bournemouth and Poole Domestic Abuse Strategy; for Dorset Domestic Abuse Strategy.

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

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

High risk victims are identified using the CAADA DASH risk indicator checklist.

The aims of a MARAC are as follows:

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

After sharing all relevant information that they have about an adult at risk, the representatives discuss options for increasing the safety of the adult at risk and agree a co-ordinated action plan. The MARAC is not a risk management process for children but will consider the risks posed to children and link to safeguarding children processes. Likewise the MARAC is not a risk management process for perpetrators but will link to MAPPA. At the heart of a MARAC is a working assumption that no single agency or individual can see the complete picture of the life of a person at risk but all may have insights that are crucial to their safety, as part of the co-ordinated community response to domestic violence and abuse.

The person at risk does not attend the meeting but is represented by an Independent Domestic Violence Advisor (IDVA). Good practice indicates that all victims that are referred to the MARAC should also be offered the support of an IDVA but the service is optional in that the adult at risk does not have to engage with the IDVA. The role of the IDVA is to provide an independent domestic violence and abuse support service and advocate on their behalf at the MARAC meeting.

The MARAC will seek better protection for those who disclose domestic violence or abuse and are at highest risk of being injured or killed. Referrals to the MARAC are made through the MARAC administrator located within the domestic abuse team of Dorset Police. Details of the risk assessment and referral process can be found at www.dorsetforyou.com/marac. Further general information on the MARAC can be found at www.caada.org.uk.

If a Safeguarding Adults referral therefore indicates there could be concerns that the situation indicates that the adult at risk is a victim of domestic violence/abuse, stalking or honour-based violence and this is confirmed by a subsequent investigation and risk assessment, a decision must be taken at the strategy meeting or case conference about referral to MARAC and who should make that referral. In most cases this would be the Safeguarding Adults manager (IM).

Agreement should also be sought regarding how the victim will be supported and which agency will take the lead role in this.

MARAC meetings are held every three weeks in Bournemouth and Poole and monthly in Dorset County. Any agency working with adults at risk should ensure that immediate actions to seek assistance from specialist domestic violence agencies are made before the case is heard at the MARAC.

4.12.1 Key considerations when working with domestic violence/abuse

- The person causing harm of the alleged domestic violence/abuse should not be informed of the domestic violence/abuse disclosures or of the referral to the MARAC.
- Professionals should not attempt to mediate in cases of domestic violence/abuse or work jointly with both the victim and alleged perpetrator but should rather provide the individual who is experiencing the violence with information about specialist domestic violence services, where safe and appropriate to do so.
- A CAADA-DASH domestic violence/abuse RIC should be undertaken with the adult at risk and must not be conducted in the presence of the person alleged to have caused

the harm. This principle also applies when conducting any needs assessment or mental capacity assessment.

- For those unable to speak directly to the adult at risk to complete the risk assessment, a referral can still be made to the MARAC based on the risks identified through the Safeguarding Adults process and based on professional judgement.
- The mental capacity of the adult at risk needs to be established in regard to their wishes.
- Positive intervention is an active approach to taking steps to reduce the risk. This may be done with or without the consent of the adult at risk, particularly where the risk of harm is regarded as high. Every effort should be made to engage the adult at risk in this process, where it is safe and appropriate to do so.
- Consideration should be given to the context of the abuse. The interventions need to be proportionate to the risks identified having regard to the intent or motivation of the person causing the harm, for example, inadvertent harm caused by a carer. (NB it would not be regarded as domestic violence unless the carer was a relative or intimate partner of the adult at risk – see the definition of domestic violence).
- When gathering information regarding the person alleged to have caused the harm, it is imperative that intelligence checks, history and background enquiries are made of appropriate agencies to ensure that, when conducting the risk identification and assessment process, this is based on best information to enable effective intervention and defensible decisions. Identified risk factors and appropriate interventions to manage risk will be discussed at the strategy meeting.
- Any activity connected to the person alleged to have caused the harm needs to be mindful of any potential risks that it may pose to the adult at risk. It is not a requirement in all cases to disclose information that is held if it will increase the risk.
- Sensitive information about the alleged person who has caused the harm can be shared under Section 115 of the Crime and Disorder Act 1998, and the Data Protection Act 1998, provided that criteria outlined in the legislation are met.
- The consent of the adult at risk should be obtained before sharing any information with relatives or friends. If the adult at risk has given consent but by sharing the information the risk to the person concerned is raised then the information should not be shared until that risk is removed. It is not recommended that any information is shared with relatives or friends particularly in high risk domestic violence cases. Where honour based violence is involved sharing information with friends or family could be extremely risky and harmful.
- In high risk domestic violence cases it may be necessary to share information with other agencies through the MARAC without consent to reduce the risk of serious harm or death. In some circumstances e.g. honour based violence it may be safer to share information without the victim's consent or knowledge to best protect them.
- Cases not reaching the threshold for MARAC or considered high risk will still be managed under the Safeguarding Adults process with strategy discussions taking place to develop appropriate support for the adult, including referral to specialist domestic violence services (see 4.12.2). Doing nothing is not an option.

4.12.2 Referrals to specialist domestic violence/abuse support services

As highlighted above, the MARAC exists to respond to and discuss cases of domestic violence and abuse where there is a very high risk of harm. If the person who is experiencing domestic violence and abuse is not assessed as being at high risk of further harm there are alternative support options that are available, for example, consideration should be given to referring or signposting the individual to a local specialist domestic violence or abuse service, where it is deemed appropriate and safe to do so and where the victims indicates that it is their wish to receive further help.

Local specialist domestic violence and abuse services provide emotional and practical support and to the person experiencing the domestic violence or abuse in relation to safety planning, housing options, civil and criminal legal options and in some cases counselling. Refuges can provide secure accommodation to women who leave home to escape violence. Local authorities' housing departments and housing advice centres will also be able to provide support for victims faced with homelessness as a result of domestic violence. There are also a number of national helplines which can support victims and perpetrators.

Information on services in Dorset County and national support agencies and helplines can be found on www.dorsetforyou.com/dvahelp. The website also contains downloadable leaflets for Dorset outreach services and a help and advice leaflet for victims living in Dorset. Bournemouth Domestic Violence Outreach Project 01202 547641/ Poole Domestic Violence Outreach Project 01202 71077/ Bournemouth 24 hour helpline 01202 547755 Poole 24 hour helpline 01202 748488.

Those not aware of the specialist services available in their area can contact their local Domestic Violence Co-ordinator based within the local authority: for Bournemouth & Poole- 01202 223242, for Dorset- 01305 228516 or Police Safeguarding referral unit – 01202 222 777, the National Domestic Violence Helpline on 0808 2000 247 to obtain this information.

4.13 Hate Crime

Hate crime is defined by the Police as any incident that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person's religion, belief, gender identity or disability.

It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence. In addition it includes incidents that do not constitute a criminal offence.

Apart from individually charged offences under the Crime and Disorder Act 1998, local crime reduction partnerships can prioritise action where there is persistent antisocial behaviour that amounts to hate crime.

The police and other organisations should work together to intervene under Safeguarding Adults policy and procedures to ensure a robust, co-ordinated and timely response to situations where adults at risk become a target for hate crime. Co-ordinated action will aim to ensure that victims are offered support and protection and action is taken to identify and prosecute those responsible.

Anyone can be a victim of harm regardless of sexuality or gender. However lesbian, gay, bisexual and transgender (LGBT) individuals could face additional concerns around

homophobia and gender discrimination. There may be concern that individuals would not be recognised as victims or be believed and taken seriously. Abusers may also control their victims, threatening to 'out' them to friends, family or support agencies. Professionals may need to seek advice from LGBT organisations to assist in the support of victims.

4.14 Honour-based violence

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

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

The Foreign and Commonwealth Office has a forced marriage unit which is available to help both victims of forced marriage and professionals.

<http://www.fco.gov.uk/en/travel-and-living-abroad/when-things-go-wrong/forced-marriage/>

Karma Nirvana is a charity which helps victims of forced marriage and honour based violence.

<http://www.karmanirvana.org.uk/>

4.15 Forced marriage

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

The guidance contained in the multi-agency practice guidelines, *Handling cases of forced marriage* (Home Office, 2009), recommends that cases involving forced marriage are best dealt with by child protection or 'adult protection' specialists.

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

4.16 Multi-Agency Public Protection Arrangements (MAPPA)

All agencies should be alert to the possibility that any individual could be engaged in a series of incidents of abuse and therefore be considered as a perpetrator. In this case agencies have a duty to report incidents to the police as part of the pathway referral process. It is possible that if employees or service users have previously resided outside Dorset that there may be a history of similar offending recorded elsewhere and it is incumbent on all agencies to carry out checks with the police where evidence comes to light that may be a cause for concern.

All agencies should ensure adherence to safe recruitment practice that includes enhanced CRB checks when any staff are involved in work that brings them into contact with adults at risk.

The Criminal Justice Act (2003) places a duty on the Police, Probation, Prisons, local authorities, health agencies and other public bodies to exchange information about potentially dangerous offenders and to work together to manage the risk they pose. The process for management of dangerous offenders is the Multi Agency Public Protection Arrangements (MAPPA).

Any offender who meets the criteria should be referred into the MAPPA process. Offenders are managed on three Levels: 1, 2 and 3. (Level 3 being the highest) The level is determined by the number of agencies involved, complexity of risks and resources committed, that are required to manage an offender's risk. Management by MAPPA can include enhanced reporting requirements, additional home visits, night curfews, residence at approved addresses or a requirement to attend treatment programmes. It will always include additional control measures specific to protecting victims. These measures include exclusions from particular areas and prohibitions from contact with named victims or groups like adults at risk or children.

These arrangements include managing sexual offenders, who are monitored closely and for whom conditions might include active surveillance, electronic monitoring, or living in Approved Premises.

Risk management is a dynamic process that will be informed by recognised risk assessment tools. Regular reviews of risk management plans are a requirement under MAPPA procedures and any agency will be accountable for their contribution to plans. Any risk management decisions will consider the requirement to disclose information in order to manage risk. Adults at risk will be appropriately informed of any risk management plans.

This strategy re-enforces the primary priority that available resources are deployed, in order to protect the public from those who pose the highest risk. The strategy is also underpinned by the recognition that public protection is best achieved by the control and rehabilitation of offenders in our communities.

The local MAPPA unit contacts are:

Tel: 01202 664086 or

Email: nikki.sanderson@dorset.probation.gsi.gov.uk

Further information can be found on the link below

<http://www.noms.justice.gov.uk/protecting-the-public/supervision/mappa/>

4.17 Human Trafficking

If an identified victim of human trafficking is also an adult at risk, the response will be co-ordinated under the Safeguarding Adults process. This will include organisations that have a role to play in dealing with victims of human trafficking, including 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. If the victim is a child, the situation will be dealt with under child protection procedures.

The early identification of victims of human trafficking is key to ending the harm they suffer and to providing the assistance necessary. Front-line employees need to be able to identify the signs that someone has been trafficked.

There is a national framework to assist in the formal identification and help to co-ordinate 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.

4.18 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. None of these factors should be considered in isolation but in conjunction with the particular circumstances of the individual: identity or personal crisis, particular personal circumstances, unemployment or underemployment and criminality. All of these may contribute to alienation from UK values and a decision to cause harm to symbols of the community or the state.

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. Local safeguarding structures have a role to play for those eligible for adult safeguarding.

A referral should be made to the Dorset Police Safeguarding Referral Unit regarding any individuals identified that present concern regarding violent extremism. The SRU can be contacted on 01202 222 777.

4.19 Allegations against carers who are relatives or friends

There is a clear difference between unintentional harm caused inadvertently by a carer and a deliberate act of either harm or omission, in which case the same principles and responsibilities for reporting to the Police if a crime is suspected and/or the Adult Safeguarding contact point, apply.

In cases where unintentional harm has occurred this may be due to lack of knowledge or due to the fact that the carer's own physical or mental needs make them unable to care

adequately for the adult at risk. The carer may also be an adult at risk. In this situation the aim of Safeguarding Adults work will be to support the carer to provide support and to help make changes in their behaviour in order to decrease the risk of further harm to the person they are caring for.

A carer's assessment should take into account the following factors:

- Whether the adult for whom they care has a learning disability, mental health problems or a chronic progressive disabling illness that creates caring needs which exceed the carer's ability to meet them.
- The emotional and/or social isolation of the carer and the adult at risk.
- Minimal or no communication between the adult at risk and the carer either through choice, mental incapacity or poor relationship.
- Whether the carer is not 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.

4.20 Harm by children

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

4.21 Child Protection

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 harm and neglect.

Everyone must be aware that in situations where there is a concern that an adult at risk is or could be being harmed or neglected and there are children in the same household or in regular contact, they too could be at risk. Reference should be made to the Pan-Dorset Inter-Agency Safeguarding Children Procedures. If there are concerns about harm or neglect of children and young people under the age of 18, referral must be made to the relevant children and families social care department.

http://www.bournemouth-poole-lscb.org.uk/inter-agency_safeguarding_procedures

4.22 Transitions between Adult and Children's Services

Robust joint working arrangements between children's and adult services need to be put in place to ensure that the medical, psychosocial and vocational needs of children moving from children's to adult services, including children with health or disability needs, leaving care are addressed as they move to adulthood and there are no gaps left in assessments of needs and service provisions.

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

Good practice includes:

- Having policies and procedures which support effective transition processes.
- Shifting the general view of risk as a potential danger for a child, to one of potential opportunity but acknowledging potential risks for an adult.
- Managing risks as a phased process with awareness of the psychological and emotional issues.
- Managing family expectations (being clear about the level of support and resources available).
- Taking time to get to know the young person and their family, especially if they have communication difficulties.
- Acknowledging the rights of adults to take more responsibility for their decisions.

4.23 Guidance on responding to cases of self neglect

Managing the balance between protecting adults at risk from self neglect against their right to self determination is a serious challenge for the public services. The following guidance aims to support good practice in this area.

In the majority of cases the community care assessment/ care programme approach, review and risk assessment procedures will be the best route to provide an appropriate intervention in situations of self neglect.

Where an adult at risk is unable to agree to have their needs met because they lack capacity to make this decision, then the 'best interest' process should be used.

The Safeguarding Adults Policy & Procedures may be usefully applied where all other routes have been explored:

- Where an adult at risk has been identified as having been subject to 'serious self neglect that could result in significant harm'

and

- They have the capacity to make relevant decisions but have refused essential services without which their health and safety needs cannot be met

and

- The care management process/ care programme approach has not been able to mitigate the risk of this 'serious self neglect that could result in significant harm'.

4.23.1 Responding to cases of self neglect where the adult at risk is reluctant to engage with services

In cases where there is evidence of serious self neglect, which could result in significant self harm, agencies who are aware of the problems sometimes struggle to find an approach which enables them to jointly engage and agree plans to resolve the concerns. Whilst people who are self neglectful itself does not meet the Safeguarding Adults criteria it is also recognised that these policies and procedures may offer a structure and process which, with the agreement of all concerned, could provide a helpful framework in which to address the problems identified.

1. Undertake capacity assessment(s) and record when, where and by whom the assessment(s) was/were carried out (note: capacity assessments are both decision and time specific). See Section 4.23.
Where an adult at risk is unable to agree to having their needs met because they lack capacity to make this decision, then the 'best interest' process should be used.
Where an adult at risk has capacity to make relevant decisions, follow the procedure below.
2. Convene a Multi-agency meeting to critique the care plan and to consider options for encouraging engagement with the adult at risk, ie: consider which professional is best placed to successfully engage; would the adult at risk respond more positively to a health or a voluntary agency professional?
3. Having established an alternative/holistic care plan, the adult at risk's resistance to engagement should be tested by the re-introduction of the new plan by the person or the agency most likely to succeed (this would be decided by the care planning process).
4. If the plan is still rejected, the meeting should reconvene to discuss a review plan. The case should not be closed just because the adult at risk is refusing to accept the plan. Legal advice should be taken if required.
5. If the care management process/care programme approach has not been able to mitigate the risk of 'serious self neglect,' which could result in significant harm,' it should be referred to the safeguarding adults process.

This process will not affect an individual's human rights but it will ensure that partner agencies exercise their duty of care in a robust manner and as far as is reasonable.

4.24 Capacity, Consent and Best Interests – Mental Capacity Act 2005

A fundamental Principle of Common Law and of the Mental Capacity Act 2005, is that every adult has the right to make his/her own decisions and is assumed to have capacity, or be able, to do so, unless it is proved otherwise.

‘No Secrets’ Department of Health 2000 Guidance about mental capacity says ‘if someone has the ‘capacity’ and declines assistance, this limits the help that he or she may be given. It will not, however, limit the action that may be required to protect others who may be at risk of harm. In order to make sound decisions, the adult at risk’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’.

Assessing whether someone has capacity to make decisions is complex. Some people may need help or support to be able to understand the decision they are being asked to make, to know how to make a choice, or to be able to communicate but this does not remove their right to make their own decisions.

Any assessment of a person’s mental capacity can only be made in relation to the specific decision or proposed action in question at that particular time. A person may be capable of making a straightforward decision but less able to make a complex one.

Professionals may need to support people in understanding that decisions need to be made and why, what the effects may be and check whether there are any alternatives. They should know the most effective way to communicate and how to explain things in a way which can be understood. They may also know of other sources of help and advice which will enable individuals to reach a decision and express a choice.

The Mental Capacity Act 2005 for England and Wales was implemented in 2007 to empower and protect people who may lack the capacity to make some decisions for themselves. For further information click on this link <http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf>

The Act is underpinned by 5 key principles:

- A presumption of capacity – every adult has the right to make their own decisions and is assumed to have capacity to do so unless proved otherwise.
- Individuals must be supported to make their own decisions with all practicable help.
- Unwise decisions do not by themselves mean the person lacks capacity.
- Best interests – anything done for or on behalf of people without capacity must be in their best interests.
- Least restrictive alternative – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

Deciding whether people can make their own decisions:

The Act sets out a 2 stage test of capacity which must be followed in relation to the specific decision or proposed action in question at that particular time.

Stage 1: Impairment or Disturbance

Is there an impairment or disturbance in the functioning of the mind or brain? This must be indicated by symptoms, behaviour or the presence of a diagnosis.

Stage 2: Inability to Make a Decision

If the first stage is met, the second stage of the test is undertaken and four questions should be answered:

Is the person:

- a) Unable to understand the relevant information?
- b) Unable to retain the information long enough to make a decision?
- c) Unable to use or weigh that information as part of the process of making a decision?
- d) Unable to communicate the decision?

If the answer is yes to any of these questions, then the person lacks the capacity in relation to the specified decision.

However, in all of the above areas, the assessment should take each question separately and consider what steps can be taken to improve the person's understanding, for example:

- Does the person have all or a sufficient, relevant amount of information needed to make this decision? If there is a choice, has the information been given on any alternatives?
- Could the information be explained or presented in a way that is easier for the person to understand?
- Are there any particular times of the day when the person's understanding is better or particular locations where they feel more at ease? Can the decision be put off until the circumstances are right for the person concerned?
- Can anyone else help or support the person to make choices or express a view such as another family member, carer or independent advocate?

Those involved in assessing capacity need to be satisfied that everything practicable has been done to help and support the person to participate to the fullest extent in the process involved in making this particular decision.

Best interests consultation and decision making:

Any decision made on behalf of a person who lacks the capacity to make their own decision must be made in the 'best interests' of that person. This means trying to find out what is most important to the person concerned and what they would have wanted, not what would make life easier for the people involved in their care. Consultation of all relevant persons is required.

Best Interests Checklist

- Don't make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or aspect of his/her behaviour.
- Try to identify all the issues and circumstances relating to the decision in question which are most relevant to the person who lacks capacity.
- Consider whether the person is likely to regain capacity (e.g. after receiving medical treatment). If so, can the decision wait until then?
- Do whatever is possible to permit and encourage the person to participate or to improve his/her ability to participate as fully as possible in making the decision.
- If the decision concerns the provision or withdrawal of life-sustaining treatment, you must not be motivated by a desire to bring about the person's death. Don't make assumptions about the person's quality of life. Try to find out the views of the person lacking capacity, including:
 - The person's past and present wishes and feelings – both his/her current views and whether the person has expressed any relevant views in the past, either verbally, in writing or through behaviour or habits.
 - Any beliefs and values (e.g. religious, cultural or moral) that would be likely to influence the decision in question.
 - Any other factors the person would be likely to consider if able to do so.

Consult other people, if it practicable to do so, for their views about the person's wishes, feelings, beliefs or values. However, be aware of the person's right to confidentiality – not everyone needs to know everything in particular, try to consult:

- Anyone previously named by the person lacking capacity as someone to be consulted.
 - Carers, close relatives or friends who take an interest in the person's welfare.
 - Any attorney of a Lasting Power of Attorney made by the person.
 - Any deputy appointed by the Court of Protection to make decisions for the person.
- Or**
- For decisions about major serious treatment or a change in accommodation and where there is no-one who fits into any of the above categories, an Independent Mental Capacity Advocate.
- Weigh up all of the above factors in order to determine what decision or course of action is in the person's best interests.

Court of Protection, Lasting Power of Attorney, Public Guardian Deputies and Independent Mental Capacity Advocates (IMCA)

The Act has put in place the further additional safeguards for those lacking capacity.

The Act deals with two situations where a designated decision-maker can act on behalf of someone who lacks capacity:

Lasting Powers of Attorney (LPAs) – The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This is similar to the previous Enduring Power of Attorney (EPA) in relation to property and affairs but the Act also allows people to empower an attorney make health and welfare decisions. Before it can be used an LPA must be registered with the Office of the Public Guardian (see below). EPAs created before October 2007 can still be registered but it is not possible to create a new EPA.

Court appointed deputies – The Act provides for a system of court appointed deputies which replaced the previous system of receivership. Deputies can be appointed to take decisions on welfare, healthcare and financial matters as authorised by the Court of Protection (see below) but will not be able to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues. People appointed as receivers before October 2007 retain their powers concerning property and affairs but are now treated as deputies.

The Act created a new public body and a new official to support the statutory framework, both of which are designed around the needs of those who lack capacity:

The Court of Protection – The new Court has jurisdiction relating to the whole Act. It has its own procedures and nominated judges. It is able to make declarations, decisions and orders affecting people who lack capacity and make decisions for or appoint deputies to make decisions on behalf of people lacking capacity. It deals with decisions concerning both property and affairs, as well as health and welfare decisions. It is particularly important in resolving complex or disputed cases involving, for example, about whether someone lacks capacity or what is in their best interests.

The Public Guardian – The Public Guardian has several duties under the Act and is supported in carrying these out by the Public Guardian Office (PGO). The Public Guardian and his staff are the registering authority for LPAs and deputies. They supervise deputies appointed by the Court and provide information to help the Court make decisions. They work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating.

The Act also includes three further key provisions to protect vulnerable people:

Independent Mental Capacity Advocate (IMCA) – An IMCA is someone appointed to support a person who lacks capacity but has no one to speak for them, such as family or friends. They are only involved where decisions are being made about serious medical treatment or a change in the person's accommodation where it is provided by the National Health Service or a local authority. The IMCA makes representations about the person's wishes, feelings, beliefs and values, at the same time as bringing to the attention

of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary.

Advance decisions to refuse treatment – The Act creates statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they should lack capacity in the future. The Act sets out two important safeguards of validity and applicability in relation to advance decisions. Where an advance decision concerns treatment that is necessary to sustain life, strict formalities must be complied with in order for the advance decision to be applicable. There must be an express statement that the decision stands “even if life is at risk” which must be in writing, signed and witnessed.

A criminal offence – The Act introduced a criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

The Act also sets out clear parameters for research

Research involving, or in relation to, a person lacking capacity may be lawfully carried out if an “appropriate body” (normally a Research Ethics Committee) agrees that the research is safe, relates to the person’s condition and cannot be done as effectively using people who have mental capacity. The research must produce a benefit to the person that outweighs any risk or burden. Alternatively, if it is to derive new scientific knowledge it must be of minimal risk to the person and be carried out with minimal intrusion or interference with their rights.

Carers or nominated third parties must be consulted and agree that the person would want to join an approved research project. If the person shows any signs of resistance or indicates in any way that he or she does not wish to take part, the person must be withdrawn from the project immediately.

Code of Practice (<http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf>)

There is a statutory Code of Practice to accompany the Act. The Code provides guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do these things themselves. Those who have a duty of care to a person lacking capacity, such as attorneys, deputies, IMCAs, professionals and paid carers must have regard to the Code.

Excluded Decisions

Some types of decisions can never be made by someone on behalf of another person who lacks capacity and the Act does not change this. This is because these decisions or actions are either so personal to the individual or because other laws govern them. These include decisions such as marriage or civil partnership, divorce, sexual relationships and voting. They also include decisions about treatment for mental disorder where someone is being detained and treated under Part 4 (Consent to Treatment) of the Mental Health Act which allows the person to be treated without their consent.

Restraint or deprivation of liberty

Section 6 of the Act defines restraint as the use or threat of force where an incapacitated person resists and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person and if the restraint used is proportionate to the likelihood and seriousness of the harm.

Section 6(5) makes it clear that an act depriving a person of his or her liberty within the meaning of Article 5(1) of the European Convention on Human Rights cannot be an act to which section 5 provides any protection.

The Government has added provisions to the Mental Capacity Act

2005 (The Act), the Deprivation of Liberty Safeguards.

These safeguards focus on some of the most vulnerable people in our society, those who for their own safety and in their own best interests need to be accommodated under care and treatment regimes that may have the effect of depriving them of their liberty but who lack the capacity to consent.

The deprivation of a person's liberty is a very serious matter and should not happen unless it is absolutely necessary and in the best interests of the person concerned. That is why the safeguards have been created: to ensure that any decision to deprive someone of their liberty is made following defined processes and in consultation with specific authorities.

Deprivation of Liberty Safeguards

The safeguards provide a framework for approving the deprivation of liberty for people who lack the capacity to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty.

These safeguards are an important way of protecting the rights of many vulnerable people and should not be viewed negatively. Depriving someone of their liberty can be a necessary requirement in order to provide effective care or treatment. By following the criteria set out in the safeguards and explained in this Code of Practice, the decision to deprive someone of their liberty can be made lawfully and properly.

The safeguards legislation contains detailed requirements about when and how deprivation of liberty may be authorised. It provides for an assessment process that must be undertaken before deprivation of liberty may be authorised and detailed arrangements for renewing and challenging the authorisation of deprivation of liberty.

The Code of Practice is available from (<http://www.publicguardian.gov.uk>)

How does this Code of Practice relate to the main Mental Capacity Act 2005 Code of Practice?

This document adds to the guidance in the main Mental Capacity Act 2005 Code of Practice ('the main Code'), which was issued in April 2007 and should be used in conjunction with the main Code. It focuses specifically on the deprivation of liberty safeguards added to the Act. These can be found in sections 4A and 4B and Schedules A1 and 1A of the Act.

How should this Code of Practice be used?

This Code of Practice provides guidance to anyone working with and or caring for adults who lack capacity but it particularly focuses on those who have a 'duty of care' to a person who lacks the capacity to consent to the care or treatment that is being provided, where that care or treatment may include the need to deprive the person of their liberty. This Code of Practice is also intended to provide information for people who are, or could become, subject to the deprivation of liberty safeguards and for their families, friends and carers, as well as for anyone who believes that someone is being deprived of their liberty unlawfully.

In this Code of Practice, as throughout the main Code, references to 'lack of capacity' refer to the capacity to make a particular decision at the time it needs to be made. In the context of the deprivation of liberty safeguards, the capacity is specifically the capacity to decide whether or not to consent to care or treatment which involves being kept in a hospital or care home in circumstances that may amount to a deprivation of liberty, at the time that decision needs to be made.

What is the legal status of this Code of Practice?

As with the main Code, this Code of Practice is published by the Lord Chancellor, under sections 42 and 43 of the Mental Capacity Act 2005. The purpose of the main Code is to provide guidance and information about how the Act works in practice. Both this Code and the main Code have statutory force, which means that certain people are under a legal duty to have regard to them. In addition to those for whom the main Code is intended, this Code of Practice specifically focuses on providing guidance for:

- people exercising functions relating to the deprivation of liberty safeguards,
and
- people acting as a relevant person's representative under the deprivation of liberty safeguards.

Decisions must always be made on the facts of each individual case.

4.25 POSITIVE RISK MANAGEMENT GUIDANCE

Risk Management Guidance

Risk Assessment and Risk Management skills are central to all decision making for safeguarding adults at risk.

When an alert is received about an individual, a risk assessment must be undertaken as part of the investigation process.

This guidance has been developed as a possible model which may provide a structure and guide for informing professional decisions around preventing and managing risks through Safeguarding plans.

Risk assessment and management decisions should be undertaken with the full involvement of the service user, or relevant person, and form part of the multi-agency safeguarding adult's conference.

Complex decision-making around rights v responsibilities in safeguarding.

The following issues will need to be given consideration at every stage of the investigation and risk management process:

- **Mental Capacity and Consent**
- **Best Interests**
- **Confidentiality & Information Sharing**
- **Deprivation of Liberty (Care Homes / Hospitals)**
- **Human Rights**

These decisions should be made in conjunction with the relevant Codes of Practice and Dorset, Bournemouth and Poole's Policies and Procedures.

At all stages regard should be had to risks posed to other adults and particularly any child protection issues.

The Adult at Risk's wishes in Response to Risk

It is good practice to involve the service user at every stage of an investigation and safeguarding planning. Service users with capacity have the right to make choices and decisions which professionals may consider to be unwise. Bearing this in mind, professionals have a duty of care to ensure that service users are fully informed of the risks they are taking and of all the available options to prevent or minimise risks.

It is important to acknowledge the choices that service users make and to provide appropriate support to enable them to live as safely as possible. It is equally important to ensure that services users are aware that they can change their mind and should be encouraged to seek help when they need it.

Service users also need to be made aware that, in cases of serious risk to themselves, children or other adults at risk, it may be necessary to override their wishes.

Where service users lacks capacity for risk management decisions, proposed actions to safeguard will need to be considered through the “Best Interests” process.

Evaluating potential seriousness of risks and consideration of benefits V harms

In evaluating the level of risk further to information being gathered and throughout the investigation, there is a need to consider the potential seriousness of the risk. An indicator of the level of seriousness of the risks identified requires a risk rating of High/ Medium/ Low.

This is only intended as a rough guide, and you will still need to use your own professional judgement. It should be remembered that all abuse is serious and that the categories of High/ Medium/ Low are indicators for the urgency of the required response and determining a proportionate action.

The level of seriousness has been broken down into four areas as below:

Alleged perpetrators relationship with the adult at risk

| Feature | High Risk | Medium Risk | Low Risk |
|---|--|--|-------------------------------------|
| Perceived power by Adult at risk | Seen as in a powerful position by adult at risk | Adult at risk knows how to contact help. | Stranger with brief contact. |
| Access to Adult at risk | Unrestricted and unsupervised. | Unrestricted but supervised. | In group situations only. |
| Level of Contact | Intimate Care or access to adult at risk's finances. | Support with activities of daily living. | Social contact |
| Access to other Adults at risk | Unsupervised access to adults at risk. | Supervised access to adults at risk. | Minimal contact with adults at risk |

Adults at risk situation

| Feature | High Risk | Medium Risk | Low Risk |
|-------------------------------------|--|--|---|
| Physical Dependency | Physically dependent for all functions. | Physically independent but requires help or support to go out. | Physically independent. |
| Level of understanding | No comprehension of situation. | Feels something is wrong. | Aware that they have been abused. |
| Access to advocacy / support | Isolated contact only with perpetrator or institution. | Some contact with potential advocates. | Regular contact with potential advocates. |
| Judgement | Complete trust in others. | Some understanding that some things are wrong. | Understands abuse and has some coping strategies. |

History of abuse and intent

| Feature | High Risk | Medium Risk | Low Risk |
|-------------|------------------------------|----------------------------|---|
| Frequency * | Repeated | Occasional / Rare | Single incident/ No history of abuse |
| Intent | Planned. | Omission or ignorance. | No clear intent to harm or exploit |
| Extent | 4 or more vulnerable adults. | Less than 4 adult at risk. | adult at risk only. |

* Where there is a history of abuse, a chronology of incidents should be completed.

Seriousness and impact of abuse

| Feature | High Risk | Medium Risk | Low Risk |
|----------------|--|---|--|
| Physical | Deliberate assault or grievous bodily harm. | Injury, inappropriate care requiring medical treatment. | Limited discomfort felt by adult at risk |
| Psychological | Adult at risk frightened. Inequalities of power / authority. | Psychological well being adversely affected. | Emotional needs of adult at risk not recognised or met. |
| Sexual | Sexual assault forced viewing of pornography. | Inappropriate touching. | Non contact abuse including verbal harassment. |
| Financial | Fraud or theft of large sum of money or property. | Misuse of money or property belonging to adult at risk. | Taking small items of little significance from vulnerable adult. |
| Neglect | Life threatening or requires medical Attention. | Emotional or physical health affected by poor care. | Adult at risk's potential not fulfilled. |
| Discriminatory | Threatening leading to fears for safety. Hate Crime. | Refusal access to service / essential support. | Occasional harassment related to issues of difference. |



Extremely Serious **Serious**

In evaluating risks it is also important to develop a view of the potential benefits and harms for the service user within the circumstances in which they find themselves. In determining these benefits it is also useful to develop a view of the potential for these benefits and harms occurring to give an indication of the level of potential risk.

Where a service user does not have capacity to make informed choices about the identified risks it is all the more important to consider the risks in benefit and harm terms along side the potential seriousness, as this will be very useful when making best interest decisions.

Table One indicates some of the potential benefits and harms for service users and Table Two goes on to look at potential likelihood of these occurring

| <u>Table One:</u> | |
|--|--|
| <u>SOME EXAMPLES OF POTENTIAL BENEFITS / HARMS FOR SERVICE USERS</u> | |
| <p style="text-align: center;"><u>POTENTIAL BENEFITS</u></p> <ul style="list-style-type: none"> • Maintains independence • Maintains important relationships • Remains in familiar Environment • Continues to pursue interests • Special needs can be met in this setting. | <p style="text-align: center;"><u>POTENTIAL HARMS</u></p> <ul style="list-style-type: none"> • Physical injury • Life is / will be threatened • Depressive illness / suicide • Neglect (personal hygiene, inadequate diet, heating etc) • Isolation • Vulnerability to crime, harm, exploitation • Support systems/ relationships will breakdown • Aggression towards others • Wandering / getting lost • Inability to manage finances. |

| <u>Table two:</u> | |
|--|---|
| <u>SOME EXAMPLES OF FACTORS INDICATING THE LIKELIHOOD OF:</u> | |
| <p style="text-align: center;"><u>BENEFITS OCCURRING</u></p> <ul style="list-style-type: none"> • Past history suggests success • Understands risks & participates in assessment & care plan • Support is available • Competent staff providing support • Able to summon help in emergency | <p style="text-align: center;"><u>HARMS OCCURRING</u></p> <ul style="list-style-type: none"> • Past history of not coping in similar situations • Service user unable to understand level of risk & participate in care plan • Lack of support • Care staff lack expertise / adequate training • Unable to summon help in an emergency • Carers under stress and not able to continue • Susceptible to exploitation by others • Abuse planned and / or repeated. |

Management of Risks

Once the risks have been identified and evaluated in terms of potential serious and harms versus benefits, the service user must be engaged in making choices about managing these. When, as a result of the adult at risk's own choices and decisions, it is not possible to take steps to improve their safety in some areas this must be clearly recorded. All risk decisions should be reviewed regularly, with the adult at risk, as part of the Safeguarding Plan.

Any actions taken to prevent or minimise risks should be cognisant of the service user wishes and choices, but also in line with legislation and requirements to safeguard others. No single statutory framework for "risk taking" or safeguarding adults exists as such. Some key legislation will be included, for example:

Mental Capacity Act 2005
Mental Health Act 1983, amend 2007
Domestic Violence, Crime and Victims Act 2004
Human Rights Act 1998
Youth Justice and Criminal Evidence Act 1999
Sexual Offences Act 2003
Care Standards Act 2000
National Assistance act 1948
Public Interest Disclosure Act 1998

Consideration of all the above factors should form the basis of an adult Safeguarding plan

Many agencies can play a part in taking actions to reduce the risk of further abuse and or neglect. When taking these actions the agency responsible for each action should be clearly identified within the safeguarding plan.

Some possible actions may include:

- Provision of services such as respite / day care
- Enhanced support for carers
- Support to develop Social networks
- More intense monitoring
- Improved opportunities to contact services / advocates
- Mental Health assessment
- Psychological support
- Actively engaging service user in assessment process
- Keeping safe work

For further guidance on Safeguarding plans please see the section on Safeguarding plans in paragraph 3.7.4.

4.26 ADDITIONAL GUIDANCE FOR MANAGING LARGER SCALE SAFEGUARDING ADULTS INVESTIGATIONS INVOLVING REGULATED AND CONTRACTED CARE SERVICES

INTRODUCTION

- This protocol should be read in conjunction with the Bournemouth and Poole Safeguarding Adults and the Dorset Safeguarding Adults Boards Policy and Procedures.
- This guidance is provided to assist investigations instigated under Pathway 4, where a number of adults at risk have been harmed or is at risk of being harmed in a regulated or contracted care setting. This will include both residential care and nursing homes and domiciliary social care services
- This guidance may also be helpful in other circumstances where a number of adults have experienced harm or are at risk of harm; for example in a hospital or where an individual, or group of individuals, have targeted a number of service users.
- Large scale investigations will involve a wide range of agencies concerned with both the protection of individual adults and quality of care issues.
- Careful planning and co-operative multi-agency working is required at all stages of the investigation.
- This protocol aims to reflect the Department of Health's Agenda for "Dignity in Care" as outlined in the following statement.

High quality care services that respect people's dignity should:

1. Have a zero tolerance of all forms of harm.
2. Support people with the same respect you would want for yourself or a member of your family.
3. Treat each person as an individual by offering a personalised service.
4. Enable people to maintain the maximum possible level of independence, choice and control.
5. Listen and support people to express their needs and wants.
6. Respect people's right to privacy.
7. Ensure people feel able to complain without fear of retribution.
8. Engage with family members and carers as care partners.
9. Assist people to maintain confidence and a positive self-esteem.
10. Act to alleviate people's loneliness and isolation.

INDICATORS FOR LARGE SCALE INVESTIGATIONS : PATHWAY 4

On receipt of an Alert and throughout the course of an investigation, the Investigating Manager will need to consider if the alleged harm indicates that there could be a risk to other adults at risk. This may arise for example when:

This level of response would apply to complex Alerts raised in respect of 4 or more adults at risk in the following circumstances:

- Institutional harm
- Serious allegations of harm.
- A number of criminal offences may have been committed.

- Multiple breaches of Health and Social Care Act 2008 may have occurred.

The Senior Manager and Head of Adult Social Services should always be notified of a decision to carry out a Pathway 4: Large Scale Investigation.

When it becomes apparent that a Large Scale Investigation needs to take place, a Service Manager may decide to Chair the Safeguarding Adults Investigation, depending on the level of seriousness.

PARTNERSHIP WORKING

In these circumstances a number of different agencies are likely to be involved in the investigation so it is important that everyone involved is aware of their respective roles and responsibilities. All investigations will follow the guidance contained in the Multi-Agency Safeguarding Adults Policy and Procedures.

Multi-agency knowledge, skills and information sharing are essential to sound decision making and securing positive investigation outcomes for service users.

ORGANISING LARGE SCALE INVESTIGATIONS

When an investigation involves a number of people who have experienced harm or are at risk of harm, the issues are often complex; involving standards of service as well as a series of individual investigations.

It is essential that, whilst addressing concerns about the quality of service provision, each individual's civil rights are not compromised.

NB. A large scale investigation may require a series of individual safeguarding adults investigations to address allegations of harm specific to each individual.

The Local Authority has lead responsibility for safeguarding adults. In carrying out this responsibility the Chair will co-ordinate the overall investigation and ensure that all relevant agencies are involved.

PATHWAY 4: LARGE SCALE INVESTIGATION CHECKLIST

The following checklist should be read in conjunction with the guidance provided in Part 3.

The checklist is not exhaustive and not all issues will be relevant to every investigation but it is important that consideration is given to all these issues to facilitate the detailed planning required in complex investigations.

Many of the above issues will need to be reconsidered as the investigation progresses and new information is received.

PLANNING ISSUES TO BE CONSIDERED:

- Joint response and decision making between agencies.
- Clarify issues to be investigated.
- Agree what is not to be investigated.
- Agree roles and responsibilities for each agency (e.g. Local Authority, Police, CQC, Health, Provider Services etc).
- Agree timing of investigation actions (including complaints and staff disciplinaries).
- Ensure any intervention does not compromise any possible Police investigation (unless there are overriding safety needs).
- Obtain background information.
- Identify all people affected by investigation (staff and service users).
- Consider whether concerns warrant a recommendation for suspension of staff, local authority placements or service contracts.
- Obtain documentary information e.g. protocols, care plans, plans of building and maps of area.
- Maintain a chronology of all incidents related to the investigation.
- Keep a clear record of all policy decisions related to the investigation, including copies of strategy and conference minutes.
- Legal advice, where appropriate, should be taken as early as possible.
- Identify Lead Adult Safeguarding Investigator and agree information sharing arrangements.
- Preservation of evidence and preparation for medical examination.
- Joint response to risk assessment and management.

MANAGEMENT ISSUES TO BE CONSIDERED:

- Identify key managers from all appropriate agencies.
- Clarify operational procedures and whether Police Major Incident procedures apply.
- Jointly agree staffing commitment and location of investigation.
- Ensure that employees involved do not or are not seen to have any non-professional interest in the service or other elements to be investigated.
- Prepare for interview of vulnerable witnesses – specialist staff and interview facilities to be made available (Police & Social Services).
- Agree and prepare joint press release / liaise with press officer.
- Consider involvement of other Local Authorities.
- Consult on Management action and where appropriate agree on issues relating to disciplinary action and suspension.
- Plan for security of records.

PROFESSIONAL ISSUES TO BE CONSIDERED

- Identify differing agency priorities
- Regular briefing and information sharing for relevant staff and managers; which may need to be daily for some cases.
- Support and protection for referrers.

- Care arrangements for adults at risk; including therapeutic support.
- Consideration of individual needs in relation to race, culture, age, gender, sexuality, religion, beliefs and disability.
- Language and communication needs.
- Advocacy services; including IMCA.
- Help – line facilities or identified contact point

POST INVESTIGATION ACTION

- Debriefing for all employees involved.
- Lessons learnt or 'best practice' identified from the investigation should be made available to all employees and agencies involved in the investigation so that any training issues can be addressed.
- A summary of all Large Scale Investigations should be prepared and sent to the Safeguarding Adults Lead in the LA and the Chair of the SAB.
- If circumstances warrant referral for a Serious Case Review then this should be arranged.

4.27 Planning and Conducting the Interview(s)

Investigators who have undertaken the training on the Achieving Best Evidence in criminal proceedings (ABE) model will conduct the interviews.

<http://www.justice.gov.uk/guidance/docs/achieving-best-evidence-criminal-proceedings.pdf>

4.28 Record Keeping

All records should be:

Timely

Records should be made as soon as possible.

Accurate

If mistakes in information have been recorded, they are unlikely to be questioned by a new worker. The inaccurate information will be perpetuated inadvertently. At times, information may be gathered in a stressful situation. However, every effort must be made to ensure accuracy. It will be advisable to check the information recorded at a later date.

Factual

It is essential to record the nature and the source of the information.

- What is said and by whom.
- What was observed and by whom.

Hearsay and third party information must be clearly recorded as such.

Ethical

All records should be non-judgmental and non-discriminatory. It may be a useful guide to record information with an assumption that the person you are writing about will read it.

The importance of good record keeping is essential for all agencies and not just Local Authorities. “Good record keeping is essential for Local Authorities so that when they are challenged – as is increasingly likely – they are able to demonstrate that decisions were not taken unlawfully or with maladministration. Defensive record keeping can easily become poor record keeping. This renders decision making opaque and difficult to defend against challenge.” (Mandelstam, M., 1998, page 163)

From a legal perspective, the Human Rights Act 1998, which came into effect 1st October 2000, brings into English law a distinct and different approach to thinking about rights, responsibilities and remedies. Additionally, courts appear increasingly willing to hold Local

Authorities, other statutory agencies and individual practitioners, to legal account. In the light of this, it is important to keep detailed records.

Record keeping is an integral part of the professional practice and should assist the process. It is not separate from the process and not an optional extra to be fitted in if time and circumstances allow.

Practitioners must be aware of the Human Rights articles and if they feel that they are possibly contravening any Human Rights article, they must refer to this in written records, including a justification.

For more information regarding the Human Rights Act, refer to the "Code of Practice".

Procedure

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 all relevant agency and adult at risk's records into a file to record all actions taken. In the case of providers of services these should be available to the commissioners of services and to the Care Quality Commission.

When Should Information be recorded?

- Records must be kept from the time that a concern, allegation or disclosure is made.
- Each entry must be dated and timed.
- The name of the person recording the information must be written in full. Do not use initials.

What to Record

- All entries must provide factual information, for example, times, dates, names of people contacted.
- Avoid expressions of opinion (remember that the person you are writing about may have the right to read what you have said).
- All contact with the adult at risk and person who may have caused harm must be recorded.
- Record the exact words the adult at risk and person who may have caused harm used.
- Use body maps to illustrate any physical injuries.
- All consultation with a Manager and/or Senior Manager must be recorded.
- When contacting other agencies the questions asked and information received must be recorded.
- If a decision is made not to contact the Police, the details of why this decision was made and on whose authority it was made must be recorded.
- All telephone calls, those received and made in relation to the abuse, must be recorded even if there was no reply to outgoing calls.
- Those who attend Safeguarding Strategy Meetings must be named.

- The decisions taken at all meetings must be recorded.
- It is essential to demonstrate how an assessment of risk, responsibility, rights, autonomy and protection of the adult at risk was undertaken.
- If no investigation is to take place, the reasons why and on whose authority this decision was taken must be recorded.

How to Record Information

- All records should be typed.
- If this is not possible, they must be written in black ink.
- Any alteration to records must be made by drawing a single line through the word(s) and initials of person making alteration.
- Correction fluid must not be used.

Other Documentation

- Any rough notes made during the investigation must be kept with the record.
- Minutes from Safeguarding Strategy Meetings must be kept with the record.
- Minutes from the Case Conference must be kept with the record.
- All Safeguarding plans and reviews must be kept with the record.

Legal Requirements

- Records should not breach a person's legal rights
- All agencies should identify arrangements, consistent with principles of fairness, for making records available to those affected by and subject to the investigation. (See "No Secrets" -Section 6.17.)
- Service user alleged to have caused harm.
 - If the alleged person who may have caused harm is a service user then information about his/her involvement in an Safeguarding Adults investigation, including the outcome of the investigation, should be included on his/her case records. (See "No Secrets" -Section 6.18.)

Storing of Information

- All records must be stored in accordance with your own agency's policies with regard to the Data Protection Act 1998
- Standards of Recording
 - Best practice in recording is based on key principles of partnership, openness and accuracy. Effective recording is part of the total service to the user.

4.29 Chairing Safeguarding Adult's meetings

The Chair will usually be the Investigating Manager of the Lead Agency (see paragraph 3.6.2.2 and 4.3.4 for further information on the Investigating Manager role). The Chair is responsible for ensuring the Safeguarding Adults meeting is arranged, taking into account any particular access or communication needs.

As part of their role, the Chair is responsible for:

- Arranging meetings in accordance with Safeguarding Adults Policy & Procedures.

- Ensuring a minute taker is appointed and briefed about their role.
- Ensuring information sharing and confidentiality protocol is adhered to
- Establishing an agenda for meetings.
- Facilitating the full participation of everyone at the meeting.
- Ensuring Safeguarding plans are produced, based on risk assessments.
- Ensuring attendance sheets are fully completed and minutes are circulated appropriately.
- Checking and signing minutes prior to circulation.
- Promoting the involvement of adults at risk and their carers (where appropriate) in Safeguarding meetings.
- Responding to requests for amendments to minutes
- Requesting reports (signed and dated where possible) to be used as part of the meeting
- That the relevant forms are completed by the appropriate person

A more senior officer may chair a Safeguarding Strategy meeting if:

- More than one person is at risk and it is an investigation
- CQC have concerns about the provider
- There are previous concerns of a serious nature
- It may be a service used by several local authorities or organisations.
- It is likely to have a high profile

4.30 Minute Taking

Minutes of meetings should provide a reflection of the meeting as a whole and accurately record what was discussed, the stated opinions of others and what the outcomes are in terms of actions, roles and responsibilities – (safeguarding plan). They do not necessarily need to be word for word. Minutes are the responsibility of the Chair and therefore the minute taker and Chair need to work closely together.

Below are some guidance notes to consider when taking minutes as part of the Safeguarding Adults process.

- Minutes should be written in the past tense
- The full names of those involved in the meeting and those discussed should be used
- Where possible, written reports should be provided for the meeting and if agreed by the Chair, attached as a copy to the minutes, thus saving the need for a further written précis of the reports.
- The Safeguarding Adults minutes template should be used where available and the type of meeting must be clear e.g. strategy meeting.
- The meeting Chair should spend some preparation time with the minute taker prior to the meeting to familiarise them with the issues/agenda and any specific requirements for that meeting.
- The minute taker may want to sit next to the Chair.
- The minute taker should be able to request clarification, if required, during the meeting.

- Minutes should be sent to the Chair of the meeting to check and amend, (if required) before circulation. The Chair also needs to sign the minutes once agreed, before circulation.
- Circulation of minutes is the responsibility of the chair. An attendance sheet should be completed and all those attending and giving apologies should receive a copy unless agreed otherwise at the meeting.
- Password protect all minutes circulated by e-mail and mark any posted minutes as confidential, (see LA guidance).
- Aim to have minutes typed and circulated within 10 days of the meeting.
- Requests for amendments to minutes following circulation must be addressed to the Chair.

4.31 Safeguarding & Prevention

The prevention of abuse must be the goal of everyone concerned with the well being of adults at risk. Everyone in contact with adults – carers, professionals and the public – have a vital role to play in stopping abuse from happening. Prevention of abuse is the goal of all in contact with adults at risk. There is a wide range of ways in which carers – formal and informal, users themselves and the wider public can contribute to the prevention of adult abuse.

1 Formal carers, professionals, and managers

Research shows that a significant number of abuse incidents involve formal carers, professionals and managers – people paid to care for and advise adults at risk. This fact places a responsibility both on those staff and those responsible for the practice of paid staff – in terms of management and supervision – to ensure that they are safe to work with adults at risk. This means that all the processes and checks surrounding who works with adults at risk, and how they work must incorporate the avoidance of abuse.

including:

- how staff are recruited;
- the policies and procedures staff work to;
- how staff are inducted and trained, especially concerning professional standards, policy and procedures and the possibility of abuse; and
- how staff are supervised and supported.

Managers, agencies and professions share responsibility for ensuring that staff are ‘fit for work’, whether as a home carer, residential worker, nurse, social worker or solicitor.

Ensuring that those working in the caring professions are ‘fit for work’ is increasingly viewed as a high priority and recent years have seen the development of a number of national initiatives in this area, such as the Independent Safeguarding Authority List.

It is the responsibility of managers and agencies to invoke and cooperate with these initiatives to the fullest extent. Local managers are best situated to know whether someone can, and is, performing to appropriate standards. Hence it is the responsibility of local managers to monitor performance and to intervene if risks exist. If, however,

managers do not take this responsibility seriously, then it is the responsibility of peers and others involved to take action using agencies' whistle-blowing and abuse policies. Further information concerning managerial responsibilities is available. Many professions also have a code of conduct, or similarly named documents, which set out good practice for the profession. Some examples of these are those for doctors, nurses, solicitors, occupational therapists and social care workers. By definition, action in default of the code of conduct involving an adult at risk may constitute abuse.

2 Informal carers

In the vast majority of instances, informal carers are the mainstay of ensuring that adults at risk are protected from abuse and as such they should be supported and aided in this task. Carers are entitled to an assessment of their needs in their own right. In a smaller number of situations it is informal carers who present a risk to the adults at risk; sometimes by reacting inappropriately to the care situation they face. In many cases it is understood that no deliberate harm is intended and the solution is to offer assistance.

It is important to ensure that informal carers are made fully aware of the danger of abuse, the warning signs and indicators, and how they can get advice and help when needed. What advice and assistance the informal carer may need will depend on the risks faced by the adult at risk as shown by the care assessment and other similar processes. For example, a young adult at risk living in the community will face different risks to an older service user attending a day centre. A starting point for all informal carers will be ensuring that they are made aware of the *Multi-Agency Safeguarding Adults Policy & Procedures* and any provider organisation policy and procedures. Other sources of advice for carers are available.

In instances where an informal carer presents a risk to the adult at risk, it is the responsibility of assessors and provider organisations to do whatever is needed to reduce the risk to ensure the safety of the adult at risk. Documenting discussion with the adult at risk concerning their wishes is imperative. Likewise a full care/risk assessment is central to understanding how best to safeguard the adult.

3 Service users

Although adults at risk will vary in their ability to understand risk, most can be helped to greater awareness of what abuse is, how abusers operate and how to protect them and benefit from help. Helping adults at risk to protect themselves has to start from an understanding of the kinds of risks the adult at risk may face and their current ability to protect themselves. This is a matter of asking some basic questions for each adult at risk with whom there is contact.

- What kind of abuse is this adult at risk at risk of?
- Where might the risk arise?
- Who may be a potential abuser of this adult at risk?

There are many ways in which adults at risk can be helped to reduce the risks they may face, including:

- Increased awareness of the fact of adult abuse and how and where it may happen and who can be an abuser (see, for example, *Keep Safe* a booklet from the Home Office on personal safety).
- Understanding and skills related to how to avoid potentially abusive situations.
- Knowledge of what to do if an abusive situation arises: how to get help; how to report concern.
- Helping adults at risk to protect themselves to their maximum ability should be a high priority activity for both formal and informal carers.

4 Direct Payments

Anyone who is purchasing his or her own services through the Direct Payments system and the relatives of such a person should be made aware of the arrangements for the management of adult safeguarding in their area so that they may access help and advice through the appropriate channels. Care managers, who play a role in Direct Payments, could be asked to help users who are at risk of abuse.

Because the national ISA register does not currently routinely cover employees recruited by service users there is potentially a heightened risk of those posing a danger to adults at risk using this route to avoid detection. Service users should be made aware of this and advised to use an “umbrella” body to ensure that a Criminal Records Bureau check is completed on their behalf.

A similar situation is likely to apply to the individual budget scheme as it is rolled out. See the dedicated Department of Health website for more details of the progress of the scheme.

5 The public

In some instances the public have a vital role in safeguarding adults at risk through the prevention and detection of abuse. Consequently it is the responsibility of all agencies and professionals to play their part in ensuring that there is a good level of public awareness of adult abuse and how concerns can and should be reported.

Safeguarding Adults Boards and specialist managers have a key function in this area in terms of promotional materials and liaison with important organisations (for example financial institutions and voluntary organisations), but these initiatives should be supported by all those in contact with adults at risk, e.g. through links with neighbours and friends, local services and shops and other people in contact with adults at risk.

Information, advice and support for carers and families is available from a variety of charitable organisations.

The International Network for the Prevention of Elder Abuse also provides an awareness raising toolkit for use in community settings.

PART 5. Glossary & Acronyms

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

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

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

Adult at Risk – adults who need community care services because of mental or other disability, age or illness and who are, or may be unable to, take care of themselves against significant harm or exploitation. The term replaces ‘vulnerable adult’.

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

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

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

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

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

Capacity – is the ability to make a decision about a particular matter at the time the decision needs to be made.

Care Setting/ Services – includes health care, nursing care, social care, domiciliary care, social activities, support setting, emotional support, housing support, emergency housing, befriending and advice services; also services provided in someone’s own home by an organisation or paid employee for a person by means of a personal budget.

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

Case Conference – is a multiagency meeting held to discuss the outcome of the investigation and to put in place a Safeguarding Plan.

CID – Criminal Investigation Department – Department within the Police Service that deal with the investigation of crime that requires investigation by a detective but does not come under the remit of a specialised unit.

Clinical Governance – is the framework through which the National Health Service (NHS) improves the quality of its services and ensures high standards of care.

CMHT (Community Mental Health Team) – teams are made up of professionals and support employees who provide specialist mental health services to people within their community.

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

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

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

DASH (Domestic Abuse, Stalking & Harassment and Honour-based violence) – risk identification checklist (RIC) is a tool used to help frontline practitioners identify high-risk cases of domestic abuse, stalking and honour-based violence.

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

FACS (Fair Access to Care Services) – is a system for deciding how much support people with social care needs can expect, to help them cope and keep them fit and well. It applies to all the local authorities in England. Its aim is to help Social Care workers make fair and consistent decisions about the level of support needed and whether the local council should pay for this.

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

IM (Safeguarding Adults Investigating Manager) – professionals or Managers (usually in a Social Care or Community Mental Health Team (CMHT) suitably qualified and experienced who have received Safeguarding Adults training. IMs are responsible for co-ordinating all Safeguarding Adults activity by organisations in response to an allegation of abuse.

IMCA (Independent Mental Capacity Advocate) – Advocates were established by the Mental Capacity Act 2005. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as family member or friend who is able to represent the person.

Intermediary – is someone appointed by the Courts to help a vulnerable witness give their evidence either in a Police interview or in a Court.

Investigation – is a process to gather evidence to determine whether abuse took place.

Investigator – is the employee in Adult Social Care and/or Police of any organisation who leads an investigation into the allegation of abuse.

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

MAPPA – (Multi-Agency Public Protection Arrangements) – are statutory arrangements for managing sexual and violent offenders.

MARAC (Multi-Agency Risk Assessment Conference) – is the multi-agency meeting of organisations that manage high-risk cases of domestic abuse, stalking and honour-based violence.

Mental Capacity – refers to whether someone has the mental capacity to make a specific decision or not.

NHS (National Health Service) – is the publicly funded healthcare system in the UK.

OASys (Offender Assessment System) – a standardized process for the assessment of offenders, developed jointly by the National Probation Service and the Prison Service.

OIC (Officer in Charge) – is the Police officer responsible for an investigation.

OoHO (Out-of-Hours Officer) – is the Social Worker on duty in the Out-of-Hours Service.

OoOS) – Out-of-Hours Service Social Services team that responds to out-of-hours referrals where intervention from the Council is required to protect an adult or child at risk and where it would not be safe, appropriate or lawful to delay that intervention to the next working day.

PALS (Patient Advice and Liaison Service) – is an NHS body created to provide advice and support to NHS patients and their relatives and carers.

Person causing the harm – is the person or adult who is alleged to have caused the abuse or harm.

PGO (Public Guardian Office) established in October 2007, under the Mental Capacity Act to support the Public Guardian and to protect people lacking capacity by registering enduring powers of attorney, lasting powers of attorney and supervising Court of Protection appointed deputies (see paragraph 4.6.3.2).

Public Interest – a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

QIPP (Quality, Innovation, Productivity and Prevention) – is a Department of Health initiative to help NHS organisations to deliver sustainable services in better, more cost-effective ways.

Referral – an alert becomes a referral when it is passed on to a Safeguarding Adults referral point and accepted as a Safeguarding Adults referral.

RIC (Risk Identification Checklist) – risk identification checklist (RIC) is a tool used to help frontline practitioners identify high-risk cases of domestic abuse, stalking and honour-based violence.

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

Safeguarding Adults Lead – is the title given to the employee in an organisation who is given the lead for Safeguarding Adults. The role may be combined with that of alerting manager, depending on the size of the organisation.

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

SAB (Safeguarding Adults Board) – represents various organisations in a Local Authority who take the lead in co-ordinating and improving safeguarding adults work.

Serious Case Review (SCR) – is undertaken by the Safeguarding Adults Board (SAB) when a serious case of adult abuse or death as a result of abuse or neglect, takes place. The aim is for agencies and individuals to learn lessons to improve the way in which they work.

SHA (Strategic Health Authority) – manage the NHS locally and provide a link between the Department of Health and the NHS.

SI (Serious Incident) – a term used by the National Patient Safety Agency (NPSA) in its National Framework for Serious Incidents in the NHS requiring investigation. It is defined as an incident that occurred in relation to NHS funded services resulting in serious harm or

unexpected or avoidable death of one or more patients, employees, visitors or members of the public.

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

Strategy discussion – is a multi-agency discussion between relevant organisations involved with the adult at risk to agree how to proceed with the referral. It can be face-to-face, by telephone or by email.

Strategy meeting – is a multi-agency meeting with the relevant individuals involved and with the adult at risk where appropriate, to agree how to proceed with the referral.

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

Wilful Neglect – is an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves

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