Together let's fight adult abuse

Safeguarding adults at risk
Multi-agency policy and procedures

Rochdale Borough Safeguarding Adults Board
Issued March 2012

Contents

1) Glossary

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

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

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

Adult at risk: means 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 a 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 abused 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 staff 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.

ASBRAC: Anti-social Behaviour Risk Assessment Conference

Care setting/services: includes health care, nursing care, social care, domiciliary care, social activities, support setting, emotional support, housing support, emergency housing, befriending and advice services *and* services provided in someone's own home by an organisation or paid employee for a person by means of a personal budget.

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

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

CIDs (Criminal Investigation Departments): are the units within the Police that deal with the investigation of crime that requires investigation by a detective but does not come within the remit of Community Safety Units (CSUs) or other specialised units.

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

CMHTs (community mental health teams): are made up of a team of professionals and support staff 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.

CPA (Care Programme Approach): was introduced in England in the joint Health and Social Services Circular HC(90)23/LASSL(90)11, 'The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services', published by the

Department of Health in 1990. This requires health authorities, in collaboration with social services departments, to put in place specified arrangements for the care and treatment of people with mental ill health in the community.

CPS (Crown Prosecution Service): 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.

CSUs (Community Safety Units): dedicated staff who receive special training in community relations, including local cultural issues. The CSUs will investigate the following incidents: domestic violence, homophobia, transphobia and racism, criminal offences where a person has been targeted because of their perceived 'race', faith, sexual orientation or disability.

DoLS (Deprivation of Liberty Safeguards): are measures to protect people who lack the mental capacity to make certain 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.

EDT (Emergency Duty Team): is the social services team that responds to out-of-hours referrals where intervention from the council is required to protect a vulnerable child or adult, and where it would not be safe, appropriate or lawful to delay that intervention to the next working day.

FACS (Fair Access to Care Services): is as 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.

GMP (Greater Manchester Police): is the police force responsible for policing Greater Manchester.

Head of Safeguarding Adults: this is the title of the manager in Rochdale who leads, manages, and develops Safeguarding services to address the safeguarding needs of all Adult Care service groups.

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.

IMCAs (Independent Mental Capacity 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 a 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 court.

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

Investigation: is a process to gather evidence to determine whether abuse took place.

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

LGBT (lesbian, gay, bisexual and transgender): is an acronym used to refer collectively to lesbian, gay, bisexual and transgender people.

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 forum of organisations that manage high-risk cases of domestic abuse, stalking and 'honour'-based violence.

Mental Capacity: is the ability to make a decision about a particular matter at the time the decision needs to be made.

NHS (National Health Service): is the publicly funded healthcare system in the UK.

OASys (Offender Assessment System): a standardised 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.

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

PALS (Patient Advice and Liaison Service): is an NHS body created to provide advice and support to NHS patients and their relatives and carers.

Planning 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.

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-efficient ways.

RBSAB: Rochdale Borough Safeguarding Adults Board.

RBSCB: Rochdale Borough Safeguarding Children Board

Referral: an alert becomes a referral when it is passed on to a Safeguarding Adults referral point and accepted as a Safeguarding Adults referral.

Responsible Managers: are professionals or managers suitably qualified and experienced who have received Safeguarding Adults training. They are responsible for coordinating all Safeguarding Adults activity by organisations in response to an allegation of abuse.

Safeguarding Adults: is used to describe all work to help adults at risk stay safe from significant harm. It replaced the term 'adult protection'.

Safeguarding Adults lead: is the title given to the member of staff 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 care/protection/safety plan and monitoring and review arrangements.

Serious Case Review (SCR): is undertaken by a Safeguarding Adults Board when a serious case of adult abuse takes place. The aim is for agencies and individuals to learn lessons to improve the way in which they work.

SHAs (Strategic Health Authorities): manage the NHS locally and provide a link between the Department of Health and the NHS.

SI (Serious Incident): is 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, staff, visitors, or members of the public.

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

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

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.

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.

2) Introduction

The purpose of this document is to set out the RBSAB policy on Adults at Risk.
(See **Section 3** for definition).
It includes a statement of principles for use by Adult Social Care Services and Housing, Health, the Police and other agencies for both developing and assessing the effectiveness of our local safeguarding arrangements.

The RBSAB's policy objective is to **prevent and reduce the risk of significant harm to Adults at Risk** from abuse or other types of exploitation, whilst **supporting individuals in maintaining control over their lives** and in making informed choices without coercion.

We believe that **safeguarding is everybody's business** with communities playing a part in preventing, detecting and reporting neglect and abuse. Measures need to be in place locally to protect those least able to protect themselves. Safeguards against poor practice, harm and abuse need to be an integral part of care and support. We will achieve this through partnerships between local organisations, communities and individuals.

Our Vision

Our vision is that the Rochdale Borough Safeguarding Adults Board will lead work in our communities to ensure that for adults who are at risk or in vulnerable situations, the agencies who support them and the wider community together can:

- develop a culture that does not tolerate abuse;
- raise awareness about abuse;
- prevent abuse from happening wherever possible;
- where abuse does happen, support and safeguard the rights of people who are harmed to:
    1. stop abuse continuing
    2. access services they need, including advocacy and post-abuse support
    3. have improved access to justice

Principles

Empowerment - We will give individuals relevant information about recognising abuse and the choices available to them to ensure their safety. We give them clear information about how to report abuse and crime and any necessary support in doing so. We consult them before we take any action. Where someone lacks capacity to make a decision, we always act in his or her best interests. We will strive to ensure that individuals feel that they are consulted about the outcomes they want from the safeguarding process.

Protection - Our local complaints, reporting arrangements for abuse and suspected criminal offences and risk assessments work effectively. Our governance arrangements are open and transparent and communicated to our citizens so that individuals feel that they are provided with help and support to report abuse.

Prevention - We can effectively identify and appropriately respond to signs of abuse and suspected criminal offences. We make staff aware, through provision of appropriate training and guidance, of how to recognise signs and take any appropriate action to prevent abuse occurring. In all our work, we consider how to make communities safer. We will ensure that individuals are supported to take part in the safeguarding process to the extent to which they want, and to which they are able.

Proportionality - We discuss with the individual and where appropriate with partner agencies the proportionality of possible responses to the risk of significant harm before we make a decision. Our arrangements support the use of professional judgement and the management of risk so that individuals feel that they are confident that the responses to risk will take into account their preferred outcomes or best interests.

Partnership - We have effective local information-sharing and multi-agency partnership arrangements in place and staff understand these. We foster a “one” team approach that places the welfare of individuals above organisational boundaries. Individuals will be confident that information will be appropriately shared in a way that takes into account its personal and sensitive nature, and that agencies will work together to find the most effective responses for their own situation.

Accountability - All agencies are clear about their roles and lines of accountability. Staff understand what is expected of them and others. Agencies recognise their responsibilities to each other, act upon them and accept collective responsibility for safeguarding arrangements. Individual will be aware of the roles and responsibilities of all those involved in the solution to the problem.

Further information

No Secrets

This document builds on “No Secrets”, which will remain as statutory guidance until at least 2013.
In the principles described above, we have taken account of the responses to the public consultation on “No Secrets” in 2008/09, the implementation of the Mental Capacity Act 2005, and the drive towards increasing personalisation of services.

Vision for social care

The Government published A Vision For Adult Social Care: Capable Communities And Active Citizens in November 2010. In this, they have set out a new direction for adult social care, putting personalised services and outcomes centre stage.
They emphasise the crucial role of local government and front-line workers and carers in the delivery of personalisation, giving them the freedom and responsibility to improve care services.
The section on protection makes it clear that we should protect people when they are unable to protect themselves, and that this should not be at the cost of people’s right to make decisions about how they live their lives.

Social Care Outcomes Framework

The Government has developed Transparency in Outcomes: A Framework for Quality in Adult Social Care, which aims to empower councils, local people and the wider social care sector to undertake new leadership roles. It provides support to the critical link between adult social care and other local partners.

3) Adults at risk

Definition of an adult at risk

1. The term ‘adult at risk’ has been used to replace ‘vulnerable adult’. This is because the term ‘vulnerable adult’ may wrongly imply that some of the fault for the abuse lies with the adult abused.

2. The term ‘adult at risk’ is used as an exact replacement for ‘vulnerable adult’, as used throughout No secrets. However, this section gives some more detail as to what this term can mean in practice.

3. This following definition is taken from the current Department of Health guidance: ***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 against significant harm or exploitation’*** (DH, 2000).

4. Other definitions exist in partner organisations. An adult at risk *may* therefore be a person who:
    - is elderly and frail due to 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 carer such as a family member/friend who provides personal assistance and care to adults and is subject to abuse
    - is unable to demonstrate the capacity to make a decision and is in need of care and support.

    (This list is not exhaustive.)

5. This does not mean that just because a person is old 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.

6. In the context of Safeguarding Adults, the vulnerability of the adult at risk is related to how able they are to make and exercise their own informed choices free from duress, pressure or undue influence of any sort, and to protect themselves from abuse, neglect and exploitation.

7. It is important to note that people with capacity can also be vulnerable. An adult at risk’s vulnerability is determined by a range of interconnected factors including personal characteristics, factors associated with their situation or environment and social factors.

Mental Capacity

1. 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 abuse
    - to participate to the fullest extent possible in decision making about interventions.

2. 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.

3. The Act says that: a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or brain.

4. 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 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).
5. 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 simple medical examination but not to major surgery. Their ability to make a decision may also fluctuate over time.

Principles of the Mental Capacity Act 2005

1. An adult at risk has the right to make their own decisions and must be assumed to have capacity to make decisions about their own safety unless it is proved (on a balance of probabilities) otherwise.
2. Adults at risk must receive all appropriate help and support to make decisions before anyone concludes that they cannot make their own decisions.
3. Adults at risk have the right to make decisions that others might regard as being unwise or eccentric and a person cannot be treated as lacking capacity for these reasons.
4. Decisions made on behalf of a person who lacks mental capacity must be done in their best interests and should be the least restrictive of their basic rights and freedoms.

Ill Treatment and Wilful Neglect

1. An allegation of abuse or neglect of an adult at risk who does not have 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.

2. Section 44 of the Act makes it a specific criminal offence to wilfully ill treat or neglect a person who lacks capacity.

Consent

1. It is always essential in safeguarding to consider whether the adult at risk is capable of giving informed consent. If they are, their consent should be sought. This may be in relation to whether they give consent to:
    - an activity that may be abusive – if consent to abuse or neglect was given under duress, 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. The person must be given information and have the opportunity to consider all the risks and fully understand the likely consequences of that decision over the short and long term
    - the recommendations of an individual protection plan being put in place
    - a medical examination
    - an interview
    - certain decisions and actions taken during the Safeguarding Adults process with the person or with people who know about their abuse and its impact on the adult at risk.

2. If, after discussion with the adult at risk who has mental capacity, they refuse any intervention, their wishes will be respected *unless*:
    - there is a public interest, for example, not acting will put other adults or children at risk
    - there is a duty of care to intervene, for example, a crime has been or may be committed.

Abuse

1. For the purpose of the Safeguarding Adults policy and procedures the term *abuse* is defined as ***a violation of an individual's human and civil rights by any other person or persons which results in significant harm***. (DH, 2000)

2. Abuse 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 abused

3. Abuse is about the misuse of power and control that one person has over another.

4. Where there is dependency, there is a possibility of abuse or neglect unless adequate safeguards are put in place.

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

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

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

Significant harm

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

   - ***ill treatment (including sexual abuse and forms of ill treatment which are not physical)***
   - ***the impairment of, or an avoidable deterioration in, physical or mental health***

   and/or

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

2. 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.

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

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

5. Abuse can be viewed in terms of the following categories:
   - physical
   - sexual
   - psychological/emotional
   - financial and material
   - neglect and acts of omission
   - discriminatory
   - institutional.

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

Physical abuse

This is the physical ill treatment of an adult, which may or may not cause physical injury. Examples of physical abuse are hitting, pushing, pinching, shaking, misusing medication, scalding, the misuse or illegal use of restraint, inappropriate sanctions, exposure to heat or cold and not giving adequate food or drink.

Restraint

1. Unlawful or inappropriate use of restraint or physical interventions and/or deprivation of liberty is physical abuse.
2. There is a distinction to be drawn between restraint, restriction, and deprivation of liberty. A judgement 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.
3. In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence.
4. 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.
5. 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.
6. 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, Mental Capacity Act *Code* and the Deprivation of Liberty Safeguards (DoLS).

Sexual abuse

This is any form of sexual activity tht the adult does not want and to which they have not consented, or to which they cannot give informed consent.

1. Rape and other sexual assaults are among the most serious offences investigated by the Police. The trauma that victims suffer presents unique challenges to any investigation.
2. It is incumbent on all staff to ensure that they are aware of the standards set out in this policy and procedures document and to ensure confidence of achieving the best possible response to the adult at risk.
3. Staff should also make reference to any additional policies held by their organisation.
4. All staff should be aware of their individual roles and responsibilities to maximise all evidential opportunities to assist any investigation of a sexual nature and the

minimum standards required regarding immediate response, recording and reporting.

5. Some examples of sexual abuse/assault include the direct or indirect involvement of the adult at risk in sexual activity or relationships which:
    - they do not want or have not consented to
    - they cannot understand and lack the mental capacity to be able to give consent to
    - they have been coerced into because the other person is in a position of trust, power or authority, for example, a care worker.
6. They may have been forced into sexual activity with someone else or may have been required to watch sexual activity.

Key principles

1. The most important priority is to ensure that the urgent medical and welfare requirements of the adult at risk are met.
2. Preserve any potential forensic opportunities, and record verbatim the disclosure made by the adult at risk.
3. 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.
4. Sexual relationships or inappropriate sexual behaviour between a member of staff and a service user are always abusive and will lead to disciplinary proceedings. This is additional to any criminal action that has been taken.
5. 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.
6. 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 abuse require a risk assessment, intelligence gathering and appropriate information sharing with relevant partners.

Psychological / Emotional Abuse

1. This is behaviour that has a harmful effect on the person's emotional health and development or any form of mental cruelty that results in:
    - mental distress
    - the denial of basic human and civil rights such as self-expression, privacy and dignity
    - negating the right of the adult at risk to make choices and undermining their self-esteem
    - isolation and over-dependence that has a harmful effect on the person's emotional health, development or well-being.
2. It is the wilful infliction of mental suffering by a person who is in a position of trust and power to an adult at risk. Psychological/emotional abuse results from threats of harm or abandonment, being deprived of social or any other sort of contact, humiliation, blaming, controlling, intimidation, coercion and bullying. It undermines the adult's self-esteem and results in them being less able to protect themselves and exercise choice. It is a type of abuse that can result from other forms of abuse and often occurs at the same time as other types of abusive behaviour.

3. Behaviour that can be deliberately linked to causing serious psychological and emotional harm may constitute a criminal offence. Specialist advice from the police should be sought.

Financial abuse

1. Financial abuse is a crime. It is the use of a person's property, assets, income, funds or any resources without their informed consent or authorisation. It includes:
    - theft
    - fraud
    - exploitation
    - undue pressure in connection with wills, property, inheritance or financial transactions
    - the misuse or misappropriation of property, possessions or benefits
    - the misuse of an enduring power of attorney or a lasting power of attorney, or Appointeeship.

Neglect and acts of omission

1. Neglect is the 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 that a reasonable person would be expected to provide.
2. Behaviour that can lead to neglect includes including ignoring medical or physical needs, failing to allow access to appropriate health, social care and educational services, and withholding the necessities of life such as medication, adequate nutrition, hydration or heating.
3. Neglect can be intentional or unintentional.
4. Intentional neglect would result from:
    - wilfully failing to provide care
    - wilfully preventing the adult at risk from getting the care they needed
    - being reckless about the consequences of the person not getting the care they need.
5. If the individual committing the neglect is aware of the consequences and the potential for harm to result due to the lack of action(s) then the neglect is intentional in nature.
6. Unintentional neglect could result from a carer failing to meet the needs of the adult at risk because they do not understand the needs of the adult at risk, may not know about services that are available or because their own needs prevent them from being able to give the care the person needs.
   It may also occur if the individuals are unaware of or do not understand the possible effect of the lack of action on the adult at risk.

Discriminatory Abuse

1. Discriminatory abuse exists when values, beliefs or culture result in a misuse of power that denies opportunity to some groups or individuals. It can be a feature of any form of abuse of an adult at risk, but can also be motivated because of age, gender, sexuality, disability, religion, class, culture, language, race or ethnic origin.

2. It can result from situations that exploit a person's vulnerability by treating the person in a way that excludes them from opportunities they should have as equal citizens, for example, education, health, justice and access to services and protection.

Institutional Abuse

1. Institutional abuse is the mistreatment or abuse or neglect of an adult at risk by a regime or individuals within settings and services that adults at risk live in or use, that violate the person's dignity, resulting in lack of respect for their human rights.
2. Institutional abuse 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.
3. Institutional abuse can occur in any setting providing health and social care. A number of inquiries into care in residential settings have highlighted that institutional abuse is most likely to occur when staff:
    - receive little support from management
    - are inadequately trained
    - are poorly supervised and poorly supported in their work
    - receive inadequate guidance.

    The risk of abuse is also greater in institutions:
    - with poor management
    - with too few staff
    - which use rigid routines and inflexible practices
    - which do not use person-centred care plans
    - where there is a closed culture.

Deprivation of Liberty Safeguards (DoLS)

1. DoLS apply to people who have a mental disorder and who do not have mental capacity to decide whether or not they should be accommodated in the relevant care home or hospital to be given care or treatment.
2. These safeguards provide protection to people in hospitals and care homes. Care homes and hospitals must make requests to a local authority for authorisation to deprive someone of their liberty if they believe it is in their best interest.
3. RMBC (Adult Care) undertakes supervisory functions on behalf of the Primary Care Trust (PCT). All decisions on care and treatment must comply with the Mental Capacity Act and the Mental Capacity Act Code of Practice.
4. The Care Quality Commission (CQC) has also issued guidance for providers of registered care and treatment services on DoLS.
5. Reference should be made to the RMBC and health trust for procedures relating to DoLS. See also information on the DH website (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476)

Hate Crime

1. Hate crime is defined 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.

2. 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.

3. 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.

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

5. Anyone can be a victim of abuse 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.

Domestic Abuse

1. Domestic abuse is defined as 'any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members regardless of gender or sexuality'.

2. Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family; see ACPO, 2004.

3. Whatever form it takes, domestic abuse is rarely a one-off incident and should instead be seen as a pattern of abusive and controlling behaviour through which the abuser seeks power over the victim.

4. Domestic abuse occurs across society, regardless of age, gender, 'race', sexuality, wealth and geography. The figures show, however, that it consists mainly of violence by men against women. Children are also affected both directly and indirectly and there is also a strong correlation between domestic violence and child abuse.

5. 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.

6. 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.

7. The abusive partner should not be informed of any disclosures.

8. 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 (this list is not exhaustive).

9. Support for those affected by domestic abuse is available in Rochdale from:
    - Rochdale Women's Refuge: Tel. 01706 860157
    - Women's Housing Action Group: Tel. 01706 718180
    - Rochdale Inter-agency Domestic Violence Forum: Tel. 01706 718923

MARAC (Multi-Agency Risk Assessment Conference)

The MARAC is part of a coordinated community response to domestic abuse, incorporating representatives from statutory, community and voluntary agencies working with victims/survivors, children and the person alleged to have caused harm.

The MARAC aims to:

- Share information to increase the safety, health and well-being of victims/survivors – adults and their children;
- Determine whether the person alleged to have caused harm poses a significant risk to any particular individual or to the general community;
- Construct jointly and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;
- Reduce repeat domestic abuse incidents;
- Improve agency accountability; and
- Improve support for staff involved in high-risk domestic abuse cases.

Contact details for MARAC:

There are twelve Multi Agency Risk Assessment Conferences (MARACs) in Greater Manchester (one per police division).

The referral form (which includes criteria for referral) is available for download from the CAADA (Co-ordinated Action Against Domestic Abuse) website. Link here: http://www.caada.org.uk/practitioner_resources/RIC%20with%20Quick%20Start%20Guidance%20%20Disclaimer%2021052009.pdf

MARAC referrals can only be made by uploading them onto the SharePoint site and cannot be sent by email. The twelve MARAC sites are on the secure AGMA server (Association of Greater Manchester Authorities).

Please contact your agency's **MARAC Co-ordinator** to do this.

Contact details for MARAC Co-ordinators: http://www.endthefear.co.uk/wp-content/uploads/2011/09/Contact-details-forMARAC-Co0ords2.doc

SharePoint training is delivered once a month at Nexus House, Ashton under Lyne. The training is free and lasts for approximately 2.5 hours.

Meeting dates and cut off dates for referrals are available on the SharePoint Site. There is also a protocol for convening emergency MARACs

For further information in relation to SharePoint Access and training please contact:-
Julie Church-Taylor | MARAC & Public Protection Training Coordinator
0161 856 1947 | e-mail: Julie.church-taylor@gmp.pnn.police.uk.

ASBRAC (Anti-Social Behaviour Risk Assessment Conference)

Tackling Anti-Social Behaviour is a priority issue across the pan-Lancashire area with many new initiatives being adopted to improve partnership working and improve outcomes for victims and communities.

Identifying and supporting the most vulnerable victims has been central to this work following a number of high-profile tragic cases nationally, and partners in Lancashire have made an early and well developed response to tackling the problem.

The ASBRAC framework was developed in Blackpool and has been adopted over the last few months by Community Safety Partnerships pan-Lancashire.

Similar to the established MARAC process for domestic abuse, ASBRAC brings together local agencies to address the harm caused to ASB victims, and prioritise interventions. The process identifies low, medium and high risk victims of ASB and identifies support from the point of referral. It provides multi-agency meetings to consider and address the most complex and high risk cases and identify interventions. ASBRAC facilitates better information sharing and provides a transparent record of action taken to support the vulnerable in our communities.

Referral to the ASBRAC in Rochdale is via the Principal Community Safety Officer, Community Safety Unit, Town Hall, The Esplanade, Rochdale. Tel: 01706 924691

Female Genital Mutilation (FGM)

1. Female genital mutilation (F.G.M.) relates to all procedures involving the partial or total removal of the external genitalia or other injury to the female genital organs for non medical reasons.
2. FGM is illegal in the U.K. under The Female Genital Mutilation Act 2003.This offence involves mutilation of a female's labia majora, labia minora or clitoris.
3. Under the Female Genital Mutilation Act 2003 , a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's or woman's labia majora, labia minora or clitoris except for necessary operations performed by a registered medical practitioner on physical and mental health grounds; or an operation performed by a registered medical practitioner or midwife on a girl / woman who is in labour or has just given birth for purposes connected with labour or birth (these exceptions are set out in section 1(2) and (3) of the act).
4. It is an offence for anyone (regardless of their nationality and residence status) to perform FGM in the U.K. or to assist a girl to perform FGM on herself in the U.K. When mutilation takes place in the UK, the nationality or residence status of the victim is irrelevant.
5. It is an offence under the FGM Act 2003 for a UK national or permanent UK resident to perform FGM, or to assist a girl / woman to perform FGM on herself outside the UK. It is also an offence to assist FGM carried out abroad, by anyone (including foreign nationals); although in some cases the offence is limited to the situation where the victim is a UK national or permanent UK resident. This would cover taking a girl / woman abroad to be subjected to FGM. "Local authorities can apply to the courts for various orders to prevent the individual being taken abroad for mutilation", Children Act 1989(S47).

For further guidance see the Rochdale Joint Practice Guidelines on Safeguarding Children and Adults at Risk of Female Genital Mutilation.

Honour Based Violence

1. Honour-based violence is a crime, and referral must always be made to the police.
2. 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.
3. Many of these victims will contact police or other organisations, but many are so isolated and controlled that they are unable to contact the police.
4. Alerts that may indicate honour-based violence include domestic violence, concerns about forced marriage or enforced house arrest and missing persons reports.
5. 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.

Forced Marriage

1. Forced marriage is a term used to describe a marriage in which one or both of the parties are 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.
2. 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.
3. 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.
4. In this case action will be coordinated with the police and other relevant organisations.

Human Trafficking

1. If an identified victim of human trafficking is also an adult at risk, the response will be coordinated under the Safeguarding Adults process.
2. 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.
3. The adult at risk should receive the support and advice they need and be safely repatriated if this is the future plan.
4. If the victim is a child, the situation will be dealt with under the Rochdale child protection procedures.
5. The early identification of victims of human trafficking is key to ending the abuse they suffer and to providing the assistance necessary. Front-line staff need to be able to identify the signs that someone has been trafficked.

6. There is a national framework to assist in the formal identification and help to coordinate the referral of victims to appropriate services; this is called the National Referral Mechanism.

7. 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.

Assisted Suicide

1. Situations when a person may express a wish to die may include:
    - People with life threatening illnesses approaching the end of life;
    - Those with progressive irreversible conditions who predict a future situation in which they perceive that their life as being extremely poor with no potential for improvement;
    - Those with mental health and learning disability issues for whom continuing to live feels like a major challenge;
    - Individuals coping with complex debilitating or multiple long-term conditions.
2. The Local Authority has a duty to investigate a proposed assisted suicide where the individual concerned is considered to be vulnerable as defined in No Secrets (i.e. in the terms of this policy, Adults at Risk).
3. Assisted suicide is illegal in all parts of the UK and carries a maximum penalty of 14 years imprisonment.
4. A person commits an offence under Section 2 of the Suicide Act 1961 if they act in a way that is capable of encouraging or assisting the suicide or attempted suicide of another person, and if that act was intended to encourage or assist suicide or an attempt at suicide.
5. If an individual (A) arranges for someone else (B) to act in a way that is capable of encouraging or assisting the suicide or attempted suicide of another person (C), and person B carries out that act, then individual A has committed an offence.

See CPS website for more information: http://www.cps.gov.uk/consultations/as_policy.html

Carers and Safeguarding Adults at Risk

(Extract from: ADASS (2011): Carers and Safeguarding Adults – Working Together To Improve Outcomes)

Definition of Carer

There is currently no single agreed definition of what is meant by the term “carer”.
We have used the definition contained within Commissioning for Carers [2009]2 published by the Princess Royal Trust for Carers and developed jointly with a number of organisations including ADASS:
“A carer spends a significant proportion of their time providing unpaid support to a family member, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems.”

Key Issues

1. Carers have a range of roles regarding safeguarding: as partners and informants; themselves as vulnerable to harm and abuse; as abusers.

2. The vast majority of carers strive to act in the best interests of the person they support. There are times, however, when carers themselves experience abuse from the person to whom they are offering care and support or from the local community in which they live.
3. Risk of harm to the supported person may also arise because of carer stress, tiredness, or lack of information, skills or support. Sadly, also, there are times where harm is intended.
4. Sometimes, professionals may place undue confidence in the capacity of families to care effectively and safely. This is coming to be known as “the rule of optimism”. We need to keep it in mind.
5. There are seven key messages to consider :

   Leadership – Safeguarding is everybody’s business with Directors and local Boards listening, learning as well as leading on improved safeguarding outcomes and outcomes for carers.

   Partnership – Safeguarding Adults Boards engage with carers and local stakeholders and work together for better safeguarding practice and outcomes for those involved in safeguarding processes.

   Empowerment - Carers have access to information, advice and advocacy that is understandable and empowers them to share concerns and change harmful circumstances.

   Prevention – Community engagement, public and professional awareness is encouraged and accessible, and understandable information is available to carers that reduces risk of abuse.

   Recognition & Reporting – Partnerships and practitioners understand the barriers to recognition and reporting and work in partnership to overcome them and ensure access to justice.

   Protection & Proportionality– Responses have the person concerned at their centre and enable those at risk to inform outcomes linked to proportionate and protective services and supports. Risks are managed and harmful and abusive situations stopped**.**

   Learning & Accountability – Impacts are understood, practice monitored and safeguarding experiences and outcomes monitored to learn from the experiences of carers and people at risk of harm and those who seek to help them. Staff have the competencies and operational culture to support this.

Carers Speaking Up

Recognition of risk of harm or harmful behaviours is critical to prevention and protection of people. Communities and carers have important roles in protecting people who may be unable to protect themselves.

Barriers to Sharing Concerns

1. The barriers to carers sharing concerns are likely to be similar to those identified in relating to other comments and concerns mechanisms within health and social care. They may shape carer responses to safeguarding concerns and are likely to embrace:
   a) Issues relating to understanding and awareness
      - lack or awareness or being unsure if it is wrong or not; being unclear about rights and standards or what “abuse” means;

- organisational and staff attitudes to concerns - defensive not responsive.

b) Issues relating to communication

- uncertainty about who to go to, how to do so and opportunities to do so
- lack of someone to talk to or a source of trusted advice and support
- difficulty in communication (access, availability, means, or sensory) including language and literacy barriers
- respect or deference to people "authority" roles (sometimes age related)
- unsatisfactory earlier experiences around sharing or raising concerns
- staff don't seem to listen or appear to understand concerns
- nothing changed or no feedback; "confidentiality"

c) Issues relating to consequences of saying something

- feelings of the person they are concerned for: asked not to say or make a fuss, minimisation of events, brought it on themselves etc.
- worries about the impact on the care of the person supported
- difficulty recalling what happened or a fear of not being believed or wrong
- guilt or fear of personal comebacks or being seen as a nuisance or ungrateful for care being given by others
- lack of confidence in following up concerns linked to carer's own emotional pressure and stress
- fear of social services involvement and unwanted care alternatives

2. Carers can help us to understand what is going on and about the risks faced by the person they support and know well. Carers are often well placed to spot distress and to offer support during a safeguarding investigation where this is appropriate.
   Their knowledge as "expert partners" and often as "advocates" for the person they support can be helpful in scoping and managing risks in a proportionate, enabling and sustainable way. Where carers are not involved or treated as partners who are listened to, the chances of unrecognised or unreported risks of abuse and neglect may well increase. We should always listen carefully to what a carer has to say and to retain an open mind about this.

3. Staff, volunteers, communities along with carers all have an important role in speaking up for people who may be vulnerable, more at risk of harm and less able to protect themselves.
   Getting this message across is one of the keys to prevention, recognition, reporting and responding to neglect and abuse; in enabling people to feel supported and to maintain a sense of choice and control over their situation.

Carers at Risk of Harm

1. The risk of deterioration in carers' health and well-being as a consequence of their caring responsibilities is well documented. For some this is seen as something that comes with the territory: the price of caring. There is a point, however, where the behaviour of the person supported, intentionally or not, can fall into the category of abuse. Recognition, reporting and responding to carers at risk of harm in these circumstances may not be easy. The situation may be complicated by carer denial, or guilt, or by a sense of shame in asking for help, or by the existence of some areas the carer may not be confident about.
2. Risk of abuse increases where the carer is isolated and not getting any practical and/or emotional support from their family, friends, professionals or paid care givers.

3. Such risk factors tend to be greater where the carer lives with a person with dementia or is a partner or close relative. Timely and careful assessment is critical in such circumstances, and the focus of local safeguarding work invariably embraces potential needs for support on both parts.
4. This may include exploration of capacity for change in order to decrease the risk of further harm. Even where support is available some carers may still feel unsupported and unrecognised. Information and advocacy support may help.
5. Dementia is a progressive disease and care givers are often faced with escalating demands. These may include emotional, social, physical and financial burdens and having to cope with behavioural and personality changes that are of concern. Carers can become “hidden victims” of abuse. There is some evidence that carers of people with dementia are more at risk of experiencing depressive symptoms. These can be overlooked or go undiagnosed and untreated.
6. There may be risks of financial abuse where carers who are trying to support a relative involved in serious substance misuse. Where carers feel powerless they may feel less able to report that they are experiencing abuse. The possible consequences for the supported person of sharing concerns about, for example, violence directed towards them or stealing, may also lead to silence.

Carers Who Harm

1. Some of the situations that place carers more at risk of harm also have within them factors that increase the risk of carers being involved in causing harm. This potential vicious circle is something that early intervention, information, sensitive assessment and skills in carer support and recognition can help to avoid.
2. Risks tend to be greater where the carer:
    - has unmet or unrecognised needs of their own
    - are themselves vulnerable
    - has little insight or understanding of the vulnerable person’s condition or needs
    - has unwillingly had to change his or her lifestyle
    - are not receiving practical and/or emotional support from other family members
    - are feeling emotionally and socially isolated, undervalued or stigmatised
    - has other responsibilities such as family or work
    - has no personal or private space or life outside the caring environment
    - has frequently requested help but problems have not been solved
    - are being abused by the vulnerable person
    - feels unappreciated by the vulnerable person or exploited by relatives or services
3. The seven most commonly reported situations by GPs, where it is reasonable to consider the risk of elder abuse or neglect, were seen as including:
    - Carers with problems of their own e.g. psychological, alcohol
    - Older people with dementia who are left alone all day
    - Older people in households where too much alcohol is drunk
    - Carers who get very angry about the burden of caring
    - Older people with dementia who are violent towards their carer
    - Carers who are unable to meet properly the needs for daily care of the older person
    - Older people living with adult with a severe personality disorder

Unintentional Harm

1. Abuse or neglect does not have to be deliberate, malicious or planned. Sometimes events and actions may be clouded by stress and isolation brought on by caring. Often, carers will be trying their best and some may not have the information they need. Carers may not know what is or is not the right way to do things [e.g. moving and handling]. They may feel what they are doing is all-right if it keeps the person safe [e.g. restraint or no independent travel]. It may involve a reluctance to change or to listen to the case for change. The need for change may be seen as criticism or as a lack of real understanding about their situation.
2. The latter may be a particular issue for some parent carers of adult "children" for whom they have given a lifetime commitment. Pressures on such carers can increase at times of service change and the emphasis on more independence, choice and control. The process of ageing will take its toll on both carer and cared for. This can lead to *mutual caring*, the extent of which may not be disclosed. It may also lead to inappropriate restrictions on choice and daily living.
3. In some cases both the carer and the supported person can be considered to be vulnerable and more at risk of harm. The needs of the adult at risk who is the alleged subject of abuse should be addressed separately from the needs of the person alleged to be causing them harm. The risk of further abuse must always be considered along with the extent to which the abuse or neglect flows from the needs of the person causing or at risk of causing significant harm.
4. There may also be situations where a previously dominant parent has become dependent and role reversal has taken place. Increasing dependence can be perceived as being "difficult". Role reversal may be resented or become a source of anxiety to the carer. The potential for adverse impacts on understanding, care and support suggest careful assessment

Intentional Harm

1. Some actions by carers or their impacts may be unintentional and arise from lack of coping skills or unmet needs. Others may be intentional. The issue is always one of impact on the individual affected by the carer's actions or lack of action.
2. Outcomes should be person centred and not process driven. Careful assessment risk enablement; consistency and competence in safeguarding functions; and, in working with carers are all essential.
3. Families and carers make an invaluable contribution to society. Support of carers is seen as integral to the way agencies seek to work. We need to keep in mind, however, the potential of *"the rule of optimism" to* affect professional perceptions and recognition of risk of harm, abuse or neglect.
4. This may arise from:
    - generalised assumptions about "carers";
    - uncritical efforts to see the best;
    - concerns about consequences of intervention;
    - minimising concerns;
    - not seeing emerging patterns or not ensuring a consistent focus on the person at risk.

Situations where harm is not inadvertent but arises from harmful intent on the part of the carer may not be seen as such. Exclusion of agencies may be accepted with a consequent impact on ability to protect from harm. Deliberate acts of harm or omission leading to neglect should always engage safeguarding procedures and police referral as appropriate.

4) Raising an alert

This section covers:

- responsibilities of the person raising the alert
- responsibilities of the alerting manager
- factors to consider when raising an alert**.**

1. Alerts

Alerting refers to the duty of all staff (professionals and volunteers) of any service involved with adults at risk to inform the relevant manager of a concern that an adult at risk:

- has been harmed, abused or neglected or
- is being harmed, abused or neglected or
- is at risk of being harmed, abused or neglected.

A concern may be:

- a direct disclosure by the adult at risk
- a concern raised by staff 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.

Alerts may be made by anyone, including the Adult at Risk themselves.

2. Responsibilities of the person raising the alert

Taking immediate action

- Make an immediate evaluation of the risk and take steps to ensure that the adult is in no immediate danger.
- Where appropriate, dial 999 for an ambulance if there is need for emergency medical treatment, in line with information-sharing considerations (see below).
- Consider contacting the police if a crime has been or may have been committed, in line with information-sharing considerations (see below).
- 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
- Contact the children and families department if a child is also at risk.
- If possible, make sure that other service users are not at risk.

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.

Preserving evidence

The first concern must be to ensure the safety and well-being of the alleged victim. 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 you cannot actually see anything.
- If in doubt contact the police and ask for advice.

Responding to an adult at risk who is making a disclosure

- Assure them that you are taking them seriously.
- Listen carefully to what they are telling you, stay calm, get as clear a picture as you can, but avoid asking too many questions at this stage.
- Do not give promises of complete confidentiality.
- Explain that you have a duty to tell your manager or other designated person, and that 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 you will try to take steps to protect them from further abuse or neglect.
- If they have specific communication needs, provide support and information in a way that is most appropriate to them.
- Do not be judgemental or jump to conclusions.

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.

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. Written records must reflect as accurately as possible what was said and done by the people initially involved in the incident either as a victim, suspect or potential witness.

The notes must be kept safe as it may be necessary to make records available as evidence and to disclose them to a court.

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

- date and time of the incident
- exactly what the adult at risk said, using their own words (their account) about the abuse and how it occurred or exactly what has been reported to you
- appearance and behaviour of the adult at risk
- any injuries observed
- name and signature of the person making the record if you witnessed the incident, write down exactly what you saw.

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

Informing a manager

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

Referring
If the alert was made by a member of staff (or a volunteer), the referral would normally be made by their line manager or the designated Safeguarding Adults lead.
But anyone can refer:

- if discussion with the manager would involve delay in a high-risk situation
- if the person has raised concerns with their manager and they have not taken action.

If you have authority to decide whether to make a Safeguarding Adults referral, or where professional or service practice allows, you may make the referral directly.

3. Responsibilities of the alerting manager
An alerting manager is the person within an organisation, care or support setting designated to make Safeguarding Adult referrals. Once the concern has been raised with the alerting manager, they must decide without delay on the most appropriate course of action.

Health staff will need to refer to their trust's procedures on clinical governance and Safeguarding Adults as well as the Safeguarding Adults policy and procedures.

Supporting immediate needs
In line with information-sharing considerations, the alerting manager may need to take the following actions:

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

Speaking to the adult at risk

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

- speaking to them in a private and safe place and informing them of any concerns
- getting their views on what has happened and what they want done about it
- giving them information about the Safeguarding Adults process and how that could help to make them safer
- supporting them to ask questions about issues of confidentiality
- explaining how they will be kept informed
- identifying communication needs, personal care arrangements and access requests
- explaining how they will be kept informed and supported
- discussing what could be done to ensure their safety.

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

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

Person alleged to have caused harm

- Consider liaison with the police regarding the management of risks involved.
- However, if they are a member of staff and an immediate decision has to be made to suspend them, the person has a right to know in broad terms what allegations or concerns have been made about them.
- If the person causing harm is another service user, action taken could include removing them from contact with the adult at risk. In this situation, arrangements must be put in place to ensure that the needs of the person causing harm are also met.
- Ensure that any staff or volunteer who has caused risk or harm is not in contact with service users and others who may be at risk, for example, whistleblowers.

Deciding whether or not to make a referral

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

A referral should be made when:

- the person is an adult at risk and there is a concern that they are being or at risk of being abused or neglected, and at risk of significant harm
- the adult at risk has capacity to make decisions about their own safety and wants this to happen
- the adult at risk has been assessed as not having capacity to make a decision about their own safety, but a decision has been made in their best interests to make a referral
- a crime has been or may have been committed against an adult at risk without mental capacity to report a crime and a 'best interests' decision is made

- the abuse or neglect has been caused by a member of staff or a volunteer
- other people or children are at risk from the person causing the harm
- the concern is about institutional or systemic abuse
- the person causing the harm is also an adult at risk.

Factors to consider when raising an alert

- Is there any doubt about the mental capacity of an adult at risk to make decisions about their own safety? Remember to assume capacity unless there is evidence to the contrary. (Capacity can be undermined by the experience of abuse and where the person is being exploited, coerced, groomed or subjected to undue influence or duress.)
- How vulnerable is the adult at risk? What personal, environmental and social factors contribute to this?
- What is the nature and extent of the abuse?
- Is the abuse a real or potential crime?
- How long has it been happening? Is it a one-off incident or a pattern of repeated actions?
- What impact is this having on the individual? What physical and/or psychological harm is being caused? What are the immediate and likely longer-term effects of the abuse on their independence and well-being?
- What impact is the abuse having on others?
- What is the risk of repeated or increasingly serious acts involving the person causing the harm?
- Is a child (under 18 years) at risk?

Getting the consent of the adult at risk at referral stage

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

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

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

Making a decision not to refer

If the adult at risk has capacity and does not consent to a referral and there are no public or vital interest considerations, they should be given information about where to get help if they change their mind or if the abuse or neglect continues and they subsequently want support to promote their safety. The referrer must assure themselves that the decision to withhold consent is not made under undue influence, coercion or intimidation.

A record must be made of the concern, the adult at risk's decision and of the decision not to refer, with reasons. A record should also be made of what information they were given. It is recommended that organisations have a separate part of the adult's file or record that is clearly labelled 'Safeguarding'.

Making a decision to refer without consent
If there is an overriding public interest or vital interest or if gaining consent would put the adult at further risk, a referral 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 refer and the reasons, unless telling them would jeopardise their safety or the safety of others.
If the adult at risk is assessed as not having mental capacity to make decisions about their own safety and to consent to a referral 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.

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

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

Who should be informed?
Where relevant the alerting manager should consider informing:

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

Recording
If not already done so by the alerter, the person making the referral must record:

- the allegation in the exact words of the person or description of the first witness
- the views and wishes of the adult at risk
- any actions and decisions taken at this point.

Supporting staff
Managers are responsible for:

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

5) Making/receiving a referral

This section covers:

- where to refer to and how to make a referral
- receiving a referral and gathering the facts

1. A referral is the direct reporting of an allegation, concern or disclosure to a Safeguarding Adults referral point.
2. A referral will place the information about the concern in a multi-agency context.
3. A referral begins a process of gathering facts, assessment of the allegation, assessment of the adult at risk's needs and a risk assessment to decide whether the Safeguarding Adults policy applies.
4. This should be done in consultation with the alerting manager and all relevant organisations. This decision must be made on the same working day or within 24 hours of the referral reaching the appropriate team.

Where to refer to and how to make a referral

1. Referrals will be taken from *anyone* who has a concern that an adult is at risk of harm.
2. The referral may be made by phone (see telephone number in **Appendix E**) or the referrer may use their own agency's referral form or the Multi-agency Referral form (**Appendix A)**.
3. Some referrers in a professional capacity may be asked to complete a Multi-agency Referral Form (**Appendix A)** and send it to the Access and Enablement Team, if the Key Team within Adult Care is not known.
4. If the referral is made by a member of the public, a member of the family, a friend, a carer, a neighbour or anonymously, a written referral would not be expected.
5. The matter can additionally be reported to the police where a crime is committed or suspected.

Information

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

Details of the referrer

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

Details of the adult at risk

- Name(s), address and telephone number
- Date of birth, or age
- Details of any other members of the household including children
- Information about the primary care needs of the adult, that is, disability or illness
- Funding authority, if relevant
- Ethnic origin and religion

- Gender
- Communication needs of the adult at risk due to sensory or other impairments (including dementia), including any interpreter or communication requirements
- Whether the adult at risk knows about the referral
- Whether the adult at risk has consented to the referral and, if not, on what grounds the decision was made to refer
- What is known of the person's mental capacity and their views about the abuse or neglect and what they want done about it (if that is known at this stage)
- Details of how to gain access to the person and who can be contacted if there are difficulties

Information about the abuse, neglect or physical harm

- How and when did the concern come to light?
- When did the alleged abuse occur?
- Where did the alleged abuse take place?
- What are the details of the alleged abuse?
- What impact is this having on the adult at risk?
- What is the adult at risk is saying about the abuse?
- Are there details of any witnesses?
- Is there any potential risk to anyone visiting the adult at risk to find out what is happening?
- Is a child (under 18 years) at risk?

Details of the person causing the harm (if known)

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

Any immediate actions that have been taken

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

The alerting agency may be asked to confirm the referral in writing if this is a locally agreed requirement.

Referrals to the police

1. Staff must make it clear whether they are reporting a crime or suspected crime, or seeking advice.
2. Referral must also be made to the relevant local authority.
3. In an emergency call the police on 999.
4. If a crime has been or may have been committed, report immediately to the police *unless* the adult at risk has mental capacity, does not want a report made and there are no overriding public or vital interest issues.
5. The police may also be contacted later, if more information becomes available and it becomes apparent that a crime has been committed.

Receiving a referral and gathering the facts

On receipt of a referral the Safeguarding Adults referral point should take the following action:

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

Referrals to a MARAC

If the concern indicates high-risk domestic violence, a referral should be made to MARAC (Multi-agency Risk Assessment Conference**)**. See Section 3 for contact details.

Decision to accept as a Safeguarding Adults referral

1. The following factors apply when making a decision to accept a referral:
    - The adult at risk may not have the mental capacity to make decisions about their own safety.
    - The abuse or neglect has occurred on property owned or managed by an organisation with a responsibility to provide care.
    - The person causing the harm is:
        - Staff
        - a volunteer(s)
        - someone who only has contact with the adult at risk because they both use the service
    - Other people are at risk from the person causing harm and they are also adults at risk
2. In the above situations, action should be taken under the Safeguarding Adults procedures even if the adult at risk does not want any action taken. They should be informed of the decision, the reason for the decision and reassured that no actions will be taken which affect them personally without their involvement.
3. In other situations, for example, domestic violence, if, in consultation with relevant organisations, there is seen to be a high level of risk, a multi-agency strategy discussion or meeting may be held even if the adult at risk does not want any action taken. This would enable discussions around providing the adult at risk with support and signposting to relevant organisations e.g. Victim Support, counselling services, etc.

When the adult at risk may not have mental capacity to consent to the process

1. Where there is concern that the adult at risk may not have mental capacity to make relevant decisions, it is important that their capacity is appropriately assessed as soon as possible.
2. It may be established that with appropriate support, they are able to make their own decisions.
3. If it is established that the adult at risk lacks capacity, feedback will be given to them and anyone who is acting in their best interests, for example, their attorney or court appointed deputy, unless they are implicated in the allegation.
4. If the person has no suitable family or friend who can be consulted regarding their best interests, an advocate or an IMCA should be instructed in line with the IMCA referral policy.
5. An IMCA may be instructed if it is felt that it will be beneficial to the adult at risk, even if they have family, friends and carers available to consult.
6. The Responsible Manager must ensure that contact is made with a carer or personal representative.
7. The Responsible Manager will also decide in consultation with other relevant organisations what will be fed back at this point to the person causing the harm.

If the adult at risk has capacity

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

- find out from them what is happening
- talk to them about your concerns
- carry out a risk assessment with them to find out if they understand the risk and what help they may need to support them to reduce the risk if that is what they want
- be satisfied that their ability to make an informed decision is not being undermined by the harm they are experiencing and is not affected by intimidation, misuse of authority or undue influence, pressure or exploitation if they decline assistance
- reassure them that they will be involved and supported in all relevant decisions and actions that are taken to protect them.

Deciding when not to use the Safeguarding Adults procedures

1. It may be decided not to use the Safeguarding Adults procedures when there is enough information to decide that:
   - the situation does not involve abuse, neglect or exploitation, in which case another service may be appropriate
   - the adult at risk is not an adult who is covered by these procedures. They can then be signposted to other services or resources
   - the adult at risk has the mental capacity to make an informed choice about their own safety, there are no public interest or vital interest considerations and they choose to live in a situation in which there is risk or potential risk.

2. Concerns regarding adults with so-called ‘low level needs’ will not be excluded from action under the procedures where there are risks that the harm to the person puts their independence and well-being at risk and leads to a deterioration in their ability to protect themselves. Such adults include:
   - adults with low-level mental health problems/borderline personality disorder

- older people living independently in the community
- adults with low-level learning disabilities
- adults with substance misuse problems
- adults self-directing their care.

3. Under adult social care eligibility guidance (DH 2010) published by the Department of Health, the position is as follows.
   (a) For people falling within the community care service user groups (as defined in legislation), a safeguarding concern will give rise to a duty on the local authority to assess that person under s.47 of the NHS and Community Care Act 1990.
   (b) Once an assessment has been carried out (or, in urgent cases, even before), and it is established that abuse or neglect has occurred or will occur, the person's need will – under the guidance – be 'critical' or 'substantial'. A legal obligation then arises to provide assistance, by way of community care services under one or more pieces of community care legislation.
4. If a decision is made not to follow the Safeguarding Adults procedures a record must be made with the reasons.
5. The referrer must also be informed of the decision in a timely way, the reasons for it and information given about any alternative services which have been offered, if this does not breach the adult's confidentiality.
6. The Responsible Manager will designate the most appropriate person to feed back to the adult at risk. This will often be the alerting manager or the alerter.
7. Where the person does not have mental capacity, they should still be included in the process.
8. Feedback will also be given to the person acting in their best interests, for example, their carer or court appointed deputy.

Role of the alerting manager in contributing to the decision to use the Safeguarding Adults procedure

1. The alerting manager must cooperate within the Safeguarding Adults process and play an active role in the decision.
2. They should:
   - take part in a strategy discussion or meeting if required
   - communicate all the information they have about the potential risk
   - be prepared to give advice about an interim protection plan and receive information about what action is planned
   - provide the name of the alerter so that they can be contacted by the Responsible Manager
   - find out from the Responsible Manager what they will do next and how and when they will be informed about what will be happening
   - agree at this stage what they will tell the alerter and the adult at risk – if possible within the same working day.
3. If the alerting manager is the manager of the service where the adult at risk attends or where the abuse took place, they have particular responsibilities to:
   - feed back to the alerter, thank them for making the alert and make sure the alerter knows how to contact them

- make sure they have the name and contact details of the Responsible Manager
- record all conversations, discussions and decisions at this stage
- feed back as required to the organisation's lead manager for Safeguarding Adults
- meet any other requirements to provide information internally or to external bodies, for example, the CQC.

4. If the alerting manager does not agree with the decision that has been made, they can ask for an explanation. If they are still not satisfied they can contact the organisation's lead manager for Safeguarding Adults, or if there is no one in that position, another manager within the organisation. If the disagreement remains unresolved, a complaint can be made to the relevant local authority complaints officer.

Supporting an adult at risk who makes repeated allegations

1. An adult at risk who makes repeated allegations that have been investigated and are unfounded should be treated *without prejudice*.
2. Each allegation must be responded to under these procedures.
3. A risk assessment must be undertaken and measures taken to protect staff and others and a case conference convened, where appropriate
4. Each incident must be recorded.
5. Organisations should have procedures for responding to such allegations that respect the rights of the individual, while protecting staff from the risk of unfounded allegations.

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

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

Medical treatment and examination

1. The individual in the Adult Care Services or the Police taking the initial referral should be aware that if this is a serious or life threatening situation, medical examination may already have been sought. If this is the case, it is important to note where and when the examination took place and by whom. The person taking the referral should immediately request a medical report and if possible photographic evidence.
2. If medical treatment is needed, an immediate referral should be made to the person's GP, Accident and Emergency (A&E) or a relevant specialist health team.
3. In cases of physical abuse it may be unclear whether injuries have been caused by abuse or some other means (for example, accidentally) and medical or specialist advice should be sought.
4. If forensic evidence needs to be collected, the police should always be contacted and they will normally arrange for a police surgeon (forensic medical examiner) to be involved.
5. Where it is necessary to arrange a medical examination, the individual's particular needs and circumstances should be taken into account when deciding on who is the most appropriate doctor to conduct it. In a number of cases, a decision regarding medical examination may not be clear. The following factors should be considered during initial emergency inter-agency strategy discussions or planning meetings:

- Length of time elapsed between the alleged abuse and receiving the referral
- The distress to the Adult at Risk of a medical examination
- The significance of information, which may be gained from the examination
- Delay in arranging a medical examination, could jeopardise medical treatment or the collection of forensic evidence
- The involvement of any family members or carers
- The need to accompany and support the adult at risk and provide reassurance and the identification of someone appropriate to do so (consider an advocate)
- The Adult at Risk must be asked for their agreement to undergo a medical examination, where this is necessary, unless they lack capacity and the doctor feels a medical examination is in their best interests. The decision must be taken in accordance with the principles of the Mental Capacity Act and with due regard to their previous wishes, views of any family or friends, LPA, or advocates etc.
- Where the Police have agreed for the Police Surgeon to see the Adult at Risk the medical examination must be arranged by the Police and investigating care manager or identified health professional as soon as possible.
- Where the Police do not feel that it is appropriate for the Police Surgeon to see the Adult at Risk and the Investigating Officer or other professionals involved consider that a medical examination is necessary, the Adult at Risk's GP may undertake the examination. The investigating officer should arrange for this. The GP must be informed about why the request is being made and alerted to the fact that a medical report may be required.
- If a decision is made not to seek a medical examination, the Investigating Officer or identified health professional must record the reasons for this.

Information Sharing

1. Information sharing between organisations is essential to safeguard adults at risk of abuse, neglect and exploitation.

2. 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 protection plans.
3. 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, protecting adults at risk establishes a general principle that an incident of suspected or actual abuse 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 member of staff belongs to the organisation and not to the individual employee. An individual employee cannot give a personal assurance of confidentiality to an adult at risk.

- An organisation should 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 abuse or harm.
- Confidentiality must not be confused with secrecy, that is, the need to protect the management interests of an organisation should not override the need to protect the adult.
- Staff 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

Checklist for staff

1. Sharing Information with smeone ese

a. Does the person requesting the information need it to do their job?

b. Have you got the client's consent to pass the information on?

c. If not, can you justify passing on the information without consent?

d. Are you sure the person requesting the information is who they say they are?

e. Will anonymised information do?

f. Do you need to pass on the whole record/file? (Try to pass on the minimum information necessary

2. When You Are Requesting Personal Information

a. Do you need the information to do your job?

b. Can you use anonymised information?

c. Do you need the whole file/record?

d. If you only need minimum details, or a summary, please only request this.

Appendix A: Safeguarding adults at risk – interagency alert form – confidential

PART A

This part should be completed when safeguarding alerts need to be communicated to Rochdale Adult Care Service by other agencies.

Date:	

Information about yourself	
Name:	
Position / job title:	
Agency / Organisation:	
Address:	
Tel. No:	Email address:

Basic information regarding the Adult at Risk			
Name:		ALLIS / NHS / ID Number (if known)	
Address:			

Details of the alert:

Contact details:
Access and Enablement Service
Telephone number: 0844 264 0867
Fax number: 0845 833 9004

PART B This part should be completed by Rochdale Adult Care Service.

Name of Adult at Risk:		ALLIS / NHS / ID Number (if known)	
Action taken:			
Progress to Safeguarding Adults at Risk procedures? Yes ☐ No ☐			
Reason, if not progressed:			

Response to Agency / Organisation raising the alert:
Date:
Name:
Position / Job title:

6) Strategy discussions and planning meeting

Roles and responsibilities

1. Safeguarding investigations can involve more than one line of enquiry that needs to be coordinated. 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 coordinated at strategy discussions and planning meetings.
2. 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.
3. The person identified to undertake the investigation will be designated the 'investigating officer' for the purpose of the Safeguarding Adults process.
4. Agreement must be reached about respective roles and responsibilities of organisations during the investigation, including agreement on lead responsibilities, specific tasks, cooperation, communication and the best use of skills.
5. Identify any possible personal safety issues for the person who will conduct the investigation and plan to address these
6. 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.
7. Action that may lead to legal proceedings should take precedence over other proceedings and there should be discussion and coordination of those processes to avoid prejudicing such investigations
8. 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
9. 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
10. Where joint investigations or assessments are planned, there should be clear agreement between the organisations concerned as to their respective roles and responsibilities
11. Agree how communication will be maintained during the investigation
12. Identify who will be the responsible person within each participating organisation for any agreed actions
13. Decide who else needs to be informed
14. Identify whether there are children at risk, agree a referral to the children and families team and who will make the referral
15. If the situation indicates that the adult at risk is being subjected to domestic violence and the risks are high, agree a referral to MARAC. Designate the organisation and the person who will complete the MARAC risk assessment and make the referral. This can be done by the Responsible Manager. The MARAC process does not replace the Safeguarding Adults process, but adds benefit to any risk assessment.

16. If the alert was made by a service user or a member of the public about abuse 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.

Strategy dscussions

1. Where an allegation or a disclosure of abuse has been made management level strategy discussions must occur on the same day. Such discussion should be shared with other agencies and exist to ensure the following:-
    - That the immediate safety and protection of the Adult(s) at Risk has been prioritised and arranged appropriately.
    - To clarify whether a crime has been committed which will require the immediate attention of the Police.
    - That all relevant parties with a need to know have been appropriately informed and updated of the immediate protection plan.
    - That an investigating officer is appointed in order to begin the process of co-ordinating the investigation. This should be a Care Manager, Social Worker, identified Health Professional or Police Officer who has received training and who is competent in the investigation of abuse of Adults at Risk and the assessment of need.
    - Responsible managers will ensure that staff undertaking the investigation are clear about their responsibilities in receiving a referral of abuse.
    - That, **if necessary,** a planning meeting is arranged. <u>The responsible manager will make a decision in consultation with another manager, and will record the decision making process</u>.

2. All decisions taken during these discussions together with the underpinning rationale must be recorded. This includes any decision not to hold a planning meeting, or a decision not to invite the Adult at Risk, their carer or advocate to a planning meeting.

3. 'No further action' should be based on shared decision making processes and should not be the responsibility of one individual.

Deciding whether to hold a Planning Meeting

1. The planning meeting is a meeting of professionals to decide the process to be followed after considering the facts. There must be careful consideration about inviting the person at risk. In a very small number of cases, it may be appropriate to invite the person causing harm. However, this decision must be taken with care as their presence may compromise the meeting.

2. 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 meeting must decide who will feed back decisions to the adult at risk.

3. A decision to hold a Planning 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 staff/volunteer or the safety of a service
- whether the situation could attract media attention.

4. A decision not to hold a planning meeting might be made because there is sufficient information to indicate that:
    - the person is not at risk of abuse or neglect and there is no need to investigate or take further action under the procedures. The decision will be recorded with the reasons and an alternative plan formulated if necessary
    - no formal investigation is needed and a protection plan can be put in place to remove or reduce the risk to the adult. The adult at risk agrees with this decision and with the plan.

    The plan should specify a time for review and indicators of risk that might trigger further action under the procedures.

Planning Meetings

1. The first planning meeting if required, must take place as soon as is reasonably possible after the initial alert. In ordinary circumstances this should occur within 3 working days. This is especially important if a serious crime has occurred or the allegations are particularly complex and require immediate face-to-face action. This will be a management decision made during initial strategy discussions.

2. The Investigating Officer should co-ordinate and prepare the following information for a planning meeting:-
    - A clear verbal report detailing the factual event of the allegation or disclosure. This should include timescales and the names of relevant other individuals involved. Personal opinion should be clearly identified as such.
    - The wishes and views of the Adult at Risk at this time.
    - Are there grounds and is it likely to be in the best interests of the Adult at Risk for immediate protective action either on an informal basis or through legal action?
    - Is there still a need for a formal disclosure interview to take place under the direction of the Police that may not have been identified during initial strategy discussions?
    - If the concern is relating to a resident of a residential or nursing home, have the care standards been informed?
    - Will there be a need to break confidentiality and what is the best way for this information to be shared?
    - What will be the most conducive environment for the interview(s) to take place in? Who should be involved in this and can repeated interviewing be avoided. What other practical arrangements should be made to support the Adult at Risk, i.e. transport, child care, communication needs?
    - Is there a need to consider Special Measures? For further information see Achieving Best Evidence in Criminal Proceedings (Ministry of Justice) available from this website: http://www.justice.gov.uk/guidance/docs/achieving-best-evidence-criminal-proceedings.pdf

- Is it possible that other Adults at Risk or ordinary members of the public may still be at risk?
- Is there still a need for the Adult at Risk to undergo a medical examination, who will carry this out and what will be the necessary arrangements?
- A considered assessment of the Adults at Risk's level of distress and the impact this may have on the co-ordination of the investigation.
- How will their involvement alert the person allegedly causing harm and is there a potential threat to the Adult at Risk's safety or the collection of evidence?
- Should the individual attend the planning meeting or is there a more appropriate way to contribute to the decision making process. What preparation and support will they need if they are present?
- A considered assessment of the Adults at Risk's mental capacity should be made by co-ordinating with other individuals who know them well. Capacity should be looked at within the context of what has happened to them and their ability to understand, make decisions, and communicate their decisions about the incident(s).
- Have issues of gender, race, culture, language and communication be considered? Will an interpreter be required?
- Has everyone with a "need to know" been informed of the planning meeting and its purpose, do they wish to contribute any information?
- Is the person allegedly causing harm in need of a planning meeting, are they also an Adult at Risk? Will an "appropriate adult" be required if they are to be interviewed?

3. Suggested Agenda and format for Planning Meetings

(i) Introductions and Apologies

Ensure arrangements are made to record who attended and could not attend the meeting.

(ii) Confidentiality

Can all the information be shared with all present?

Statement of Confidentiality and arrangements for information sharing should be discussed. It may be decided some information will have limited sharing potential and arrangements should be discussed as to how this will affect the flow of the meeting.

(iii) Reports of Allegations/Disclosure by Investigating Officer

Verbal report detailing the events of the incident/disclosure and how it came to light. This should be factually based and personal opinions should be clearly identified as such.

(iv) Past History

Have there been any previous similar incidents that any of the agencies present are aware of?

(v) Capacity

A considered discussion regarding the Adults at Risk's capacity to consent. What impact will this have on potential legal or best practice action that may occur?

(vi) Risk Management

- What are the risk factors for this individual?
- What is their level of vulnerability?
- How can self determination and the person's right to be safe be optimised?
- What is the agreed perception of the seriousness of the allegations for the individual?

(vii) Immediate Protection Plan

- Is the person currently safe enough?
- What other actions need to be taken to ensure optimum safety?
- Is every risk manageable, if not why not?
- What are the Adults at Risk's ongoing support needs and how will they be met
- Is the Adults at Risk likely to co-operate with the protection plan, if not, how will this be managed?
- Planning the investigation and assessment - who will do what and when?

(viii) Information Sharing

Clarification that arrangements have been made to communicate the protection plan to all who need to know. Have carers or significant others been informed? If the Adults at Risk did not attend how will they be supported to comment on and co-operate with the protection plan.

(ix) Case Conference

- Is a Case Conference required?
- If so date should be set within an agreed timescale?
- If a Case Conference is not required how will the case be monitored and reviewed?
- What is the justification for this, how will this be communicated and recorded?

(x) Any Other Business

Who should attend?

1. Attendance at the planning meeting should be limited to those who need to know and who can contribute to the decision-making process. This should be staff of any organisation who have a role in investigating the allegation of abuse 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 protection plan.

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

3. Attendees may include:
    - the manager of an adult social care team, an integrated/joint health and social care team, central Safeguarding Adults team or a CMHT if they are not the Responsible Manager.
    - the social services care manager or key worker if the case is known to them
    - the care coordinator of the CMHT if the case is known to them
    - the police, if there are concerns that a crime has been committed
    - the person making the referral, if they are a professional
    - the officer from the CQC in line with their Safeguarding Adults protocol with regard to registered care homes
    - a 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 Responsible Manager, who can ensure that one is instructed as necessary)
    - other staff from adult social care who have a role to play/relevant involvement
    - the manager of a provider service unless they are named in the allegation, in which case advice should be sought from the CQC as to who should attend
    - a representative of the council legal department
    - a representative of any other organisation which has a role to play
    - a child protection coordinator, if there are also child protection concerns
    - the Safeguarding Adults lead for health
    - a manager from a *Supporting People*.

4. If the allegation involves a member of staff or paid carer, the planning meeting will be attended, where appropriate, by:
    - the authorised officer for contracts
    - the commissioning manager
    - the human resources (HR) officer
    - the line manager of the member of staff
    - a senior manager of the employing organisation.

5. In cases where a crime has been reported and is being investigated by police all subsequent action by other organisations must be coordinated with them. The officer in charge (OIC) of the investigation should be invited to any planning meeting. If the OIC is unavailable to attend, a strategy discussion should take place on the telephone.

6. 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 planning meeting between the police and other involved organisations about what actions they can take and when.

7. Any Responsible Manager who experiences difficulty in obtaining a police response to a referral 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 to pursue through strategic multi-agency partnerships.

Records

1. 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 Responsible Manager
    - names and contact details of attendees
    - details of the incident or the concern, with time, location and relevant details
    - type(s) of abuse suspected
    - an assessment of the seriousness/severity of harm
    - consideration of the wishes of the person 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 protection plan and what that contribution is
    - details about any disagreements and how these will be resolved
    - date for a planning meeting review, if one is to take place
    - date for the case conference.

2. 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.

3. Regard should be had to confidentiality and data protection issues. Local partnerships may have their own standard agendas and templates for the structure of strategy discussions and planning meetings.

Possible Outcomes of Strategy Discussions & Planning Meetings

Continuing the Safeguarding Adults process

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

2. If a decision is taken at the strategy discussion or planning meeting stage to continue with an investigation under the procedures, agreement should be reached on the following matters:
    - Whether the strategy or risk assessment will need to be reviewed during the investigation and make a date for that to happen.
    - The investigation should begin as soon as possible after the strategy discussion or planning meeting and be completed within 20 days of the Safeguarding Adults referral.

- If, due to the complexity of the investigation, it is clear from the outset that a longer timescale will be required, this must be agreed by all relevant organisations and a record made of 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 case conference.

Investigations and processes that could be triggered by a referral

A referral can trigger various processes that amount to a formal investigation, for example, a criminal investigation, or disciplinary procedures action under SI policies in health, or less formal investigative processes. Such investigations might include:

- a police investigation if a crime might have been committed
- an investigation by the CQC, if the concern arose in a regulated service
- an investigation under care management or the CPA
- 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 abuse or neglect was caused by a member of staff or paid carer
- investigation of a complaint by the complaints department of an organisation
- an investigation by the OPG 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 domestic abuse and there is a high risk to the person
- an investigation into a situation where forced marriage could be indicated
- 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

Continuing action through other processes

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

No further action under the Safeguarding Adults procedures

1. 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 abuse 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.

2. 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 abuse, 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.

3. A decision to discontinue the Safeguarding Adults process must be agreed by all relevant organisations and signed off by the Responsible Manager. The reasons for closing the Safeguarding Adults process should be recorded and a copy sent to planning meeting attendees. 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.

Recording
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 Responsible Manager
- names and contact details of attendees
- details of the incident or the concern, with time, location and relevant details
- type(s) of abuse suspected
- an assessment of the seriousness/severity of harm
- consideration of the wishes of the person 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 protection 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.

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

1. Adults at risk may themselves cause abuse or neglect. The identification of indicators that such a person (for example, another service user or a carer) may be a potential abuser should be included as part of any risk assessment. If a criminal offence is disclosed the police must be informed.

2. 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.

3. If a person who is an adult at risk is identified as a potential abuser this should be addressed as part of their care plan, including:
    - undertaking a risk assessment
    - devising a protection plan
    - devising a treatment plan
    - having in place a contingency safety plan
    - making arrangements for monitoring and reviewing plans.
4. Plans should involve all relevant professionals as well as family and carers where appropriate.

5. An allegation of abuse or neglect perpetrated by an adult who is 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.

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

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

1. The primary focus of the strategy discussions and planning meetings is the adult at risk. 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 in relation to the person causing the harm will include:
    - how to coordinate action in relation to the adult at risk causing the harm
    - identification, and allocation, of a separate care manager/care coordinator 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 protection plan
    - whether there is likely to be a criminal prosecution (if known at this point)
    - what information needs to be shared, and with whom.

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

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

Investigation by the organisation in which the concern has arisen

1. A decision agreeing that an organisation in which the alleged abuse or neglect has occurred may solely undertake an investigation will be made at the planning meeting on the basis of an assessment of risk and harm to the adult.

2. A clear record of this decision must be made by the Responsible Manager with reasons for the decision listed. Any organisation conducting an investigation must allow their records to be open to scrutiny by the Responsible Manager and the multi-agency process.

3. If it is decided that an investigation will be undertaken by the organisation in which the concern arose, the manager within the organisation responsible for the investigation must ensure that::
    - the adult(s) at risk is protected by implementing an immediate protection plan
    - only essential information is shared within the organisation on a need-to-know basis
    - staff or teams delivering services to the adult at risk are adequately resourced and are supported to implement the protection plan
    - if the person causing the harm is also a service user, ensure that staff delivering services to them are adequately resourced and supported to deliver the protection plan
    - a protection plan coordinator is designated
    - the relevant Responsible Manager is kept informed of the progress of the investigation and of the outcome and is given details of the protection plan and all other relevant parties
    - the protection plan is reviewed at regular intervals as long as the risk exists
    - a further referral is made to the multi-agency Safeguarding Adults procedures if the monitoring and reviews show that the protection plan is not working.

Resolution of disagreements

1. 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.

2. If disagreements still cannot be resolved, the Responsible Manager will refer to a more senior manager within their organisation (for example, the Head of Safeguarding Adults). 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 is prioritised.

7) Support to those involved in the safeguarding process

Supporting the adult at risk

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

Supporting 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). This will usually be the interviewing officer of the organisation that has a duty to investigate.
- If the person allegedly causing harm is a member of staff or a volunteer, confirm that the relevant regulatory authority has been informed. It is important to preserve the confidentiality at all times of all concerned including staff members under the Safeguarding Adults information-sharing protocols.
- The primary concern must be the safety of the adult at risk, but the person allegedly causing harm has a right to 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 abuse is. A carer may also need a carer's assessment.

Support for vulnerable witnesses

Witness support and special measures

1. 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'.

2. 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.

3. 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.

4. 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.

Victim Support

1. 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.

Keeping families and others concerned informed and supported

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

2. 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.

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

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

Support for Staff involved in the Safeguarding Process

1. Managers should give consideration to the need for staff to share their feeling resulting from their involvement in the safeguarding process.
2. Alerters / referrers should be informed of the outcomes of the process if possible.
3. Managers at any level should enable de-briefing sessions so that staff can reflect on good practice and / or lessons learnt following the safeguarding process.

Complaints and Appeals Regarding the Safeguarding Adults Process

Complaints

1. 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.

2. 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.

3. If the complaint results from the experience of the adult protection/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 Responsible Manager and the chair of the RBSAB must be notified of the complaint and the findings.

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

5. 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 protection plan review)
    - complaints about an individual professional.

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

6. 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.

Appeals

1. An appeal against the decisions made as a result of the Safeguarding Adults process, and including decisions about measures to be put in place to protect the adult at risk, may be made by the adult at risk, their carer, friend or personal representative including an advocate.

2. If an appeal is raised by any partner organisation it should be referred to the relevant Responsible Manager and to the chair of the RBSAB who will make a decision in consultation with relevant partner organisations about what action to take.

3. When considering what action to take as a result of an appeal the following should be considered:
    - whether there has been an obvious deviation from the Safeguarding Adults planning and investigation process
    - whether there has been a flaw in decision making at the strategy discussion, planning meeting, or case conference, that is, decisions made without key information having been presented or where key information has not been taken properly into account
    - whether one organisation had evidence that other organisations were involved in the issues but they were not brought into the decision-making process, for example, the role of the PCT and adult social care or CMHT staff in the support of a private/voluntary provider
    - whether there were issues about when new information was submitted to the Safeguarding Adults investigation following the outcome of a case conference
    - whether a conflict of interest has been identified in the make-up of the investigation team and/or the chair of the Safeguarding Adults strategy meeting and/or case conference.

4. The Court of Protection offers a potential route for the resolution of complaints or disagreements about the Safeguarding Adults process e.g. 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.

8) The investigation process

The purpose of the Investigation

1. To determine the level of risk and the needs of the Adult(s) at Risk and the urgency and the appropriateness of further action.
2. To determine what steps can be taken to reduce the risk and provide for identified services if required, this may involve introducing or increasing services.
3. The purpose of the **criminal** investigation is to establish whether a crime has been committed against any Adult(s) at Risk. If so, who committed the crime, and to gather all the facts surrounding the incident in a way which will allow them to be presented at any future criminal prosecution.

Risk Assessment

1. In determining how serious or extensive abuse must be to justify intervention, the law commission builds upon the concept of significant harm introduced in the Children Act 1989, which states:

   “Harm should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development”.

2. The seriousness or extent of abuse is often not clear when concerns are first expressed. It is important, therefore, when considering the appropriateness of intervention, to approach reports of incidents with an open mind. In making any assessment of "seriousness”, the following factors need to be considered.
   - The vulnerability of the individual
   - The nature and extent of the abuse
   - The length of time it has been occurring
   - The impact on the individual
   - The risk of repeated or increasingly serious acts involving this or other Adult(s) at Risk and / or children.
   - The capacity to consent

Other considerations:

- The relationship between the Adult(s) at Risk and the person allegedly causing harm.
- Has the alleged abuse been done deliberately, has it been planned, has the person alleged to be responsible for the abuse set out to take advantage of this or other vulnerable people?
- What are the implications for the Adult at Risk and the person allegedly causing harm?
- Is what happened against the law, should legal action be taken?

3. A process of assessment must then be followed to evaluate:
   - Whether the person is suffering harm or exploitation.
   - Whether the intervention is in the best interests of the Adult at Risk and/or in the public interest.
   - Whether the assessment accounts for the depth of feeling of the person alleging the abuse.

- In deciding what action to take, the rights of all people to make choices and take risks, and their capacity to make decisions about arrangements for investigating or managing the abusive situation should be taken into account.
- The Adult at Risk's mental capacity is a key issue. If someone has capacity to make decisions and declines help, this limits the help that he/she may be given. It will not however limit the action that may be required to protect others (for example children and other adults at risk). In order to make sound decisions, there must be an assessment of the Adult at Risk's emotional, physical, intellectual and mental capacity in relation to self-determination, consent and intimidation. Consideration should also be given to misuse of authority or undue influence.
- Assessment of the environment or context is relevant since exploitation, deception, misuse of authority, intimidation or coercion may render the Adults at Risk incapable of making his/her own decisions. Therefore, it may be important for Adults at Risk to be interviewed away from the sphere of influence of the alleged abuser or environment and to be able to make a free choice about how to proceed.
- An initial rejection of help should not always be taken at face value.

PLANNING THE INTERVIEW

1. It will be decided during the strategy discussion or the planning meeting:
    - Who will be interviewed
    - When they will be interviewed
    - Who will conduct the interview and take the lead
2. If there is a possibility of criminal proceedings it is important that repeated interviewing is avoided, as evidence may be contaminated.
3. If there is a possibility of criminal proceedings the Police will direct any disclosure interview(s).
4. Because of the dual nature of adult protection investigations, it is good practice for a social worker or other supporting professional to be present at the Police led interview. This is a different role to the appropriate adult.
5. If the interview is an Adult Care only investigation the investigating officer will interview with another professional. This may be a health professional and/or someone who knows the person well or has specialist skills in communication, for example a speech and language therapist, who can be there to help support and clarify issues.
6. Consideration needs to be given to the risks the scenario holds for the Adult at Risk, person allegedly causing harm and others. Continual reassessment of the risks should occur in order to ensure the safety of all involved.
7. There must be an accurate record of the interview(s). It should have been decided at the early planning stages whether the interview(s) will be recorded using:-
    - A tape recorder
    - A video recorder
    - Contemporaneous note taking

    This must be done in full consultation with the Adult at Risk.
8. The interview must be planned in advance, during the strategy discussions or planning meeting.

Police and Criminal Evidence Act 1984 (PACE)

1. Whether the Police interview involves the Adult at Risk, witness or a suspect, there is an obligation under PACE to provide an appropriate adult for any person the Police believe to be a vulnerable or "mentally disordered" adult.
2. The role of the appropriate adult is a dedicated one. The role has legal implications and cannot be attributed to someone after the interview because that person happened to be present, especially if that person thought they were there as a layperson.
3. It would not be appropriate for the social worker present at the interview in a supporting role to also take on the appropriate adult role.
4. The interview must be planned and a record made of the plan.

Before the interview you will need to think about:-

<u>The Person</u>

- The Adult at Risk's right to self-determination. They must be consulted at every stage
- Endeavour to know something about the person's history
- The available options should be put to the adult for their consideration
- Establish if the person has any communication and/or language needs
- Check if the person has a sensory impairment

<u>Preparing the Person</u>

- Preparing the person does not mean coaching or telling the person what to say
- The Adult at Risk should be told the purpose of the interview from the outset
- It is good practice for the interviewer to have met the Adult at Risk at least once before the interview
- The Adult at Risk should be made familiar with the interview-setting if it is unfamiliar to them
- The interviewer(s) should introduce themselves and colleagues fully and clearly
- Show your identity card
- Speak clearly
- Be honest and clear – Adults at Risk have spoken in research about being tricked as investigating officers have engaged in general conservation and then suddenly gone into very direct questioning about the alleged abuse (J Pritchard 1999)
- Explain the boundaries of confidentiality at the outset of the interview
- The issue of confidentiality should be borne in mind throughout the interview as the person may disclose incidents of abuse other than the one being investigated.

<u>Communication</u>

- It is essential to gain an understanding of how the person communicates
- It may be appropriate for the interview to be facilitated by someone who knows the person well
- It should not be assumed that a family member or care is the most appropriate person to facilitate the meeting. It can be distressing and embarrassing to discuss details of the abuse with family members present
- The investigator needs to be satisfied that the facilitator was not involved with the situation under investigation

- Establish if there is a need for translation/interpreters / Makaton or a communication board. If so, identify who will be responsible for organising those things

The Venue

- Someone will need to take responsibility for organising transport for the Adult at Risk
- The building needs to be accessible
- The room needs to be comfortable
- An interview room may not always be the most appropriate setting
- Responsibility needs to be taken for checking any equipment that is to be used
- If the person has a sensory impairment, adjustable lighting and a loop system may be necessary
- Limit external noise
- Consideration needs to be given to seating arrangements that will be comfortable and not be intrusive or intimidating
- Distractions in the room should be limited
- Consideration needs to be given to the Adult at Risk's concentration span

The Interview(s) General Issues

- It must be decided in advance amongst all participants how long the interview will last and how many breaks there will be
- The interview should always take place in private
- Every effort should be made to ensure that the environment is relaxing
- Always take account of and proceed at the persons pace
- The more clearly the account is seen to be in the person's own words, the more compelling and reliable it will be. Leading or directive questions should not be asked
- Take account of the non-verbal signals such as facial expressions, gestures, body language, fidgeting, tense posture, poor eye contact

Preparing Yourself

- Do not to patronise
- Be respectful to the person and their pace
- Speak in a clear, neutral tone of voice
- Always speak directly to the person and not the interpreter, supporter or advocate who may also be present
- Take account of the possibility that the person may have low self-confidence and poor self-esteem

Listening To the Person

- Be aware of similar themes
- Look for repetition of words and phrases
- Information may be disjointed but significant
- Summarise what has been said in order to confirm understanding

Basic Interviewing Skills

- Speak to the person as an adult

- Ensure that you have the person's attention
- Use their name
- Speak slowly and clearly
- Use short sentences and uncomplicated language
- Avoid abstract ideas
- Avoid comparative either/or questions
- Break the interview into small slots
- Do not ask more than one question at a time
- Do not incorporate more than one idea per question
- Avoid jargon
- Summarise what has been said
- Do not ask why questions, ask instead who, what, where, and when
- Stick to the issues
- Give one piece of information at a time

The investigating officer must record the interview and other information collected during the investigation. Their recording must be accurate and differentiate between fact, hearsay and opinion.

<u>After the Interview</u>

a. It is essential that the Adult at Risk receives appropriate support throughout the interview stages. It is also important that this support is continued after the investigation. The most appropriate person to provide this support should be decided during the initial planning discussions or meeting.

b. It is essential that the Adult at Risk is involved as much as possible in the subsequent decision making process.

c. If the investigation leads to a criminal proceedings the Adult at Risk will need to be informed at each stage as to what will happen next.

d. The Adult at Risk will still need support even if there is no further action in terms of the person allegedly causing harm.

e. Whatever the outcome of the investigation the Adult at Risk's wishes must be taken into account. They may experience feelings of:

    - Powerlessness
    - Guilt
    - Depression
    - Anger
    - Self blame
    - Low self-esteem
    - Inability to trust
    - Fear

f. The adult protection plan must address the issue of ongoing support.

9) The case conference and case conference review

CASE CONFERENCES

1. DECISION ABOUT WHETHER TO HOLD A SAFEGUARDING ADULTS BOARD CASE CONFERENCE

1.1 During the initial strategy discussion or planning meeting the Responsible Manager, in consultation with the Investigating Officer and any other agency involved, will decide whether to hold a Case Conference.

1.2 If it is decided not to hold a Case Conference, the Responsible Manager should record this decision and the reasons for it. The Responsible Manager should then decide the arrangements for review.

2. PLANNING A SAFEGUARDING ADULTS BOARD CASE CONFERENCE

2.1 Following the Planning Meeting if it is decided that a Case Conference should be held the Responsible Manager should identify at the earliest opportunity the date, time and venue of the Case Conference.

2.2 The Responsible Manager should identify using the Independent Chair Rota who will Chair the Case Conference. This will be a Manager from Health or Social Care who is not the line manager of the Investigating Officer undertaking the investigation and assessment. This will ensure an independent view. A request by the Responsible Manager can be made for the Head of Safeguarding to chair Case Conferences felt to be particularly complex.

2.3 The Responsible Manager needs to ensure that the Independent Chair is aware of the issues, has sight of the investigator's report within an agreed timescale, and has a list of expected participants at least 2 working days before the planned Case Conference.

2.4 The Responsible Manager will then appoint a Minute Taker. The Responsible Manager has the responsibility to assist the Minute Taker with:

- The nature of the case.
- What date the Case Conference is to be held.
- What time the Case Conference is to start and finish.
- What agenda items need to be included on the agenda following the standardised Case Conference agenda?
- What supporting papers are to be made available/required to aid discussion?
- Who should be invited to the Case Conference?

2.5 The Case Conference is a vital tool in bringing significant people together to ensure that appropriate action is taken to reduce risk and to offer further support. The following is a checklist of people who may be invited to a Case Conference:

- Independent Chairperson – not the Line Manager of Investigating Officer
- Responsible Manager – Care Manager/identified health professional
- Investigating Officer
- Adult at Risk and/or their advocate
- The person allegedly causing harm if felt to be appropriate only if the Adult at Risk not attending Case Conference

- IMCA
- General Practitioner
- Health Care Staff – District Nurses, Health Visitors, Community Nurse, Community Psychiatric Nurse
- Social Worker
- Consultant/Casualty Doctor
- Police representation
- Adult Care Service workers, included Domiciliary Care Workers, residential and day care staff
- Local Authority legal representation
- Individual's legal representation
- Housing Provider Representative
- Benefits Agency representative
- Care Quality Commission (CQC)
- Other significant people involved with the Adult at Risk including relatives

2.6 Consideration will be given as to whether if it is in the best interest of the Adult at Risk to take part in the Case Conference. If the Adult at Risk is to attend the Case Conference then support should be considered including attention to any special needs.

2.7 Where abuse has been alleged in any CQC registered service, a member of the Local Authority Commissioning Team must be invited to, and must attend, the Case Conference.

2.8 The minute taker is then responsible for:

- Requesting key people on behalf of the Responsible Manager required to attend the Case Conference. This should be undertaken within 10 days of the Planning Meeting or initial planning discussion.
- Booking the venue.
- Typing the agenda, using the standard format (see Appendix B).
- Distributing the agenda together with any appropriate information.
- Requesting from the appropriate people, papers which are to be tabled at the Case Conference and ensuring that there are enough copies for those present. These papers are confidential and should be kept secure until the Case Conference.
- Printing off an attendance sheet to take to Case Conference.

2.9 The minute taker should monitor the apologies and feed this back to the Chair and Responsible Manager. Chair may decide to postpone the Case Conference if there is insufficient representation.

2.10 The Investigating Officer will be required to prepare a report for the Case Conference. This report should cover the following areas:

- Events surrounding the incident(s)
- The Adult at Risk's relationship with the person allegedly causing harm.
- The medical condition of the Adult at Risk and the involvement of any carers/health professionals in the Investigation.
- The findings of the Investigation so far including interviews.

- Cognitive and behavioural factors.
- Home environment.
- Social networks and community support.
- Mental Capacity Act 2005 Assessments including Deprivation of Liberty Safeguards if applicable.
- The involvement of Commissioning Managers.
- The involvement, if any, from CQC.
- The involvement of any statutory or voluntary agencies.
- Protection Plan
- Risk Assessment completed so far.

3. THE SAFEGUARDING ADULTS BOARD AGENDA

3.1 There is a standardised Case Conference agenda (**Appendix B**) which must be consistently used at all Case Conferences. The Chairperson may omit or add headings that are relevant to each individual Case Conference.

3.2 All supporting papers that are to be tabled are to be indicated as “tabled” on the agenda.

4. THE SAFEGUARDING ADULTS BOARD CASE CONFERENCE

4.1 Ensure that the attendance record is fully completed and collected by the minute taker at the end of the Case Conference.

4.2 The minute taker should sit next to the Chair.

4.3 The minute taker should ensure that they have extra copies of the agenda in case attendees need them. Also take copies of the invitations sent and/or the information checklist form in case there are any queries at the meeting or if attendees do not arrive.

4.4 Reports for the Case Conference should be tabled at the start of the Case Conference. Consideration should be given to the Adult at Risk and their advocate to give them enough time to read copies of the report, except where such action would not be in their best interest or compromise the investigation. Every effort should be made to assist and support the Adult at Risk in understanding the reports.

4.5 The Investigating Officer will present a report detailing the findings of the assessment and Investigation and will report on any interim actions.

4.6 The purpose of the Case Conference is to:

- Clarify the roles and responsibilities of the various professionals involved identifying a key worker who will be given responsibility for co-ordinating the implementation of all plans made at the Case Conference.
- Consider the report from the Investigating Officer and any other professionals.
- Review the protection arrangements made during the planning discussions or Planning Meeting.
- Review the Protection Plan and make arrangements for implementing and reviewing the Protection Plan, ensuring that the plan includes action to be taken in the event of non compliance.
- Establish current levels of risk.

- Discuss and agree management of the identified risks and complete the Risk Assessment.
- Agree what action needs to be taken in relation to the person allegedly causing harm and who will be responsible for this.
- Consider what statutory interventions are required to ensure the protection of the Adult at Risk.
- Consider the need for a Case Conference Review and set a date.

4.7 During the Case Conference the Chair should consider:

- The extent of the alleged abuse.
- Whether the abuse was a one off event or part of a long standing relationship pattern.
- If there are any previous allegation/complaints.
- The impact of the alleged abuse on the Adult at Risk.
- The impact of the alleged abuse on others
- The intent of the person allegedly responsible for the abuse.
- The legality of the actions involved.
- The risk of abuse against other Adults at Risk.
- The views of the Adult at Risk against whom the abuse was allegedly perpetrated.
- The views of the person allegedly causing harm.
- Whether an appropriate Risk Assessment and Action Plan is in place.

4.8 The Chair should summarise the relevant discussion points of an agenda item before moving on to the next particularly where lengthy discussion has occurred or complex issues have been discussed, to offer guidance to the minute taker.

4.9 The Independent Chair and the Responsible Manager will need to consider if the Case Conference includes the Adult at Risk, Advocates or IMCA, the circumstances when it will not be possible to share information in their presence and ensuring that the Case Conference is conducted in such a way as gives due regard to confidentiality.

4.10 The welfare of other Adults at Risk within the service may be discussed if it is considered that others may be at risk but special care must be taken with regard to confidentiality in light of who is attending the Case Conference and this must be managed by the Chair.

4.11 At each Case Conference the definitions of what is an Adult at Risk? What is Abuse? and what is Significant Harm? should be read out by the Chair and agreement sought from all participants that they understand the definitions by which the Case Conference is convened. Minute takers should ensure that there are copies of the definitions at each meeting to read and refer to during the Case Conference.

4.12 When explaining why the Case Conference is convened the Chair should summarise the allegation that led to the Investigation, what form or forms of abuse are being investigated and the definition of the form or forms of abuse, as the decision on allegation will need to show the Case Conference decision for the form or forms of abuse.

4.13 The Case Conference should review the Risk Assessment and ensure that the Protection Plan is up to date.

4.14 The Chair must nominate a worker with responsibility to co-ordinate and monitor the Protection Plan and Risk Assessment which usually is the named Care Co-ordinator.

4.15 If the allegations(s) are upheld then the Chair must make the recommendation that if appropriate the Registered Provider considers his or her statutory responsibility under the Care Standard Act 2000 as part of their own Investigation/Disciplinary Process and their statutory responsibility under the Safeguarding Vulnerable Groups Act (2006).

4.16 The Chair is responsible at the end of the Case Conference to summarise all the actions and recommendations throughout the Case Conference, with timescales for actions and nominating key workers.

4.17 At the conclusion of the Case Conference the Chair is responsible for ensuring that only one copy of each written report is retained, these copies will be held within the Adult at Risk case file.

5. THE SAFEGUARDING ADULTS BOARD CASE CONFERENCE MINUTES

5.1 Minutes may be defined as a written record of the business transacted at a meeting and constitute the formal recording of the meeting and as such are an authoritative source of information to meeting participants.

5.2 All Case Conference minutes must be consistent in their form and content

5.3 Minutes must be clearly marked draft until signed and dated by the Chair.

5.4 Minute Takers must be mindful that Case Conference minutes may be used as evidence in a Court of Law so it is essential that minutes are produced to a consistently high quality standard.

Therefore, all the following should apply to each produced set of minutes:

- All minutes should be typed in Aerial, font size 11.
- The headings should be typed in Bold Capitals.
- The minutes should be written in proper sentences.
- Each paragraph should be only about one subject matter.
- If using bullet points, whatever written must be in proper sentences. Use only one bullet style in each document.
- Abbreviations may be used in the minutes provide that the abbreviation has been written in full with the abbreviation in brackets the first time used e.g. Mental Capacity Act (MCA).
- The Adult at Risk's name should be written in full throughout the minutes.
- The initials of the person allegedly causing harm and Alerter should be used, not their full name.
- Every time the name of the Adult at Risk or the initials of the person allegedly causing harm or the Alerter are used in the minutes these should be always followed by their appropriate role in brackets i.e. (Adult at Risk), (person allegedly causing harm) or (Alerter).

- With the exception of the Alerter or person allegedly causing harm all other attendees must be named in full.
- All action points should be clearly stated in bold at the end of the relevant agenda item.
- Each page should be numbered at the bottom centre of each page.
- Minutes should be numbered consecutively with the minute number/year number e.g. (01/12) through to the conclusion of the case which may or may not involve subsequent Case Conference Reviews

5.5 These formal minutes must be:

- Accurate
- Brief (providing nothing relevant is missed out)
- Clear
- Self contained
- Logical
- Grammatically Correct
- Free from spelling errors
- Written in proper sentences
- Written in the past tense
- Written in third party where possible

5.6 A draft copy of the minutes should be sent to the Chair **within 7 working days**. The Chair must return to the minute taker **within 5 working days.**

6. DISTRIBUTION

6.1 Once the draft minutes are returned from the Chair the minute taker should send to attendees and those who sent apologies clearly stating on the minutes that they are a draft version for comments with a covering letter.

6.2 Once all comments have been received the minute taker must pass back to Chair to make any final amendments. A final version should be signed and dated by the Chair and sent to all attendee and non attendees with a covering letter.

C. CASE CONFERENCE REVIEW

1. PLANNING A CASE CONFERENCE REVIEW

1.1 The Case Conference Review must be chaired by the same person as the Case Conference and the same Minute Taker and Attendees should be present. It may be that additional people will need to be invited and this should therefore be checked with the Responsible Manager.

1.2 The Minute Taker is then responsible for:

- Requesting key people on behalf of the Responsible Manager required to attend the Case Conference Review and request confirmation of attendance. This should be undertaken within 10 days of the Planning Meeting or initial strategy discussion.
- Booking the venue.
- Typing the agenda following the standardised Case Conference agenda (Appendix B)

- Distributing the agenda together with any appropriate information.
- Requesting from the appropriate people, papers which are to be tabled at the Case Conference and ensuring that there are enough copies for those present. These papers are confidential and should be kept secure until the Case Conference.
- Printing off an attendance sheet to take to Case Conference.

1.3 The minute taker should monitor the apologies and feed this back to the Chair and Responsible Manager. The Chair may decide to postpone the Case Conference if there is insufficient representation.

2. THE SAFEGUARDING ADULTS BOARD AGENDA

2.1 There is a standardised Case Conference agenda (Appendix B) that must be consistently used at all Case Conferences. The Chairperson may omit or add headings that are relevant to each individual Case Conference.

2.2 All supporting papers that are to be tabled are to be indicated as “tabled” on the agenda,

3. THE SAFEGUARDING ADULTS BOARD CASE CONFERENCE REVIEW

3.1 Ensure that the attendance record is fully completed and collected by the minute taker at the end of the Case Conference Review.

3.2 The minute taker should sit next to the Chair.

3.3 The minute taker should ensure that they have extra copies of the agenda in case attendees need them. Also take copies of the invitations sent and/or the information checklist form in case there are any queries at the meeting or if attendees do not arrive.

3.4 Reports for the Case Conference Review should be tabled at the start of the Case Conference. Consideration should be given to the Adult at Risk and their advocate to give them enough time to read copies of the report, except where such action would not be in their best interest or compromise the investigation. Every effort should be made to assist and support the Adult at Risk in understanding the reports

3.5 The purpose of the Case Conference Review is to:

- Monitor and review the actions following the Case Conference.
- Continue to monitor risk
- Review the current Protection Plan and amend as necessary.
- Close the investigation if all necessary actions have been taken.

3.6 The Chair should summarise the relevant discussion points of an agenda item before moving on to the next particularly where lengthy discussion has occurred or complex issues have been discussed, to offer guidance to the minute taker.

3.7 The Independent Chair and the Responsible Manager will need to consider if the Case Conference Review includes the Adult at Risk, Advocates or IMCA, the circumstances when it will not be possible to share information in their presence and ensuring that the Case Conference Review is conducted in such a way as gives due regard to confidentiality.

3.8 The welfare of other Adults at Risk within the service may be discussed if it is considered that others may be at risk but special care must be taken with regard to confidentiality in light of who is attending the Case Conference Review and this must be managed by the Chair.

3.9 At each Case Conference Review the definitions, of what is an Adult at Risk, what is Abuse? and what is Significant Harm? should be read out by the Chair and agreement sought from all participants that they understand the definitions by which the Case Conference Review is convened. Minute takers should ensure that there are copies of the definitions at each meeting to read and refer to during the Case Conference.

3.10 When explaining why the Case Conference Review is convened the Chair should summarise the allegation(s) that led to the Investigation, what form or forms of abuse, are being investigated, the definition of the form or forms of abuse and the decision made at the Case Conference on the allegation(s).

3.11 At the conclusion of the Case Conference Review the Chair is responsible for ensuring that only one copy of each written report is retained, these copies will be held within the Adult at Risk case file.

4. THE SAFEGUARDING ADULTS BOARD CASE CONFERENCE MINUTES

4.1 The guidelines for completing the Case Conference Minutes apply to Case Conference Review minutes.

5. DISTRIBUTION

5.1 The guidelines for distributing the Case Conference Minutes apply to Case Conference Review minutes.

APPENDIX B: CASE CONFERENCE STANDARD AGENDA

Private and Confidential

Rochdale Borough Safeguarding Adults Board

Case Conference for (insert Adult at Risk's name and address)

AGENDA

Date:

Time:

Venue:

1	**Apologies, Absences, Introductions & Ground Rules**
2	**Information Sharing/Confidentiality**
3	**Definitions**
4	**Explanation of Why the Case Conference is Convened**
5	**Report from Investigating Officer**
6	**Other Written/Verbal Reports**
7	**View of the Adult at Risk /Carer/Advocate**
8	**View of the person allegedly causing harm**
9	**Open Discussion**
10	**Risk Assessment – Risk Assessment Tool to be completed**
11	**Safeguarding Protection Plan/Care Plan**
12	**Mental Capacity Act/Deprivation of Liberty Safeguards**
13	**Recommendations**
14	**Decision on Allegation(s)**
15	**Action Points**
16	**Consider Necessity for a Serious Case Review**
17	**Date of Case Conference Review**

10) The Serious Case Review

INTRODUCTION

1.1 The purpose of this section is:-

- To support the view that the public interest is best served by the presence of an effective serious case review process.
- To provide guidance to the Rochdale Borough Safeguarding Adults Board.
- To facilitate a consistent approach to the process and practice in undertaking a serious case review.
- To acknowledge that there is no statutory requirement for agencies to cooperate with such reviews, however, voluntary involvement does lead to good practice development.

1.2 The document 'No Secrets' (March 2000) issued by DH and Home Office under section 7 of the Local Authority Social Services Act 1970, issued guidance on developing and implementing multi-agency policies and procedures to protect Adults at Risk from abuse.

1.3 The guidance suggests that local agencies should collaborate to achieve effective inter-agency working, through the formation of multi-agency management committees known as Safeguarding Adults Board.

1.4 The document Safeguarding Adults published by the Association of Directors for Social Services (ADASS) October 2005 provides a National Framework of Standards for good practice and outcomes in adult protection work. One of the standards in this document states that, as good practice Safeguarding Adults Boards should have in place a Serious Case Review protocol.

2.0 ADASS Standards

ADASS Standards: 1.22 – 9.10.15 (2005) recommend that:

There is a 'Safeguarding Adults' serious case review protocol. This is agreed, on a multi-agency basis and endorsed by the Coroner's Office, and details the circumstances in which a serious case review will be undertaken. For example: when an adult experiencing abuse or neglect dies, or when there has been a serious incident, or in circumstances involving the abuse or neglect of one or more adults. The links between this protocol and a domestic violence homicide review should be clear. There is a clear process for commissioning and carrying out of a serious case review by the partnership.

3.0 PURPOSE

The purpose of having a Serious Case Review is not to reinvestigate or to apportion blame.

It is:

1. To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard Adults at Risk.

2. To review the effectiveness of procedures (both multi-agency and those of individual organisations).

3. To improve practice by acting on learning (developing best practice).

4. To prepare or commission an Overview Report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents; e.g. an Untoward Incident. This protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.

Where there are possible grounds for both a Serious Case Review and a Domestic Homicide Review then a decision should be made at the outset by the two decision makers as to which process is to lead and who is to chair with a final joint report being taken to both commissioning bodies. This process will be of specific benefit when the case involves a victim aged between 16 and 18.

4.0 CRITERIA FOR SERIOUS CASE REVIEW

The Safeguarding Adults Board has the lead responsibility for conducting a Serious Case Review.

A Serious Case Review should be considered when:

1. An Adult at Risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death. In such circumstances the Safeguarding Adults Board should always conduct a review into the involvement of agencies and professionals associated with the Adult at Risk.

2. An Adult at Risk has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse of neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard Adults at Risk of abuse (See section 5 for commissioning guidance).

3. Serious abuse takes place in an institution or when multiple abusers are involved, the same principals of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case.

5.0 PROCESS FOR COMMISSIONING AND CARRYING OUT A SERIOUS CASE REVIEW

5.1 The Safeguarding Adults Board (RBSAB) will be the only body which commissions any Serious Case Reviews for adult safeguarding in the Borough of Rochdale. The Board will publicise both the process under which applications for reviews may be made and the terms of reference for each serious case review.

5.2 Application for requests will also be considered from the Coroner, MPs, Elected Members and other interested parties.

5.3 The Operations Sub–Group of RBSAB has initial responsibility for determining if a case meets the criteria for a SCR and making a recommendation to the Chair of RBSAB accordingly.

5.4 In the event of an application being turned down, the reasons need to be recorded in writing and shared with the applicant.

6.0 INITIATING A SERIOUS CASE REVIEW

6.1 **Referring for consideration for Serious Case Review**

Any individual or group who believes that a Serious Case Review is warranted should identify this with the designated Safeguarding Adult Representative of their agency, both verbally and in writing. Where a referrer does not have access to a nominated representative, then an application can be made directly.

The written referral should be passed to the Chair of the Operations Sub Group (RMBC Adult Care Head of Safeguarding) as soon as possible either directly or via the Rochdale Adult Safeguarding Team by email (SafeguardingAdultsAlerts@rochdale.gov.uk)

A referral template is available from the Head of Safeguarding.

6.2 **Screening of Referrals for Serious Case Review**

Upon receipt of the written application, the Operations Sub –Group (which must be quorate) will be convened to consider and determine if the case meets the criteria for a SCR. Upon reaching a decision, the Chair of the Operations Sub Group will then brief the RBSAB Chair immediately following the meeting, outlining the rationale for the decision.

The RBSAB Chair holds final responsibility for deciding whether or not to initiate a Serious Case Review, based on the information provided.

If the request is declined:

Members of the Operational Sub-group may determine that a full case review is not justified and that an individual management review by the agency or agencies or a Lessons Learned approach might be more appropriate. The results of any such internal enquires within member organisations must, however, be fed back to the Chair of the RBSAB on completion.

In the event of a SCR application being declined, the rationale will be recorded in writing by the Chari of RBSAB and shared with the applicant within 7 days of the decision being made.

6.3 **Acceptance of a Serious Review request**

If it is agreed, a multi-agency Serious Case Review Panel will be set up:

The RBSAB Chair will be responsible for the appointment of an Independent Panel Chair.

6.3.1 The Safeguarding Adults Board will ensure the Serious Case Review Panel Chair receives adequate support.

6.3.2 The Chair of the Panel will be responsible for establishing individual Terms of Reference and setting time scales for the review in agreement with the Safeguarding Adults Board. They will also be responsible for ensuring administrative arrangements are completed and that the review process is conducted according to the Terms of Reference.

6.3.3 CQC are to be informed by the Chair of RBSAB of any Serious Case Review taking place.

6.3.4 The Chair of the Safeguarding Board will then write to the Chief Executive Officer, of all the agencies involved for nominations to the Serious Case Review Panel.

6.3.5 Membership of the Serious Case Review Panel will be comprised of appropriate representatives of the agencies.

6.3.6 Each agency will nominate a representative who has appropriate experience and authority.

6.3.7 The recognised Chief Executive Officer or Safeguarding Lead for the agency concerned will then be responsible for nominating a competent individual to carry out an **Individual Management Review (IMR)** and submit a comprehensive report to the SCR Panel within a time frame set by the Chair of the SCR Panel.

6.3.8 The person tasked by the Agency to complete the IMR should be deemed competent to do so, and be sufficiently independent of the relevant safeguarding investigation.

6.3.9 The IMR should look openly and critically at both individual and organisational practices.

6.3.10 The Chief Officer and Safeguarding Lead of the agency will provide the IMR Lead with ongoing support to complete the IMR in a timely fashion.

6.3.11 The IMR Lead is expected to prioritise work relating to the Review, and provide any information requested by the Chair of the SCR Panel in a timely manner.

6.3.12 The main objectives of the Individual Management Review are to:

- Look openly and critically at organisational and individual practice, including internal and cross-agency governance arrangements;
- Establish if the case indicates that changes could and should be made;
- Identify how any such changes may be introduced;
- Propose any other action required.

6.3.13 To achieve these objectives, the following need to be completed:

- Identification and reading of file material;
- Interviews of relevant practitioners and managers;
- Establishment of a chronology;
- A determination of services provided as a result of the decisions made;
- An analysis of involvement;
- A summary of ‘lessons learnt’;
- Recommendations for practical action.

6.3.14 Once a Serious Case Review has been initiated, any decision not to proceed with it will be taken by the quorate Board.

7.0 CONDUCT OF SERIOUS CASE REVIEW

7.1 Initial Meeting

This will agree:

- the Terms of Reference;

- the ‘evidence’ required from each participant;
- the support and other resources needed (any perceived deficits to be referred to Chair of Safeguarding Adults Board);
- the time scales within which the review process should be completed;
- dates, times and venues of meetings;
- the nature and extent of legal advice required, in particular: Data Protection, Freedom of Information, and Human Rights Act.

7.2 **Serious Case Review – receipt of evidence**

This stage of the meeting is a formal ‘information sharing’ session where agencies will be encouraged to query and comment on the reports presented.

Each agency involved will be asked to:

- Present and examine the chronology of events, highlighting any discrepancies
- Present a comprehensive report of the actions by their agencies
- Ensure any other management reports and other relevant information are made available

7.3 **Serious Case Review – discussion of evidence/’adjudication’**

This stage is where the assessment of alternative courses of action takes place.

The review panel will:

- Cross-reference all agency management reports and reports commissioned from any other source;
- Examine and identify relevant action points;
- Form a view on practice and procedural issues;
- Agree the key points to be included in the report and the proposals for action.

7.4 **Issues Arising**

If at any stage whilst undertaking the procedure contained in 7.3, information is received which requires notification to a statutory body, e.g. GSCC, CQC, ISA regarding significant omission by individual/s or organisations this should be undertaken by the Chair without delay.

The Chair of the review panel should report back to the Safeguarding Board and a decision made as to whether the Serious Case Review process should be suspended pending the outcome of such notification.

7.5 **Report Stage**

The review panel will complete the review of IMR reports and those commissioned from any other sources and advise the Chair on the production of an Overview Report which brings together information, analyses it and makes recommendations. The Chair will ensure that the Overview Report is written and delivered within agreed timescales.

7.6 **Acting on the Recommendations of the Serious Case Review**

On completion, the Overview Report will be submitted to the Safeguarding Adults Board Chair who will:

- Ensure contributing agency's Chief Executive Officer receives a copy of the Overview Report;
- Ensure that the Overview Report contains an Executive Summary that can be made public;
- Ensure each agency translated the recommendations from the Overview Report into an Action Plan, which should be endorsed at senior level by each Agency.

The Action Plan will indicate:

- Responsibilities for various actions;
- Time-scales for completion of actions;
- The Intended outcome of the various actions and recommendations;
- Mechanisms for monitoring and reviewing intended improvements in practice and/or systems;
- To whom the report or parts of the report should be made available, and indicate the means by which this will be carried out;
- The process for dissemination of the report and/or key findings to interested parties, for the receipt of feedback and for any debriefing to staff, family members and, where appropriate, the media.

7.7 **Recommendations**

The Safeguarding Adults Board will ensure that all recommendations are actioned and will request a progress report from the Agencies.

The Action Plan will remain on the Safeguarding Adults Board agenda until such time that all recommendations have been implemented.

It will be the responsibility of the Operations Sub-Group to produce the Integrated Action Plan.

The Quality Assurance, Audit, and Performance Sub-group will monitor progress on the implementation of all the recommendations.

OTHER CONSIDERATIONS FOR A SERIOUS CASE REVIEW

- There will be a need to address the budgetary requirements for undertaking a Serious Case Review.
- Time scales for the completion of a Serious Case Review will need to be put in place to ensure that the process takes place within a timely and specific framework. By comparison, a Domestic Violence Homicide Review aims to be completed within three months.
- Safeguarding Adults Boards are advised to liaise with their local Coroners Office to ensure that the arrangements for undertaking a Serious Case Review are acceptable.
- Due regard for criminal/civil process should be observed at all times.
- Arrangements to obtain or secure records through statutory agencies should be utilised whenever appropriate, e.g. Police, CQC.
- Circumstances may arise whereby it is appropriate to consult or involve a victim of abuse or a relative. This involvement should be carefully considered.

- The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public authorities, known as the ‘right to know’, came into force in January 2005.
- There are ‘absolute’ and ‘qualified’ exemptions under the Act. Where information falls under ‘absolute exemption’, the harm to the public interest that would result from its disclosure is already established.
- If a public authority believes that the information is covered by a ‘qualified exemption’ or ‘exception’ it must apply the ‘public interest test’.
- The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considered that the public interest in withholding the information is greater than the public interest in disclosing it.
- The Data Protection Act 1998.
- Children Act 1989.
- There may be need for the completion and implementation of media and communication strategies.

AppendiX C: Serious case review referral form

ROCHDALE METROPOLITAN BOROUGH COUNCIL

Rochdale Borough Safeguarding Adults Board

Rochdale Borough Safeguarding Adults Policy
SERIOUS CASE REVIEW REQUEST FORM

This form should be used with the Safeguarding Adults Serious Case Review Toolkit. When completed it should be passed to your manager to be sent to Adult Care Services, Floor 1, Oldham Road, Middleton M24 1AY FAO Jane Timson. Email – safeguardingadultsalerts@rochdale.gov.uk

Person requesting Serious Case Review:
Job Title:
Organisation:
Workplace:
Address:
Contact number:
E Mail:
Other names contact:
Job title:
Contact No:

Brief details of incident and reason for the referral. Please include how you feel this meets the following criteria for a Serious Case Review: 1. An Adult at Risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death. 2. An Adult at Risk has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse of neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard Adults at Risk of abuse. 3. Serious abuse takes place in an institution or when multiple abusers are involved, the same principals of review apply

Continue on separate sheet if necessary

Agencies known to be involved in case: (include contact name)

Any other information you feel is relevant:

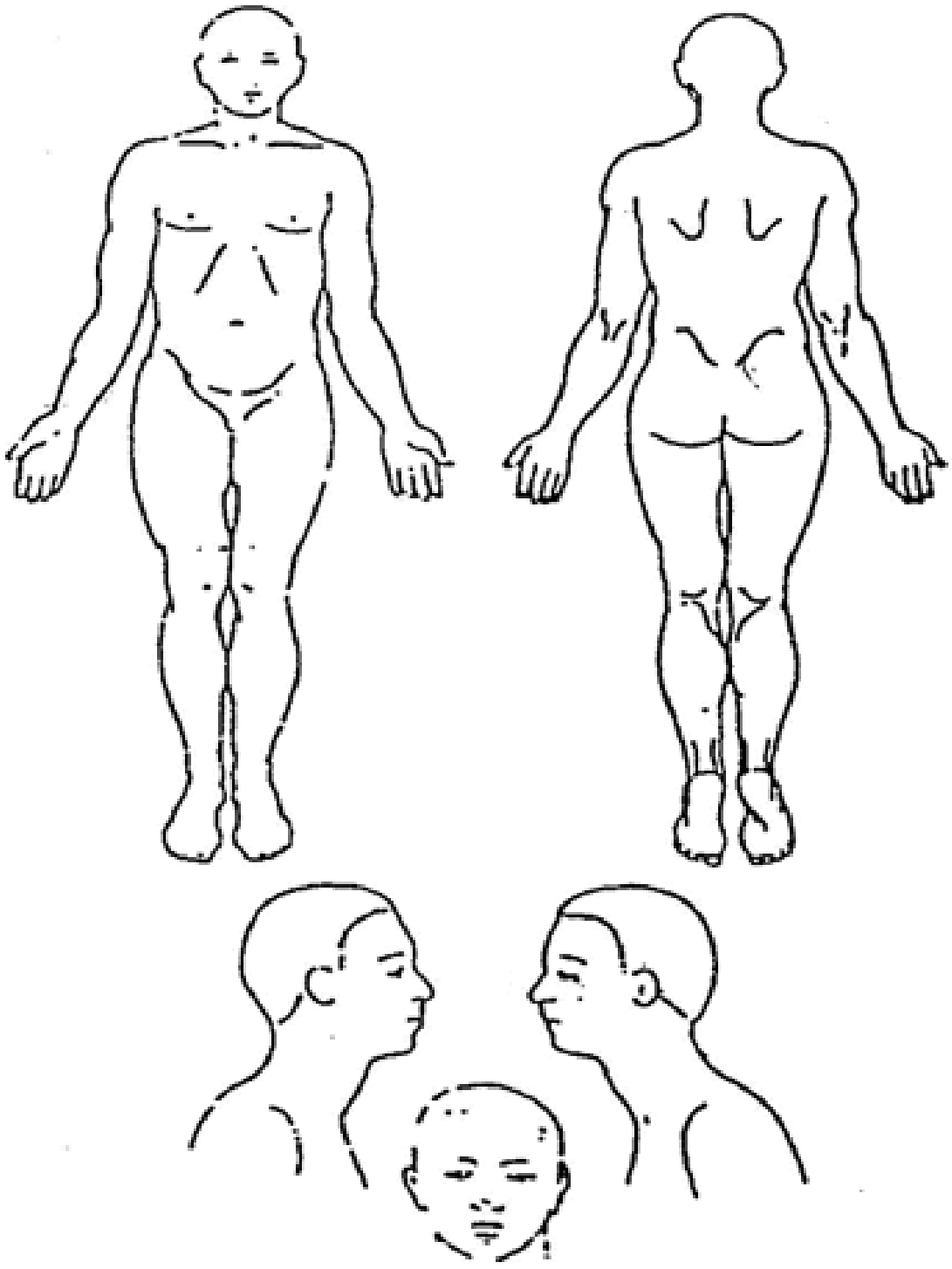
Signed:

Print Name:

Date:

CC:

Appendix D – Body map



Appendix E – Contact numbers

1 Day time telephone number for Rochdale Adult Care Services

Adult Care Access and Enablement Service

Phone: **0844 264 0867**

2 Adult Care Emergency Duty Team (out of hours)

Phone: **0845 1212975**

3 Care Quality Commission (CQC)

Phone: **03000 616161**

4 Police contact number

In emergency phone **999**

In non-emergency phone **101**

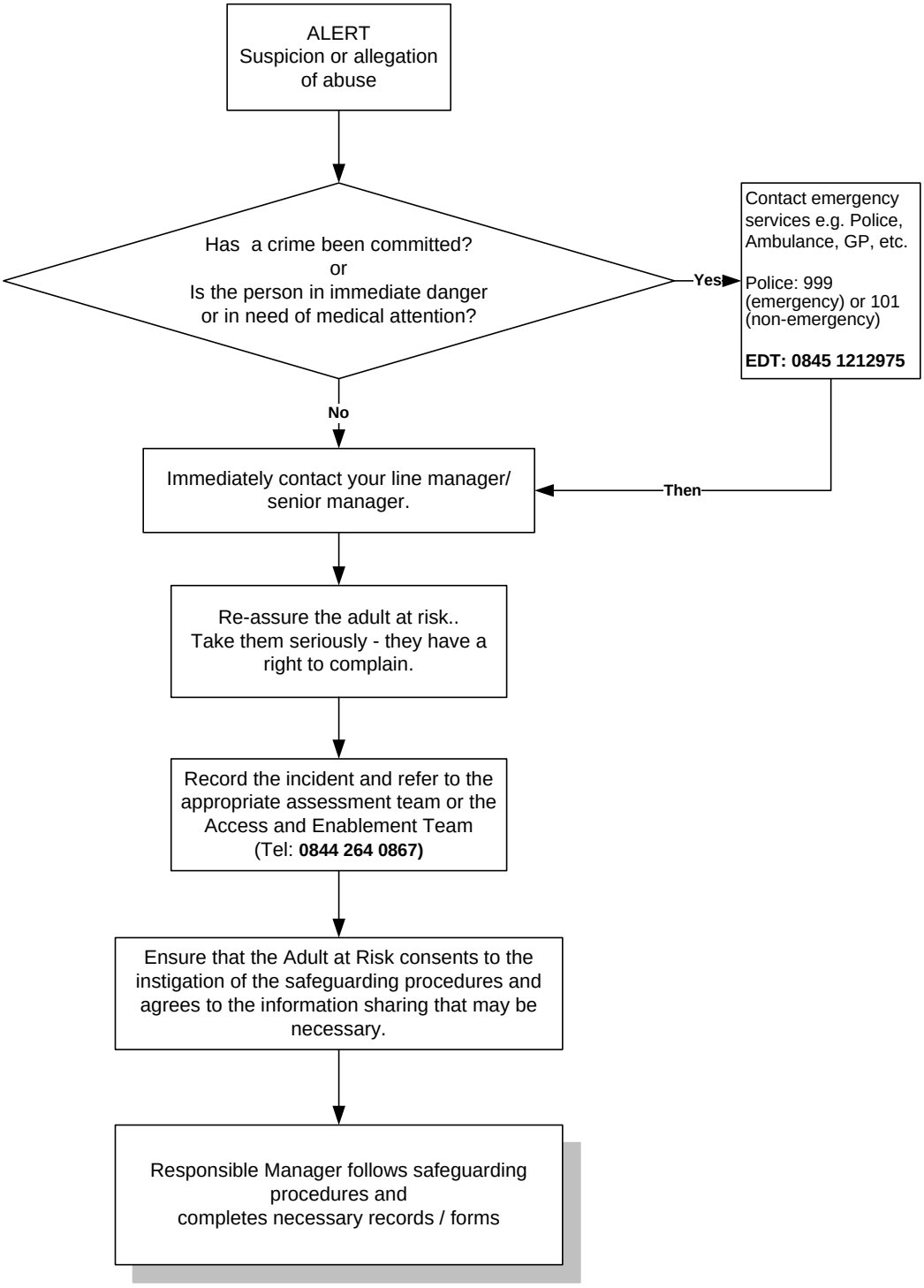
5 Adult Care Safeguarding Team

Phone: **01706 923004**

Flowcharts

ADULT ABUSE - SUMMARY OF ACTION TO BE TAKEN

What is Abuse? "Abuse is a violation of an individual's human and civil rights by any other person or persons"



ADULT ABUSE - INVESTIGATION CO-ORDINATION