

June 2011

Safeguarding Adults

**County Durham
Inter-Agency
Policy and Procedure**

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SECTION 1 GOVERNANCE ARRANGEMENTS

1.1 Introduction to County Durham Inter Agency Policy and Statement of Commitment

'Safeguarding Adults', a document published in October 2005 by the Association of Directors of Social Services (ADASS), is a national framework of standards for good practice and outcomes in adult protection work - now known as 'safeguarding work'. (1) It builds on the sound foundations already established by many multi-agency groups, who in response to the launch of 'No Secrets' devised and implemented shared protocols for protecting 'vulnerable adults' from abuse.

The commitment of Durham's Multi-Agency Safeguarding Adults Board to these standards is reflected within the following policies and procedures documentation which are in turn influenced and underpinned by the evolving legislation and guidance relevant to safeguarding work.

Moreover, in response to the Government's emerging 'personalisation agenda' the Board is additionally committed to shifting towards an approach to tackling issues of abuse which more strongly recognises individual's human rights and their rights as citizens, and has a greater emphasis on prevention.

Note: Personalisation or Self Directed Support is a national agenda aiming to promote more choice and control for people accessing and using social care and support services. Personalisation enables people to have more control over their lives, and be active citizens rather than passive recipients of services. Within Personalisation it is important to consider risks and keeping people safe from harm, however risks need to be weighed up alongside benefits, and risk should not be an excuse to restrict people's lives. For further information on Personalisation in County Durham, see www.durham.gov.uk/yourlifeyourchoice

"Abuse is a violation of an individual's human and civil rights by any other person or persons." No Secrets (Department of Health 2000)

The Durham Multi-Agency Safeguarding Adults Board has agreed to adopt a clear policy of zero-tolerance of abuse within each of its component organisations.

The Board recognises that it is every person's right to live their life free from violence and abuse.

It takes seriously its duty placed on public agencies under Human Rights legislation to intervene proportionately to protect the rights of citizens.

And

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It embraces the principle that any adult at risk of abuse or neglect should be able to access public organisations for advice, support and appropriate individualised protection and care interventions, which enable them to live without fear and in safety.

1 The term 'safeguarding work' means all the work which enables an adult who is or may be eligible for community care services to retain independence, well-being and choice, and to access their human right to live a life that is free from abuse and neglect.

1.2 The Safeguarding Adults Board

1.2.1 The Role of the Multi-Agency Safeguarding Adults Board

In Durham, safeguarding adults work is led by a multi-agency Board that includes membership of the leading statutory organisations and encourages engagement with the independent and voluntary sectors. The public, service users and carers are also engaged with the group. All support and have helped to develop this policy document and procedural guidance.

Accountability for leading the development of the Safeguarding Adults Board is presently located with the Local Authority. This responsibility is designated to the Head of Adult Care for Adults Wellbeing and Health, who holds the position of chair.

The Board includes representatives to and from relevant strategic partnerships and is supported by a number of sub-groups. The latter advise on the forward-planning function of the Board's work and support it in achieving its objectives. The Board and sub-groups each work to clear terms of reference.

The Board is endorsed by and understands its links with the Local Strategic Partnership. It also has strong links with the Safer Communities Partnership, the Domestic Violence Partnership and the Strategic Safeguarding Board (Children).

Plans for 'safeguarding adults' are owned by these wider partnerships too, and are included within agreements for specific partnerships working with the people covered by this policy, i.e. 'adults who may be eligible for community care services'.

1.2.2 Board Members

Chair - Head of Adult Care, Adults Wellbeing and Health, Durham County Council

Safeguarding Adults & Practice Development Manager, Adults Wellbeing and Health, Durham County Council

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Head of Safeguarding & Specialist Services, Children & Young People's Services, Durham County Council

Associate Clinical Director, Nursing and Clinical Governance, County Durham Primary Care Trust

Director of Nursing, Allied Health Professionals and Patient Safety, Darlington Primary Care Trust

Director of Nursing, County Durham & Darlington NHS Foundation Trust

Director of Nursing, Tees, Esk & Wear Valley NHS Foundation Trust

Detective Chief Inspector, Head of Vulnerability, Durham Constabulary

Director of Offender Management, Durham Probation

Regional Safeguarding Adults Lead, Healthcare Commission

Regulation Manager, Care Quality Commission

Governor, Her Majesty's Prison Service, Durham

1.2.3 Joint Systems

Each partner agency will have its own internal 'safeguarding adults' procedural guidelines, which should be consistent with the multi-agency policy and procedure, and clearly describe the responsibilities of all of the workers who operate within them.

Where appropriate, those partner agencies who perform such functions should also agree to integrate assessment tools which identify risk of abuse and neglect into their assessment practice and risk management protocols, and adopt a process for carrying out an annual audit of cases concerning the abuse of service users.

Furthermore, each partner organisation should ensure that its staff and volunteers at all levels, as well as any students on placement, have access to relevant information and training, and have the necessary knowledge and skills to enable them to fulfil their individual roles in relation to safeguarding work.

Workers/volunteers must be able to:

Recognise risks from different sources and in different situations, e.g. risks from other service users, colleagues, relatives and carers;

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Accurately record facts - contemporaneously - with any concerns of abuse or neglect, and actions taken as a result;

Effectively signpost any person seeking information about living a life free from abuse and neglect; and

Make appropriate referrals about safeguarding adults concerns, domestic violence and hate crime and child protection concerns.

Each partner organisation/agency must have a 'speaking out', or 'whistle blowing' policy and procedure (**Confidential Reporting Code**) that is cross-linked to their safeguarding adults policy, and make sure that it is made available to all staff, volunteers and students. All workers, whether paid or voluntary should know who they can contact to report concerns of risk of abuse or neglect. Finally, regular recorded supervision for staff and volunteers too, should address safeguarding adults issues (sometimes to discuss practice in specific cases) and - along with the appraisal process - identify related training needs.

Where services are commissioned by statutory public agencies, the same standards should be applied. Commissioning and Contracts Officers should monitor individual services to ensure compliance with this policy and procedural framework.

1.2.4 Dignity Statement

The Safeguarding Adults Partnership is committed to ensuring that service users, their families and carers are at the centre of the caring process. We will ensure that people receiving care and support from Adults Wellbeing and Health are listened to; have their views taken into account; are treated with respect and have their dignity maintained at all times. Dignity in care is integral to all aspects of our service delivery.

1.3 Policy and Statement of Commitment

This policy document constitutes a statement of commitment by the Safeguarding Adults Board to respond to every adult “who is or may be eligible for community care services” (NHS and Community Care Act 1990) and whose independence and well-being is at risk due to abuse or neglect (see the Adults Wellbeing and Health ‘Fair Access to Care’ criteria (Fair Access to Care Services Eligibility Framework – A/111 and Fair Access to Care Services A/110).

Furthermore, the Board recognises its public duty to protect the human rights of all citizens, including those who are the subject of concern but are not covered by the safeguarding procedural framework, and also those who are not the subject of initial concern. It recognises that this duty is the responsibility of each of its member organisations, who through a shared network of initiatives will offer signposting, advice and support services aimed at enabling all people to live lives that are free from violence, harassment, humiliation and degradation.

The accompanying procedural framework and practice guidance documentation should inform the practice of all organisations working in partnership for the protection of adults at risk (formerly known as ‘vulnerable adults’, (2) and should be applied in all situations where the possibility of the abuse or neglect cannot be ruled out. The procedures apply to all adults at risk of abuse, whether permanently or temporarily resident within the boundaries of Durham county, to all perpetrators, and in all settings, including peoples own homes, residential and nursing homes, day centres, places of work, colleges, hospitals, GP’s surgeries and police stations. To this end, travelling, refugee or homeless adults and their families may require specific consideration to ensure that preventative and safeguarding services are accessible to them, and that services are provided in a manner which addresses their needs and facilitates their engagement.

2 The term ‘vulnerable adult’ has become confused as a result of the multiple definitions used within current legislation and Government policy. It was always a contentious definition because it located the cause of abuse with the victim rather than placing responsibility with the actions or omissions of others. Consequently ‘Safeguarding Adults’ (ADASS 2005) introduced the updated term, ‘adult at risk’. See section 3 for further information.

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1.4 Aims of the Policy

The aims of this policy and the accompanying inter-agency procedural framework and guidance are as follows.

To raise awareness amongst all citizens - paid and voluntary workers, carers, service users and the general public - that some adults may be rendered at greater risk to a range of abuses because of the ageing process, physical or mental ill-health, learning disability, physical or sensory impairment or substance misuse or dependence. All citizens should have access to information about how to gain safety from abuse and violence, and that should include information about safeguarding adults procedures.

To ensure that the partner agencies have in place preventative measures to lessen the likelihood of abuse occurring.

To ensure that wherever abuse or neglect are suspected or reported, a consistent, supportive response will be made from partner agencies across County Durham. That response will recognise each adult's rights: the right to independence and well-being, to protection from harm, and to make choices and take risks.

To ensure that quality assurance measures and outcome information specific to safeguarding adults work are used to improve safeguarding processes, access and involvement, public information and inter-agency training.

And

To ensure that monitoring data is used to inform strategic planning and development of initiatives and services that target 'hard to reach' groups, and promote safety and recovery from abuse.

1.5 Principles

The good practice principles which underpin this policy and procedural framework apply to all of our work with adults countywide.

Furthermore, the committee and partnership agencies agree: -

To work co-operatively across all organisations on the identification, investigation, treatment and prevention of abuse of vulnerable adults.

To maintain equal opportunities by ensuring that:

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Equality of opportunity will be available to all 'adults at risk' (formerly referred to as 'vulnerable adults') regardless of their identity or personal circumstances; and

All assessments and investigations under this policy will be carried out in a setting, manner and language appropriate to the level of understanding and cultural background of each person concerned.

To endorse the joint agency procedures on safeguarding adults.

To implement this policy statement through the work of the County Durham Safeguarding Adults Board, across all partner organisations, addressing the requirements for:

A common definition of abuse;

A common system of recording abuse;

The joint investigation of allegations of abuse;

The provision of relevant information to staff and to the general public;

The provision for staff of timely and consistent legal advice and support;

Engagement at a national level to clarify the policy and legislative framework under which work on abuse is conducted;

Identifying the resources necessary to fulfil the expectations of work in this area; and

An understanding across all staff groups and the wider public of the factors that may lead to abuse, and of how abuse may be prevented.

Finally, implementation of the policy statement will incorporate plans for training and for the management structures and systems necessary to support the work.

1.5.1 In relation to working with adults who are at risk from abuse

In situations where there is a risk of abuse or neglect, or where abuse is suspected or alleged, the following principles should also be applied. All adults have the right to:

Access appropriate information in order to be able to identify behaviour which constitutes abuse;

Live a life free from violence, fear and abuse;

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Be protected from harm and exploitation; and

Except where the rights of others would be compromised, make their own choices in relation to safety from abuse and neglect.

As determined by the Mental Capacity Act, 2005 (MCA), interventions by members of the partnership agencies will be based on the presumption of mental capacity. Consequently, unless it is determined that an adult does not have the ability to understand and make decisions about his or her own personal well-being and safety, that person also has the right to follow a course of action that others may consider unwise, including one which could lead to them being abused (although consideration will also need to be given to the safeguarding needs of others who as a consequence may be adversely affected, e.g. fellow service users, relatives etc.). This is particularly relevant where people choose to use a Personal Budget to purchase non-traditional care & support services.

It therefore follows that:

Where a person chooses to live with the risk of abuse, safeguarding interventions should include access to information and support services that help minimise the risk; and

Safeguarding action should usually be taken in consultation with the adult concerned, and in a way that does not undermine the person's own right to make informed choices and decisions.

It is also important that decisions made at any one time are not taken to be irreversible or non-negotiable. Safeguarding interventions must ensure that when an adult with mental capacity takes a decision to remain in an abusive situation, he or she does so without intimidation, with an understanding of the risks involved, and has access to appropriate services should they change their mind:

All adults at risk can expect arrangements to be made that will promote their safety, independence and well-being in both the short and longer term.

Additionally, adults at risk have the right:

To independent advocacy and/or support;

And to be kept informed of safeguarding processes and outcomes.

Of course, where an adult is judged to lack capacity, any actions taken by safeguarding professionals in order to protect that individual from

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harm will be made in his or her best interest and in line with the Mental Capacity Act code of practice.

For further information about mental capacity, please refer to Section 16.

1.5.2 In relation to informal carers who are suspected as perpetrators

The safeguarding adults procedural framework is not intended to be punitive. There are other procedures and judicial processes that fall outside of - but which may be used alongside or following the application of - the safeguarding policy and procedural guidance, that follow a punitive course.

Carers who are family or friends will wherever possible be offered support when suspected or alleged abuse is reported in good faith. For example, in domestic situations, the factors that could be exacerbating abuse will be carefully considered, carer's views and opinions sought, and thought given as to how they might be better helped to provide care appropriately in order to sustain their caring role (carers are entitled to an assessment of needs in their own right). This intervention should enable adults at risk, who are deemed to have mental capacity, to remain safely in their own homes with their own families if that is what they wish.

In such situations carers will also be kept informed of processes and outcomes as long as this does not conflict with the best interests of the adult at risk.

1.5.3 In relation to employed or voluntary care workers reporting suspected abuse

Wherever possible, care workers should be offered training, support and guidance in working with adults at risk of abuse and neglect, and how to recognise risks from different sources and different situations. They should be able to confidently act upon their concerns.

For care workers employed in regulated services (Care Quality Commission), this is a mandatory requirement under The Care Homes Regulations 2001 and The Domiciliary Care Regulations 2002. Care workers too should be offered support when allegations are made against them, and they should be kept informed of safeguarding processes and outcomes, but again only if this does not conflict with the best interests of the adult.

1.5.4 In relation to the perpetrator, where he or she is an 'adult at risk'

The Safeguarding Adults Board recognises that perpetrators have rights. Where an alleged perpetrator is also deemed to be at risk - for example if he or she is another service user or carer - the right of access to independent advocacy or support applies.

Additionally, the procedural framework allows for an assessment of the nature of the risk(s) posed by the alleged perpetrator. This may result in the provision of community care services for that person, or sign-posting to appropriate mainstream services as part of the safeguarding plan drawn-up for the adult at risk.

All alleged perpetrators have the right to know the nature of the concerns about their behaviour, to have a right of reply, and to correct any information held about them that is not accurate.

1.5.5 Forced marriage and honour based violence

Forced marriage is regarded as a form of domestic abuse and, where it involves an 'adult at risk', is a safeguarding issue. It is not a practice advocated in any religion or as a cultural norm and is often used as a means to preserve so-called 'family honour'.

Honour based violence is again a safeguarding issue when it involves adults at risk as victims. It is perpetrated with the motivation of controlling behaviour within families and protecting perceived cultural and religious beliefs and/or honour, and to control autonomy and sexuality. Whilst such violence is predominantly perpetrated against females, males can also be victims.

In respect of both forms of abuse the Safeguarding Adults Board has a shared commitment to identifying and reducing the risks faced by adults from diverse communities with County Durham.

1.6 Equality and Diversity

The Board recognises that society is made up of adults with diverse and unique identities. This is reflected in the safeguarding adults procedural framework. Every intervention made by partner agencies will aim to take into account each person's individuality to avoid discrimination on grounds of race, religion, ethnicity, age, gender, sexual orientation, disability or language.

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1.7 Prevention

It is far better to put in place strategies to minimise the likelihood of abuse occurring – preventative strategies – than to deal with abuse after it has happened.

There are aspects of people's lives that increase their vulnerability to abuse. These include:

Lack of inclusion in social networks, including education and employment;

Dependency on others (who may misuse their position) for vital needs including mobility, access to information and control of finances;

Social acceptability of low standards for care and treatment;

Social acceptability of domestic abuse; and

Dynamics of power within institutional care settings.

(‘Safeguarding Adults’, ADASS 2005)

It follows then, that the individual member organisations which constitute Durham's Safeguarding Adults Board will each commit themselves to the prevention of abuse and neglect in the development of their own planning and commissioning processes, and within direct service delivery.

1.7.1 In the Community

Services that deal with crime and disorder, regeneration, and health and well-being will ensure that they are accessible to, influenced by, and monitor the inclusion of people covered by this safeguarding adults policy.

Local audits of education, leisure and commercial activity will include the monitoring of involvement by people most vulnerable to abuse.

Reports of the regular monitoring and audit of services, and each organisation's policies in respect of access and inclusion will be shared with the Board on an annual basis. Audit information will also include reference to provision of activities aimed at enhancing the personal safety of individuals, e.g. assertiveness courses, self-defence training, personal safety advice and provision of personal safety equipment, along with attendance/take-up rates.

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In particular, services that respond to issues of crime prevention and to incidents of violence and abuse will ensure that they are accessible to the people covered by this policy.

Commissioners of community care services will collect data about assessed needs for crime prevention measures and victim support services and work with local agencies to meet identified needs.

Frontline organisations that provide housing, education, leisure and health and social care services will commit themselves to making information about crime prevention available and accessible to service users, and where appropriate, support people to access mainstream services to enhance their safety.

Commissioners, regulators and licensing bodies of mainstream services will ensure that individuals and agencies from whom services are procured implement appropriate safeguards and responses to safeguarding adults issues.

The separate organisations which comprise the Board ensure that all people known to pose a risk to others within the community - including those covered by the safeguarding policy - are the subject of plans drawn-up under public protection and specialist multi-agency risk management arrangements (see reference to Multi Agency Public Protection Arrangements-MAPPA, Multi Agency Risk Assessment Conference-MARAC and Potentially Dangerous Persons Protocol-PDP in Section 18).

And

The Safeguarding Adults Board will establish a multi-agency system for reviewing serious cases to ensure that the necessary lessons are learned to improve responses to suspected, alleged and substantiated abuse.

1.7.2 Within service delivery

Adults receiving community care services can be at risk whilst receiving them, both in care settings and in their own homes. Successful prevention of adult abuse and neglect demands that service providers tackle the factors which contribute to its occurrence at all levels. It also requires commissioners (Adults Wellbeing and Health and the Primary Care Trusts for example) and regulators (Care Quality Commission) to ensure that standards that prevent abuse and neglect are met. Over and above this, the safeguarding agencies can form agreements with local providers of community care services, encouraging achievement of even higher standards.

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Within Self Directed Support, people can choose to purchase support services from non-regulated providers via a Direct Payment. Where this option is to be considered, commissioners from Adults, Wellbeing & Health will ensure effective Risk Assessment is implemented and Risk Management plans should be developed together with service users to minimise risk of abuse or neglect wherever possible.

[A/019 – Guidance on Risk Management](#)

[A/123 – Appointing a Suitable Person to Act on behalf of a Service User who lacks Mental Capacity.](#)

[A/015 – Risk Procedure](#)

Adults, Wellbeing & Health – as the commissioner of the Direct Payment will apply Safeguarding Adults procedures wherever necessary in these cases. Formal monitoring, auditing and review arrangements are implemented by Adults, Wellbeing & Health in all cases where people are in receipt of a [Direct Payment \(A/113\)](#)

Where regulated care services are commissioned, however, as a minimum, each of the partners will have:

A clear, well-publicised policy of 'zero-tolerance of abuse' within its organisation; ([Dignity at Work](#), [Bullying and Harassment Policy, Procedure and Toolkit](#))

A safeguarding adults policy consistent with this inter-agency policy; ([Safeguarding Adults Policy and Statement of Commitment \(A/121\)](#))

clear procedural framework covering all incidents of abuse from any person towards any other, which is publicised and made available to all staff, volunteers, service users and carers in a range of appropriate and accessible formats;

a clear policy and procedure for reporting to the Police all suspected crimes taking place within its service (e.g. assault, harassment or theft), including those committed by staff, volunteers, students on placement, service users and in the case of residential settings, visitors;

clear policies against discrimination and harassment towards any person - e.g. staff, volunteers, service users, carers - on any grounds, including disability, age, race, faith, gender or sexuality; ([Bullying and Harassment Policy, Procedure and Toolkit](#))

a code of conduct in place for all staff and volunteers, setting clear standards for relationships between people in a position of trust and service users, this must be compatible with the law, including the Sexual Offences Act 2003 and professional standards set out by the Nursing and Midwifery Council (NMC), the General Social Care Council

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(GSCC), the General Medical Council (GMC) and other professional registering bodies; ([Code of Conduct for Employees](#))

a protocol cross-referenced with safeguarding adults procedures by which staff and volunteers can raise concerns, along with protection for staff who speak out ('whistleblowers') in accordance with guidance produced by 'Public Concern at Work'; ([Confidential Reporting Code](#))

a commitment to implementing the Adults Wellbeing and Health information sharing protocol in respect of safeguarding adults cases, and to nurturing an 'open culture' within partner agencies where good communication between staff and managers and stakeholders is encouraged ([Joint Protocol for Information Exchange IA/001](#), [SAP Information Sharing Protocol IA/003](#), [Multi-Agency Information Sharing Protocol – County Durham, Tees Valley and North Yorkshire – IS/063](#));

A clear, accessible and well-publicised complaints procedure, which includes information about how to contact and escalate concerns to external bodies such as regulators and service commissioners; ([Adult Services Complaints Procedure REP/025](#))

Effective quality assurance and governance processes that are cross-referenced with safeguarding adults issues; and

A clear policy and procedure for dealing with staff disciplinary and grievance issues. ([Disciplinary Policy, Procedure and Toolkit](#) and [Grievance Policy, Procedure and Toolkit](#))

Each partner agency additionally will ensure its organisation has clear operational guidelines in accordance with regulations and best practice in respect of:

recruitment standards and examining the employment history and references of all job applicants, identifying employees for whom Criminal Records Bureau (CRB) standard and enhanced checks and Independent Safeguarding Authority registration checks are required and ensuring that these, along with any other appropriate post-Richard vetting protocols are carried out;

provision of robust induction and relevant ongoing training to ensure that all staff and volunteers are able to identify and report concerns of abuse or neglect;

its response to concerns or allegations that a member of staff has perpetrated or contributed to abuse, including the process for suspension, transfer to a non-care position or supervised work on a precautionary basis, and interface with any Police investigation; and

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referral to the Independent Safeguarding Authority of Managers, staff or volunteers whose employment is covered by the Department of Health list (for ISA those undertaking 'regulated' or 'controlled' activities) and who are dismissed or leave/resign because it is believed they have harmed a vulnerable adult, whether or not in the course of their employment.

The following organisations will have a legal obligation to refer relevant information to the ISA:

Adult Care Management/Safeguarding Teams and Safeguarding Children's Teams;

Professional bodies and supervisory authorities (e.g. regulators, the Charities Commission, the Public Guardian etc.) as named in the Safeguarding Vulnerable Groups Act;

Employers and service providers of regulated and controlled activities; and

Personnel suppliers (e.g. employment agencies and education institutions).

Health and social care providers particularly will ensure that:

guidance is in place for staff undertaking personal and intimate care tasks with service users, moving and handling tasks, physical interventions (formerly control and restraint), control and administration of medicines, handling of services users' finances and risk assessment and risk management, all of which must be referenced with safeguarding adults procedures;

Along with clear procedures for reporting, dealing with, recording, and monitoring of: serious incidents; accidents; health and safety issues; violent and challenging behaviour; tissue viability and sexuality and relationships between service users - again all of which must all be referenced with safeguarding adults procedures.

Essentially in health care and social care settings:

every service user's care-plan (sometimes also referred to as a 'person-centred plan', 'lifestyle-plan', or 'support-plan') will need to be cross-referenced to safeguarding issues and where an issue has been identified this will include a risk assessment in relation to the person's safety and any risk they may pose to others;

methods for addressing identified risks will be clearly documented and where appropriate joint risk assessment processes such as care

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management/care co-ordination, the [care programme approach \(CPA - A/CM/085\)](#) the risk enablement panel, the [potentially dangerous persons protocol \(PDP - IA/007\)](#) [multi-agency public protection arrangements \(MAPPA\)](#) or multi agency risk assessment conference ([MARAC- IA/006](#)) will be used;

Incidents in which a service user has been at risk of harm or has been harmed will be reported and monitored and, where appropriate and in accordance with current regulations, a referral will be made via the safeguarding adults procedures and to the commissioning body (organisation purchasing the service) and relevant regulatory bodies; and

In health settings this may also necessitate implementation of the Department of Health's protocol for the investigation of patient safety incidents involving unexpected death or serious untoward harm (essentially a protocol promoting liaison and effective communications between the National Health Service, the Association of Chief Police Officers and the Health & Safety Executive).

Furthermore, each partner organisation will:

Carry out regular reviews of critical incidents not referred to the safeguarding adults procedures and where appropriate undertake a root cause analysis.

Commissioners and regulators will:

Regularly audit reports of risk of harm and require providers to address any issues identified - where there is a series of minor incidents a root cause analysis may need to be carried out.

In both cases, where necessary, subsequent recourse to the safeguarding route will be taken.

Additionally:

Commissioners will actively liaise with the Safeguarding Adults Board and regulatory bodies, and make regular assessments of the ability of service providers to effectively safeguard users – they will use these assessments as a key factor in their decision making.

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1.8 Training

The Safeguarding Adults Board has agreed: -

To ensure that this safeguarding adults policy and accompanying procedural guidance are available to, and understood by, the widest possible audience.

The Board will therefore: -

Oversee a training sub-group tasked with addressing all multi-agency safeguarding adults related workforce development and training issues.

Build and oversee the implementation of a safeguarding adults workforce development strategy that is jointly and appropriately resourced.

Work towards ensuring that staff and volunteers within each of the statutory partner agencies along with the wider social care and health community, meet jointly agreed safeguarding competency requirements - based on national occupational standards - appropriate to their individual roles.

Ensure that multi-agency training meets relevant national occupational standards for each of the target groups (e.g. National Qualifications Framework/Learning Disabilities Awards Framework, Post Qualifying Social Work Award, NHS Knowledge and Skills Framework).

And

Work towards developing training/education that is tailored specifically for and accessible to service users and carers, to enable them - as far as possible - to understand and manage risk, to protect themselves from harm, and to know who they can speak with to report abuse or neglect.

1.9 Access and Involvement

This inter-agency policy and procedural framework has been drawn-up in consultation with representatives from each of the stakeholder groups highlighted in Section 1 at 1.2.2. The Safeguarding Adults Board commits itself to continuing to work in this way. Annual reviews of the safeguarding work carried out by the partnership agencies, and of this document, will therefore be carried out inclusively, and comments will be invited from all stakeholders.

Any necessary updates to the policy, procedures and supplementary good practice guidance will be made available to the partner agencies.

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Stakeholders, including service users, carers and the public, may forward their views about the policy and procedures by writing, telephoning or e-mailing Adults Wellbeing and Health's Safeguarding Adults and Practice Development Manager.

Telephone no.: (0191) 3835182

E-mail: lee.alexander@durham.gov.uk

Address: Adults Wellbeing and Health
Durham County Council
Priory House
Pity Me
Durham
DH1 5RR

Copies of this document can be made available in a range of accessible formats including large-print, audio-tape, Braille and other languages too. Requests should be directed to the Safeguarding Adults and Practice Development Team at the above address or telephone number.

1.10 Quality and Development

The Safeguarding Adults Board has agreed: -

To carry out an annual review of the safeguarding adults policy and procedural guidance, and in so doing make improvements based on consultation with those who use the documents.

To ensure that the work of the Safeguarding Adults Board is carried out with due regard to the evolving legislative and best practice guidance framework that underpins safeguarding activity, and also that it meets the objectives of 'No Secrets' (DH 2000) and 'Safeguarding Adults: a National Framework of Standards for Good Practice and Outcomes in Adult Protection Work' (ADASS 2005). Nationally published recommendations made by the Commission for Social Care Inspection in its report, 'Raising Voices – Views on Safeguarding Adults' (2008) will also be taken into account.

And

To adopt in its work the principles of 'Best Value' and a commitment to continuous development.

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1.11 Complaints

If anyone has any reason to believe that concerns about safeguarding adults issues have not been properly addressed by Adults Wellbeing and Health, they may make a formal complaint by contacting the department's Complaints Officer or any Adults Wellbeing and Health Manager.

If those concerns relate to the way safeguarding issues have been handled by one of the Health Trusts, the Care Quality Commission or the Police, then contact should be made directly with the relevant organisation.

Concerns relating to the management of safeguarding matters by the independent and voluntary sectors should in the case of regulated services be forwarded to the CQC. Concerns about non-regulated services should be directed to Social Care Direct.

The Adults Wellbeing and Health Complaints Officer can be contacted at:

Telephone no: 01388 527956

E-mail: janet.beyleveld@durham.gov.uk

Address: Adults Wellbeing and Health
Durham County Council
Quality Standards Team
County Hall
Durham
DH1 5UG

SECTION 2 ROLES AND RESPONSIBILITIES

2.1 Roles and responsibilities

This policy and procedural framework highlights the importance of the adoption of a preventative strategy by each of the partner organisations. It is expected therefore that every statutory body, every commissioned service and every agency signing-up to this policy will be careful to include the aim of preventing abuse and neglect as key to any future service modernisation and development.

Should this preventative action fail, the various partner agencies/organisations each have defined responsibilities in law to respond to suspected and alleged abuse. These are described in more detail at part eight of this document, where individual agencies other than Adults Wellbeing and Health should insert their own procedural guidance.

The responsibilities of Adults Wellbeing and Health, along with the specific key roles of its employees are set out below.

The roles of the Police, the Crown Prosecution Service and the Care Quality Commission, who have specific responsibilities or duties, and powers, are also included here.

N.B. Each partner agency - including Adults Wellbeing and Health - will need to nominate a person(s) or designated professional post(s) within their own hierarchical structure to whom service users, the public, employees, trainers, assessors, students on placement and volunteers may report alerts. The person/post holder who takes on this role will need to be in a position of seniority within his or her organisation and through regularly updated training keep a current knowledge of good practice in safeguarding matters.

2.2 Adults Wellbeing and Health

DCC's Adults Wellbeing and Health function has a 'duty of care' to enable people who are or may be eligible for community care services to access appropriate support where needed, to live a life that is free from abuse and neglect. This may mean carrying out an assessment of the risks faced by an adult, and where these exist at a critical or substantial level (see the Council's 'Fair Access to Care' criteria - [Fair Access To Care Services – A/110](#) and [Fair Access to Care Services Eligibility Framework – A/111](#)), developing a 'safeguarding plan'.

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Furthermore, employed staff, students on placement and volunteer workers each have an individual responsibility to protect people from immediate and continuing harm by making known their concerns about suspected abuse, or risk of abuse or neglect, so that proper consideration can be given to whether or not further action is needed. If any individual fails to make known his or her concerns, then this constitutes a failure in their duty of care. This could be considered as negligent practice, which may in some cases lead to disciplinary action being taken by the Local Authority.

All staff, students and volunteers have a responsibility to apply these procedures where the possibility of abuse cannot be ruled out. Furthermore, initial rejections of help by an adult at risk should not always be taken as final. Provision of a safe place or other suitable options should be considered to allow the person the space and time to feel more comfortable about making a free choice about how to proceed.

2.3 Key Individual and Team Roles

2.3.1 Alerter

Anyone can be an alerter. An alerter can be any person in contact with, or who has knowledge of an adult about whose safety they have concerns, or who they believe to be at risk of abuse or neglect.

It is the alerter's responsibility to pass on his or her concerns to the appropriate safeguarding partnership organisation.

Service users, carers and members of the public who witness or suspect that abuse is or may be happening are encouraged to contact Social Care Direct to alert the safeguarding partners in order that an appropriate response may be made. If a Social Worker or other lead practitioner already works with the adult, then an alert may also be made directly to that person.

Employees (including Adults Wellbeing and Health professionals), visiting trainers and assessors, students on placement and volunteer workers should follow their agency's 'speaking out' or safeguarding procedures to report their concerns to an identified senior worker or Manager. They may alternatively contact Social Care Direct, the Police or in the case of a registered service the CQC if they have reason to believe that the identified worker, Manager or service provider is implicated.

Where an adult at risk is in immediate danger, then the alerter – without putting him or herself at risk - should also take steps to ensure the person's safety and seek medical help.

2.3.2 Designated post holders to whom alerts or concerns may be reported

Each partner agency and service provision - including Adults Wellbeing and Health and its directly provided services (County Durham Care and Support) - should have a nominated person(s) or designated professional post(s) to whom service users, the public, employees, students and volunteers may report alerts. The designated person will usually be a Manager.

On receipt of information about suspected or alleged abuse, the designated person or postholder is responsible for following his or her individual agency's guidelines to determine whether or not to refer the case to Social Care Direct as a safeguarding matter. He or she in consultation with the service provider should also consider the application of the agency's disciplinary procedures, for the protection of service users and implicated staff.

Where there is any doubt about whether to proceed to referral, the designated person should seek advice from a safeguarding worker from the Adults Wellbeing and Health, Safeguarding and Practice Development Team or alternatively Social Care Direct, who will consult a senior Adults Wellbeing and Health Manager.

Referrals must be made to Social Care Direct, or in the case of a registered service, the CQC, and in the case of a registered service; the CQC should also be notified. They will then liaise with Adults Wellbeing and Health

2.4 Social Care Direct

Social Care Direct is a single access point for safeguarding referrals. Social Care Direct will accept referrals from any member of the public and from any organisation.

Social Care Direct will log the alert onto the Social Services Information Database (SSID). They will pass on a safeguarding referral to the relevant Adults Wellbeing and Health (AW&H) Manager for the geographical area in which the adult resides, or alternatively the specialist team best equipped to make a safeguarding decision.

There will be occasions where service users already known to AW&H locality/specialist teams become the subject of alleged safeguarding adults concerns, and those alerts are made directly to the teams. Once alert details have been taken by a team member, they should either be faxed or e-mailed (not telephoned) to Social Care Direct, who will enter

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the information onto SSID. Alerters - whether professional or members of the public - should not be expected to make the same alert twice.

However, where alerters contact any team other than Social Care Direct as a first point of contact, with alleged safeguarding concerns that have not already been shared with an AW&H professional, then calls should be transferred back to Social Care Direct who will proceed in the usual way.

2.5 Adults Wellbeing and Health Manager

An appropriate Adults Wellbeing and Health Manager (sometimes employed by one of the Primary Care Trusts or ADDACTION, with line management responsibility for a multi-disciplinary team) will receive safeguarding referrals from Social Care Direct, or sometimes from Social Workers or lead practitioners already working with an adult at risk.

The Manager will log the receipt of the referral onto the SSID (if not already done by a Social Worker or other lead practitioner) and consider its contents. Where the possibility of abuse cannot be ruled out, he or she will determine the level of urgency for action and instigate a strategy discussion involving all of the necessary agencies. Contact will be made with the Police where appropriate and additionally in the event of a death, the Coroner's Office.

The Adults Wellbeing and Health Manager at this stage must also consider contact with the other multi-agency risk management partners (Multi-Agency Public Protection Arrangements (MAPPA)/Multi-Agency Risk Assessment Conference (MARAC)/Potentially Dangerous Persons Protocol (PDP). There are two reasons for this: to check whether the adult(s) at risk, the alleged perpetrator(s) or setting are known, and to share information about the alleged perpetrator(s) if it is believed they continue to pose significant risk.

It is the Manager's responsibility to take immediate steps to ensure that the adult is kept safe while initial enquiries are made, and keep a robust record of all discussions, risk assessments, decisions and actions.

The strategy discussion will identify a Lead Officer who will take responsibility for chairing the strategy if it is held as a meeting, and subsequently for co-ordinating any investigative action.

N.B. Outside of the safeguarding process and within his or her normal supervisory duties, the Adults Wellbeing and Health Manager will also ensure through supervision and appraisal that all staff participate in safeguarding training at a level appropriate to their grade and role.

And

Where a member of the Manager's team is implicated in the allegation, then he or she with advice from a senior Manager or Personnel Officer must take steps to implement the Council's disciplinary procedures and temporarily remove the worker from the situation whilst safeguarding investigative work takes place. This is to protect the interests of all parties.

2.6 Lead Officer

The Lead Officer may or may not be an employee of Adults Wellbeing and Health, but will hold an appropriately senior post within his or her organisation (see above). For Adults Wellbeing and Health employees this means at Manager Level or equivalent.

The Lead Officer will take responsibility for chairing strategy discussions where these take place as a meeting, and ensuring that everyone participating understands and agrees to uphold the department's policy on confidentiality and information sharing. If the decision making Manager has not already done so, then the Lead Officer must consider contact with the multi-agency risk management partners (MAPPA/MARAC/PDP).

Unless circumstances dictate that the Police or the CQC should lead the investigative process, the Lead Officer will also be responsible for co-ordinating any enquiries into the suspected or alleged abuse or neglect, and ensuring that information is shared in accordance with this guidance and recorded using the appropriate database. This will involve requesting any necessary legal advice and the support of suitable link workers for adults placed by other Local Authorities or Health Trusts.

At the conclusion of safeguarding intervention where referrals to the Independent Safeguarding Authority are necessary, it is the responsibility of the Lead Officer to check that these are made by the appropriate employing agency. If the employer is reluctant to make the referral, then in the case of a registered service this should be reported to the CQC who will take follow-up action. The Lead Officer will also need to continue to liaise with the employer to ascertain what decision was reached by the Department of Health/Department for Education and Skills about the referral. The outcome of all enquiries and contacts must be recorded on the safeguarding file.

The Lead Officer will collate all records made by the safeguarding and investigative team.

Additionally, throughout the course of the safeguarding process the Lead Officer will ensure the continuing suitability of any interim

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arrangements made by the Adults Wellbeing and Health Manager to protect the adult(s) at risk from further harm.

Lead Officers will need to be separately identified within each individual organisation's procedural guidance.

2.7 The Investigative Team

The investigative team will comprise a multi-disciplinary group of professionals brought together by the Lead Officer by means of a strategy discussion. This group may include representatives from Adults Wellbeing and Health, the Police, one or more of the Health Trusts, the CQC and the service provider where involved and deemed 'fit'.

The investigative team collectively will agree the process for investigation, and other action necessary to address the suspected or alleged abuse.

The team will plan the investigative or other enquiry-making processes and identify the roles and responsibilities of those involved. They will consider as part of that planning the wider issues of communication, language, culture, religion and gender and ensure that any special needs are appropriately met.

Upon completion of its enquiries, the investigative team will make recommendations for action to resolve the difficulties identified.

The team will ensure that a complete set of records is kept throughout its investigation and will be responsible for producing a comprehensive final report.

2.8 Assessing Officer

If at the point of referral to Social Care Direct the adult at risk does not already have a Social Worker or other lead practitioner, then one must be allocated by the appropriate Manager as a matter of urgency. He or she will from that point take on the role of 'Assessing Officer'.

The Assessing Officer may be a Social Worker, a Care Manager/ Co-ordinator or another qualified professional, e.g. a District Nurse (from the placing Authority where the adult originates from another County*) who as part of a multi-disciplinary integrated or specialist team is normally responsible for implementing the assessment process via Self Directed Support or Single Assessment or care co-ordination process (where service users have complex mental health needs or a complex learning disability).

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He or she will be responsible for carrying out an assessment of the presenting level of risk threatening the person's independence. This may involve the arrangement of suitable advocacy support. The Assessing Officer will record the outcome of the assessment using the appropriate electronic format, and share this with the Manager and in turn the Lead Officer and investigative team. He or she may also be involved in drawing-up a safeguarding plan with the adult.

Assessing Officers may additionally be required to participate in the investigative process, as long as this does not conflict with the best interests of the adult at risk.

*For more information about the role of host Authorities, see the section on 'Cross-boundary investigations' at section 10.11.

2.9 Safeguarding Adults Practice Officers

Safeguarding Practice Officers take the lead on improving practices and driving up standards in care settings. There are four main strands to their role: -

To work proactively and provide specialist advice and input into Adults Wellbeing and Health's commissioning/contracts monitoring and quality assurance processes.

To provide advice and guidance to care services on matters of good practice in relation to safeguarding and the promotion of the Government's 'Dignity in Care' agenda.

And

To work reactively to support the safeguarding adults executive strategy meeting and multi-agency investigative processes.

To work with Adults Wellbeing and Health commissioning/contracts teams and the CQC to develop remedial service action plans and monitor compliance with the same. Failure to comply may result in decommissioning; Safeguarding Adults Practice Officers will additionally be involved in this process.

2.10 Executive Officers

In some situations, for example where an adult has died as a result of suspected or alleged abuse or neglect, or where multiple, organised or institutional abuse is alleged, it may be necessary for the Adults Wellbeing and Health Manager to instigate an 'executive planning meeting'. Where this is necessary, a number of other significant professionals or Executive Officers operating at the most senior levels

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within their organisations will be involved in the safeguarding process. An Executive Officer will normally be appointed as 'Executive Lead Officer' in such cases.

N.B. Each partner organisation will need to carefully consider at what level of seniority within their own agency these individual roles should be allocated. Identified key players will need to have the full support of their line-manager, have received relevant training, and have the necessary knowledge and skills to properly fulfil their responsibilities according to the safeguarding adults policy and procedural guidance.

2.11 The Health and Safety and Staff Care Team

The Health and Safety and Staff Care Team are involved in predominantly three strands of work. These are: -

Health and Safety

Ensuring that Adults Wellbeing and Health Managers and staff implement the Council's health and safety policy and procedures – this includes provision of health and safety training, carrying out specific risk assessments where Managers lack the necessary expertise, and taking a lead role in the inspection, monitoring and auditing of workplace activities.

Undertaking independent onsite investigations into accidents/incidents and offering advice to Managers on any subsequent preventative measures. This would also include referral to the Health and Safety Executive of reportable incidents (including some safeguarding adults incidents).

Disability

Providing advice and support to disabled Adults Wellbeing and Health employees, their Managers and the service as a whole.

Identification and resolution of disability discrimination issues with regard to Adults Wellbeing and Health.

Staff Care

Optimisation of attendance at work by Adults Wellbeing and Health employees, including the development of policies and practices around issues of staff welfare.

Ensuring that Adults Wellbeing and Health employees are aware of ways in which they can gain access to counselling and support services where

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needed (this may be required following involvement in particularly complex and upsetting safeguarding work).

The team will work proactively with Adults Wellbeing and Health to identify safe working practices and promote staff welfare in order to reduce the likelihood of harm to service users and staff, and reactively in response to reports of accidents/incidents involving service users and staff.

2.12 The Financial Protection Team

The Financial Protection Team deals with state benefits on behalf of those service users who have been assessed as 'mentally incapable' of dealing with their own finances, and who have no friends or family who are suitable to take on this role. Most commonly the team will make an application to the Department for Works and Pensions for 'Corporate Appointeeship'. Where this arrangement is in place, the team will pay a service user's bills and ensure they have sufficient money to meet their day-to-day needs.

In cases where the person who lacks capacity has other savings or assets, or is additionally in receipt of an occupational pension, the Finance Services Manager may be appointed by the Court of Protection to act legally on their behalf in respect of managing their finances and property. This arrangement is known as 'Financial Deputyship'; the team will deal with day-to-day financial management issues for the service user and is required to act in his or her best interests at all times.

The team also takes the lead role where 'Protection of Property' is required, for example where a service user is admitted to hospital or residential care for a period exceeding two weeks and has no suitable representatives to look after keys and visit the property to check for valuables that need to be removed for safekeeping.

2.13 Additional Contributors

It may on many occasions be necessary for the Adults Wellbeing and Health Manager or Lead Officer to call on the skills and expertise of others. For example, the Mental Health Act 2005 introduced the role of an 'Independent Mental Capacity Advocate'. The involvement of advocacy support generally may also be necessary, along with input from specialist interpreters and in some cases victim support services.

In cases of fatal, organised or institutional abuse, the input of legal advisors and the Council's Media Management Team may also be invited by the Executive Lead Officer or Lead Officer.

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2.14 The Police

In some instances abuse may involve the commission of a criminal offence; and adults at risk are entitled to the same protection by law that is enjoyed by all other citizens. Alleged criminal offences differ from all other non-criminal forms of abuse in that the responsibility for initiating investigative action lies with the Police. Decisions regarding prosecution are the responsibility of the Crown Prosecution Service. Therefore, whenever alerts about alleged abuse suggest that a criminal offence may have been committed, it is essential that the Police are contacted as a matter of urgency. Criminal investigation by the Police takes priority over all other lines of enquiry, although the safety of victims must also be ensured.

As a general rule, consideration should be given in all cases to inviting the Police to take part in strategy discussions and follow-up meetings where the possibility of abuse cannot be ruled out. The Police must be invited to all executive planning meetings (executive level strategy meetings called in response to allegations of serious, multiple or institutional abuse).

Their focus: -

The Police have a general responsibility for the protection of life and limb. The prevention and detection of crime and the involvement of the Police in cases of adult protection stem from this responsibility.

The Police focus is to determine whether a criminal offence has been committed, to identify the offender(s) and to secure the best possible evidence for criminal proceedings.

All Police Officers are required to adhere to these inter-agency safeguarding adults procedures when investigating offences perpetrated against adults, or where it is believed an adult may be at risk of significant harm. Additionally, all investigations must be conducted in accordance with the requirements of current legislation and guidance approved by the Association of Chief Police Officers (ACPO) and Durham Constabulary's own policies and procedures.

Involving the Police

Safeguarding adults referrals must be reported to the Police Vulnerability Unit at the earliest opportunity and out of hours such incidents should be reported to the Children's Services Emergency Duty Team.

Important considerations are the wishes and best interests of

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the victim. Where a victim expresses an informed decision not to proceed or refuses to provide a statement or co-operate with a Police investigation, then it is unlikely (but not impossible) that a prosecution will ensue. Public interest considerations may on occasions override the victim's wishes.

It must be remembered however that in criminal cases the burden of proof lies with the prosecution and is beyond 'all reasonable doubt'.

Safeguarding professionals and Police Officers responding to an initial report of an incident alleging a criminal offence perpetrated against an adult at risk (vulnerable adult) must therefore ensure the preservation of forensic and other evidence and the following should be considered:

What evidence is available to substantiate the allegation;

The best interests of the victim;

The wishes of the victim, or the victim's family when the victim cannot make an informed decision (as long as this does not present a conflict of interests); and

The seriousness of the incident or allegations and the implications for the victim.

Throughout the investigative process, the Police may also act in an advisory capacity; update the Lead Officer of any relevant information in order that the partnership can focus on the safety, protection and support of the adult and any others who may be at risk. In such circumstances it is of paramount importance that discussions take place with the investigating Police Officers to ensure that nothing is being actioned or undertaken with the alleged victim that could compromise or undermine a criminal investigation.

A nominated member of staff represents the Police on the Durham Multi-Agency Safeguarding Adults Board.

2.15 The Crown Prosecution Service

When the Police have gathered all available evidence, unless the crime is of a minor nature and the offender admits to it, the case will be referred to the Crown Prosecution Service (CPS) for pre-charge advice.

The CPS will review the matter within agreed timescales in accordance with the Code for Crown Prosecutors and the CPS policy and guidance on prosecuting domestic abuse. They will also take into account any local protocols to which the CPS has signified its agreement. Advice will

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be issued to the Police for them to take further action if this is deemed appropriate.

If a prosecution is started, but in the course of a continuing review a decision is taken not to go ahead, the Crown Prosecutor who makes the decision will usually write to the victim to explain the reason for discontinuance. In cases of violence or sexual abuse where discontinuance is being considered, a second opinion will be normally sought from another experienced prosecutor before any action is taken.

2.16 Intermediaries

Section 29 of the Youth Justice and Criminal Evidence Act 1999 provides for the examination of a vulnerable witness to be conducted by an Intermediary approved by the Courts. An Intermediary is someone approved by the Court - with the necessary experience and skills - who will communicate to the witness any questions, asked by the Court, the defence and the prosecution teams, and relay back his or her answers. An Intermediary may also provide communication assistance at the investigation stage, however they are not investigators, and their role is not the same as that of the Appropriate Adults, Witness Supporter or Expert Witnesses. In some cases an Intermediary will be the difference between a witness being able to testify or not.

2.17 The Care Quality Commission (CQC)

A nominated member of staff will represent the Care Quality Commission (CQC) on the Durham Multi-Agency Safeguarding Adults Board. That person's membership will be in an advisory capacity, rather than as a decision maker.

Occasions where the Commission may be involved: -

The Commission will be involved in safeguarding adults activity where there is concern that an adult who uses a regulated service is or may be suffering from abuse (as defined by 'No Secrets' guidance).

In relation to regulated services – residential care and nursing homes, domiciliary care agencies and nurses' agencies – alerts are most commonly identified by Regulation Inspectors either during office duty or during an inspection or complaint investigation. It is the responsibility of a Regulation Manager to decide whether the alert is a safeguarding matter and to allocate the case to an Inspector.

The Inspector in turn will refer the matter to Social Care Direct and will await notification from the Local Authority as to whether safeguarding adults procedures are to be invoked.

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Where the alert has been made by a third party (a member of the public for instance), he or she will be advised about the referral process and told that they may be contacted by Adults Wellbeing and Health.

Where the alert is made by a registered service provider, then they will be advised to refer to Social Care Direct. If they refuse to do so, then the Commission will make the contact and subsequently decide what to do about the provider's refusal (in relation to fitness).

Wherever possible, the Commission will take part in the strategy discussion, but only in cases where a regulated service is involved. The Regulation Inspector will use his or her knowledge and a current risk assessment of the service to reach a decision as to whether or not to attend. The Commission will expect to receive minutes of any strategy discussion or meeting whether or not an Inspector has been able to participate.

As a general rule, the Commission will only consider attending the strategy discussion if it is suspected that:

There has been a breach of the Care Standards Act or Regulations; and

The Registered Manager or Responsible Individual has failed to take appropriate preventative action, or to respond appropriately to the situation.

Examples of situations where the Commission is likely to attend a strategy discussion include those where:

Urgent or complex regulatory action is indicated; or

The nature of the concern relates to existing enforcement action.

The Commission will share information with the strategy discussion/meeting on a 'need to know' basis, in accordance with its information sharing policy. It will make sure that all information shared is lawful and that its employees adhere to the Commission's relevant code of practice.

The Commission expect the Local Authority's Manager or Lead Officer to share with the Commission any information it is believed they should possess, whether or not an Inspector participates in the strategy discussion.

The Commission does not expect that a decision committing the regulatory body to any action will be taken at a strategy discussion without prior agreement.

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A Regulation Inspector from the Commission could appropriately take the Lead Officer role where the concerns relate to the fitness of a Registered Manager or Responsible Individual, or a breach of the Care Standards Act or Regulations is suspected.

Circumstances where this might be considered include:

Allegations about a registered person;

A service which has a high risk rating; and

A service where enforcement action has already been started and the referral is about a related matter.

However, as each situation is different, the Commission's involvement will need to be discussed and decided upon a case-by-case basis.

Investigations of possible breaches of care standards/fitness of registered individuals: -

Where the Commission is the main investigating organisation, evidence of a possible breach of the Care Standards Act or Regulations can only be gathered by its Inspectors, not by representatives of any other agency. Interviews of Proprietors and managerial or care staff cannot therefore be undertaken in conjunction with a member of the investigative team who is not employed by the Commission.

The Commission will not necessarily produce written reports for multi-agency safeguarding meetings/conferences. However, the Commission does expect to receive minutes of any safeguarding meetings/conferences and copies of any agreed action plans that relate to regulated services.

A representative from the Commission will co-operate with these procedures to review any agreed safeguarding plans, usually within a period of six months.

2.18 The Health and Safety Executive

The Health and Safety Executive (HSE) and Local Authorities are responsible under Section 18 of the Health and Safety at Work Act etc. 1974, for making adequate arrangements for the enforcement of health and safety legislation with a view to securing the health, safety and welfare of workers and protecting others, principally the public.

2.19 Investigative Responsibilities

The Police will conduct an investigation where there is an indication of the commission of a serious criminal offence (other than a health and safety offence) and the HSE, the Local Authority or other enforcing authority will investigate health and safety offences. There will usually be a joint investigation, but in the rare occasions where this would not be appropriate, there will still be liaison and co-operation between the investigating parties.

2.20 Prosecution

Health and safety offences are usually prosecuted by the HSE, the Local Authority or other enforcing authority in accordance with current enforcement policy. The Crown Prosecution Service (CPS) may also prosecute health and safety offences, but generally only when prosecuting other serious criminal offences, such as manslaughter, arising out of the same circumstances. The Police will also have an interest in establishing the circumstances surrounding work-related deaths in order to assist the Coroner's inquest.

Incidents that must be referred to the HSE

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995 (RIDDOR) place a legal duty on employers, self-employed people and people in control of premises to report the following to the HSE:

- work-related deaths;
- major injuries;
- over-three-day injuries;
- work related diseases; and
- Dangerous occurrences (near miss accidents).

Reporting timescales	
Without delay	Deaths, major injuries and dangerous occurrences
Out of normal working hours	Fatal accidents at work Accidents where several workers have been seriously injured Accidents resulting in serious injury to a member of the public Accidents and incidents causing major disruption,

	such as evacuation of people, closure of roads, large numbers of people going to hospital etc.
Over 3 days	Some dangerous occurrences, e.g. near misses (where something happens that does not result in an injury, but could have done)

Referrals to the HSE

Referrals to the HSE, instigated by the Local Authority, will be made by the Health and Safety and Staff Care Team.

2.21 The Coroner's Office

Coroners are 'Independent Judicial Officers', and are often Lawyers or Doctors. Each Coroner has to have a deputy, and between them they have to be available all of the time. Coroners are supported by the work of Coroners Officers, who receive reports of death and make enquiries on the Coroner's behalf.

A death should be referred to the Coroner if:

- the cause of death is unknown;
- the deceased was not seen by the certifying Doctor either after the death or within fourteen days before the death;
- the death was violent or unnatural, or where there are suspicious circumstances;
- the death may be due to an accident (wherever it occurred);
- the death may be due to self-neglect or neglect by others;
- the death may be due to an industrial disease or may be related to the deceased's employment;
- the death may be due to an abortion;
- the death occurred during an operation or before recovery from the effects of anaesthesia;
- the death may be a suicide; or
- The death occurred during or shortly after detention in Police or prison custody.

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It is the Coroner's duty to find out the medical cause of a reported death where it is not already known, and to enquire about its cause if it was due to violence or was unnatural. The Coroner may ask a Pathologist to examine the body, and may also hold an inquest. An inquest cannot decide who was to blame; it is an inquiry to find out who has died, and how and where they came by their death, so that the death can be registered.

Sometimes an inquest may show that something needs to be done to prevent a recurrence. The Coroner can draw public attention to this and will inform the necessary bodies, including for example Local Authorities or Government departments.

Deaths related to safeguarding concerns which fall into the categories listed above, must be reported to the Coroner. In most cases the Police or a Doctor will undertake this task.

2.22 The Office of the Public Guardian

The Court of Protection (the Court) and the Office of the Public Guardian (OPG) have powers, duties and responsibilities towards vulnerable adults who lack mental capacity. The Public Guardian, supported by the OPG, supports and promotes decision making for those who lack capacity or want to plan for their future, within the framework of the Mental Capacity Act 2005. The Court is a superior Court of record that makes decisions in relation to the property and affairs and health care and personal welfare of adults who lack capacity.

The OPG uses a more narrowly defined interpretation of vulnerable adults than the one used by 'No Secrets'.

The OPG's Safeguarding Vulnerable Adults Policy covers any person:

- Who has a Deputy appointed by the Court, or
- Is a donor of a registered Enduring Power of Attorney (EPA) or Lasting Power of Attorney (LPA) or
- Is someone for whom the Court authorised a person to carry out a transaction on their behalf under S16 (2) of the Mental Capacity Act 2005 (single orders).

This includes young people aged 16 or over who are defined as adults under the Mental Capacity Act 2005.

Local authorities can refer to the OPG in respect of any concerns relating to anyone who falls within the above definition.

In respect of adults who are eligible for support under County Durham Inter-Agency Safeguarding Adults procedures, the OPG will support the

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investigative process by working in partnership with the local authority; and the police where a crime has been committed.

The OPG is involved in safeguarding vulnerable adults in a number of ways, including:

- Promoting and raising awareness of the services of the OPG and Court of Protection, and legal safeguards for people who lack mental capacity.
- Investigating reported concerns about the actions of a deputy or registered attorney, or someone acting under a single order from the Court of Protection.
- Working in partnership with other agencies to respond to suspicions and allegations of abuse of its clients.

Local authorities can be involved with the OPG in a number of ways, including:

- Seeking information about legal processes that may protect someone who lacks mental capacity, or resolve a situation.
- Requesting a search of the register of attorneys and deputies.
- Discussion and advice about specific cases, seeking help with an investigation, progressing joint investigations or seeking advice about options.
- Reporting concerns and requesting that the OPG carries out an investigation about the actions of a deputy, someone acting under a registered power of attorney, or someone authorised by the court to carry out a transaction on behalf of someone who lacks capacity.

The OPG general enquiry contact details are as follows:

Tel. 0845 330 2900

E-mail: customerservices@publicguardian.gsi.gov.uk

For urgent requests and reporting concerns contact:

Tel. 0207 664 7274

SECTION 3 WHAT IS ABUSE

3.1 Definitions and Categories of Abuse

There is no nationally agreed single definition for the term 'adult abuse'. And the term 'vulnerable adult' especially, has become confused as a result of the multiple definitions used within current Government policy.

Moreover, since the publication of 'No Secrets' in 2000, there have been significant legal and policy changes in the field of adult social and health care. 'Fair Access to Care' (Department of Health 2002) particularly, stresses 'risk to independence and well-being' as the key criteria for determining eligibility for care services, and people are increasingly being supported to access services of their own choosing, rather than have social care professionals and health professionals step in to provide protection.

Social care language and philosophy too have been modernised. As a result, in safeguarding adults work, the concept of the 'vulnerable adult' - always a contentious definition because it located the cause of abuse with the victim rather than placing responsibility with the actions or omissions of others - has been replaced with an assessment determining the level of risk posed by abuse and neglect to the quality of life of the individual concerned.

There are many different acts and omissions that constitute abuse and neglect and these can be perpetrated to varying degrees of severity. For the purposes of implementing these inter-agency procedures, the Durham Safeguarding Adults Board endorses a 'zero tolerance' approach. Abuse is abuse however experienced - even if not always intended as such - therefore all alerts will be taken seriously and dealt with in the manner most appropriate to the individual circumstances.

3.2 Definition of Common Terminology

3.2.1 'Adult at risk' (formerly referred to as a 'vulnerable adult')

An 'adult at risk', is someone **aged eighteen or over, who is or may be eligible for community care services and whose independence and well-being would be at risk if they did not receive appropriate health and social care support.**

This definition also specifically includes those people whose need in relation to safeguarding is for access to mainstream services such as the Police.

The person may have a physical impairment, a sensory loss, or a learning disability - perhaps present from birth or due to advancing age, chronic illness or injury. They might self-harm, be dependent upon or misuse substances such as alcohol or drugs, or experience physical or mental ill-health.

An adult at risk isn't necessarily a service user either. He or she might also be a carer: a family member or friend who provides personal assistance and care to another adult on an unpaid basis.

The adult at risk for the purposes of applying this policy and procedure in individual cases will however need to be either a permanent or temporary resident of Durham County.

3.2.2 Adult 'abuse' and 'neglect'

Abuse – "the misuse of power by one person over another – has a large impact on a person's independence. Neglect can prevent a person who is dependent on others for their basic needs exercising choice and control over the fundamental aspects of their life and can cause humiliation and loss of dignity." (*'Safeguarding Adults', ADASS 2005*)

- Abuse is a violation of an individual's human and civil rights.
- Abuse may consist of a single act or repeated acts.
- It may be physical, verbal or psychological.
- It may be an act of neglect or an omission to act.
- It may occur when a person is persuaded to enter into a financial or sexual transaction to which he or she does not consent or cannot consent.
- Abuse may be deliberate, or unintentional.

And

- Abuse may cause harm temporarily over a period of time.

3.2.3 'Perpetrator of abuse'

Anyone can be a perpetrator of abuse. Abuse can occur in any relationship, especially where there is an expectation of trust and the abuser is well known to the person being abused.

Abuse can occur in situations where there is an imbalance of power or control and the abuser misuses that power either intentionally or unintentionally, or for their own benefit or gain.

An individual, a group, or an organisation may perpetrate abuse. An abuser may be a relative, a friend or neighbour, a paid or voluntary care worker or other health care or social care professional, a non-carer or a stranger.

3.2.4 'Safeguarding'

In recognition of the changing legislative context as referred to above, previous references to 'the protection of vulnerable adults' and to 'adult protection' work, are now replaced by the new term '**Safeguarding Adults**'. This phrase means all the work which enables an adult who is or may be eligible for community care services to retain independence, well-being and choice, and to access their human right to live a life that is free from abuse and neglect.

3.3 Types of abuse and how to recognise them

Abuse of a person often includes behaviour that is abusive in one or more of the categories described below. Many or all of these types of abuse may be perpetrated as the result of deliberate intent, negligence or ignorance.

There are general indicators, or signs and symptoms that if present separately or in combination, may suggest the possibility of some kind of abuse or neglect. These are outlined below. More specific indicators linked to the different types of abuse are described under each heading.

None of these indicators are conclusive to an act of abuse having taken place, but members of the partnership should be alert to the possibility.

General signs that abuse may have taken place, or may still be ongoing include:

- difficulty experienced by practitioners in gaining access to the adult on their own, or the adult gaining opportunities to contact them;
- the adult not getting access to medical care or appointments with other agencies;
- isolation of the adult;
- regular transferring of the adult's case from one agency to another, or 'agency hopping';

- repeated visits by the adult to a General Practitioner (GP) or Accident & Emergency department for no obvious reason, or where there is no apparent change in health or medical circumstances;
- reluctance by the adult or his supporters to seek GP or medical help;
- refusal by the adult to accept support from a previously trusted carer/care worker; and
- Where one or more agencies – e.g. Police or welfare, raise concerns.

3.3.1 Psychological abuse

There is a psychological element to all forms of abuse, whether sexual, financial, physical, institutional, familial or professional. The adult at risk may be left feeling very insecure, hopeless, fearful, low in self-respect or rejected. Inevitably this can be damaging to the person's physical and mental health.

Psychological abuse may include:

- a calm but very destructive attitude toward the adult;
- intimidation, e.g. threats of physical harm, shouting, swearing or name-calling, racist comments, withdrawal of the adult from a valued activity, or deprivation of normal contact;
- humiliation, e.g. name calling, making a person feel ashamed of involuntary behaviour, or making physical appearance or disability a target for ridicule;
- indifference, e.g. denying or failing to recognise the adult's choice, opinion, privacy and dignity, or the intentional or unintentional withholding of information from the adult;
- emotional blackmail, e.g. threats of abandonment by a partner/carer to leave;
- the denial of basic human rights and civil liberties, e.g. negating a person's beliefs or culture through racial abuse;
- denial of the adult's sexuality; and
- The treatment of adults as children.

Signs that psychological abuse may be taking place include:

- low self esteem, depression or tearfulness;

- lack of confidence or anxiety;
- a feeling of worthlessness, and perhaps self-abuse or self-neglect;
- agitation;
- ambivalence or resignation;
- increased levels of confusion, a decreased ability to communicate or urinary or faecal incontinence;
- sleep disturbance;
- the adult feeling or acting as if they are being watched all of the time;
- the adult withdrawing themselves from valued social activities or contacts;
- the adult using language that they wouldn't normally, e.g. communication that sounds like things that the perpetrator might say;
- the adult showing signs of behaviour that is out of character, e.g. overtly promiscuous, sexually overt, anger or verbal outbursts; and
- The adult showing deference or submission to the perpetrator.

3.3.2 Physical abuse

Physical abuse is the physical ill-treatment of an adult, which may or may not cause physical injury.

This may include:

- hitting, punching or slapping;
- pushing or shaking;
- kicking;
- pinching or scratching;
- Improper administration of medications or treatments or denial of prescribed medications/treatments.

Physical abuse can also occur when people are not provided with adequate care and support, causing them unjustifiable physical discomfort. This can include:

- inappropriate use of restraint or sanctions such as forced isolation; and
- The withholding of food, drink or necessary aids to mobility or independence such as walking aids, hearing aids, spectacles or dentures.

Signs that physical abuse may be taking place can include:

- injuries in unusual places, e.g. cheeks, ears, neck, inside of mouth or buttocks;
- injuries that are the shape of objects, e.g. a hand, teeth marks, a cigarette burn or rope burn;
- injuries to head or scalp, e.g. black eyes;
- the presence of several injuries, bruises or scars of a variety of ages (look for fading);
- burns or scalds with clear outlines or that have a uniform depth over a large area like the buttocks for instance;
- unexplained fractures, dislocations or sprains;
- injuries that have not received medical attention;
- marks of physical restraint;
- skin infections;
- dehydration or unexplained weight changes;
- medication being 'lost' or misplaced;
- evidence of over or under use of medication;
- sleep deficit or unexplained fatigue;
- a change in the adult's usual behaviour patterns or physical functioning;

- behaviour that indicates that the adult is afraid of the perpetrator or is avoiding the perpetrator, or is afraid in the presence of certain objects;
- the person flinches at physical contact or asks not to be hurt;
- he or she seems reluctant to undress or uncover parts of the body; and
- A person being taken to many different places to receive medical attention.

3.3.3 Sexual abuse

Sexual abuse includes acts which involve physical contact, and others that do not. It can include an isolated incident of assault, or sexual acts within an ongoing relationship where the adult is unable to give consent, either because of impaired capacity or because the power imbalance in the relationship is too great for the consent to be considered important by the perpetrator.

Abuse usually involves acts performed by the perpetrator on the person being abused, but adults at risk might sometimes be forced or persuaded to do things to themselves, the perpetrator or others.

Contact sexual abuse may include:

- sexual acts to which the adult has not consented or could not consent, or where he or she was pressured into giving consent, e.g. rape, sexual assault, penetration or attempted penetration of vagina, anus or mouth with or by penis, fingers or other objects; and
- Being touched in a sexualised manner on the breasts, genitals, anus or mouth, or masturbation of either or both persons.

Non-contact sexual abuse may include:

- voyeurism, e.g. the adult being forced or coerced to be photographed or video-taped, or made to let other people look at their body;
- being subjected to indecent exposure; and
- Serious sexual teasing, innuendo or harassment.

Any sexual activity involving staff and service users will be regarded as contrary to professional standards and hence abusive.

Signs that sexual abuse may be taking place:

- sexually transmitted diseases, recurrent bouts of cystitis or unexpected pregnancy;
- pain, itching, tears, bruises or bleeding in genital or anal areas;
- bruises on the abdominal area, inner thighs or breasts;
- torn or blood-stained underwear;
- evidence of soreness when the adult is sitting or walking;
- unexplained problems with catheters or going to the toilet;
- 'love bites';
- oral infections;
- behaviour that shows the adult is trying to take control of their body image, e.g. symptoms of eating disorders such as anorexia or bulimia and evidence of self-harm;
- withdrawal;
- the adult using overtly sexualised behaviour or language that is unusual for them;
- disturbed sleep patterns; and
- Any sudden changes in behaviour, particularly incontinence or confusion.

3.3.4 Financial or material abuse

Financial or material abuse involves an individual's funds, resources or possessions being taken or inappropriately used by a third party. There are certain factors that may increase the risk of a person being financially abused: for instance where he or she lacks capacity or numeracy skills; where he or she lives alone and is regarded as 'vulnerable' within the local community; or where there is a dependence on other people with the management of finances.

Service users who choose to manage their own Personal Budgets within Self Directed Support via a Direct Payment may be considered to be at higher risk of financial abuse. Adults, Wellbeing & Health staff use robust risk assessment to minimise and manage such risks. ([A/019 – Guidance on Risk Management](#); [A/123 – Appointing a Suitable Person to](#)

[Act on behalf of a Service User who lacks Mental Capacity.; A/015 Risk Procedure; A/113 – Guidance on Direct Payments\)](#)

Financial or material abuse may include:

- theft, fraud or extortion through threat;
- exploitation, e.g. preventing the adult access to independent legal advice, or exerting pressure to influence the drawing up of a will;
- the misuse or misappropriation of property, possessions or benefits by someone who has been trusted to handle the adult's finances, or who has assumed control of their finances by default; and
- Preventing the adult's access to his or her funds or possessions.

Signs that financial or material abuse may be taking place:

- sudden loss of assets or unexplained withdrawals from a person's bank/savings account;
- unusual or inappropriate financial transactions;
- the disappearance of bank statements, other documents or valuables including jewellery;
- visitors whose visits always coincide with the day the person's benefits are cashed;
- a person's inability to explain what is happening to their income;
- insufficient food in the house or bills not being paid;
- loans being taken out by the adult in circumstances that give cause for concern;
- disparity between the adult's assets and living conditions;
- reluctance on the part of family or friends or the person controlling funds to pay for replacement clothes or furniture;
- the person who is managing the adult's finances being overly concerned with money, or perhaps experiencing some kind of financial difficulty themselves;
- a feeling that the adult is being tolerated in the family home due to the income their benefits generate, and not being included in the activities the rest of the family enjoys; and

- Recent changes in property title deeds, or alteration of wills or signing over of assets.

3.3.5 Neglect and acts of omission

Neglect is the deliberate withholding of, or unintentional failure to provide a necessary level of care and support for an adult to meet his or her identified/assessed needs. Active neglect is a refusal to meet care-giving obligations. Passive neglect on the other hand is a general failure to fulfil those obligations.

Where either type of neglect results in the impairment of, or an avoidable deterioration in physical or mental health, or the impairment of physical, intellectual, emotional, social or behavioural development, this is considered ill-treatment.

An act of omission may also occur when a health or social care professional fails to meet the standards required of them by their professional code of conduct, e.g. standards set out by the Nursing and Midwifery Council (NMC), General Medical Council (GMC) or the General Social Care Council (GSCC).

Significantly, the Mental Capacity Act 2005 introduces a new criminal offence of 'wilful neglect', which if proven in a court of law may result in prosecution.

Neglect and acts of omission may include:

- an adult's medical or physical care needs being ignored to such an extent that their health and well-being is impaired;
- administering too much, too little, or the wrong type of medication;
- a failure to allow the adult access to appropriate health, social care or education services;
- the withholding of the necessities of life, such as adequate nutrition, heating or clothing; and
- A failure to intervene in situations assessed to be dangerous to the adult or others around them, especially when the person lacks capacity to assess risk.

Signs that neglect or acts of omission may be taking place:

- malnutrition and/or dehydration;

- unexplained rapid or continuous weight loss or weight gain;
- poor physical condition, e.g. skin ulcers or excoriation, pressure sores or a pale or sallow complexion;
- hypothermia due to inadequate heating or lack of suitable clothing;
- the adult not having access to necessary aids to mobility or independence, e.g. walking aids, hearing aids, spectacles or dentures;
- the adult being exposed to unacceptable risk;
- the wearing of inadequate or inappropriate clothing;
- evidence of untreated medical problems;
- evidence of personal care support not being given, e.g. poor hygiene, incontinence odour, dirty fingernails, old food residue in-between teeth, broken or missing dentures or stained clothing;
- the adult being left in a soiled or wet bed, or expected to sleep in dirty or soiled bedding;
- callers/visitors being refused access to the person; and
- missed medical appointments and a carer's/care worker's reluctance to involve health and social care professionals in the person's care.

If neglect is due to a carer being overstretched or under-resourced, the carer may seem very tired, anxious or apathetic.

3.3.6 Discriminatory abuse

Discriminatory abuse is motivated by oppressive and prejudicial attitudes towards a person's disability (including physical or sensory impairment, learning difficulty or mental ill-health), their age, race, gender, religion, cultural background, sexual orientation or social situation, or dependence on substances such as drugs or alcohol.

Discriminatory abuse may include:

- psychological abuse, e.g. slurs, harassment, name-calling, bullying or indifference;
- physical abuse or assault;
- sexual abuse;

- financial abuse;
- inequality in access to or standards of statutory service provision such as health or social care or Police or housing services;
- breaches in civil liberties and denial of rights, e.g. the right to vote or to make a complaint; and
- Neglect.

Signs that discriminatory abuse may be taking place:

- an older person being acutely aware of their age or of 'being a burden';
- the same may apply to a person who has a physical or sensory impairment;
- the adult may seem overly concerned about how others perceive their behaviour, skin colour, sexual preference etc.;
- the adult may try to be more like other people and hide their individuality;
- the adult may react angrily when attention is drawn to their individuality;
- the adult's carer may be overly critical or anxious about these issues;
- disparaging remarks may be made; and
- The person may be made to dress differently.

3.3.7 Multiple or institutional abuse

Multiple or institutional abuse includes the practice of an abusive regime or culture which denies an adult or group of adults the care, support, dignity and respect to which every human has a right.

Institutional abuse may occur when an individual's needs and choices are ignored or trivialised in order to make an institution or organisation easier to manage and run and/or to save the organisation's resources.

Multiple or institutional abuse may include:

- any one or combination of the forms of abuse described above, especially neglect or omission;

- the involvement of more than one abuser, and sometimes a number of adults will experience the abuse, e.g. hate crime against particular groups, or several family members mistreating an adult who is dependent upon them in some way;
- professional and non-professional staff including Managers and volunteers misusing their position of power over the adults in their care;
- inappropriate use of medications to manage an adult's behaviour; and
- Bad practice in services not being reported and going unchecked and unchallenged.

Multiple or institutional abuse may not come to light until years after the event. Signs that this type of abuse may be taking place are:

- arbitrary decision making by the agency/organisation or service;
- in residential homes, strict, regimented or inflexible routines for rising, retiring, mealtimes, going to the toilet and bathing etc.;
- over-medication of people;
- evidence of inappropriate physical interventions taking place;
- the absence of effective care plans and risk assessments;
- a lack of regard for people's dignity and need for privacy;
- denial of individuality and opportunities to make informed choices and take responsible risks;
- lack of stimulation and opportunities for people to engage in social and leisure activities;
- lack of provision to meet specific cultural or spiritual needs;
- lack of personal clothing and possessions; and
- In care settings an unsafe and unhygienic living environment.

3.3.8 Professional abuse

As a result of the serious case review commissioned by Surrey County Council to establish whether any lessons could be learned from the multi-agency safeguarding partners in respect of the Bournemouth case,

a recommendation was made that their procedures should recognise a new category of abuse - professional abuse.

They define this as follows:

'Professional abuse is the misuse of therapeutic power and abuse of trust by professionals, the failure of professionals to act on suspected abuse/crimes, poor care practice or neglect in services, resource shortfalls or service pressures that lead to system failure and culpability as a result of poor management systems/structures.'

3.3.9 Domestic abuse

Domestic abuse is a serious crime, the impact of which cuts across all social, geographical and cultural groups. 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 their victim. It is a crime largely perpetrated in private and with few witnesses; as a consequence it is under reported and under recorded.

The Government's definition of domestic abuse – which has been adopted by the Safeguarding Adults Board – is as follows:

'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults, aged 18 or over, who are or have been intimate partners or family members¹, regardless of gender and sexuality². This includes issues of concern to black and minority ethnic communities such as so called 'honour based violence', female genital mutilation and forced marriage.'

Where victims of domestic abuse are adults at risk, the safeguarding adults procedural framework should still be followed, and professionals from the domestic abuse specialisms – including a representative from the Police and a Senior Community Safety Officer – should be invited to participate at the strategy stage. Additionally, in high-risk situations, a referral to the Multi-agency Risk Assessment Conference (MARAC) should be considered. See also the appendices for the MARAC referral form and risk assessment document.

Signs that domestic abuse may be taking place:

- symptoms of physical and/or sexual abuse;
- the adult feeling guilty and 'to blame' for the abusive situation;

- a child in the family becoming unusually protective of his or her mother, father or siblings, sometimes by intervening to prevent physical assault;
- the adult 'escaping' into substance misuse or dependence; and/or
- The adult expressing homicidal thoughts or actions.

For information on how to refer domestic abuse, see 18.71 Referring Domestic Abuse.

¹ Family members are defined as mother, father, son, daughter, brother, sister and grandparents - whether directly related, in-laws or step family.

² Men, those in same sex relationships and in the transgender community experience domestic abuse too.

3.4 Forced marriage

A forced marriage is one where one or both of the spouses do not, or perhaps in the case of an adult at risk, are not able to consent to the marriage and an element of duress is involved. Duress can include physical, psychological, sexual and emotional pressure. Forced marriage is regarded as a form of domestic abuse for adults, and where children are involved, child abuse. It is not a practice advocated in any religion or as a cultural norm. It is often used as a means to preserve the so called 'family honour' and is not to be confused with an arranged marriage, where the spouses have the choice to accept or reject the arrangement.

Forced marriage happens to both males and females. The majority of victims are females between the ages of 13 and 30 and it can occur in the UK or overseas. The majority of forced marriages reported to date are from victims in South Asian communities, although there have been cases involving families from Africa, parts of Europe including Poland, the Middle East and travelling communities.

The Forced Marriage (Civil Protection) Act 2007 establishes a range of provisions to protect those who have been forced or are facing a forced marriage, and a 'Forced Marriage Protection Order' is to be introduced. The focus of such an order is on the protection of the victim; it might require passports or travel documents to be handed over, stop someone from being taken abroad, prevent the marriage taking place, stop contact with the victim and can allow a change of name. Applications, which will need to be made to the Family Court, can be made by the victim, any person on behalf of the victim with the court's permission, or a relevant third party on behalf of the victim where the court's permission is not required (guidance regarding relevant third parties is

yet to be developed although this category may well include Local Authorities).

Forced marriage cases require a completely different working approach to the usual guiding social work principles, since the victim's family - far from being advocates and protectors - are the perpetrators of abuse and pose the most risk to the adult at risk. The agencies involved in dealing with these cases will need to be fully sensitive to the issues surrounding forced marriage in order to understand the need for confidentiality, which is essential to the safety of the victim.

In the context of safeguarding, adults at risk who are forced into marriage or are facing forced marriage can be referred through the safeguarding procedural framework, but given the paramount importance of confidentiality, the Police must be contacted for advice immediately.

3.5 Honour-based violence

So-called 'honour based violence' (HBV) is a fundamental abuse of human rights. It cuts across all cultures, nationalities, faith groups and communities and transcends national and international boundaries. But HBV is not a *form* of violence; rather, it is a *reason* given for the perpetration of violence. HBV practices are used to control behaviour and exert power within families in order to protect perceived cultural and religious beliefs and/or honour, and to control female autonomy and sexuality. Such violence can occur when perpetrators perceive that an individual has shamed the family and/or community by breaking their 'honour code', and can be derived from issues such as:

- Inappropriate make-up or dress;
- The existence of a boyfriend;
- rejecting forced marriage;
- Pregnancy outside marriage;
- Interfaith relationships;
- leaving a spouse or seeking divorce;
- Kissing or intimacy in a public place; or
- becoming too westernised in the eyes of the family.

Victims are predominantly (although not exclusively) women, and most are killed or injured by their husbands. Fathers, mothers and brothers

too have been responsible for killing or injuring a daughter in the family. A small percentage of victims are male – those deemed to be involved in an inappropriate relationship (homosexual or as partners of the female party), or for showing support for the victim. HBV can additionally be a child protection issue.

Features of this type of crime include relatives colluding or conspiring and aiding and abetting the violence or killing, them planning the act in advance and/or trying to conceal the act to appear as suicide or accident, and an agreement that the victim deserves to die. Incidents of HBV can include murder, un-explained death (suicide), fear of or actual forced marriage, female genital mutilation, controlling sexual activity, domestic abuse, child abuse, rape, kidnapping, false imprisonment, threats to kill, assault, harassment and forced abortion (this list is not exhaustive, indeed, any incident or crime can potentially be HBV motivated - e.g. missing person report).

In the context of safeguarding, adults at risk affected by honour based violence can be referred through the safeguarding procedural framework. However - as with forced marriage - given the paramount importance of confidentiality, the Police must be contacted for advice immediately.

3.6 Equality/hate incidents and crime

Durham County Council's '*Corporate Equality Plan*' describes equality or hate incidents as those which are caused by someone who has a prejudice against a group of people. The plan provides some examples of incidents which should be referred: -

- Any racist incident believed to be racist by the victim or any witnesses. It is unlawful to discriminate on grounds of race, colour, and nationality, and faith, ethnic or national origin. Gypsy and Traveller communities are also covered by race legislation.
- Homophobic incidents motivated by prejudice against lesbian, gay or bisexual people. 'Straight' people may also be victims of incidents related to sexual orientation.
- Incidents aimed at people of a particular faith, asylum seekers or refugees.
- Incidents aimed at disabled people, including people with learning disabilities or mental health needs.
- Incidents in which age may be a factor – particularly for older or younger people.

And

- Gender incidents, including those relating to the trans community (transvestite, transgender or transsexual people).

In the context of safeguarding work, adults at risk who are affected by/are victims of equality or hate incidents and crime should be referred to the safeguarding adults procedures. And, as with other safeguarding concerns that might constitute criminal activity, serious incidents including attack, domestic abuse and threatening behaviour should always be reported to the Police who will take any necessary immediate action and may also choose to participate as partners in the safeguarding process.

3.7 Significant cumulative risk that requires safeguarding intervention, but where recognition is dependent on multi-agency information sharing

Following the serious case review conducted on behalf of Cornwall County Council in response to the death of Steven Hoskins, there is an identified need for safeguarding adults partner agencies to be alert to the fact that some adults may be exposed to serious risk to life and limb, even when there is no apparent evidence of safeguarding adults concerns. Only when agencies begin to share their disparate and seemingly low-risk pieces of information about such adults, does it become clear that a multi-agency safeguarding intervention is required.

Therefore, in order that an appropriate, proportionate, and as far as possible timely response can be made by the multi-agency safeguarding partners, single agencies must contact Adults Wellbeing and Health and share information about adults who:

- have a number of emergency care episodes relating to assault/having taken an excess of drugs and/or alcohol; and/or
- make repeated calls to the Police to any one address or for any one person; and/or
- attract a number of complaints from neighbours, or concern from social landlords in respect of poor tenancy standards; and/or
- Make repeated referrals to Adults Wellbeing and Health with concerns about issues including bullying, unpaid rent, stolen money etc.

Calls must be made to Social Care Direct in accordance with the guidance described in section 7.

SECTION 4 MAKING AN ALERT

4.1 Alert

4.1.1 Making an alert

An alert will be regarded as an appropriate expression of concern about the safety and well-being of an adult at risk. It will always be taken seriously, even where the Alerter remains anonymous.

Whoever you are, if you see something that concerns you and recognise or suspect that abuse is or may be happening you must do the following:

- if the adult at risk is in danger, ensure his or her immediate safety, call 999 and seek medical help if you need to (remember to say that a 'vulnerable adult' (3) is involved); and
- Make sure that any evidence is preserved/protected.

N.B. All employees in all situations should be authorised to call the Police and/or Ambulance Service without referring to a senior Manager in situations where this would cause delay and there is an immediate risk of harm or need for treatment. Not to do so may later be considered as negligent, and staff may be deemed as failing to fulfil their duty of care. It is every adult's human right to expect to receive immediate help.

Then: -

If you are a service user, carer or a member of the public:

- call Social Care Direct on 0845 850 5010 and an Officer will take immediate steps to deal with the situation – outside Social Care Direct's operating hours the Emergency Duty Team will respond in the same way on the same number.

If you are an employee, student on placement or a voluntary worker:

- and you know or suspect that an adult has been abused by a member of the public, a family member or neighbour or another service user, you must report your concerns to the designated person or post holder (usually a Manager) identified within your agency's guidelines; or

2 Emergency services and some other statutory organisations may still use the term 'vulnerable adult'; they may not be familiar with the term 'adult at risk'.

- if you know or suspect that another worker or volunteer has perpetrated abuse against an adult, or has neglected to provide proper care and support which has resulted in the person being harmed, follow your agency's 'speaking out' procedures to alert an appropriate person to the situation – this will usually be the same designated person/post holder referred to above – in both cases he or she will take steps to deal with the situation;
- if however you suspect that the designated person is implicated in the abusive practice, then you can make an alert to Social Care Direct, or in the case of a registered service, to the CQC; and
- You must write down your concerns as soon as it is practicably possible, you may need to refer to your notes later if the alert progresses to a safeguarding investigation.

If you are a Social Worker or other Adults Wellbeing and Health lead practitioner:

- and you receive an alert or are party to a disclosure, then you must e-mail or fax the alert to Social Care Direct to have it logged onto SSID, and immediately report the matter to your Manager – alerters (whether professional or members of the public) should not be expected to make the same alert twice.

The e-mail address for Social Care Direct is:

socialcaredirect@durham.gov.uk

N.B. It is possible for a lead practitioner to be appointed as the Assessing Officer for a safeguarding case.

4.1.2 If you work outside of Adults Wellbeing and Health and your concerns are not taken seriously

If you work for any agency other than Adults Wellbeing and Health and have made an alert or have 'spoken out' (blown the whistle) about suspected or alleged abuse but you believe your concerns have not been properly addressed, then you can call Social Care Direct where your concerns will be taken seriously or you can ask your manager to refer to an Integrated Team Manager for a second opinion.

4.1.3 Disclosures

If someone discloses abuse to you:

- stay calm and try not to show that you are shocked;

- listen carefully rather than question the discloser directly;
- be sympathetic;
- be aware that medical and criminal evidence may need to be preserved, so do not attempt to remove torn or soiled clothing and avoid touching or moving anything in the immediate environment;
- report the disclosure to your line-manager or alternatively if necessary the Police and/or Social Care Direct; and
- Write down what was said and what you saw as soon as you possibly can (see 'recording' overleaf).

Tell the person:

- that talking to you was the right thing to do;
- that you will take their disclosure seriously;
- that what happened wasn't their fault;
- that you have to tell an appropriate Manager and that you cannot keep the information to yourself; and
- If it is considered that the person has capacity, your Manager will seek their consent to make a referral to Social Care Direct and that their decision will be respected unless other adults or children are also at risk, e.g. within a residential or other registered service – this is so that steps can be taken to protect those people too.
If there is any doubt about whether the person has the capacity to make informed decisions in these circumstances arrangements should be made to conduct an appropriate mental capacity test.

Do not:

- put yourself at risk;
- press the person for more details;
- stop the adult from freely recalling significant events - they may not tell anyone again;
- contact the alleged perpetrator(s);
- be judgmental;
- make promises that you cannot keep, e.g. that you won't tell anyone or that you won't let the abuse happen again;

- tell anyone who does not need to know – remember to uphold your agency's confidentiality policy; and
- Do not talk with the alleged perpetrator(s) or pass on any information about the adult at risk, particularly in relation to the person's whereabouts if they have been taken to a place of safety.

4.1.4 Timescales

As a general rule, alerts should be made as soon as abuse or neglect is witnessed or suspected.

Employees/volunteer workers/students will need to make a preliminary risk assessment, and consider the following issues: -

- Is the adult at risk still in, or about to return to the place where the suspected/alleged abuse happened?
- When will the alleged perpetrator(s) next have access to the adult or others who might be at risk?

And

- What degree of harm is likely to be suffered if the alleged perpetrator is able to come into contact with the adult or others again?

This will influence the speed with which alerters make their concerns known. The main objective should always be to act in the adult's 'best interests' and to prevent further harm.

4.1.5 Allegations of historical abuse

Allegations or disclosures relating to abuse or neglect that are said to have occurred more than six months prior to the date of alert should still be reported to Social Care Direct - in the same way as contemporary concerns - so they can be passed on to the relevant Adults Wellbeing and Health Manager.

It will be important for the AW&H Manager to ascertain whether the alleged perpetrator(s) is/are still have contact with the 'adult(s) at risk', and if so, determine how best to proceed. Depending on individual circumstances and the length of time that has elapsed, it may not always be possible to invoke the safeguarding procedures. Even so, alternative interventions may be considered, including assessment and risk management, or referral to other advisory or support services.

4.1.6 Recording

You should aim to:

- write down what you saw if you witnessed the abuse, or what was said if a disclosure was made to you;
- use exact words and phrases wherever possible;
- note the setting and anyone there at the time - describe any significant points about the adult's appearance, demeanour and mood and also about the environment, e.g. whether any furniture appeared to have been disturbed, or if any property was missing or damaged;
- Consideration should be given as to whether a photographic or digital image record of any evidential issues should be made (one must be mindful that when using personal equipment that it is possible that memory cards etc. may be seized by the police as evidence and not returned until a case has been concluded).
- separate out factual information from your opinion;
- use a body map to illustrate any physical injuries, the location of any wounds or bruises and their size and colour etc.;
- write down who you reported your concerns to, e.g. your Manager, Social Care Direct or the CQC and whether you contacted the Police or other emergency services – include the dates and times of your discussions and contacts;
- write down any decisions/actions taken from these discussions/contacts;
- use Ball point pen with dark ink so your notes can be photocopied; and
- Be aware that your notes may be required later as part of a safeguarding investigation, legal action or disciplinary enquiry - always sign and date everything you have written.

N.B.

1. Records should be contemporaneous, i.e. made as soon as possible after the event. Information sometimes needs to be gathered in a stressful situation, yet every effort must still be made to ensure accuracy.

2. It is always advisable to check your notes before they are submitted as evidence.
3. Additionally, when making telephone calls about safeguarding matters, never leave confidential or sensitive information on an answering machine.

4.1.7 Suspected or alleged abuse or neglect in services provided by the Health Trusts

Primary, Acute and Mental Health Care Trusts have their own procedures for dealing with allegations of abuse. These should be compatible with the inter-agency framework and held at partner health settings.

It will be the responsibility of each Trust's designated decision-making post holder to determine whether a safeguarding referral to Social Care Direct is necessary, or whether the allegation should be investigated internally as a clinical incident (Safeguard) or using the Trust's complaints procedures. Nevertheless, even where internal investigations are undertaken, advice and support for the adult at risk may still be requested from any of the other partner agencies. For example a Social Worker or similarly suitable professional may be required to assist with safeguarding or other assessment and planning processes to address post-incident care and support needs.

Implementation of mechanisms for sharing information between the partners - as described in Section 15 - will help to ensure that an independent and objective view is taken of how allegations are progressed and whether they are being appropriately dealt with.

For Health Trust employees: -

If you are employed by, placed as a student with, or work as a volunteer for one of the Trusts, you must immediately report your concerns using your agency's 'speaking out' or safeguarding procedures. If you have reason to believe your concerns have not been taken seriously, you may contact Social Care Direct, the Police, Care Quality Commission or the Health Ombudsman.

For members of the public, including patients: -

If you are a patient or visitor to a hospital or other health setting, you should immediately report your concerns to a senior Manager on duty at the time. You may additionally report your concerns to Social Care Direct, the Patient Advice and Liaison Service (PALS), the Acute Trust, the Local Primary Care Trust or the Commission if you have reason to believe your initial alert was not properly addressed.

4.1.8 False allegations

All allegations of abuse will be taken seriously. However, some people do make false allegations and sometimes on a regular basis.

Where an alerter is known to have made false allegations in the past, then the Lead Officer, the Police and the regulatory bodies will need to be informed.

Where a false allegation has been made by the adult at risk, then the strategy discussion and any subsequent safeguarding assessment and planning work will need to take account of the adult's requirements for ongoing support and possibly counselling to address his or her needs in this respect, and to reduce the likelihood of any further false allegations in the future.

Support for, and the future protection of individuals implicated as alleged perpetrators will also need to be considered.

Where does this fit in?

Alert

- decision making by designated postholders (to refer or not)
- referral to Social Care Direct
- decision making by Adults Wellbeing and Health Team Managers (to strategy or not)
- strategy discussion/meeting (sometimes at Executive Officer level)
- risk management/protection
- safeguarding assessment
- investigation and reporting
- safeguarding care-planning and review
- post-investigation debriefing (sometimes referred to as safeguarding case conference), organisational/remedial planning and safeguarding case review

And

- monitoring

These procedures should be read in conjunction with each partner agency's own organisational guidelines. There is an expectation on the providers of all services commissioned by the statutory safeguarding partners that these will dovetail with the Durham Safeguarding Adults Board inter-agency framework. The suitability of and level of adherence to individual safeguarding procedures will be measured as part of the contracts monitoring process.

It is therefore important to make it clear that wherever a provider service suspects any form of abuse, there is an expectation that the person in charge will ALWAYS raise an alert in line with the steps described in this procedural framework. The alert to Social Care Direct

must be made as quickly as possible to allow for timely decision making/investigation to take place.

At the same time, the provider will need to consider the most appropriate course of action required to protect service users from the potential of further abuse, and to prevent any contamination of evidence which in turn might jeopardise the investigative process.

4.2 Sharing information

The sharing of information in relation to safeguarding adults work across County Durham is governed by the multi-agency information sharing protocol, which should be referred to in the application of these procedures.

The very nature of safeguarding work necessitates the sharing of essential information between partner agencies. The reasons for this are:

- to establish facts;
- to ensure accuracy;
- to assess risk and facilitate protection in the immediate term; and
- To facilitate successful inter-agency preventative strategies in the longer term.

Agencies also need to share information in more general terms:

- to manage, plan and commission services;
- to train staff;
- to set and meet professional standards and performance targets; and
- To inform local and national research initiatives.

In whatever information sharing context, society in general should reasonably expect that partner agencies will act in a way that supports the public. The partnership committee will therefore co-operate in the sharing of information on the basis of the principles outlined below:

- the adult at risk will have access to his or her case files, according to the Adults Wellbeing and Health protocol governed by Data Protection legislation;

- again, in line with the principles of the Data Protection Act 1998, information will be shared as appropriate and when it is the adult's best interests;
- 'best interests' will be determined by proper evaluation of the consequent risks;
- where information is shared, the purpose for sharing will be explained to the adult;
- confidentiality will not be confused with secrecy;
- before information is shared, informed consent will be obtained, however, if this is not possible or where other adults or children are exposed to risk, consent may be overridden;
- it is therefore not ethical or realistic for agencies to guarantee absolute confidentiality where there are concerns about abuse, particularly when other people may be at risk; and
- all exchanges of information will be carried out in accordance with the Data Protection Act 1998, the Human Rights Act 1998, and the guidance of Caldicott Committee Report 2000 (see the appendices).

There will also be in place an information sharing protocol between each of the partner organisations, and those contracted to provide services by them, that covers all aspects of safeguarding adults work. This protocol will include reference to the rights of adults to access data held about them.

The adult at risk's capacity to consent to disclosure of information, or refuse disclosure of information, should always be a primary consideration. If the individual lacks the capacity to consent, then consideration should be given to whether disclosure is necessary in line with Data Protection Act principles. The wishes of the adult at risk will be important, but not determinative in considering whether the information will be disclosed. Confidentiality then is still not absolute, and may be overridden where there is a likelihood that foreseeable harm may result from withholding of information.

Where a decision is taken to share information/not share information, the reasons behind this decision and details of the information shared will be recorded in full.

4.3 Confidentiality and sharing of information

'Speaking out' (previously referred to as whistleblowing)

'Speaking out' is the process by which employed staff or voluntary workers may raise serious concerns about practice in the workplace and have those concerns properly addressed.

This safeguarding policy and procedural framework must be read in conjunction with each partner organisation's own 'speaking out' policy. (See DCC 'Confidential Reporting Code').

Effective speaking out helps:

Ensure staff play their part and feel valued in developing and delivering good practice;

Promote individual and collective accountability within each organisation;

Deter poor practice and abuse;

And therefore minimise the risk of abuse occurring, promoting a timely and positive response in the event that it should take place.

Employed staff, volunteers, trainers, assessors and students on placement are often the first people to see or suspect poor practice or misconduct within an agency or organisation, but are often worried about the possible implications of raising their concerns. A clear and accessible speaking out policy helps workers to share their concerns with the right person at the right time. An open management style and a culture where honesty and trust are valued will also encourage workers to speak up to uphold service users' rights.

Staff teams need to be involved as a matter of course in raising standards within their own agencies. Regular training, supervision and appraisal too, offer workers the chance to reflect on their own professionalism whilst raising an awareness of what constitutes good practice, and how to recognise and act upon poor/inappropriate practice.

But Managers, senior officers and - in the case of service provision – Proprietors can all be guilty of poor practice too, and there may be occasions where it is necessary for staff to raise their concerns through an alternative and sometimes external route. Speaking out procedures should therefore incorporate information about how to contact the statutory safeguarding bodies including the Police, Adults Wellbeing and Health and the Care Quality Commission.

Finally, wherever possible, organisations should also enlist the support of trades unions and professional organisations to back up and promote individual speaking out policies and procedures. A link to further information about the legislation that underpins disclosure of concerns can be found in the appendices.

SECTION 5 MAKING A REFERRAL

5.1 Making a referral

5.1.2 If you are a designated person/post holder who has received an alert.

If you are the designated person or post holder within your agency (usually a Manager) to who alerts of suspected or alleged abuse must be reported, and you have been notified of concerns by a service user, member of the public, colleague, employee, student or volunteer worker, then you will need to:

- review the information you have been given about the alleged abuse and any action taken by the alerter; and
- Gather as much additional information as possible from whichever necessary source to enable you to make a decision about whether or not the reported concerns constitute abuse.
- Where there are concerns regarding pressure damage caused by possible abuse or neglect the skin damage protocol (www.safeguardingdurhamadults.info) should be used to help decide whether a safeguarding referral is required.

You must also remember that:

- In order for an allegation to be addressed through safeguarding procedures, concerns will need to relate to an identified individual(s) or an identifiable service.

Where the possibility of abuse cannot be ruled out you must, within one working day of receiving the alert:

- report this to Social Care Direct on 0845 850 50 10; and then
- Produce a verbal and subsequent written report, which includes precise factual details of the allegation, and where available the source (identity of alerter) to support any decision you make - this may be needed at a later date should safeguarding intervention or wider investigation be necessary. The written report should be sent to Social Care Direct who will forward it to the relevant Team manager.

N.B. If you work for an agency outside of Adults Wellbeing and Health, this action should be taken in conjunction with your agency's own organisational guidance, which in any case should mirror this inter-agency framework.

5.1.3 Suspected crime

If a crime is suspected, no attempts should be made by your service to question the adult at risk or any other witnesses. This will be done as part of a formal Police investigation and/or safeguarding assessment.

Incidents of physical, sexual and financial abuse and neglect may all constitute potential criminal behaviour, and must be treated as such until otherwise determined by the Police/Crown Prosecution Service.

5.1.4 Uncertainty about how to proceed

If you are uncertain whether or not to refer a matter to Social Care Direct, a formal pre-referral consultation process is available from one of the safeguarding workers on the Adults Wellbeing and Health Safeguarding Adults and Practice Development Team, who will assist you in deciding how best to proceed.

Their number is (0191) 3835165

If needed, you must make this contact within one working day of receiving the alert. If it becomes clear during the consultation process that an identifiable adult(s) has/have been abused or exposed to significant risk, then Adults Wellbeing and Health has a duty to respond by implementing its safeguarding procedures.

The information discussed during the course of all pre-referral consultations, along with the outcomes, will be recorded by Adults Wellbeing and Health and if necessary a safeguarding referral, or a referral for social work involvement/assessment will be auctioned.

Staff approaching the Safeguarding Adults and Practice Development Team for advice must themselves also ensure that accurate records are made of the identified concerns and of all consultations made in the course of deciding upon an appropriate course of action. These will need to include the names and designations of the people they have spoken with and the dates and times at which the discussions took place.

5.1.5 Suspension, staff disciplinary procedures and support for implicated staff in the independent and voluntary sectors

If you are the Responsible Individual or Manager for an independent or voluntary sector service about which an allegation has been made, you are advised to use your own internal human resources/suspension/staff disciplinary procedures to protect the interests of the adult(s) at risk and any staff members concerned. If your service is registered then

you should also discuss your actions with the regulatory bodies, including the Care Quality Commission.

5.1.6 Suspension

Suspension is not a disciplinary measure. It is a neutral act and should not be an automatic response. Employers should consult their own organisational procedures for guidance and process.

Suspension should be considered in cases where:

- there is cause to suspect an adult has been harmed, and that person, or others remain at risk if the alleged perpetrator remains at work;
- the allegation warrants investigation by the Police;
- any safeguarding investigation would be impeded by the alleged perpetrator's presence in the workplace; or
- The allegation is so serious that it might constitute gross misconduct, and therefore, grounds for dismissal.

Managers who decide not to use suspension as an immediate protective measure in any of the above circumstances must be confident that they are properly managing any continued potential risk to service users. They must be able to justify their rationale to the multi-agency strategy meeting. It is important to note however, that only employers have the power to suspend implicated staff; they cannot be forced to take this action by any other agency, including the Police.

Managers must keep robust records of their decisions/actions in any event.

5.1.7 Support

As soon as possible after an allegation has been received, the accused worker should be advised to contact his/her Union or professional association. Human Resources should be contacted at the earliest opportunity in order that appropriate support can be provided by the agency's occupational health or employee welfare arrangements. Support should be routinely available to all staff who are the subject of an allegation.

If a suspended employee is to return to work, the employer should arrange whatever helps and support is considered most appropriate to facilitate the process. This could include a phased return, or the allocation of a mentor. Careful thought should also be given to the management of the employee's continued contact with the adult(s) to whom the allegation of abuse related.

5.1.8 Continued involvement of designated post holders/ Registered Managers/Responsible Individuals

Providing the service is not implicated in the allegation, a representative e.g. a Manager - usually the designated post holder who received the alert - or the Responsible Individual (Proprietor) will be involved in the strategy discussion/meeting and investigative processes.

There is an expectation that all Managers and staff providing services to adults at risk will co-operate fully with any safeguarding investigation and will comply with all recommendations identified as part of the adult's post-incident safeguarding care-plan and any additional safeguarding organisational/remedial plan.

5.1.9 Allegations against Adults Wellbeing and Health employees

If you are a Manager within Adults Wellbeing and Health (provider or non-provider) who is notified about an allegation of abuse that implicates an AW&H employee, you should seek advice from an appropriate senior Manager about taking steps to invoke the Council's disciplinary procedures. This may involve the suspension of staff implicated by the allegation.

Alleged behaviours of concern should be considered within the context of the types of abuse described in Section 3. Concerns relating to inappropriate relationships between members of staff and service users are included within this list (see also guidance on special considerations in relation to sexual abuse in the Section 3).

The Manager to whom the concern is first reported must not:

- investigate or ask leading questions if seeking clarification about the allegation;
- make assumptions or offer alternative explanations; or
- Compromise confidentiality protocols.

He or she must:

- treat the matter seriously;
- keep an open mind;
- make a written record of the allegation (see 'recording' at 4.1.6);

- report the matter to a senior Manager, who will consider whether and how to apply human resources/disciplinary procedures in order to best manage any risk; and
- Make a referral for safeguarding adults intervention, applying the principles and timescales set out in this inter-agency procedural framework.

The non-provider Adults Wellbeing and Health Manager to whom the referral is allocated will decide whether the allegation falls within the scope of the safeguarding procedures, and the strategy process will determine the most appropriate way to investigate and deal with the concerns.

Careful records of the methodology, chronology and findings of the safeguarding investigation will need to be kept; including signed and dated witness statements, since these may be required by the senior Manager conducting any parallel disciplinary enquiry.

Note

1. Safeguarding/disciplinary investigations should continue to a conclusion even if the implicated person refuses to co-operate.
2. In the event that an implicated employee resigns or ceases to provide their services (in the case of agency or bank workers) either before or during the safeguarding/disciplinary investigative process, this must not prevent the allegation from being followed-up in accordance with these procedures, or a conclusion being reached. Of course it may not be possible to apply any disciplinary sanctions if the person's period of notice expires before the process is complete.
3. It will however still be possible to make a referral about the person to the Independent Safeguarding Authority and/or to any professional registering body that the person holds membership to. See Section 13 for further information.
4. 'Compromise agreements' (where an employee agrees to resign, the employer agrees not to pursue disciplinary action, and both agree a form of wording to be used in any future reference) should not be used, and in any event will not prevent a thorough Police investigation where one is required.

5.1.10 Action in response to unsubstantiated allegations

Where it is concluded that there is insufficient evidence to substantiate an allegation, Adults Wellbeing and Health senior management team, in conjunction with the Workforce Support Team and with legal advice from the Council's Solicitor if necessary, will need to consider what further action, if any, needs to be taken. If the allegation is unfounded, this outcome should be recorded and made clear to the employee.

5.1.11 Information to be kept on an employee's personnel file

Adults Wellbeing and Health must keep a clear and comprehensive summary of the case record on a person's confidential personnel file and give a copy to the individual.

The record should include details of how the allegation was followed-up and resolved, the decisions reached, and action taken. The record should be kept at least until the person reaches normal retirement age, or for ten years if longer.

The record will serve as an accurate account of the incident for future reference and provide clarification if needed if any future Criminal Record Bureau disclosure reveals an allegation that did not result in prosecution or conviction. Importantly, it will prevent unnecessary reinvestigation should the allegation resurface in future.

5.1.12 learning lessons

At the strategy debrief stage the Lead Officer should review the circumstances of the case to determine whether there are any lessons to be learned, how these will be shared, and if any recommendations need to be made in respect of improving policy, procedural guidance, working systems and team and individual practice.

Lessons learned will need to be shared with the Durham Safeguarding Adults Board.

5.1.13 Allegations against Durham Shared Lives (formerly Adult Placement) Carers

Durham Shared Lives (DSL) schemes operate in a similar way to fostering agencies in recruiting, assessing, approving and supporting individuals and families - known as 'Durham Shared Lives Carers' - who provide a range of services to people who need assistance to live in and take part in their community. Schemes are regulated under the Care

Standards Act 2000; they are subject to regular inspection by the Care Quality Commission and are each allocated a quality rating.

Durham Shared Lives Carers are not employed by Adults Wellbeing and Health; they are approved rather than employed. DSL schemes can also be run by the independent and voluntary sectors. Allegations against Durham Shared Lives Carers (DSLCS) must be referred to Social Care Direct, and dealt with using the safeguarding adults procedural framework.

According to the good practice guidance issued by NAAPS (originally the National Association of Adult Placement Schemes), the safety of the adult in the placement is paramount, appropriate steps should be taken to secure this, and all allegations should be carefully and rigorously investigated. However, the organisation also reminds us that safeguarding processes should not in themselves be abusive, and we should take care that our interventions do not damage good placements beyond repair.

DSL Carers found guilty of misconduct relating to the harm of an adult at risk will have their approval terminated by an independent panel, and their registration with the CQC may be cancelled.

DSL Scheme Managers must make a referral to the ISA whenever an AP carer is reasonably considered to be guilty of misconduct that has harmed an adult at risk, or has placed them at risk of harm.

More information can be found at the NAAPS website:

<http://www.naaps.co.uk>

5.1.14 Allegations against staff employed by the other statutory safeguarding agencies

If you are a Manager within one of the other statutory safeguarding agencies (e.g. one of the Health Trusts or the Police) who is notified about an allegation of abuse that implicates one of your employees, you should seek advice from an appropriate senior Manager about taking steps to invoke your organisation's human resources/disciplinary procedures. This may involve the suspension of staff implicated by the allegation.

Alleged behaviours of concern should be considered within the context of the types of abuse described in Section 3. Concerns relating to inappropriate relationships between members of staff and service users are included within this list (for special considerations in relation to sexual abuse, please see Section 3).

The Manager to whom the concern is first reported must not:

- investigate or ask leading questions if seeking clarification about the allegation;
- make assumptions or offer alternative explanations; or
- Compromise confidentiality protocols.

He or she must:

- treat the matter seriously;
- keep an open mind;
- make a written record of the allegation (see 'recording' at 4.1.6 above);
- report the matter to a senior Manager, who will consider whether and how to apply human resources/staff disciplinary procedures in order to best manage any risk; and
- Make a referral for safeguarding adults intervention, applying the principles and timescales set out in this inter-agency procedural framework.

Careful records of the methodology, chronology and findings of the safeguarding investigation will need to be kept; including signed and dated witness statements, since these may be required by the senior Manager conducting any parallel disciplinary enquiry.

SECTION 6 CAPACITY AND CONSENT

6. Capacity and consent

Knowing whether consent has been given by an adult at risk to what would normally be perceived as an abusive situation is crucial to determining whether abuse has or has not actually occurred.

'Everyone has a right to follow a course of action that others judge to be unwise or eccentric, including one which may lead to them being abused. Where a person chooses to live with a risk of abuse the safeguarding (care) plan should include access to services that help minimise the risk.' (*Safeguarding Adults' ADASS 2005*)

6.1 Capacity

It is essential therefore for practitioners following these procedures to consider capacity issues when deciding how best to respond when abuse is suspected or alleged.

In line with the principles underpinning the Mental Capacity Act 2005, these procedures are based on the presumption of capacity. Every adult has the right to make his or her own decisions, and in every situation it will be assumed they have the capacity to do so, unless it is proved otherwise. A lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour which might lead others to make unjustified assumptions about capacity.

The Act also makes clear that people have the right to be supported to make their own decisions, and must be given all appropriate help before anyone concludes a lack of capacity. It also stipulates that anything done for or on behalf of people without capacity must be in their best interests and least restrictive of their basic rights and freedoms.

6.2 Testing capacity

A single clear four-step test for determining whether a person lacks capacity has been introduced. Because the capacity of some adults may fluctuate and they may or may not be able to make a decision about how to pursue their safety at the time it is needed, the test must be applied in a way that is decision specific. It will help an independent expert or identified practitioner make a judgement about whether a person can make a particular decision at a particular time.

In the case of suspected or alleged abuse, the Adults Wellbeing and Health Manager receiving the referral from Social Care Direct, or the person's Social Worker or other lead practitioner (where the adult is

already known to the department) will need to determine whether the person understands the nature of the concerns and choices facing them. Any issues of power imbalance in the relationship between them and the alleged perpetrator will need to be taken into consideration. The context for such professional decision making would ideally be the strategy discussion.

If every reasonable effort has been made to assist the adult's understanding of the situation and to enable them to communicate their wishes – which may involve commissioning the skills of an advocate or interpreter, and perhaps victim support – and there still is good reason to question the person's capacity or ability to give informed consent, then this test should be applied.

The practitioner carrying out the test will normally be a qualified Social Worker or medical practitioner, but could also be another professional – a Police Officer for example. The outcome of the test must always be fully recorded and kept on the adult's case file. The test may be undertaken outside of, or pursuant to Court proceedings.

6.3 Consent

For the purposes of the safeguarding adults procedural framework, consent has been divided into three categories: -

The informed consent of an adult at risk to live with that risk, and in a suspected or alleged abusive situation.

The adult's consent to share information about the risk/situation and take part in a safeguarding assessment.

The adult's consent to the investigation of the suspected or alleged abuse and agreement to the drawing-up of a safeguarding plan.

6.4 Consent where the adult at risk has capacity

If it is decided that the adult does have the mental capacity to make an informed decision about the concerns facing them and the choices they have, then the following will need to be determined:

Whether the person did give consent to the action or actions that were suspected or alleged as being abusive;

if consent was given, whether the adult chooses to continue to live with the risks they face and in what could be an abusive situation, and whether they are willing to participate in the safeguarding process (It must be noted that a person can not legally consent to an act that amounts to a physical assault, the person committing the assault would

still be criminally liable even though the victim may have agreed to the act taking place);

If consent was not given to the suspected/alleged abusive act, whether the adult will agree to information being shared with other necessary parties; and

Whether they will agree to an investigation being carried out by the agencies that have the appropriate legal powers and responsibilities.

It is important to note that where the rights of others may be compromised by not sharing and acting on the information, e.g. where the suspected or alleged abuse has taken place in a care setting, or where another adult or child is at risk of harm, then there will often be a duty for the partnership organisations to intervene regardless of the adult's expressed wishes.

Similarly, in accordance with national guidance issued by the Association of Chief Police Officers (ACPO) and the Crown Prosecution Service (CPS), in some cases where the adult chooses to withdraw an allegation of abuse - especially in cases of domestic abuse - the Police may still take the decision to pursue conviction if they consider this as a suitable course of action.

6.5 Where the adult who has capacity chooses to live with risk and will not agree to investigation of the suspected or alleged abuse

If the adult chooses to live with the risks they face, they must be offered support to help them understand those risks and how to minimise them.

6.6 Validity of consent

Partnership professionals will need to consider whether the adult has made this choice of his or her own free will, or has been/is still exposed to coercion or intimidation. If this is believed to be the case, then the validity of the adult's decision may be questionable, and efforts should be made to offer the adult distance from the situation in order to facilitate more informed decision making.

Bearing this in mind, with the adult's consent a safeguarding assessment will need to be carried out and a safeguarding care plan drawn-up and agreed.

Without consent, and where coercion or intimidation is suspected, and significant risk of harm exists, the partners should agree upon and adopt the best mechanisms for monitoring the situation and offering a level of intervention and support that is acceptable to the individual –

although an over-riding duty of care to the individual and other adults at risk and/or children may exist. All decisions made and actions taken will need to be properly recorded. Where any doubt exists about how to proceed in such situations, the partnership professionals should always, without exception, seek legal advice.

6.7 Where the adult at risk has capacity, and consents to the sharing of information and investigation of the suspected or alleged abuse

Where capacity is present and the adult gives consent to the necessary agencies taking safeguarding action, then the procedures described in Section 7 must be followed. This will again include the drawing-up of a safeguarding plan with the person.

It is considered good practice to involve the adult at risk, with support where necessary, as a partner in the strategy/discussion meeting. This may not always be practicable for a number of reasons, including: risks to the safety of the adult; risks to the safety and rights of others (including the alleged perpetrator); the potential contamination of evidence; certain conflict situations.

Careful consideration must always be given when making such decisions and when the adult at risk is not to be directly involved, the rationale must be recorded in the strategy documentation.

Where a person for one of these reasons cannot be included as a full partner, then the Adults Wellbeing and Health Manager convening the strategy meeting, or alternatively the Lead Officer, must agree with them how their views are to be incorporated into the strategy making process.

6.8 Where the adult at risk does not have capacity

If it is determined that the adult does not have capacity, then the safeguarding agencies should act in that person's best interests: that is do whatever is necessary to protect their safety, health and well-being, and promote their continued independence. Any action taken must meet Human Rights standards and be proportionate to the perceived extent and risk of seriousness of the alleged abuse. Intervention must not be arbitrary or unfair, and it must have a basis in law, e.g. under duty of care, to prevent crime, or to protect the public.

The Mental Capacity Act 2005 provides a checklist of factors that decision makers must work through in deciding a person's best interests. The adult at risk should ideally be supported to put his or her wishes into a written statement for the decision makers to consider. The Act also gives the adult's carers and/or family members the right to

be consulted, although any potential conflict here needs to be recognised.

If the sharing of information and investigation of the suspected or alleged abuse is determined to be in the adult's best interests, then the procedures outlined in Section 7 must be followed.

6.9 Additional considerations in respect of sexual abuse

Where suspected or alleged sexual abuse of a person with learning difficulties, or any another adult whose capacity to consent needs to be tested takes place, the following issues must be considered:

Whether the person gave consent;

whether the person could give his or her consent based upon their understanding of their relationship with the alleged perpetrator and whether they understood the nature of what was happening; and

whether the person was prevented from giving consent or coerced into giving consent by being under undue pressure in that particular situation, e.g. an imbalance of power in the relationship where the alleged perpetrator was a care-giver, other professional or family member, or where physical force, threat of violence or reprisal, or deceit or exploitation was used.

Sections 29 through to 42 of the Sexual Offences Act 1993 address issues relating to the sexual abuse of adults with a 'mental disorder' using the definition given by Section 1 of the Mental Health Act 1983 as, *'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind'*. Someone with a learning disability or dementia for example, would fall within this definition. The Sexual Offences Act offers the protection of law to people who cannot or have been prevented from giving consent and also extends to specific instances relating to sexual acts between care workers and service users.

6.10 Advance decisions

The Mental Capacity Act 2005 introduced new statutory rules with clear safeguards to enable people to make decisions in advance to refuse care or treatment should lose capacity in the future. The Act does however stipulate that an advance decision will have no application to any treatment which a Doctor considers necessary to sustain life, unless strict formalities have been complied with. Those formalities are that the decision must have been made in writing, and be signed and witnessed. In addition, it must include an express statement that the decision stands 'even if life is at risk'. It should be noted however, that

the compulsory treatment provisions of the Mental Health Act 1983 (as amended by the 2007 Act) would override an advance decision which concerns treatment for mental disorder.

This new right impacts on safeguarding work, since any properly drawn-up advance decision may result in health care professionals especially, following a course of action that might in any other circumstances be misinterpreted as neglect or omission.

In all cases where an advance decision is in place, professionals providing care and carrying out safeguarding work must seek legal advice. Employees of Adults Wellbeing and Health can obtain this advice from the Council's Solicitor.

6.11 Providing care without incurring legal liability and permissible use of restraint

The Mental Capacity Act also clarifies that where a person is providing care or treatment for someone who lacks capacity, then that person can provide the care "without incurring legal liability".

Proper assessment of capacity and best interests will be key, but the provision means that actions that would otherwise result in a civil wrong or crime, e.g. if someone has to interfere with an adult's body or property in the ordinary course of caring – by giving an injection perhaps, or using a person's money to buy things for them - may now be undertaken without liability.

It remains however that the restraint or restriction of liberty or movement of an adult who lacks capacity is only permitted if the person applying it reasonably believes it is necessary to prevent harm to the adult, and if the restraint used is proportionate to the likelihood and seriousness of that harm.

Safeguarding partner agencies will need to take careful account of the above provisions in their decision making and investigative processes, and legal advice should always be sought.

6.12 Advocacy and support

In general, advocacy is needed when people are at risk of being disbelieved, devalued, marginalised or discriminated against. In the safeguarding context, advocacy focuses upon empowerment of the adult at risk.

Advocacy has been defined in a variety of ways which relate to the following:

- the adult's ability to speak for him or herself;
- the adult's need for someone independent from the presenting situation to represent them; and
- His or her need for expertise in the management of that particular situation.

The four main types of advocacy support are: -

1. **self advocacy** - where with some assistance a person is able to speak out on his or her own behalf;
2. **citizen advocacy** – a supportive partnership between a person who is not in a good position to speak up, and a family member, a friend or a trained volunteer who stands by them;
3. **problem focused advice or representation** (including professional, formal, specialist, legal, crisis or representational advocacy) – an immediate short term response to an identified problem, event or change in a person's life;
4. **Case advocacy** – a short term task-centred relationship between a trained advocate and a person who is not in a strong position to independently exercise his or her rights.

Advocacy aims to support adults at risk in the following ways:

By ascertaining the adult's past and present wishes and his or her feelings;

By encouraging and permitting an adult who lacks capacity to participate in any decision making to the fullest extent to which he or she is capable; and

By promoting the general principle that the course least restrictive of the adult's freedom of decision making is most likely to be in his or best interests.

Appointing an advocate:

The gathering of information to establish the need for an advocate should begin at the first point of contact with the adult at risk. This need should be referred to the person's Social Worker who will make the necessary arrangements.

Where an adult at risk does not have a Social Worker or other lead practitioner at the point of alert to Social Care Direct, then one must be allocated as a matter of urgency. He or she will from that point take on the role of 'Assessing Officer'. The appointment of an Assessing Officer is the responsibility of the appropriate Adults Wellbeing and Health Manager for the geographical integrated or specialist team receiving the referred case.

In deciding whether advocacy support is necessary, the Assessing Officer will need to consider what type of advocacy support the adult requires, e.g. the involvement of specialist skills or knowledge in relation to the law or welfare rights for instance. In the interests of equal opportunities, the person's first language, ethnicity and any other special needs will also have to be taken into account.

N.B. Advocacy workers may not participate in the safeguarding investigative process. They may act only in support of the adult at risk.

Independent Mental Capacity Advocate:

In relation to adults who lack capacity, the Mental Capacity Act 2005 introduced the role of Independent Mental Capacity Advocate (IMCA). Criteria for referral to the IMCA service, which must be met before any involvement can be agreed, is set out in the Adults Wellbeing and Health '*Advocacy- appointing an Independent Mental Capacity Advocate Procedure*' (A/CM/052 appendix 6). An IMCA can act for an adult who lacks capacity and has no one to speak up for them. The IMCA can make representations about the adult's wishes, feelings, beliefs and values, at the same time as bringing to the attention of the safeguarding decision makers all factors that are relevant to the decision. If necessary the IMCA can also challenge decision makers on behalf of the adult.

It is the responsibility of the adult's Assessing Officer to enlist the services of a suitable Independent Mental Capacity Advocate. Where specialist IMCA service referral criteria is not met, then a general Advocacy Worker could instead be appointed

SECTION 7 REPORTING AND SOCIAL CARE DIRECT

7.1 Social Care Direct

Social Care Direct (a part of Durham County Council's Adults Wellbeing and Health) is the single point of referral in Durham for all reports of suspected or alleged abuse or neglect.

Regardless of the time of day or night, a safeguarding referral may be made to Social Care Direct on 0845 8505010.

Staff can e-mail referrals to: Socialcaredirect@durham.gov.uk

Emergency Duty Team takes responsibility after normal office hours, weekends and Bank Holidays

7.1.1 Gathering information

In response to any call regarding a safeguarding matter, the Social Care Direct Officer will immediately:

- Ask for the name of the referrer, but will also explain that information may be given anonymously;
And
- Ask questions of the referrer and gather as much information as possible about the alleged abuse – this will need to be recorded.

The Social Care Direct Officer will need to find out:

- The name(s) of the identified adult(s) at risk, their contact information
- relevant details of their gender, race, faith, culture and any special communication or access needs;
- Details and circumstances of abuse
- Risk factors
- Impact on the adult(s) concerned;
- Setting/location of incidents or alleged abuse
- Occasion(s) where it took place;
- the name and date of birth of the alleged perpetrator(s) if known;
- Identity of any witnesses; and
- Any immediate action taken to safeguard the adult(s), including contact with the Police or other emergency services and a crime number if appropriate.

Where information is received by fax or e-mail, the gathering of this information is still necessary where it is not self evident.

7.1.2 Assessing and responding to the information

To meet the criteria for a Safeguarding referral, the adult must be an 'adult at risk' (formerly referred to as a 'vulnerable adult')

An 'adult at risk' is someone aged 18 or over who is or may be eligible for community care services and whose independence and well-being would be at risk if they did not receive appropriate health and social care support.

The Social Care Direct Officer will next need to:

- Check all available records to determine whether or not the adult(s) at risk or perpetrator(s) are already known; and
- Assess the initial referral information and decide upon the most appropriate immediate response to the concerns.

If the referral concerns possible neglect or abuse that has led to skin damage (www.safeguardingdurhamadults.info) Social Care Direct will check whether the skin damage protocol (www.safeguardingdurhamadults.info) has been used in determining whether a referral should be made.

The Social Care Direct officer should not attempt to re-contact the victim / alerter unless a safe number can be established as it may place the person in a vulnerable position. Any future contact can be planned at a subsequent strategy meeting.

Social Care Direct & Emergency Duty Team will respond to potential adult safeguarding concerns in the following ways:

- Accept the safeguarding referral from a referrer who is a designated post holder e.g. experienced care professional who has received an alert & already decided that a safeguarding referral is required
- Decide a safeguarding referral is required on the basis that abuse cannot be ruled out & person is at critical or substantial risk*
- Decide that referral does not constitute a safeguarding referral & standard referral is required for an assessment of need e.g. Vulnerable Adults Concern Form from the police should be screened carefully and not automatically be considered as safeguarding
- Decide that concern does not constitute safeguarding referral & signpost assistance from agencies such as Victim Support, the

Police, Domestic Violence services, Housing agencies or even a refuge

* Safeguarding Adults Risk Support Tool

Social Care Direct must use Safeguarding Adults Risk Support Tool, which provides examples types and factors of abuse which will help SCD decide whether they can rule out abuse or not. (See Risk Support Tool).

Where a safeguarding telephone referral is made by another agency, then the designated post holder making the call will be expected to follow up his or her initial contact with a written referral to Social Care Direct. The caller must be reminded of this responsibility.

7.1.3 Recording the information

The Social Care Direct/Emergency Duty Officer will need to record the information gathered at referral, along with a brief summary of any consultation that took place with the Social Care Direct or Emergency Duty Team Manager about how to respond. This will need to be entered onto the Social Services Information Database (SSID) using the correct coding to indicate suspected abuse:

SAFA (Safeguarding Adults Referral) or SAFA Establishment must be used. SCD will also create the Safeguarding Adults Record on SSID which will then appear in the Manager's User In tray under 'On going safeguarding incidents'.

7.1.4 Recording referrals for alleged perpetrators who are 'adults at risk' and also have community care needs

Social Care Direct must ensure that a Safeguarding referral is recorded for the victim only – not the alleged perpetrator. Referrers often focus on the perpetrator rather than the victim but the perpetrator should not be confused with the subject of the referral. There may be some instances where the perpetrator is a victim as well and this will require a referral. However, if the alleged perpetrator needs care and support, a normal referral can be made by the Lead Officer.

The exception to this would occur where both of the adults are victims, and it not clear which of them is the primary perpetrator.

7.1.5 Cumulative concerns indicating serious risk

Single agencies holding information about adults who:

- have a number of emergency care episodes relating to assault/having taken an excess of drugs and/or alcohol; and/or

- make repeated calls to the Police to any one address or for any one person; and/or
- attract a number of complaints from neighbours, or concern from social landlords in respect of poor tenancy standards; and/or
- Make repeated referrals to Adults Wellbeing and Health with concerns about issues including bullying, unpaid rent, stolen money etc.

Must report this information to Social Care Direct.

These episodes in themselves may not constitute safeguarding concerns. Considered in the context of cumulative risk however, safeguarding intervention may be required.

Social Care Direct will log the information and screen it in the context of previous concerns reported in relation to the individual concerned. At the stage when the individual's SSID history indicates a significantly high level of risk that cannot be managed through standard care management interventions or via the risk enablement panel, then the case will be referred to the safeguarding adults procedural framework.

7.1.6 Allocation to a Manager

Social Care Direct must ensure that each safeguarding referral is sent to the appropriate Manager for decision making within one hour of the referral being accepted.

In cases where the most obvious Manager is not available (e.g. on leave), the referral will be passed to another appropriate Manager.

The safeguarding referral will be allocated to the Team/Specialism that matches the user group e. g Older Persons and the location where the alleged abuse took place. Sometimes it is not clear which is the appropriate Manager. SCD should use records of any previous involvement as a guide to see which team was previously involved e.g. Substance Misuse, Alcohol Service, Adult Mental Health, Mental Health Services for Older Persons, Older Persons or Younger Physical Disability or Learning Disability. Where there is no previous SCD must make an accurate judgement of the most appropriate specialist Manager.

7.1.7 Allocation of referrals made outside normal office hours

Allocation within one hour will of course not be possible for referrals made to the Emergency Duty Team (EDT) during the evening or over the weekend/Bank Holidays. The EDT will take immediate steps to implement the safeguarding adults procedures, manage any presenting

risk and ensure the referral is passed to the appropriate Manager at the earliest opportunity on the next working day.

The EDT will immediately refer cases of death or serious injury, or alleged multiple or institutional abuse to the senior Manager on call, who will take lead responsibility for risk management and decision-making.

7.1.8 Safeguarding Referrals taken on Open cases – existing active cases

Where a case is already open to a front line practitioner e.g. social worker, care manager or care co-ordinator, SCD will take the referral and record it on the case.

It is essential to be clear about where the alleged incident has taken place e.g. Care Home, Hospital or Day Centre.

For open cases, it is the local manager in the area where the abuse has taken place who will take responsibility for the safeguarding referral.

SCD will:

- Notify the local manager who will lead on the safeguarding incident
- Notify the existing manager who is currently responsible for the case (if different)
- The case will not normally be transferred due to input required from existing case worker.
- Enter note on SSID Case Notes to evidence who has been informed.

This process ensures that:

- The case is investigated by the manager with the local knowledge
- Both managers are made aware of the incident and can liaise as necessary to avoid any incident being overlooked.
- There is continuity of case work and professional involvement
- Confidentiality upheld as all managers can access all case records within their user group.
- Any disputes will be resolved by the appropriate senior manager.

Details for SSID data base

As for new or closed cases, SCD will also create the Safeguarding Adults Record on SSID. This will then appear in the Manager's User In tray under 'On going safeguarding incidents'. This will also appear in the Lead Officer's User In tray once Lead Officer has been recorded on SSID – (where lead Officer is different to the existing manager)

* See separate note on Mental Health Users below

7.1.9 Non DCC Service Users

DCC is responsible for Safeguarding referrals for persons who have been placed in County Durham even though they are the responsibility of another local authority (and the alleged abuse has taken place in County Durham). The referral will be allocated to the local team manager according to specialism and location of the alleged abuse. The manager will liaise with the local authority that is responsible for the case.

7.1.10 DCC Service users where alleged abuse takes place outside of the local authority

DCC is not responsible for the safeguarding referral process when the alleged abuse has taken place outside of the Local Authority. However, if SCD are contacted by the external Local Authority, they may need to take a standard referral for a re-assessment and notify the existing manager of all relevant information.

7.1.11 * Safeguarding Referrals on Users with Serious and enduring Mental Health Problems

Where a user is a new or closed case and it appears to SCD that the person's primary problems are associated with severe and enduring mental health SCD will contact the appropriate manager in the Mental Health Access Service. The referral will be logged on SSID and opened to the Manager of the above service for them to determine which team will take responsibility for the safeguarding referral.

Where case is already open to adult mental services, SCD will notify the Manager immediately by telephone to inform them that a safeguarding referral has been taken and logged on SSID. Note on SSID required to show who has been informed.

Direct contact is essential in mental health where the managers use PARIS rather than SSID as their primary electronic system.

North of County Crisis and Access Team
Tel 0191 4415888

South of County Integrated Crisis and Access Team
Tel 01325 382706

7.1.12 Receiving the referral - the Adults, Wellbeing and Health Manager's decision

Where action is deemed necessary to protect the safety of one or more adults, a safeguarding referral will be passed either from Social Care Direct, or where a case is already open from the adult's Social Worker/other professional, to an Adults Wellbeing and Health Manager who is best placed to reach a decision about whether and how to invoke the safeguarding procedures. This decision must be made within 24 hours of receipt of the referral.

Upon receipt of a safeguarding referral, the Adults Wellbeing and Health Manager must:

- ensure the referral has been logged onto the Social Services Information Database (SSID);
- consider the referral information in the context of the situation that led to the allegation being made or concerns being expressed;
- consider the reliability/credibility of the information received (see 'false allegations' at 4.1.8); and
- Decide whether the concern constitutes possible abuse.

7.1.13 Thresholds and triggers for safeguarding intervention

Can abuse be ruled out?

When determining a threshold for intervention following an allegation or concern, the first question that needs to be answered is:

Can abuse be ruled out?

If the person is suffering harm or exploitation, and is likely to have eligible social care needs, then abuse cannot be ruled out.

Where abuse cannot be ruled out

The Adults Wellbeing and Health Manager will need to carry out a risk assessment to determine the presenting risk to the adult and any others, and the level of urgency with which safeguarding action needs to be taken.

The risk assessment will need to incorporate:

- the nature of the alleged abuse in terms of maltreatment of failure to provide adequate care (act of commission or omission);
- the pattern, duration and frequency of the abuse;
- its degree and extent;
- the extent of any premeditation, threat or coercion;
- the vulnerability of the individual (considering any special needs, such as medical condition, communication impairment or disability, that may affect the individual's independence and/or physical and mental capacity);
- the impact of the abuse on the physical, emotional and psychological well-being of the adult;
- the level of personal support needed by the adult, and whether that support is normally provided by the alleged perpetrator;
- the capacity of family/main carers to adequately meet the individual's needs, and the wider family/care/environmental context;
- the level of threat to the adult's independence; and
- The likelihood of repeated or increasingly serious acts involving this or other adults and children at risk.

Adapted from 'Working Together' and 'No Secrets'

This will help the Manager determine the most appropriate response, and decide whether to implement the safeguarding adults procedural framework or to refer the concern to more suitable alternative procedures. It is important to remember however, that although a single event of abuse may pose a serious risk to the adult's well-being, it is often the accumulation of events – each of which may appear small – that causes serious harm.

The Manager may find the Safeguarding Adults Risk Support tool particularly useful here.

N.B. The tool is not intended to replace professional judgement, nor does it aim to set a defined threshold for intervention. It illustrates a range of potentially harmful situations for each category of abuse in a continuum of seriousness. By ticking each factor in the scale, the Manager should be assisted to judge the seriousness of any given allegation in a more structured way.

The tool may additionally be useful to designated-persons in their decision-making role (see Section 5).

7.1.14 How to distinguish the difference between safeguarding allegations and bad practice in care services

The Care Quality Commission has produced guidance to help its Inspectors distinguish the difference between concerns, complaints and allegations of abuse. It uses the following descriptors.

The first set of descriptors clarifies who the issue belongs to; it prompts Inspectors to consider:

- whether the CQC has the required legal authority to act and/or
 - has a 'public body obligation'
- And if
- The service is regulated.

The second set of descriptors is designed to help evaluate the information presented about the issue. This set of descriptors will be more useful to decision-making Adults Wellbeing and Health Managers.

- A concern is 'soft' information, and does not immediately impact on the outcomes for people who use the service concerned. It does not require an immediate response. Service providers should be able to look into and satisfactorily resolve most concerns.
- A complaint is information that has significant, real or potential impact on the outcomes for people who use the service concerned. A complaint in the first instance may be appropriately looked into and resolved by the service provider. Where a satisfactory outcome cannot be reached, and the service user is placed by the Local Authority, then their complaint can be escalated to the Adults Wellbeing and Health's complaints procedure, and ultimately, to the Local Government Ombudsman. In the case of self-funders, then unresolved complaints will soon be able to be escalated to the Local Government Ombudsman.
- A safeguarding issue is information of a serious nature that alleges possible abuse or criminal practice that needs to be shared with others. Safeguarding issues should be referred to Social Care Direct and dealt with according to the Durham Safeguarding Adults Board inter-agency procedural framework.

Information that is shared with will not always be simple or straightforward. Where the information contains a mix of concerns,

complaints and safeguarding alert, or any combination of the three, it may be necessary to take different action for different strands of the information.

For example:

Information	Decision	Owned by
Lost laundry	concern	Service Provider
Medicines not being recorded or stored correctly	complaint	CQC
Unexplained bruising	safeguarding issue	Local Authority

Commission for Social Care Inspection, February 2008

N.B. The descriptors are intended only as a guide, and should not replace professional judgment.

7.1.15 Consultation with the adult at risk

Decision making must take place in consultation with the identified adult(s) at risk. The adult's consent to take part in a safeguarding assessment will need to be sought, along with agreement to information being shared so that an investigation can take place. Issues of capacity will have to be taken into account (see section 16). However, where significant risk exists, and prompt action is required, or where it is not possible to contact the adult without alerting the suspected perpetrator and thereby possibly compromising any future investigative work, this may dictate the need to proceed to the strategy stage before consent can be obtained. The safeguarding strategy discussion/meeting should then provide a suitable forum for identifying the best way forward and for liaising with and obtaining the adult's consent, whilst at the same time addressing any 'duty of care' obligations to protect any others who might be involved.

It is also good practice for decisions to be made in partnership with other safeguarding agencies and if needed, with advice from the Council's Solicitor.

7.1.16 Decision to proceed

It is the Adults Wellbeing and Health Manager's responsibility to take immediate steps to ensure that the adult is kept safe while initial enquiries are made, and thereafter throughout the safeguarding process. Care must be taken to ensure that any safeguarding interventions do not further endanger the person experiencing abuse, or limit the effectiveness of any enquiries.

Contact where appropriate should always be made with the Police and any necessary regulatory bodies, e.g. the Care Quality Commission, and the Council's Health and Safety and Staff Care Team, who will liaise with the Health and Safety Executive if necessary.

At this stage, contact with the other multi-agency risk management partners should also be considered, e.g. via the Multi-Agency Public Protection Arrangements (MAPPA), Multi-Agency Risk Assessment Conference (MARAC), and Potentially Dangerous Persons (PDP) protocols (1). MARAC risk assessment and referral forms can be found in sections 18.5 – 18.7.

Consideration should also be given to making contact with substance misuse and Domestic abuse services which can, when appropriate, provide valuable help and assistance during the strategy meeting process. In many cases victims of abuse could be defined as more than one client type. It is important that services do not work in silos and that an informed decision is made regarding which is the most appropriate service or combination of services.

For a definition of domestic abuse see 3.3.9 Domestic Abuse.

For further information on consideration when dealing with persons who misuse substances see 18.1 - 18.2 Adults at risk who misuse substances.

The above agencies, in addition to any other appropriate safeguarding partners, should be invited to take part in a safeguarding strategy discussion/meeting. The strategy stage must be completed within five days of the referral being received by Social Care Direct (see Section 6 for more information).

Interviews should not yet be held with the adult or any potential witnesses, as this may jeopardise the outcome of any future investigation.

7.1.17 Cases involving allegations of multiple/institutional abuse or where an adult has died

In complex cases where a safeguarding referral indicates that:

- multiple or institutional abuse is or has been taking place, either within a service or in the wider community; or

4 For MAPPA contact the Public Protection Unit on (0191) 3839083
For MARAC contact the MARAC Co-ordinator on (0191) 3752072

- an adult has died and abuse or neglect is suspected or alleged, Then the Adults Wellbeing and Health Manager must initiate an executive strategy meeting, where a suitable multi-agency safeguarding strategy/investigation process will be agreed. The Police must always be invited to executive planning meetings.

At this stage, the information may also need to be referred as a 'serious incident' and reported to a senior Manager, who will consult with the Head of Adults Wellbeing and Health to make a decision about whether to implement the service's 'serious incident' protocol and who will refer the matter to the Council's Health and Safety and Staff Care Team if this has not already been done. In health settings too, the responsible Manager may consider it necessary to invoke the Department of Health protocol for investigating 'safety incidents' in partnership with the Police and the Health and Safety Executive.

In any of the above circumstances, the Police may also decide to implement their 'gold' strategy response protocol.

Additionally, in the event of a death, the Coroner's Office must be informed.

For further information about any of the above departmental or partner agency procedures, please refer to appendices.

7.1.18 Where alleged perpetrators have community care needs

As outlined in section 1.5.4, these procedures recognise the rights of alleged perpetrators as well as 'victims'. Some alleged perpetrators may also have community care needs and may also be deemed at risk.

Where this is the case, he or she will be afforded access to independent advocacy or support, e.g. an interpreter, translator, communication aids, or an intermediary. Indeed, this may be necessary where a criminal offence is suspected, and the Police request the allocation of an 'Appropriate Adult'. The Appropriate Adult role is a dedicated one, and must not be undertaken by anyone who is otherwise engaged in the safeguarding process.

The procedures allow for an assessment of the alleged perpetrator's needs, and the risk(s) he or she poses to themselves and others. This may result in the provision of community care services for alleged perpetrator too, as part of his or her individual care-plan.

A separate safeguarding referral for the alleged perpetrator is not necessary and should not be made, since doing so is both inaccurate and would distort safeguarding performance data. A standard referral is all that is required. The exception to this would occur where both of the

adults are victims, and it not clear which of them is the primary perpetrator. Where the alleged perpetrator is already known to Adults Wellbeing and Health, and his/her case is already open on SSID, then all that is required is a call to the relevant Team Manager.

The alleged perpetrator also has the right to know the nature of the concerns about their behaviour, has the right to reply, and to correct any information held about them that is not accurate.

The aims of the safeguarding process however, remain the same: to protect adults at risk; to minimise the risk of harm and prevent further abuse; to work closely with partners including the Police to collect evidence necessary to any legal proceedings, and to uphold the citizenship rights of all adults and children throughout.

7.1.19 Where children are involved

Where a child (ren) may be at risk, a referral must be made immediately to the Children's Services. There are different routes for concerns regarding paid workers/volunteers, and those relating to familial situations. See Section 14.5 -14.7 for further information, and refer also to the Council's 'Protocol for working together in the delivery of services to adults and children' and the Durham Local Safeguarding Children's Board 'Allegations against staff, carers and volunteers' procedural guidance.

7.1.20 Decision not to proceed

If a decision is made by the Adults Wellbeing and Health Manager not to invoke safeguarding adults procedures, the referrer will need to be informed accordingly. This must happen within one day of the initial referral being received by Social Care Direct.

The referrer may need to be signposted to alternative and more appropriate agencies, such as victim support, the Police, domestic abuse services, housing agencies or even a refuge. A decision may also be taken to offer the identified adult and/or his or her carer where appropriate, an assessment under the National Health Service and Community Care Act 1990 and/or Carers (Recognition and Services) Act 1995, Carers and Disabled Children Act 2000 or Carers (Equal Opportunities) 2004 Act. Alternatively, from 2009, the concern may be referred to the Multi-Agency Risk Enablement Panel for consideration (see Section 11.3) for more information about the Panel).

7.1.21 Recording decisions

The Adults Wellbeing and Health Manager must keep a robust record of all discussions, risk assessments, decisions and actions (see recording at 4.1.6).

7.1.22 Updating the referrer

Once a decision has been made, and having regard to issues of confidentiality and taking into account the nature of the allegation, the Adults Wellbeing and Health Manager will, by the end of the next working day, advise the referrer how their concerns will be addressed. The referrer will also need to be asked to report back any changes in the identified adult's circumstances.

Wherever possible and again within the bounds of confidentiality, the referrer will be informed of the outcome for the adult of any subsequent safeguarding intervention (usually by the Lead Officer). The Adults Wellbeing and Health Manager will need to advise the caller that this is the case.

N.B. Where the referrer has withheld their identity, feedback will of course not be possible.

7.1.23 Disagreement

Taking into account the rights of the adult at risk and any alleged perpetrators - and in accordance with protocols around confidentiality and sharing of information - a person who makes a referral of alleged abuse or raises concerns about an adult's well-being should be informed of Adults Wellbeing and Health's decision in respect of whether the matter will be dealt with using safeguarding adults procedures. It is the responsibility of the decision making Adults Wellbeing and Health Manager to make contact with the referrer.

Occasionally, a referrer may disagree with the Manager's decision. Where this is the case, the referral must be passed to a more senior Manager - including the Safeguarding Adults and Practice Development Team Manager - who will review the Manager's decision making and actions and give a second opinion. This must be done on the same day as the disagreement is raised. If the situation cannot be resolved to the referrer's satisfaction, then he or she may make representation to the Head of Adults Wellbeing and Health or access the Council's complaints procedure (see section 1.11 for more information about complaints about safeguarding).

Disagreements may also occur between the partner safeguarding agencies, either as a result of the Adults Wellbeing and Health Manager's decision, or at any other stage in the safeguarding process. When this happens the matter of contention must be referred to the Head of Adults Wellbeing and Health who will make an objective judgement about how best to proceed. This may involve liaison with senior Managers from the other partner agencies concerned.

The Safeguarding Adults Risk Support Tool may prove useful at this stage. The best interests of the adult(s) at risk must always be kept central to any judgements made.

All disagreements must be fully recorded and include details about agreed compromises (if any) and outcomes. Compromises will not be considered where these may jeopardise the safety of the adult or run counter to legislative or good practice guidance and/or individual/collective professional codes of practice.

This section of the procedures apply equally to staff employed by Adults Wellbeing and Health and placed with the department as students, as to those working for agencies out with the Council and members of the public, including service users.

SECTION 8 STRATEGY MEETINGS

8.1 Safeguarding strategy

Developing a safeguarding strategy should be a multi-agency process involving all of the partner agencies appropriate to the given circumstances. Sometimes the strategy might be developed most effectively by a meeting of the partners, which takes place face-to-face. On other occasions however, e.g. where an urgent response is required, it may be necessary and timelier to formulate the initial strategy through a series of telephone conversations, e-mails, or via a 'virtual' meeting. If the strategy meeting takes place by way of one of the above methods the team manager should record it as such on the SSID system and why it was conducted in this way. Where e-mail is used, a protocol for anonymising certain elements of information may first of all need to be agreed and used.

It is important too, to remember that strategies evolve over time. Where issues are complicated, when new information comes to light, or if people's circumstances change, further strategy discussions/meetings may need to take place to evaluate progress and review and revise planned actions and timescales.

Responsibility for convening the strategy discussion/meeting rests clearly with the Adults Wellbeing and Health Manager who has taken the decision to progress a referral of suspected or alleged abuse. He or she will also ensure that the strategy discussion identifies a Lead Officer who will chair the meeting if it takes place face-to-face. Any person appointed as Lead Officer must be appropriately trained to undertake the role and be sufficiently knowledgeable and skilled to co-ordinate the safeguarding process through to its conclusion, keeping the best interests of the adult at the centre of all work undertaken.

Each partner organisation involved at the strategy stage should be proactive in offering all available resources within their remit to enable the ongoing assessment of presenting risk and to work towards a satisfactory outcome for the identified adult(s).

8.2 In most cases the Adult Wellbeing and Health Manager will also fulfil the Lead Officer role.

The timing of strategy discussions/meetings should always reflect the level of presenting risk (as determined by the Manager's risk assessment) but in all cases a safeguarding strategy, however so arranged, must be agreed within five days of a safeguarding referral being received by Social Care Direct.

8.3 The purpose of the safeguarding strategy discussion/ meeting

Strategy discussions are necessary for four main reasons;

- so that further information from partner agencies about the adult(s) at risk, the alleged perpetrator(s) if known, and anything else that may have a bearing on the presenting risk or that would influence the safeguarding process might be gathered;
- so that responsibility for evaluating that information and making a decision about how to proceed can be shared;
- to consider the need for immediate protective action for the adult at risk and any other adults or children (if this has not already been addressed by the decision making Adults Wellbeing and Health Manager); and
- To enable investigative and other processes to be planned, identifying individual and collective tasks, responsibilities and timescales for action (remembering that investigations and assessments should be led by the partner agency with the appropriate legal powers and responsibilities).

N.B.

1. The rights and safety of staff who 'speak out', or use their agency's whistle blowing procedures will also need to be taken into account.
2. All planned strategies must aim for minimal interruption to services being provided to the adult at risk and any other individual/groups involved or affected by the partner's safeguarding work.

Without embarking on a formal investigation or interviews of the adult or any key witnesses, the strategy will need to determine whether:

- the adult at risk is aware of the allegation, and has been consulted about how he or she would like to proceed if it is possible and safe to do so;
- the adult's wishes have been recorded;
- the adult at risk has capacity to make a sound judgement in this respect, and whether there are any existing assessments referring to the person's contextual mental capacity - if there are none, and there is any doubt about the person's capacity in relation to this

matter, then the prescribed test must be used and the outcome recorded;

- any withholding of consent has been over-ruled in the best interests of the adult or any others deemed at significant risk;
- there are any issues which may relate to potential discrimination, e.g. age, race, ethnicity, language, religion, gender, sexual orientation or disability, and if so, whether the concern should be dealt with as an equality incident/potential hate crime (see Section 3 for more information about the relevant Council protocols);
- there is any documentary medical evidence of the alleged abuse and any effect it may have had on the adult(s);
- any other significant documentary evidence exists, e.g. accident or incident reports in daily care records, completed skin damage protocol (www.safeguardingdurhamadults.info), diaries or care-plan evaluations;
- any disclosure or witness statements have been completed, signed and dated prior to the involvement of Adults Wellbeing and Health and other statutory partner agencies;
- the regulatory bodies where required have been notified and involved;
- where a care service is implicated, the Council's Commissioning Services Manager has been involved in the risk classification exercise (and if necessary families and other placing Authorities have been notified that safeguarding work is in progress); and
- Where the alleged perpetrator works for Adults Wellbeing and Health, the steps described at section 5.1.9 - under the heading 'Allegations against Adults Wellbeing and Health employees' - have been followed. For staff employed by other County Council services, the relevant Human Resources team should be contacted without delay.

Strategy meetings and follow-ups should also provide a forum for:

- providing a reminder for crucial times and events such as inquests, Court cases, a perpetrator's release from custody or disciplinary hearings that might lead to further precautions becoming necessary;
- agreeing what action(s) should be taken in relation to the person(s) found responsible for the abuse;

- identifying and supporting sanctions or other interventions to be taken in relation to implicated service providers or organizations;
- identifying specific indicators that should trigger reviews and/or further investigations;
- setting out a timetable for review and monitoring arrangements to ensure that any safeguarding plans are effectively implemented – this will involve specifying timescales for agreed action and identifying individual and collective professional accountability; and
- Agreeing appropriate feedback to the adult, his or her family (where appropriate) and agencies and services on a 'need to know basis'.

The outcome of every strategy discussion/meeting will not necessarily result in the full implementation of these inter-agency safeguarding procedures. For example, a joint decision may be taken to proceed straight to the safeguarding assessment and care-planning stage. Where this is the case it remains the responsibility of the Lead Officer to ensure that the safeguarding assessment is carried out with the co-operation of the adult at risk (or an advocate where there are additional needs in relation to capacity) and that any subsequent safeguarding plans are drawn-up and agreed in consultation with the person and/or his/her supporter (see Section 9.1).

Alternatively, if the referred issues do not appear on joint consideration and with the benefit of a greater knowledge of the case to constitute abuse, then other options (See section 6.1.20) may be considered. Those options and any actions taken will need to be fully recorded and the case closed and signed-off by a senior Manager.

In all cases and for all outcomes, the referrer must be advised accordingly. If the referrer disagrees with the outcome of any strategy discussion/meeting, then the protocol for dealing with disagreements should be followed (see Section 6.1.23).

All information shared during the strategy process must be subject to agreed protocols governing confidentiality (see Section 7).

The content of all strategy discussions/meetings, whether made over the telephone, electronically or in person must be recorded using the appropriate proforma (which can be found at the back of this document). This will be the responsibility of the Lead Officer *and* the decision making Adults Wellbeing and Health Manager in the case of initial strategy discussions which take place in urgent cases.

8.4 Who should be involved?

The strategy discussion/meeting could potentially involve any or all of the multi-disciplinary safeguarding partners.

The first strategy/discussion meeting will concentrate on sharing information between partner agencies and planning how to best support the adult at risk. The adult at risk would not normally attend at this stage.

The meeting should include the adult at risk; however, the chair of the meeting should give consideration to excluding the adult at risk for the whole or part of the initial strategy meeting in circumstances

When: -

- it is considered that their presence would frustrate the information sharing process
- where he or she has mental capacity (with appropriate use of independent advocacy and victim support services) and is prevented by other considerations, for example for their safety or to protect the safety and rights of others (including those of the alleged perpetrator)
- to avoid the possible contamination of evidence

Where a service user, their family or their carers have not been involved in a strategy or executive strategy meeting every step should be taken to inform them of the outcome of the meeting at the earliest opportunity. This will apply equally where there are multiple victims.

Every effort should be made to empower the adult to play as active a part in the safeguarding process as is realistically possible. This will require careful planning to ensure that any pre-identified specialist access or other needs, e.g. for interpretation or signing support for instance, can be properly met.

Where an adult with mental capacity cannot be included as a full partner, the Adults Wellbeing and Health Manager or Lead Officer should agree with them how their views are to be incorporated into the strategy-making process.

It may also be appropriate to involve the adult's family or carers, with his or her prior agreement.

An alleged perpetrator should only be invited to take part in strategy discussions/meetings in very exceptional circumstances, e.g. where this is considered in the best interests of all parties and where a satisfactory safeguarding resolution might be reached as a result. This would first of all have to be agreed by the adult at risk (where he or she has capacity) and by the Lead Officer. This would not be appropriate for an initial strategy meeting as it is likely to frustrate the sharing of information.

Other key partners may include the Police (essential where a crime is suspected or alleged), the regulatory bodies and representatives from other statutory agencies, e.g. medical professionals who have an existing professional involvement with the adult and/or perpetrator, or who may be able to offer relevant valuable knowledge or assessment, investigative or care-planning skills. The Council's Solicitor, Commissioning Services Manager and other appropriate specialist advisors could also legitimately be invited to take part.

Consideration should be given to inviting professionals from other services such as Substance misuse and Domestic abuse services which can provide valuable help and assistance during the strategy meeting process. In many cases victims of abuse could be defined as more than one client type. It is important that services do not work in silos and an informed decision should be made regarding which is the most appropriate service or combination of services that should be employed.

For a definition of domestic abuse see 3.3.9 Domestic Abuse.

For further information on consideration when dealing with persons who misuse substances see 18.1 - 18.2 Adults at risk who misuse substances.

Where a care or support service is implicated, the Manager and/or Responsible Individual (Proprietor) if deemed 'fit' should be included as full partners in the strategy process. They will only be deemed as fit where it is clear they have had no part in the suspected or alleged abuse or neglect. Exceptions would also apply where there are good grounds to believe that the person's presence may impede information sharing and/or the investigative process. Where an alleged perpetrator is known to work for any additional service(s) in a role(s) that involves access to adults at risk and/or children, then a Manager from the other employing agency (ies) should also be notified/invited to attend.

It may of course be necessary to address the different components of an allegation and pursue any subsequent discussions in respect of action planning in separate sections of the strategy meeting, so that the needs of the different people attending can be properly accommodated. For instance, it might be appropriate for the identified adult's relative(s) to attend the section about safeguarding assessment and the drawing-up of a protection plan (providing they are not implicated in the alleged abuse). It is clearly not appropriate for any family members to participate in discussions about the alleged perpetrator or any other third parties about whom confidential information will need to be disclosed.

Confidentiality protocol for safeguarding strategy discussions, executive meetings, and safeguarding planning meetings

At the outset of any multi-agency discussion regarding safeguarding work in relation to individual cases, the decision making Adults Wellbeing and Health Manager or Lead Officer (the person co-ordinating the work) will remind all participants of their responsibilities and obligations in respect of confidentiality and information sharing. Where the parties meet together in person, each participant will sign a record to confirm their agreement to work in accordance with the good practice guidance outlined in these procedures (see Appendix 2).

All documentation will be circulated at safeguarding meetings in a controlled manner and will be clearly marked as confidential and not to be disclosed without consent. At the close of meetings papers will be returned to the co-ordinating person, unless otherwise agreed by the safeguarding partners involved.

SECTION 9 EXECUTIVE STRATEGY MEETINGS

9.1 Executive strategy meetings (formerly referred to as executive planning meetings)

Executive strategy meetings are required when any or all of the following factors are present:

- institutional abuse (the practice of an abusive regime or negligent culture within an institutional setting or care organisation) is suspected or has been alleged – this may only become apparent once the service has received a number of separate referrals about different individuals using the same service;
- multiple abuse (perhaps involving more than one abuser and causing risk or harm to more than one adult and possibly also children) is suspected or has been alleged;
- organised abuse (linked incidents), whether in a care setting or in the community is suspected/alleged;
- an adult has died and abuse or neglect is suspected or alleged;
- the alleged perpetrator(s) hold a position of authority within a care setting/organisation;
- where there are a large number of victims to be interviewed/supported;
- any other case where one partner agency alone does not have sufficient resources to carry out the full extent of safeguarding work required; and/or
- Where the case may attract significant media interest.
- Also, there may be circumstances when there are no specific allegations of abuse or neglect but there are significant concerns regarding the quality of care being provided by an establishment or organisation that indicate that service users are vulnerable and are at a high risk of suffering harm.

It may be apparent from the point of referral that an executive planning meeting needs to be convened to fully and jointly address highlighted concerns and issues at the most senior levels within the partner organisations. This however is unusual and large-scale or organised abuse sometimes only comes to light in the course of already

established safeguarding investigative enquiries, or after an adult has moved away from a service where he or she has been abused.

At whatever stage it is recognised that executive level involvement is necessary, the Adults Wellbeing and Health Manager (at the decision making stage) or the Lead Officer (where a safeguarding strategy discussion/meeting has already taken place) must at the earliest opportunity consult with one of the following senior managers in Durham county Councils Adults Wellbeing and Health :-

- The Head of Adult Care
- Operation Manager Older Persons, Physical disability and sensory support
- Operation Manager Learning disabilities and Mental Health
- The Safeguarding and Practice Development Manager
- An appropriately identified Senior Manager

The appropriate senior manager will then take steps to convene an executive strategy meeting, to which senior representatives from each of the other necessary partner agencies will be invited. Both the police and the local authority legal department will be informed of any impending executive strategy meeting and will make an informed decision, based in the nature of the concerns, regarding whether they will need to attend. A Safeguarding Adults Practice Officer will attend as a matter of course. The senior Manager may also need to inform the Council's Chief Executive depending on the severity of the allegation. An Executive Lead Officer will need to be appointed to co-ordinate the case from that point onwards, who will ensure that that everyone who can assist the inquiry will be engaged and a balanced investigation will take place.

Where commissioned and registered care services are implicated, there is also an expectation that the Council's Commissioning Services Manager and a Regulation Manager or Regulatory Inspector from the Care Quality Commission will play a key role in the executive planning process and any subsequent safeguarding work. Outcomes may result in ongoing auditing and monitoring of those services and may even involve suspension of placements, regulatory action such as enforcement or cancellation of registration, or termination of contractual arrangements (see also the decommissioning process at Section 12). Effective communication and collaboration between the partner agencies will therefore be essential.

Additionally, in the event of any safeguarding referral which requires a response at executive level and where any of the above factors are

present, the Police may take the decision to implement their 'gold' strategy response protocol.

Safeguarding strategy arrangements made at this senior level must also be made within five working days of the executive strategy meeting being identified as necessary.

As with the standard strategy process, regular follow-up meetings may need to be conducted so that plans can be jointly reviewed and revised if necessary. Protocols for information sharing and recording will need to be implemented in the same way, and minutes of strategy meetings/records of strategy discussions must only be circulated in accordance with the relevant guidance set out in these inter-agency procedures.

Media management in such cases will need to be co-ordinated at executive level.

9.2 Conducting an Executive Strategy Meeting

The chair should conduct the meeting in accordance with the structure as set out in these procedures. There are a number of issues that the chair may wish to consider both prior to and during the meeting (s):-

Attendance

The Chair must give careful consideration as to who should be invited to attend the Executive Strategy Meetings. They should consider inviting anyone whom they consider could provide any value to the investigative and decision making process. Anyone, other than authorised deputies, should not attend the meeting unless they have the express permission of the chair. If there is any suspicion that someone (i.e. the owner of an establishment, service provider manager, Health or social care professional) has acted incorrectly or who may adversely influence the outcome of any investigation following the alleged conduct they should not be invited to the meeting. The Chair must be prepared to exclude those persons for the whole or part of the meeting if they attend. It is unlikely that anyone who is the subject of a criminal investigation would be invited to attend an ESM

Conflicting Governance

Consideration should be given both at the start and during the course of the ESM process as to whether any other group/meeting should take precedence over the Executive Strategy or that may need to be informed of the issues under investigation such as:-

- An Incident Coordination Group (For a death in a Health Care Setting)

- Police Gold Group (Where there may be Serious Systematic Failings that would lead to a serious loss of confidence in the police and their partner agencies)
- Serious Untoward Incident

Legal Advice

If the case may lead to litigation against the local authority or partner agencies or where the subject of the executive strategy process is liable to request the presence of a legal representative, the chair may wish to consult with local authority legal department before any executive strategy meeting takes place.

Capacity

In ESM's that pertain to concerns surrounding individual service users There may be issues regarding whether the service user (s) has capacity? The Chair may wish to consider requesting the carrying out a capacity test, the employing an IMCA, the use of D.O.L.s and applications to the court of protection for best interest decisions and/or welfare deputies.

Referrals

The chair may also wish to confirm that referrals have been recorded on adults wellbeing and Health, SSID system regarding any identifiable individual service users?

Organisational Information / Documentation

Where appropriate the chair may request access to any documentation held by an organisation under executive strategy such as care plans, policies and procedures, incident reports etc. that may assist with the executive strategy meeting. This should also be considered in circumstances where the Manager / organisation are excluded from the meeting if it would contribute to the conducting of a balanced investigation. They should also consider requesting relevant information from partner organisations such as SSID records (AW & H), SLUETH (Police) or PARIS (TEWV). Where possible, details such as time, date and venue of events and meetings should be supplied. Where information is presented to the meeting (in the form of allegations, accounts, mitigation etc.) where there is a lack of substance or an identifiable source, further verification or corroboration should be sort to establish whether it can be relied upon as factual and accurate.

Executive Strategy Meetings will ordinarily take place in two parts (this is especially so for the initial ESM involving an organisation / Service provider). The first part will essentially consist of the formulation of

allegations / concerns, partner agency information sharing (some of which may not be appropriate to share with the Service Provider), establishing the level of risk and the construction of actions /action plan to address the issues that raised the ESM. In the second part of the meeting the chair will share the allegations / concerns, appropriate information in the form of a summary, receive the service provider's response and finalise the action plan.

It would not be normally expected for someone who is the subject of a criminal investigation to be invited to take part in the ESM and this may result in an employer / service provider not being informed of the ESM if it is considered that by informing them it may frustrate the investigation. The reason for the exclusion should be documented in the minutes. Where a person or organisation has been excluded or not informed of an ESM, they should be made aware of the procedure as soon as reasonably possible once it is considered that the reason is no longer valid.

Criminal investigations normally take precedence due to the higher level of scrutiny required by the criminal justice system. On some occasions it will transpire that there will be no criminal prosecution and in such cases it should be made clear that there may still be a need to continue investigations into issues of a non-criminal nature.

Where service users make statements in pursuit of a criminal investigation their identity will normally be revealed during the course of that investigation or any subsequent court proceedings. If the investigation does not result in a criminal prosecution there is no obligation to reveal the identity of the witness (s). Anyone making a statement to the police in connection with a criminal investigation should have an expectation of confidentiality and information should only be disclosed with the explicit consent of the person making the statement. This expectation of confidentiality would only be overridden where there are matters which are of pressing public interest. The chair of the ESM should therefore take into account the views of witnesses when making a decision whether to reveal the identity of anyone who has contributed to a criminal investigation.

The Executive Strategy process should produce a fair and impartial investigation and any report produced by an ESM should take into consideration any information provided by an individual or organisation by way of defence or mitigation. There should be an indication of what type of report it is i.e. draft, interim, final etc. and the extent of any distribution.

During the course of the meeting it will be the chair's role to ensure the following agenda items are addressed

1. Context and Focus of Meeting

To explain to the meeting why the meeting has been convened and including a brief outline of the allegations / concerns.

2. Exclusions

The chair should make a decision about whether to exclude anyone for the whole or part of the meeting. A record of the reason for exclusion should be made in the minutes of the meeting and the chair must be prepared to explain the reason for the exclusion. In the majority of cases exclusions will only take place at the first meeting.

3. Confidentiality Statement

The chair should explain the contents of the confidentiality statement to the meeting and invite each member to ensure that they are familiar with the contents and sign it accordingly.

4. Allegations / Concerns (reviewed in subsequent meetings)

The chair has responsibility for formulating the allegations / concerns. They should be clear and concise and embrace all of the issues that have been raised. They should be clearly recorded in the appropriate place in the minutes. The chair may wish to produce a draft of the allegations prior to the meeting and if further information comes to light they should be amended accordingly.

5. Stakeholder Information Sharing (including contract and legal status)

This is an opportunity for the exchange of information from the partner organisations. All communications should go through the Chair. If any of the information is of a confidential nature and not for sharing with a service provider, the person giving the information should make this clear at the time

Following the initial meeting this is an opportunity to provide an update and review of the actions from the previous meeting (s).

6. Risk Status

During the course of the meeting the chair will invite those present to consider the level of risk for the service user (s). Where the subject of the meeting is a residential provider this will be done using a traffic light system,. The chair should read out the risk criteria or circulate risk criteria sheets so the meeting can formulate an objective level of risk. (See section 11.5)

If the subject of the ESM is an individual then the meeting will be asked to consider the risk using the risk support tool (see appendix 4 of these procedures)

7. Chair's Summary

Once there has been a full exchange of information the chair should, with the assistance and agreement of the meeting, summarise the information that has been shared. This summary should be the basis of the disclosure to the service provider.

8. Determine proposed actions and timescales (reviewed in subsequent meetings)

Chair should draft actions together with the executive group to address the allegation / concerns. The actions should embrace the concept of SMART action planning, be allocated to an individual who should take responsibility for completing it and be given a date by which it should be completed. In subsequent meetings the chair will ensure the executive strategy group review the agreed actions from the previous meeting. In doing so, the progress will be updated and revisions and amendments made as necessary.

Provider Engagement

9. Summary of Issues

The chair should provide the service provider with a summary of the overall situation that has led to the meeting being convened and the allegation / concerns that have been raised.

10. Provider's response

The service provider should be given the right to reply and any information, actions instigated and mitigation should be taken into consideration.

11. Confirmation of Actions and Timescales

Once the service provider has provided a response the action list should be finalised and timescales for the completion of those action agreed.

12. Lessons learned

The chair should reflect on any lessons learnt such as systematic and procedural failing

9.3 Additional considerations for the chair at the conclusion of the ESM process

At the conclusion of the ESM process the chair will ensure all identified issues have been addressed satisfactorily. In more complex cases the chair may convene a separate debrief meeting, otherwise they will use the final ESM to achieve this. The focus will include the following: -

- Review each of the Allegations to ensure that they have all been satisfactorily addressed.
- Review each of the actions to ensure that they have all been completed.
- The Chair should consider whether everyone has been engaged that could have provided any value to the investigation.
- Does the Chair consider that this has been a balanced investigation?
- Are you satisfied that all service users identified in the executive strategy process have had all of their needs addressed? Have all SSID entries been completed?
- Collate all lessons learned from the executive strategy process
- Is there a need to review practices in the establishment/with service provider, at some date in the future, to ensure there has been no lapse in service provision?

9.4 Consideration of Management Reviews

If during the course of the executive strategy process it is identified that there are serious failings within any of the systems employed during the safeguarding process by any group of agencies or a single agency then contact should be made with the Safeguarding and Practice Development Manager who can advise which review process should be employed to remedy those failings (This may be by way of commissioning a serious case review or by some other single agency review).

SECTION 10 MULTI AGENCY SAFEGUARDING ADULTS INVESTIGATION

10.1 Multi-agency safeguarding adults investigation

The purpose of any safeguarding investigation should be to find out if and how an identified adult or adults has/have experienced abuse, and who perpetrated it. Evidence will be required to substantiate any findings and to satisfy legal, regulatory and disciplinary proceedings.

With the consent of the adult(s) and bearing in mind issues of capacity, investigative work should run parallel to the safeguarding assessment process.

The aim of any safeguarding investigation should be to identify the presenting risks to the adult and any others affected by the alleged abuse, and to determine how these can be minimised to an acceptable level through recommendation or application of a range of remedial measures. These should be set out in an organisational/remedial plan.

The aim of assessment on the other hand - although similar - should be to identify the risks to the named individual, as well as opportunities for that person to take control over the situation, and to create a safeguarding care-plan setting out measures for protecting his or her safety and well-being whilst at the same time promoting or maintaining independence.

Wherever possible, the investigative process should be completed within 28 days from the conclusion of the strategy meeting, although in complex cases a time extension may be permitted (e.g. where a criminal investigation is taking place). The reasons for the extension must be fully recorded and communicated to the adult at risk and his or her supporters, and where appropriate, the referrer.

10.2 Proceeding to an investigation

If an investigation is required, then the terms of reference for this must be jointly agreed at the strategy stage, along with individual and collective roles and responsibilities and timescales.

Wherever there is doubt about grounds to proceed with an investigation, or duties/powers to intervene, Adults Wellbeing and Health Managers and Lead Officers should always consult in the first instance with their line-manager, or subsequently/alternatively with the Council's Solicitor.

Where the alleged abuse implicates a care service or organisation, the representative for that agency should be informed of the progress of the

investigation as part of any strategy follow-up meetings. Where appropriate he or she might also be involved in an investigative capacity, providing that involvement does not compromise any Police enquiries.

If a criminal act is suspected, then the Police investigation will take precedence, although it is important to ensure that the protection of the adult(s) at risk is not unduly delayed by the process. In the case of serious accident/injury/death, the Council's Health and Safety and Staff Care Team may additionally be involved, along with the Health and Safety Executive if necessary, whose investigative intervention will also take precedence over any enquiries conducted by Adults Wellbeing and Health.

Additionally, where allegations of abuse or neglect concern a registered service and it is suspected that a breach of Regulations may have occurred or the fitness of the Registered Manager or Responsible Individual (Proprietor) is in question, then the Care Quality Commission may choose to lead the investigative process.

More information about the roles of the Police and the CQC and how these need to be supported by the other partner agencies can be found in Section 2.

Formally agreed investigation processes must commence within a 48 hour period of the conclusion of the strategy discussion/meeting.

10.3 Possible investigative actions

These will be agreed at the strategy stage and might include any or all of the following:

- joint visits with other partner agencies;
- examination of documentary evidence such as files, accident and incident reports, daily logs, financial records and medical records - for residential care services this task may be allocated to a Safeguarding Adults Practice Officer in conjunction with an Inspector from the CQC and a Commissioning Services Officer (although there are some restrictions around who is legally able to access medical records and the necessary permissions should always be sought;
- interviews with the adult(s) at risk, the referrer, witnesses and any others who are able to set the scene, as well as the alleged perpetrator(s); and
- in cases of suspected sexual or physical abuse, a medical assessment should be offered to the individual (usually by the Police) - where a

person cannot give their consent to this, or where consent is questionable, a responsible medical practitioner will have to make a judgment about whether an examination (either for health and/or evidential reasons) is likely to be in the person's best interests.

10.4 Conducting interviews with an adult at risk

The adult(s) at risk will normally need to be interviewed before the investigative team can proceed with any further enquiries, so that he or she can give as full as possible an account of what has happened. Best advice dictates that an adult at risk should not be interviewed alone or in the presence of the alleged perpetrator, especially if there is any possibility that a criminal offence may have been committed. It is therefore preferable for the adult to be accompanied by one or more of the following supporters:

- an independent advocate of the adult's choosing or as appointed by his or her Social Worker/Assessing Officer; or
- A relative or close friend (if this is considered appropriate and the person is not otherwise implicated). a language interpreter, a British
- Sign Language interpreter or a person who specializes in augmented communication methods such as word boards or Makaton for people with learning disabilities;
- An intermediary who could aid communication and understanding.

10.5 'Achieving Best Evidence' principles

Criminal investigative interviews - which will always be led by the Police - will be conducted in accordance with the guidance set out in *Achieving Best Evidence in Criminal Proceedings* (Office for Criminal Justice Reform, 2007). The guidance was published following the introduction by the Youth Justice and Criminal Evidence Act 1999, of a series of discretionary 'special measures', which may be employed by the Courts to encourage and support vulnerable or intimidated witnesses to give their best evidence. More information about 'Achieving Best Evidence' principles can be found in Section 18.

Generally speaking, out with the criminal investigation process, all interviews, as a matter of good practice, should be carried out by two interviewers. Before the interview commences, the interviewers should introduce themselves and any colleague(s) fully and clearly. The adult should be informed candidly of the purpose of the interview, and the boundaries of confidentiality should also be clearly explained. Interviewers should explain how they intend to record the discussion, e.g. by taking notes or using video or audio-tape, and in the case of

tape, obtain the adult's permission before proceeding. If consent to use data capture technology is refused, then written notes will suffice. It is useful, although not always possible, for the adult to sign and date the interview record. The interviewers must sign and date the record.

The venue should ideally be a neutral place, where the person feels safe. Suitable access arrangements where necessary will also need to be made in advance. Opportunities should be given for comfort breaks.

10.6 Conducting interviews with the alleged perpetrator(s)

Once again, interviews should always be carried out by two (or sometimes more) interviewers. In the case of a Police investigation, this may involve a Police Officer and a representative(s) from one of the other partner organizations, e.g. a Social Worker, Nurse or Regulation Inspector. Additionally, where it is clear that an investigation may lead to possible regulatory action being taken by the CQC, then evidence to support that action may only be gathered by an Inspector or Regulation Manager.

Alleged perpetrators who are employees, volunteers or students on placement may be permitted support or representation at interview, e.g. from a trades union representative, if this is in accordance with the employing/placing agency's safeguarding and human resources procedures.

Alleged perpetrators who are unpaid carers or relatives may also be enabled to invite a supporter.

Supporters should never, however, be potential witnesses who are under suspicion of involvement or collusion in the alleged abuse and who may also need to be interviewed as part of the investigative process.

In criminal investigations the alleged perpetrator will be entitled to legal representation, and in the interests of achieving best evidence, the rights of those requiring the support of an 'Appropriate Adult' must also be recognized (see Section 18 for more information).

Interview records must be signed and dated by all concerned.

10.7 All other interviews

All other interviews should be carried out in accordance with the good practice guidance outlined above as regards the conduct of interviewers and protocols around confidentiality and recording of information. Consideration must also be given to any support, access or other

specialist needs that an interviewee might have and how these can be met.

10.8 If information comes to light that a member of the strategy group/investigative team may be implicated in the allegation

If at any point during the investigative process - or indeed any other stage in the implementation of these safeguarding procedures - it becomes apparent that a member of the strategy group or investigative team may be implicated in the alleged abusive action and therefore has not been completely open and honest about his or her prior association with the case, then investigative/safeguarding proceedings must be suspended. The Lead Officer must convene an interim strategy meeting as a matter of urgency.

Whether the person implicated (who may have deceived the strategy group) is invited, will be left to the discretion of the Lead Officer, in consultation with a senior Manager. Invitation should however be dependent upon the severity of the new information brought to light. In any event, the person will have the right to know the nature of the concerns raised about their practice, will have a right of reply and the opportunity to correct any information held about them that is not accurate.

If there is sufficient substance to the concerns to indicate that the strategy member/investigative team member may be an alleged perpetrator, then he or she must be treated as such and have no further part in the safeguarding process. He or she will be entitled to support and representation in the same way as any other implicated person.

10.9 Compiling a report following investigation

At the end of the investigation a summary of all information gathered should be recorded in the form of a concise report. Each member of the investigative team might contribute to its content, drawing on his or her personal or professional knowledge, judgement and/or on specific inquiries carried out as part of the investigation. Alternatively, writing could be delegated to an identified individual who brings together and presents the evidence gathered collectively throughout the process. For Adults Wellbeing and Health staff, this can be documented using the case notes recording system.

The report should cover the following points:

- details of the initial alert and of the incident or concern which triggered the referral;
- an outline of any previous related incidents or allegations;

- a pen-picture of the adult(s) at risk and his or her circumstances, networks and social supports;
- an assessment of the adult's capacity in relation to consent and any other legal issues;
- any issues of possible/identified discrimination;
- information about the alleged perpetrator(s);
- a brief account of the investigation process (methodology) and the input of each partner agency, (preferably set out as a chronology);
- an evaluation of the evidence;
- where abuse is proven to have taken place, an assessment of how serious this has been and whether there is a risk of it escalating or being repeated;
- recommendations about future action to support the adult(s) and/or manage any ongoing risk;
- conclusions about culpability and responsibility for the abuse or harm and what needs to be done to address and resolve this;
- any other actions to be taken; and
- Recommendations about when and in what circumstances the case should be reviewed/revisited.

Where the investigation has concerned possible abuse or neglect leading to skin damage the Skin Damage Protocol (www.safeguardingdurhamadults.info) includes a suggested format for completing a report.

The completed report should be passed to the Lead Officer for decision making and shared at the multi-disciplinary de-briefing meeting. The contents of the report will be regarded as confidential and as such should be only be shared in accordance with the inter-agency protocols, perhaps to inform any future safeguarding care-planning, or in cases where an employer needs to take disciplinary action or refer a worker to the ISA. Consideration may also be given to sharing some or all of the contents of the report with the multi-agency risk management partners (MAPPA/MARAC/PDP) if this is deemed appropriate.

For more information about confidentiality and the role of the multi-agency risk management partners please refer to Section 18.

10.10 Additional considerations for the investigative process

What to do if one adult at risk abuses another

The abuse by one 'adult at risk' of another adult service user within a service setting should be addressed as a safeguarding issue.

Incidents of this nature have traditionally been approached in terms of the perpetrator's challenging behaviour and therefore not often identified as an abusive act. However, since it is not the degree of responsibility or intent of the person carrying out the act that should be the trigger for reporting abuse, safeguarding procedures should be followed.

Many service providers have become accustomed to responding internally to incidents of adults at risk abusing other service users. This has resulted in regulatory, commissioning and contracting agencies for both victims and perpetrators not always being informed of the concerns, and not given an opportunity to engage in decision making around the issues. It may also have resulted in safeguarding (formerly known as protection) protocols being ignored and more importantly, potential criminal offences not being properly investigated or resolved.

All partner agencies must have a 'zero tolerance' policy where abuse is concerned. An acceptance by service providers of bullying or abuse - no matter how low-level – will, if allowed to continue, lead to a culture that is damaging to all service users and staff.

It is essential that all instances of abuse be recognised and dealt with in the most appropriate manner. So, whilst it is clearly not necessary or desirable for every instance of service user-to-service user abuse to be investigated through formal safeguarding processes, each incident must still be recognised as an abusive act and properly addressed. This may for example involve the drawing-up of safeguarding plans for both adults. Additionally, all abusive acts regardless of whether they progress to investigation must be logged as safeguarding incidents for screening, monitoring and service development purposes.

See also section 7.1.18, 'Alleged perpetrators who have community care needs'.

10.11 Cross boundary investigations

Where Durham is 'host Authority' to an adult at risk

Where an adult from another placing Local Authority or Health Trust outside of the county uses a residential service or day or other support service within the Durham boundary and is identified as being at risk of

abuse or neglect, then Adults Wellbeing and Health will take the initial lead on referral and overall responsibility for co-ordinating safeguarding arrangements.

If allegations concern abuse which is said to have taken place/is taking place within a registered residential or nursing home or day centre, Durham will take responsibility for co-ordinating the safeguarding arrangements, although the individual roles to be adopted by the statutory bodies including the Care Quality Commission will need to be determined at the strategy discussion. Adults Wellbeing and Health will bear in mind the potential risk to all users of the service and advise any other placing Authorities, including Health Trusts, accordingly.

Where the adult at risk is a person placed by Durham within another Local Authority area, it is expected that the host Authority will assume responsibility for co-ordinating the safeguarding arrangements, but Adults Wellbeing and Health will allocate a link worker in a liaison and advisory capacity, who will also support the investigation wherever possible and draw-up any subsequent safeguarding plans with/for the adult.

10.12 Hospital inpatients who are not permanent residents of Durham

Where the adult at risk is not a permanent resident of Durham County, but is an inpatient at a Durham hospital where alleged or suspected abuse is said to have occurred, then Adults Wellbeing and Health if requested by the Health Trust will assume responsibility for co-ordinating safeguarding arrangements. The Lead Officer will request a link worker from the person's home Authority.

However, if the alleged abuse took place prior to hospital admission it is imperative that the person's home Authority be closely involved in the safeguarding process, since it may be possible that on discharge, he or she will be returning to the same environment in which they were harmed. The home Authority must be consulted immediately and a worker from Adults Wellbeing and Health may be allocated to act in a liaison/advisory capacity.

10.13 People from neighbouring Authorities

If whilst visiting Durham an adult discloses abuse that has happened within the boundaries of their own home Authority, and wishes to take further action, he or she should be supported by an appropriate professional, e.g. a Social Worker, to contact safeguarding services in their own locality.

If however the allegation concerns the conduct of a service provider in Durham, cross-boundary safeguarding procedures, with consent, will be followed.

If the adult has capacity and decides not to take further action, then the potential risk to other adults must still be considered. If risk to others does exist, then the matter should be referred to the safeguarding services in the identified locality. Wherever possible, the adult at risk who made the initial disclosure should be informed of this action.

Proper records must be kept of any/all such disclosures and interventions.

10.14 Self-funded placements

These procedures apply equally to adults who fund their own care and support arrangements. Where suspected or alleged abuse concerns the providers of care, the potential risks to other service users will also need to be assessed and acted upon.

10.15 Safeguarding people who are directing their own support (users of direct payments/personal and individual budgets)

Adults who use Direct Payments/budgets to organise their own care are not presently afforded the full protection of the current regulatory system, unless they purchase support from workers who are employed by an agency registered with the Care Quality Commission.

The Safeguarding Adults Board therefore commits itself to ensuring that adults who employ their own support or care workers will be protected by these procedures, just as any other adult in Durham. Furthermore, the Board will endeavour to establish links with support workers and organisations that are not subject to regulation or contractual obligations and encourage them to achieve the same safeguarding standards as those described above.

In terms of prevention, partnership professionals will consider how best to balance interventions to ensure that adults directing their own support are protected from abuse, without having choice and control taken away. Advice will be offered in relation to recruitment and selection processes and vetting prospective workers, along with guidance about accessing information, training and support on safeguarding, financial and employment issues. In addition, the implementation of care plans will be carefully monitored and any complex or high level risks will be referred to the Risk Enablement Panel (see Section 11.3 for further information).

Adults directing their own support will be also advised to make their support workers aware of these inter-agency procedures and to be clear with them that any issues of abuse will be reported to Social Care Direct and/or the Police.

As with any other adult, a person directing their own support may refuse safeguarding intervention or investigation. Where a person has capacity to make this decision, it will be respected. However, where there are perceived risks to others, there may be duties to intervene.

N.B. It is possible for Local Authorities to place reasonable conditions on an agreement to make Direct Payments. Such conditions might be introduced to protect an individual identified as being 'at risk', as long as they are proportionate to the risk and do not defeat the principle purpose of the scheme, which is to give people more choice and control. Therefore, if the suspected or alleged abuse concerns a person employed by the adult to provide care, Adults Wellbeing and Health might apply a condition whereby they have the right to carry out a safeguarding assessment to determine whether the Direct Payment recipient's assessed needs are being appropriately met.

10.16 Post investigation

De-briefing meetings, organisational/remedial planning and safeguarding case review

The outcome of all investigations, including those conducted at Executive Officer level, will need to be shared at a de-briefing meeting. De-briefing meetings should be held wherever possible within five working days of the completion of the safeguarding assessment and investigative process. All of those involved in the safeguarding strategy, investigative and safeguarding assessment and care-planning processes should be invited to take part. This may also involve the identified adult(s) and where necessary his or her supporters. This will enable the safeguarding partners to consider the reported outcome of the investigation and assessment and any associated recommendations. Decisions can then be jointly taken about how the ongoing needs of the identified adult(s) will be met within pooled resources and how remedial actions can best be achieved and outcomes reviewed.

At this stage, any organisational/remedial plans to supplement the adult's safeguarding care-plan will need to be drawn up and agreed, along with identified timescales for action and multi-disciplinary review. Plans must be completed within a maximum of four weeks of the investigation being completed.

In complex cases where the risk of ongoing abuse remains a significant factor, the nature and frequency of each review will vary. An initial review in any event should be held no later than six months after the de-briefing meeting and earlier if the risk increases or circumstances dictate (initial reviews of *safeguarding* care-plans should still take place after three months or earlier). The review should involve as many of the original safeguarding partners as is deemed necessary.

As part of the organisational/remedial plan review process, care should be taken by the safeguarding partners to keep under consideration the implications of any outstanding issues and processes such as:

- bail hearings;
- Court cases;
- action taken under the Health and Social Care Act 2008, referrals to Care Quality Commission, and the Independent Safeguarding Authority (ISA);
- action taken by employers including disciplinary hearings and referral of staff to ISA;
- tribunals or any other actions by professional registering bodies; and
- Parole and release dates for prison sentences.

Even in cases where an investigation finds that an allegation of abuse cannot be substantiated because of insufficient evidence, the surrounding concerns should not be dismissed. The safeguarding partners will still need to use the de-briefing meeting as a forum for deciding how the presenting risks can continue to be monitored, managed and reviewed.

It would be good practice to ensure that review dates for both types of plans, and for unsubstantiated cases, are set at the de-briefing meeting.

De-briefing meetings can also be used to identify and address the support needs of any others who have been affected by the allegation and subsequent investigation, including those who have spoken out (whistle blowers) and the perpetrator (where he or she is a 'vulnerable' adult and requires safeguarding assessment and care-planning interventions in his or her own right).

Additionally, where contracts with commissioned services have been suspended or terminated or where the registration of a care service is to be cancelled, contingency plans can be jointly drawn-up. The Safeguarding Adults and Practice Development Team Manager and Practice Officers will take the lead role in this process. Thereafter, as

necessary, the Practice Officers will provide a period of targeted support and monitoring.

Finally, the de-briefing meeting will agree if, how and with whom the investigation outcome and report will be shared. The Lead Officer will make any necessary arrangements for this to happen.

A record will need to be kept of the meeting and this will be subject to inter-agency information recording, storage and sharing protocols. Adults Wellbeing and Health's Safeguarding Adults and Practice Development Team will need to be provided with a copy of this and the investigation report for monitoring purposes.

SECTION 11 RISK

11.1 Risk/protection

Risk assessment and risk management are essential aspects of the safeguarding process and their application should be considered at every stage. As well as assessing the risk to the adult identified by the alert, the partner agencies and all participating services will need to take into account the possible risks to other people, including children. All risk assessment and risk management activities undertaken as part of the safeguarding adults process, must reflect the principles of 'positive risk taking', as described in the Adults Wellbeing and Health '*Guidance on Risk Management*' document. The guidance is to be read in conjunction with the '*Risk Procedure*'.

11.2 Risk assessment and risk management

Risk assessment, albeit on an informal basis, begins at the point of alert when the alerter - who suspects or alleges abuse or neglect has taken place - decides to take action. Whether that action is to respond to perceived threat to life and limb by telephoning the emergency services, or to make a safeguarding referral or both, the alerter is assessing the presenting risk. He or she has also to weigh up the risk to the adult against the risk of emergency intervention resulting in the accidental or intentional removal or destruction of evidence, and then make a judgement about how best to manage the situation.

On receipt of the alert, risk assessment and risk management tools need to be applied in a more formalised way. On being made aware of suspected or alleged abuse, an Adults Wellbeing and Health Manager, taking into consideration all of the information available at that time, has to decide whether to proceed to a safeguarding strategy discussion and whether the adult at risk requires immediate protection measures to be put into place. In so doing, he or she is again weighing up the risks to the adult and any other 'vulnerable' adults or children who may be affected by the situation.

If there is the possibility that a criminal offence has been committed, the Manager will also have to contact the Police, who will take responsibility for ensuring the preservation of evidence. Additionally, the Council's Health and Safety and Staff Care Team will need to be notified of any serious accidents/injuries; they in turn, if necessary, will refer the matter to the Health and Safety Executive. None of this needs to be done in isolation however, since the Police and the Council's Solicitor are always available to give advice.

The strategy stage, the investigative process, and any parallel safeguarding assessment and care-planning work all need to be

underpinned by a robust risk management approach that is shared by all of the partners and that influences the timescales within which action is taken.

The results of every risk assessment undertaken, and all subsequently agreed risk management plans/actions must be recorded on each safeguarding file. Risk management plans for adults at risk must be documented using the standard Adults Wellbeing and Health template; in Older Persons', Physical Disabilities and Sensory Impairment Teams, the risk management plan is a supplementary document to the care plan. Disagreements too should be noted. All risk assessment /management documentation should be signed and dated by everyone involved, including the adult at risk and his or her supporter/advocate where applicable.

Of course, levels of presenting risk may increase or decrease throughout the course of any piece of individual safeguarding case work. Assessments, management plans and overarching strategies will therefore need to be reviewed and evaluated in light of any new information, significant investigative findings, or changes in the adult's circumstances. To facilitate this it may be necessary for the Lead Officer to liaise with or reconvene a strategy meeting of the safeguarding professionals originally involved. Once again, ongoing discussion, interim meetings and the results of any re-assessment or planning need to be properly documented.

11.3 The Multi-Agency Risk Enablement Panel

For some cases, as an alternative to safeguarding, referral to the Multi-Agency Risk Enablement Panel may be an appropriate route. The Panel will provide a forum for discussion and decision making in complex cases, where staff may be fearful of the potential for real harm to the adult, or of litigation. The professionals involved will be able to agree how to best manage high risk situations, whilst at the same time trying to support the adult's choices and wishes. The process therefore will be as inclusive as is practicably possible.

11.4 Assessing risk where a care service is involved

Where an allegation concerns a registered residential or domiciliary care service and where there appears to be significant risk to existing/prospective service users, contact with the Care Quality Commission will need to be made by the Adults Wellbeing and Health Manager convening the strategy discussion.

He or she will also be responsible for notifying and involving the Responsible Individual and/or Registered Manager of the service in the

strategy discussion, unless it is believed they may be personally implicated in the allegation.

As soon as possible thereafter, an assessment of the presenting level of risk to the users of the service - using the classifications described below - will need to be carried out in conjunction with the relevant senior Manager and the Council's Commissioning Services Manager.

11.5 Classification of risk

Risk level green: a safeguarding adults case is being assessed /investigated within the service, but there is currently no evidence that other service users are at risk.

Risk level amber: a safeguarding adults case is being assessed /investigated and it is possible that other service users may be at risk of significant harm due to abuse or unsatisfactory practice. Some or all service users are being individually assessed in relation to these concerns.

Risk level red: a safeguarding adults case is being assessed /investigated and there is evidence of a significant risk to other service users due to abuse or unsatisfactory practice. No new placements should be made until the issues have been resolved.

11.6 Acting on the risk assessment

The results of the assessment will need to be recorded and kept with the safeguarding file, with all Databases being updated accordingly. The Managers will need to take the most appropriate action, (based on their assessment) as follows: -

- At levels amber and red consideration should be given to notifying the families/carers of other service users that an assessment/investigation is being undertaken. If other commissioning Authorities have not already been informed they should be contacted and will need themselves to take responsibility for keeping families/carers informed.
- If the service provider has not already been involved in the safeguarding process then they must be advised by the Commissioning Services Manager of any decisions taken that may affect them or their service, e.g. a temporary suspension of placements. Where a residential home has been assessed as reaching levels amber or red, the provider will also need to consider the appropriateness of admitting any new self-funding service users.

In such cases the CQC may already be considering or embarking upon enforcement action. In extreme cases this may involve application to a Magistrate for an emergency or planned closure of a residential home. It is the policy of the CQC to work closely with Adults Wellbeing and Health to ensure the best interests of service users are kept central to any planned outcomes.

See also Section 12 for information about the decommissioning process.

11.7 In the event of multiple or institutional abuse

Where a safeguarding referral reveals problems relating to poor standards of care, which appear to have become customary practice within the culture of a residential or domiciliary care service, or where larger scale abuse is alleged either within a service or in the community, then an executive planning meeting may need to be convened.

The executive planning meeting will bring together a number of other significant professionals, or Executive Officers, operating at the most senior levels within their organisations to agree upon a multi-agency safeguarding strategy. An Executive Officer will normally be appointed as Executive Lead Officer in such cases.

Where allegations/concerns implicate a care service, then the risk classification exercise described at above will also need to be carried out.

11.8 In the event of a death

In the event of the death of an adult where safeguarding concerns already exist or are raised around the time of death, the decision making Adults Wellbeing and Health Manager must contact the Police as a matter of urgency. He or she must also contact the Council's Health and Safety and Staff Care Team (who will decide whether the Health and Safety Executive need to be informed) and the Coroner's Office. The Police will take responsibility for any investigative work and will liaise with the Coroner. An executive strategy meeting, as described above, will need to be convened.

11.9 What protective actions may be considered?

If at any stage in the safeguarding process it becomes evident that an adult at risk or child may be exposed to significant harm, immediate protective measures should be considered.

Protective actions might include:

- in the case of an allegation against a worker, student on placement or volunteer, the application by the employer of suspension/staff disciplinary procedures in conjunction with the agency's human resources and safeguarding policy and procedural framework for the protection of the adult and alleged perpetrator;
- moving the adult to a place of safety, e.g. with an appropriate and willing family member, a residential home etc.;
- informing Children's Services of the concerns for the child(ren) see 6.1.19 and 13.6.to 13.8 for further guidance;
- where the alleged perpetrator is a service user at a residential or nursing home, moving him or her to an alternative appropriate placement and/or providing additional support; and
- The appointment of an independent advocate/IMCA and legal representation for the adult, especially where his or her individual interests may conflict with those of the partner agencies' legal functions.

11.10 Safeguarding assessment, care-planning and review

The safeguarding assessment process will usually run parallel to any investigative action being implemented by the partner agencies and will need to be carried out in a setting, manner and language appropriate to the level of understanding and cultural background of the adult concerned. The safeguarding assessment process must be completed within a maximum of four weeks from referral.

Based on the outcome of the safeguarding assessment, the Assessing Officer will work with the adult to draw-up a safeguarding care-plan. This will normally include strategies for minimising risk of further harm and preventing abuse. Safeguarding care-plans must be agreed within four weeks of the assessment being completed.

Where a case is already open at the point of a safeguarding referral being made, and there is a recent or 'live' assessment for the adult, then this could be used and updated accordingly, and supplemented by an updated care/risk management plan(s).

Assessments, care plans and risk management plans should all be recorded onto standard Adults Wellbeing and Health documentation.

A number of possible routes might be considered:

- provision of additional or alternative care or support services (where this involves the re-housing of an adult at risk or perpetrator who

holds a tenancy to rented accommodation, then consultation should always take place with the housing provider);

- access to advocacy, information or advice, or signposting to alternative sources of help and support such as services or activities that help improve self-esteem and confidence;
- exploring options to improve personal or environmental safety such as personal alarms, telephones, additional door locks or key safes; and
- exploration of legal remedies that might include Declaratory Relief, creating powers of attorney, or identifying a suitable appointee to assist with the adult's financial matters.

When a person does not want the safeguarding agencies to investigate alleged abuse, yet he or she is deemed to have the capacity to understand the consequences of that decision, as long as there are no other grounds or duties to intervene this must be respected. It is still possible however to work alongside the person to assess his or her needs for safeguarding support and draw-up a safeguarding care-plan.

An initial review of the safeguarding care-plan should be held no later than six weeks after the date of it being agreed. Subsequent reviews should take place at least six monthly until concerns diminish and a decision can be taken by the multi-disciplinary team that the case can be closed.

Section 12 DECOMMISSIONING

12. Decommissioning a residential service following safeguarding executive planning intervention - joint working protocol

12.1 Introduction

This protocol sets out the process to be followed by Durham County Council Adults Wellbeing and Health and partner safeguarding agencies, e.g. Primary Care Trusts (PCTs) and fellow commissioning bodies, when the decommissioning of a residential care service (including one that offers nursing) is proposed as a result of safeguarding adults executive strategy intervention.

It is intended to facilitate a collaborative approach by the partners and provide guidance to clarify individual and collective roles and responsibilities in the occurrence of service decommissioning.

The protocol is not intended to replace the Adults Wellbeing and Health [De-commissioning Process Procedure \(CO/001\)](#) and must be read in conjunction with that document and the 'Inter-agency Safeguarding Adults Procedural Guidance'. Cross-reference with additional single and multi-agency policy and procedural guidance will be required as dictated by the circumstances of each individual case.

12.2 The protocol is presented under the following headings

Definition of decommissioning

When decommissioning should be considered

The decision-making process

Short-term risk management intervention

Impact on stakeholders - areas for consideration

- Service users, their families and supporters

- Self-funded placements

- Information sharing

- Consultation

- Disagreement

- Staff support needs

Reporting into the executive strategy meeting process

Media management

Learning from the process to improve future practice

12.3 Definition of decommissioning

Decommissioning is the process by which steps are taken to cease contracting with a service provider. This may involve the withdrawal of funding in full and termination of a contract, or alternatively a decision being taken not to renew a contract with a given provider.

12.4 When decommissioning should be considered

Decommissioning in the context of this protocol would take place as the consequence of earlier safeguarding executive strategy intervention being unable to secure satisfactory outcomes. Such circumstances would be characterised by persistent failure on the part of the service to comply with specified remedial action plans within agreed timescales, exposing service users to unacceptable levels of risk.

Decommissioning should only be viewed as a 'last resort', when the safeguarding partners are in agreement that all other resolution outcome focussed options have been exhausted and that contractual compliance has been breached. However, the possibility of decommissioning needs to be considered from the outset if it is to be carried out with least negative impact.

12.5 The decision-making process

Decommissioning requires the prior agreement of each commissioning body's legal advisor, and can only be sanctioned by personnel at Corporate Director/Chief Executive level.

Decommissioning may be identified as an appropriate course of action for addressing very serious safeguarding concerns. When the exploration of this option is jointly agreed by the members of the executive strategy meeting, their decision should be communicated as a matter of urgency to the Safeguarding Adults and Practice Development Manager and the Council's Commissioning Services Team Manager, who in turn will consult with the Head of Adult Care, and a representative of the Council's Legal Services Team.

In the case of Continuing Health Care (CHC) services, the appropriate senior professional in the PCT must similarly be contacted.

The Council's 'De-commissioning Process' will need to be implemented concurrently in order that proper procedure in respect of serving notice to terminate (28 days) and consideration of any possibility of dispute resolution may be followed.

In the case of registered services, all decisions to decommission must be communicated to the necessary regulatory bodies (e.g. the CQC).

Similarly, where a serious incident has precipitated the safeguarding executive planning meeting process, the Police (who may already be involved) and possibly also the Health and Safety Executive will need to confirm that the planned decommissioning will not jeopardise any investigative activity they are required to undertake.

The Council's Commissioning Services Manager, in line with the Inter-agency Safeguarding Adults Procedural Guidance and in accordance with joint working protocols, will notify all other placing Authorities of the proposed decommissioning action. The PCT will liaise with other placing PCTs with regards to CHC out of area placements.

A designated Lead Officer will need to be appointed to oversee each instance of agreed service decommissioning. The Lead Officer will be responsible for ensuring the smooth implementation of the process, for liaison with the provider, with partner safeguarding agencies and for overseeing consultation with service users, their families and supporters. The Lead Officer will also be required to compile and present a final summary outcome report to the executive planning debriefing meeting.

12.6 Short-term risk management intervention

It may in the short-term be agreed as necessary to introduce additional or alternative management and/or staff support into a service where decommissioning has been proposed as a last option, or where the process is already underway. In such cases, only suitably qualified, skilled and experienced staff should be deployed; preferably workers with residential experience.

Safeguarding Adults Practice Officers (SAPOs) may be utilised at this point in an advisory and supportive capacity, and to monitor compliance with safeguarding action plans, contractual and health and safety requirements and good practice guidance.

12.7 Impact on stakeholders – areas for consideration

- Service users, their families and supporters
- Self-funded placements
- Information sharing
- Consultation
- Disagreement
- Staff support needs

12.8 Service users, their families and supporters

All service users affected by proposed decommissioning activity will require a new - often joint - assessment of their needs. This will be carried out by a Social Worker/Care Co-ordinator and involve any other necessary specialist professionals (e.g. where the person is eligible for referral to a CHC Nurse Assessor, or where there may be a need for Occupational Therapist input). Where mental capacity is in question, then the assessment will also need to determine the individual's capacity in the context of their ability to make an informed decision about the proposed change.

Following assessment and consultation the Social Worker/Care Coordinator/Nurse Assessor will ensure that a suitable new care package is commissioned as soon as practicably possible. The Commissioning Services Team may be able to assist with a list of current service availability. The new care package must meet the user's assessed needs and take full account of their preferences.

It will be essential for the Social Worker/Care Coordinator/Nurse Assessor to ensure that each service user's key documentation, medication, mobility aids, personal effects, information regarding dietary/cultural requirements, etc. are transferred to the new service in a timely manner (ahead of, or on the day of the move as appropriate). The transition from one service to the next should be as seamless as possible. Transportation to new services should always be provided with an escort known to the service user, and personal 'information handovers' should be offered by a worker who knows the user well. Transitional arrangements will be monitored by the SAPOs, who will also check that the receiving service registers the user with a new GP surgery if necessary.

After the move, the Social Worker/Care Coordinator/Nurse Assessor will retain responsibility for reviewing the service user's case – on a monthly basis initially or more regularly should any significant concerns exist. The SAPOs will assume a time-limited responsibility for monitoring the standard of care offered by the new service.

12.9 Self-funded placements

Service users who fund their own residential/nursing placement will equally be eligible for an assessment of need and will not be discriminated against. They too will be given the necessary support to make an informed decision about their future accommodation and care arrangements.

12.10 Information sharing

Service users (or appropriate representatives where capacity is limited) will be required to give consent to their assessment and care-planning documentation being shared for the purposes of recommissioning.

As a general tenet of good practice, clear lines of communication should be kept open at all times with all involved parties, and information sharing within the bounds of legislative requirements should be encouraged in order to allow service user's needs to be properly understood and met.

12.11 Consultation

The Lead Officer will take responsibility for arranging and overseeing consultation with service users and their families/supporters. The format and style of consultation will need to be tailored to reflect users' cognitive abilities and communication skills, and the process and outcomes clearly recorded.

Where required, appropriate advocacy or other support (e.g. interpretation) should be secured for each individual. Advocacy especially may be required where the service user has no other supporter, or where the individual's wishes regarding the proposed changes conflict with family views.

The consultation process will need to take account of service user's views, feelings and choices regarding their future care and accommodation. Some people may wish to continue using the embargoed service if it is still available; others will look for a comparative service or perhaps express a wish to explore a wider range of options, including alternatives such as 'extra care', supported housing or independent living.

12.12 Disagreement

There will be occasions where service users and/or their families/supporters disagree with the proposed decommissioning, and will not wish to leave the service that has been the subject of safeguarding adults executive planning intervention.

They will need to be offered support to understand the risks associated with their choice, to enable them to make an informed decision. In cases where service users lack contextual mental capacity, then an Independent Mental Capacity Advocate (or other advocacy service) will need to be appointed to assist professionals and families to reach a 'best interests' agreement - especially where a conflict of interests exists.

The Lead Officer must ensure that stakeholders have the opportunity to access the Council's and any other commissioning body's representation procedures, and also the Patient Advice Liaison Service (PALS) where appropriate. Consideration will need to be given to how service users might be enabled to pursue any complaints they have about the decommissioning process.

12.13 Staff support needs

The Council's 'De-commissioning Process' Procedural Guidance refers to staff-related issues, particularly in respect of Transfer of Undertakings (Protection of Employment) Regulations (TUPE). However, consideration should also be given to staff support needs that arise from safeguarding allegations made against the service, and the effect that suspension and subsequent investigation and improvement action and monitoring can have on team morale, especially where management is identified as weak.

The SAPOs can play a valuable role in this respect, monitoring the implementation of agreed service improvement plans, whilst at the same time supporting staff progress towards this from within the service setting.

12.14 Reporting into the executive strategy meeting process

The decommissioning process in the context of this protocol will be taking place as part of an agreed executive planning safeguarding adults action plan. Responsibility for monitoring progress against the plan (and gathering/collating evidence as required) will fall to the SAPOs and Commissioning Services Officers, who will report their findings to the designated Lead Officer, the Safeguarding Adults and Practice Development Manager, the Commissioning Services Team Manager? and in turn, the relevant safeguarding partners at interim multi-agency meetings.

The Lead Officer will be required to prepare a summary report for presentation at the executive strategy de-briefing meeting. The document will need to highlight outcomes, recommendations and timescales for addressing any outstanding actions (e.g. referral of staff to the Independent Safeguarding Authority (ISA) or professional registering bodies).

12.15 Media management

The appointed Lead Officer, in conjunction with appropriate senior managers from the Council and its safeguarding partners, will need to consider how best to agree and implement a joint media management

strategy. Sensitive timing of information release will be crucial to the success of the decommissioning activity.

12.16 Learning from the process to improve future practice

As part of the executive strategy debriefing meeting, time should be taken to jointly reflect on the decommissioning activity. This will provide the opportunity to identify positive outcomes and examples of good practice, and to highlight areas where improvement and further development of systems or practice are required across the agencies.

As a matter of good practice, service users and their families and supporters should also be invited to evaluate their experience of the decommissioning process; their feedback should be used to help shape future procedural guidance.

SECTION 13 THE INDEPENDENT SAFEGUARDING AUTHORITY

13. Referral of staff to the ISA

13.1 The Independent Safeguarding Authority and the Vetting & Barring Scheme.

The Vetting and Barring scheme was introduced on 12th October 2009 and as a result it is now a criminal offence for anyone who has been barred by the Independent Safeguarding Authority (ISA) to work or apply to work with vulnerable adults in a variety of regulated and controlled activities.

It is also an offence to knowingly employ a barred person in those circumstances.

This applies to both paid employment and voluntary work. Employers and a variety of professionals are now under a duty to refer anyone working with 'vulnerable adults' to ISA who they have 'caused harm or pose a risk of harm'.

13.2 The ISA

The Independent Safeguarding Authority's (ISA) Referral Guidance is for use when considering or making a referral. The ISA will receive referrals when:

- There is harm or risk of harm to children or Adult at Risk, relevant conduct has occurred or
- An individual has received a caution or conviction for a relevant offence.

13.3 The ISA has four statutory duties:

- To maintain a list of individuals barred from engaging in regulated activity with children;
- To maintain a list of individuals barred from engaging in regulated activity with Adult at Risk;
- To make well-informed and considered decisions about whether an individual should be included in one or both barred lists; and
- To reach decisions as to whether to remove an individual from a barred list.

The following bodies have a statutory duty to refer any relevant information to the ISA:

- Regulated activity providers;

- Personnel suppliers;
- Local authorities;
- Education and Library Boards;
- Health and Social Care (HSC) bodies;
- Keepers of Registers named in the legislation; and
- Supervisory authorities named in the legislation.

It is worthy of note that the ISA can only consider referrals that are related to safeguarding children or Adult at Risk in the workplace (including volunteers). Where there are other forms of misconduct not related to safeguarding children or adult at Risks in the workplace, you should refer these cases, as appropriate, to the police, local authority or relevant regulatory body.

The following have a duty to refer in certain circumstances: -

- Regulated activity providers;
- Personnel suppliers;
- Local authorities;
- Health and Social Services (HSS) bodies;
- Education and Library Boards;
- Keepers of registers; and
- Supervisory authorities.

Regulated activity providers are organisations or individuals that are responsible for the management or control of regulated activity, paid or unpaid, and who make arrangements for people to work in that activity. This will usually be an employer or a voluntary organisation. This also includes a person who manages volunteers in a regulated activity, such as part of a charitable organisation.

Personnel Suppliers are employment agencies that make arrangements with people with a view to finding those people employment, or supplying those people to employers. Personnel Suppliers are also educational institutions who arrange for their students to undertake placements as part of their studies.

13.4 When a referral should be made

A referral must be made to the ISA when a regulated activity provider, such as an employer or volunteer coordinator or a responsible person in relation to controlled activity:

1. withdraws permission for an individual to engage in regulated or controlled activity,

Or

Would have done so had that individual not resigned, retired, been made redundant

Or

Been transferred to a position which is not regulated or controlled activity; because

2. They think that the individual has:

Engaged in relevant conduct;

Satisfied the Harm Test; or

Received a caution or conviction for a relevant offence.

If both conditions have been met the information *must* be referred to the ISA.

Where an individual has left an employment before any final disciplinary decision due to harm or risk of harm to a child or Adult at Risk this information must also be referred to the ISA.

Although there is a legal duty to refer in certain circumstances from 12 October 2009, there is also the power (but not a mandatory duty) for local authorities, Education and Library Boards, HSC bodies, keepers of registers and supervisory authorities to make a retrospective referral to the ISA. This is when there is evidence that an individual has engaged in relevant conduct prior to 12 October 2009 and that the person is engaged or may engage in regulated or controlled activity.

13.5 Adult at Risk

A Adult at Risk is defined in full under section 59 the 2006 Act

In summary, a person is an Adult at Risk if they have attained the age of 18, and they:

- are in residential accommodation;
- are in sheltered housing;
- receive domiciliary care;
- receive any form of health care;
- are detained in lawful custody;
- are by virtue of an order of a court under supervision by a person exercising functions for the purposes of Part 1 of the Criminal Justice and Court Services Act 2000 (c. 43), in England and Wales;
- They are by virtue of an order of a court under supervision by a probation officer in Northern Ireland;
- is receiving a welfare service defined as the provision of support, assistance or advice by any person, the purpose of which is to develop an individual's capacity to live independently in accommodation or support their capacity to do so;
- they receive any service or participate in any activity provided specifically for persons due to age, disability, prescribed physical or mental problem, expectant or nursing mothers in accommodation or a person of a prescribed description not falling in the above;

- Payments are made to them (or to another on their behalf) in pursuance of arrangements under section 57 of the Health and Social Care Act 2001 (c.15), in England and Wales;
- Payments are made to them (or to another on their behalf) in pursuance of arrangements under section 8 of the Carers and Direct Payments Act (Northern Ireland) 2002 (c.6); or
- They require assistance in the conduct of their own affairs.

13.6 Relevant conduct

Relevant conduct is set out in the 2006 Act, Schedule 3 sections 4(1) and 10(1) and state:

Relevant conduct is any conduct:

- That endangers a child or Adult at Risk or is likely to endanger a child or Adult at Risk;
- If repeated against or in relation to a child or Adult at Risk, would endanger them or would be likely to endanger them;
- That involves sexual material relating to children (including possession of such material);
- That involves sexually explicit images depicting violence against human beings (including possession of such images), if it appears to ISA that the conduct is inappropriate; or
- Of a sexual nature involving a child or Adult at Risk, if it appears to ISA that the conduct is inappropriate.

13.7 Harm Test

The harm test is defined in the 2006 Act, Schedule 3 section 5 and is satisfied if the relevant person believes that an individual may:

- harm a child or Adult at Risk;
- cause a child or Adult at Risk to be harmed;
- put a child or Adult at Risk at risk of harm;
- Attempt to harm a child or Adult at Risk; or
- incite another to harm a child or Adult at Risk.

13.8 Relevant offence

A relevant offence for the purposes of referrals to ISA

Is an automatic inclusion offence as set out in the Safeguarding Vulnerable Groups Act 2006 (Prescribed Criteria and Miscellaneous Provisions) Regulations 2009 and the Safeguarding Vulnerable Groups (Prescribed Criteria and Miscellaneous Provisions) Regulations (Northern Ireland) 2009.

A copy of these regulations can be found at www.opsi.gov.uk or www.statutelaw.gov.uk

13.9 Regulated Activity

- Regulated activity is defined in Schedule 4 of the 2006 Act. There are four ways you may be involved in regulated activity. In general terms, an individual is involved in regulated activity if they:

Undertake an activity of a specified nature (i.e., teaching, training, instruction, care, supervision, advice, guidance, treatment, therapy or transport) that involves contact with children or Adult at Risks on a frequent, intensive or overnight basis.

Frequent = once a month or more

Intensive = three or more days in any period of 30 days or

Overnight = between 2am and 6am

Example: A sports coach who provides swimming lessons to Children under sixteen once a week, will be teaching and training on A frequent or intensive basis and therefore is undertaking regulated activity.

Or

Undertake any activity in a specified place (i.e., schools, childcare premises including nurseries, residential homes for children, children's hospitals, children's detention centres, adult care homes or residential care or nursing homes) that provides the opportunity for contact with children or Adult at Risks on a frequent, intensive or overnight basis. This is providing that activity is a form of work (paid or voluntary) and is carried out for or in connection with the purposes of the establishment.

13.10 Controlled Activity

Controlled Activity is set out in sections 21–23 of the 2006 Act.

In general terms, an individual is involved in controlled activity if they are ancillary support workers in Further Education, or healthcare settings (e.g., cleaner, caretaker, catering staff, receptionist) which is done frequently or intensively and gives the opportunity for contact with children or Adult at Risks.

Frequent = once a month or more

Intensive = three or more days in any period of 30 days

Example: A member of catering staff at a hospital who on a frequent or intensive basis provides a food service to patients on the wards.

Or

Working for or on behalf of specified organisations (e.g., Local Authorities in the exercise of its education or social services functions) frequently or intensively in roles which give them the opportunity for access to sensitive records about children or Adult at Risks.

Frequent = once a month or more

Intensive = three or more days in any period of 30 days

Barred people can sometimes be employed in controlled activity, depending on the nature of the role and providing tough safeguards are in place such as stringent supervision.

13.11 Suspension without Prejudice

It is important to note that withdrawal from regulated or controlled activity does not include suspension without prejudice on its own without any substantive evidence, as this would be a neutral act and there would be no evidence at this point to support the thought that a person has engaged in relevant conduct, or that the harm test is satisfied.

13.12 Contacting ISA

The ISA may be contacted via one of the following channels:

By telephone on 01325 953 795

By email to isadispatchteam@homeoffice.gsi.gov.uk

By post to Independent Safeguarding Authority
Post Office Box 181
Darlington DL1 9FA

Further information can be obtained from the ISA website www.isa.gov.org.uk regarding the Vetting and Barring Scheme (VBS).

All referrals to the ISA (ISA Referral Form including supporting evidence and documents) should be posted to the ISA at the above address.

Guidance taken from ISA Referral Guidance V.2009/02

SECTION 14

14.1 Young people and children at risk of significant harm – joint working protocol

It is recognised that in some safeguarding situations, the adult at risk may either be living as part of the same family unit as a child/children, or have significant contact with a child/children by virtue of parental responsibility, legal order or extended family relationship or social network. In such circumstances, structured interface and collaboration between the safeguarding partner agencies will be necessary and the professionals involved will need to follow the Council's *'Protocol for working together in the delivery of services to adults and children'*.

The protocol clearly sets out that in all situations *'... the welfare and safety of the child is paramount even when this conflicts with the interests of the parent or carer.'* It goes on, *'the safeguarding of vulnerable members of the community is a collective responsibility and all workers have a duty of care and responsibility to identify those who may be at risk and act appropriately.'*

14.2 The responsibilities of workers providing services to children

The protocol states, *'... a worker providing services to a child must make a referral to the appropriate Adult Services Team if they identify any risk factors in relation to an adult who has care of or significant contact with that child, that are beyond the scope of their provision to address.'*

Risk factors would include:

- *'... the needs of the adult (which) impact on their ability to meet the physical and emotional needs of the child or any child they provide care for';*
- *'... the conduct of the adult through acts of omission or commission (which) place a child at risk or have a detrimental impact on the child's welfare';*
- *'... needs of the adult (which) place additional demands on the child - e.g. as a carer - that give rise to a need for support services for the child;*

And where

- *'... The needs or conduct of the adult have a detrimental impact on the welfare of a vulnerable adult in the same household or family unit.'*

14.3 The responsibilities of workers providing services to adults

The document goes on, *'...a worker providing services to an adult must make a referral to Childrens' Services if they identify any risk factors to any child that is a member of that adult's family unit, or who they have any significant contact with.'*

And, *'... all meetings regarding adult service users must, if the person is a parent, explicitly consider the needs of and/or risk factor for any child concerned.'*

14.4 In relation to information sharing

Additionally, the protocol describes circumstances under which information may be shared between safeguarding partner agencies without the consent of the adult at risk. These include situations where:

- *'... concerns have been raised by another service or third party about a child that the service user is either a parent or carer of, or who (he or she) has significant contact with'; and*
- *'... the worker identifies concerns about a child or vulnerable adult who the person they are providing a service to is either a parent or carer of, or who (he or she) has significant contact with.'*

The document clarifies however, that *'... in general when concerns necessitate a worker sharing personal information without the consent of the service user, they should inform the service user that they intend to do so unless this may place the child, the vulnerable adult or others at risk.'*

14.5 Child protection arrangements

Some young people are subjects of child protection arrangements or other forms of support within Childrens' Services because they are identified as being at risk of harm. Where a practitioner has reasonable suspicion that there is risk to a child or young person, it is essential that they maximise the potential for safe partnership - with (where appropriate) a parent for example - and share the relevant information about the risk and intervention across the necessary professional boundaries.

Durham Area Child Protection Committee's *'Child Protection Procedures'* (2004) state: -

'It is the duty of professionals, whether they are providing services to children or adults to place the needs of the child first.'

And

'... The key factor in deciding whether or not to disclose confidential information is proportionality, i.e. is the proposed disclosure a proportionate response to the need to protect the child's welfare? The amount of confidential information disclosed and the number of people to whom it is disclosed should be no more than is necessary to meet the public interest in protecting the health and well-being of the child.'

14.6 Transitional arrangements - young people

When a young person known to Childrens' Services is about to reach the age of eighteen, his or her case may be transferred to Adults Wellbeing and Health. This is known as transition. He or she may be eligible for an assessment of need under NHS and Community Care Act legislation, and within this assessment the young person's need for safeguarding support will be considered.

In keeping with Adults Wellbeing and Health's transition arrangements, the young person's current Social Worker must consult the Children and Families Manager about the proposed transfer at the earliest opportunity after the person's sixteenth birthday. This allows good time for a suitable practitioner to consider eligibility, assess need and risk, and where appropriate make plans with the young person and their current support/case worker to put in place a safeguarding plan.

14.7 Allegations of adult abuse/neglect which implicate workers or adult placement carers who may also have access to children

In any case where a serious safeguarding adults allegation is made about the conduct of person also known to have access to children - through work (with adults at risk or with children), or as a paid carer or volunteer - this should be communicated to the Local Authority's nominated 'Senior Manager'.

The Senior Manager, in accordance with the Durham Local Safeguarding Children Board '*allegations against staff, carers and volunteers*' procedures, will report the concern to the Local Authority Designated Officer (LADO). He or she must do this within one working day. The LADO in turn will decide on the most appropriate course of action for establishing whether the person is deemed suitable to have contact with children.

Serious concerns about the potential risks posed to children by workers, paid carers or volunteers who have access to children in their family life, must be reported to Childrens' Services (see above).

SECTION 15 SERIOUS CASE REVIEW

15. Serious case review

15.1 Inter Agency Serious Case Review Procedure

Serious Case Reviews investigate possible systems failures following a 'high impact event' where there has been serious harm to an adult or adults at risk. They may also be used in cases where a 'high risk and near miss' event resulting in a substantial risk of harm is identified. Such events are referred to as 'serious incidents'.

A serious incident is defined as the following:

- An adult at risk has sustained a potentially life-threatening injury through abuse or neglect
- Serious sexual abuse
- Sustained serious and permanent impairment of health or development through abuse or neglect

And for those instances above, the case gives rise to concerns about the way in which local professionals and services work together to safeguard Adult at Risks.

- An adult at risk dies and abuse or neglect is known or suspected to be a factor
- Serious abuse within an institution
- Serious abuse within an institution with multiple abusers

Following a serious incident involving an adult at risk, partner agencies will initiate their internal investigation procedures. During the course of the initial enquiries the agency may find that issues are highlighted that suggest immediate corrective action is necessary to prevent a further re-occurrence and that it would be beneficial to share this information with partner agencies as there is a multi agency interest. Information on the issue should be referred to the Safeguarding and Practice Development Manager who will inform the Head of Adult Care.

- 1) At the conclusion of an internal agency investigation of a serious Incident involving an Adult at Risk, agencies will consider if the outcomes/findings need to be shared with partner agencies. The reasons for sharing the outcomes/findings of an investigation this could include:
 - The case indicated there may be failings in the local operation of formal Adult at Risk protection procedures which go beyond the handling of the specific case.
 - The case had implications for a range of agencies/professionals.
 - Local procedures/protocols need to be changed.

- Local procedures/protocols are not adequately implemented/ understood/acted upon.

2) Each agency will identify a single point of contact. On the conclusion of the investigation and the agency's view that the outcomes/ findings are to be shared with partner agencies the case would pass to the single point of contact who would refer the case to the Chair of the Safeguarding Adults Board Serious Incident Sub Group or delegated representative, namely the Safeguarding and Practice Development Manager.

3) The referring agency and Safeguarding Practice Development Manager will review the case and decide if it is to be subject of a serious case review in line the criteria for conducting such a review (see definitions above).

4) If it is agreed the case will be subject to a serious case review, the case would be entered on the Multi Agency Serious Incidents Register by the Safeguarding Adults Development Officer within 5 working days of receipt of the notification.

5) Within 30 working days, the Serious Incident Sub Group and Safeguarding Adults Development Officer would coordinate the drafting of a multi agency action plan based on the outcomes of the agency review for presentation to the Adult Safeguarding Board.

6) Following agreement by the Board partner agencies would disseminate and implement the action plan.

7) Agencies would report on progress in respect of implementation of the action plan on a six monthly basis to the Serious Incident Sub Group.

8) The Safeguarding Adults Development Officer will monitor and report on progress to the Board until the action plan is discharged by the Board.

SECTION 16 LEGAL AND ETHICAL CONTEXT

16. Legal and Ethical Context

As 'Safeguarding Adults' points out, the law in respect of the abuse of adults at risk (vulnerable adults) is varied and complex, defined by various separate Acts of Parliament promoting the welfare of adults, governing the provision of community care services, the confidentiality and sharing of information and the operation of the criminal justice system.

Adults at risk are generally protected from crime by the same statutes as other citizens. Yet for many people using community care services, gaining access to the same level of protection and realisation of justice as other members of the public often requires the intervention of specialist professionals. This is because where vulnerable adults are concerned, issues of consent, power and reliability are key in both legal and ethical terms.

For example, in cases which may lead to prosecution in the Courts, the following will need to be considered:

- whether or not consent was validly given to the alleged abuse and how that can be demonstrated;
- whether the testimony of the adult and any other witnesses can be realistically regarded as reliable;
- in criminal proceedings, whether available evidence can prove 'beyond all reasonable doubt' that the offence took place as charged; and
- In civil proceedings, whether the available evidence can demonstrate 'on the balance of probability' that the act of abuse took place as alleged.

Any additional support needs of the adult at risk, along with those of the alleged perpetrator if he or she too is a 'vulnerable adult' (using legal terminology) will therefore need to be taken into account. These may include the need for the support of mainstream advocacy services, an 'Independent Mental Capacity Advocate', an 'Appropriate Adult', or even a Legal Advocate to protect the interests of the adult where they may run counter to those of the host Authorities or service providers.

The training and support needs of staff must also be recognised, since many practitioners involved in the safeguarding process will find themselves embarking on unfamiliar territory when carrying out interviews with the purpose of gathering information and evidence for

presentation in the Courts. 'Achieving Best Evidence In Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, Including Children' (Home Office 2000), provides valuable information about best practice in training and preparing staff to undertake this aspect of safeguarding work and is a useful resource for multi-agency partnerships. Wherever possible, 'achieving best evidence' training should be developed and provided jointly with partners who have the necessary expertise, most particularly the Police. A summary of the principles of 'Achieving Best Evidence' (ABE) is provided within this document.

16.1 Three levels of legal intervention

Safeguarding legal interventions can be divided into three separate categories (3):-

Primary intervention – essentially prevention

Secondary intervention – identifying and directly responding to allegations of abuse and neglect

And

Tertiary intervention – remedial action to address the negative consequences of abuse and prevent further abuse or harm

Information about the most significant aspects of existing legislation and guidance - listed under these three categories - is provided in the table overleaf. It is not intended to be fully comprehensive, nor does it suggest a legal interpretation of the Acts and Regulations. It must not, therefore, be used as a substitute for legal advice; this must be obtained from a solicitor or an organisation's Legal Service. A list of additional relevant legislation and guidance and associated web-links can be found in the appendices.

³ Professor Jill Manthorpe, 2008 (King's College London and Director of the Social Care Workforce Research Unit)

SECTION 17 COMPLAINTS

17.1 Where an alert or disclosure can be dealt with using, or alongside the complaints procedure

There may be occasions where an alert or disclosure does not constitute a safeguarding matter and can be dealt with as a complaint.

Every organisation that provides treatment, care and support to adults and whose services are subject to regulation or are commissioned by one of the statutory bodies must have a complaints procedure which service users and their supporters can access. In the case of services commissioned by Adults Wellbeing and Health, complaints may also be raised and investigated through the Local Authority's procedure. With regulated services, where Care Homes Regulations or Domiciliary Care Agencies Regulations may have been breached, or the fitness of a Registered Manager or Responsible Person (Proprietor) is in question, then the Care Quality Commission use their powers to inspect as a means of looking into the matter.

There may be times when an expression of concern or dissatisfaction is raised through an organisation's complaints procedure because it is not clear that abuse is suspected – perhaps the complaint comprises a number of elements – and is subsequently recognised as requiring safeguarding action. In such cases where further enquiries identify the possibility of abuse having taken place, then safeguarding procedures must be implemented as a matter of urgency.

It is also quite possible that a concern may lead to safeguarding procedures being invoked alongside a complaints investigation and/or criminal or disciplinary procedures. In such cases, careful thought needs to be given to the possible consequences for the outcome of each course of action to achieve the most effective resolution to the problem.

If safeguarding procedures are to be used, then the interface between this procedural framework and the others must be discussed at the strategy stage.

Other situations may arise where abuse has potentially taken place, but no complaint has been made and no alert raised. As an example, incidents can sometimes be uncovered during the course of a disciplinary investigation, which may even lead to the dismissal of a worker in line with his or her employer's personnel procedures. The employer must then make a decision about whether to initiate the inter-agency safeguarding procedure or the organisation's own complaints procedure.

This decision will need to involve a careful assessment of risk, and should not be taken in isolation. The advice of an Adults Wellbeing and Health senior Manager or the Council's Solicitor should always be sought.

In either case, where a worker is dismissed on the grounds of a substantiated allegation of abuse, then he or she must be referred to the Independent Safeguarding Authority (ISA). Some perpetrators working in the health or social care sectors will also be registered with professional bodies who must additionally be informed of proven malpractice, misconduct, neglect or abuse.

SECTION 18 (SUPPLEMENTARY GUIDANCE)

18.1 Adults at risk who misuse substances

Dependency on, or misuse of substances – including drugs and alcohol – can increase an adult's risk of harm or neglect.

The County Durham and Darlington Drug and Alcohol Action Team Partnership (DAAT) have developed a strategy for reducing or eliminating some of the harms associated with substance misuse. Such harms might include (but are not limited to):

- spread of blood borne viruses via injecting or sexual activity;
- overdose or unintentional injury;
- increased risk through co-morbidity (e.g. drug misuse combined with alcohol misuse and/or mental health problems);
- septicaemia, wound infections and other infections resulting from injecting; and
- Other general/primary health care problems and sexual and dental health problems.

These types of harm are not necessarily of themselves safeguarding adults issues, and can usually be effectively addressed by the range of interventions currently offered by the DAAT.

In some cases however, an individual's own substance-induced behaviour, or the consequential short or longer term impact of substances on the person's mental capacity, can increase the risk of harm. For example he or she might exhibit behaviour that suggests either a willingness to be drawn into a risky situation, or a vulnerability that could make them easily suggestible and open to coercion, e.g. prostitution where consent is invalid.

It is widely acknowledged that adults who misuse substances often live chaotic and risky lifestyles; as such a proportion of the concerns that come to light may constitute safeguarding issues. The majority however will be managed through standard DAAT interventions.

18.2 When should we use safeguarding adults procedures?

Cases involving adults who are exposed to a real risk of serious harm to life and limb that cannot be successfully managed by DAATP professionals alone, should be dealt with using the safeguarding adults procedural framework. This approach should enable the risk to be assessed, managed and shared by a wider range of partner disciplines.

18.3 Adults at risk involved in prostitution, who do not have capacity to consent to the activity

Prostitution of adults at risk who are unable to consent to the activity (both male and female) is a form of sexual exploitation and as such must be viewed as abuse and referred to the safeguarding adults procedures.

This type of exploitation takes place in the form of the exchange of sexual activities for commodities such as money, alcohol, drugs, shelter, protection and accommodation etc., and is often perpetrated by other adults who use coercion, threats and/or violence.

Whilst the act of prostitution is not illegal, offences do exist which make the selling or buying of sexual services in a public place illegal. Additionally, the Sexual Offences Act 2003 makes provision for three categories of offence which offer adults with a learning disability or 'mental disorder' extra protection from sexual abuse.

Common predisposing factors associated with an adult at risk becoming involved in prostitution include low self-esteem, a history of being a victim of abuse (particularly sexual abuse), substance misuse, self-harming behaviour, and sexually uninhibited behaviour as a result of a disability.

Any safeguarding intervention should involve the Police from the outset, and attempt to engage the adult with the necessary support services to achieve a successful exit strategy.

Adapted from guidance produced by East Sussex County Council

18.4 People who deliberately self-harm

When a child, young person or adult exhibits deliberate self-injurious behaviour, this can sometimes be a sign that he or she is a victim of abuse. Of course, this will not always be the case; people self-harm for different reasons and each individual case will require an individual response.

The Government makes it clear that preventing self-harm by children and young people is a safeguarding issue. The prevention and management of self-harm is also a key part of the National Service Framework for 'Mental Health' (DH 1999); not least because just over one percent of patients seen in hospitals after harming themselves go on to commit suicide during the following twelve months, and up to five percent do so over the following decade.

All known instances of deliberate self-injurious behaviour must be referred to an appropriate health or social care team, who can work in a

measured way with the self-harming person to determine the underlying cause(s), minimise further injury or damage and eventually - where realistically possible - pursue complete cessation.

For health and social care professionals, the referral to an appropriate discipline of people who deliberately self-injure falls under the common law 'duty of care'. What this means in practice is that any person employed by, working in a voluntary capacity for, or placed as a student with any of the partner safeguarding agencies has a duty to report deliberate self-injurious behaviour, so that the right kind of interventions can be planned and made. Not to report known instances of deliberate self-harm could be considered as neglect.

Judgement will then need to be made on a case-by-case basis as to whether a referral for safeguarding work is required. Where the self-injurious behaviour is found to be a symptom of abuse, then this action clearly will be necessary. Similarly, where a service user has deliberately harmed themselves and appropriate advice and support has not been sourced by the service provider, or where the provider has failed to adequately support a user through the proper implementation of a prescribed care-plan or care programme approach, then this may also constitute negligence and consequently require referral as a safeguarding matter.

18.5 Multi-Agency Public Protection Arrangements (MAPPA)

MAPPA arrangements were introduced by the Criminal Justice Act 2003 as a vehicle for locally assessing and managing offenders who pose a risk of serious harm. The Act defines serious harm as death or serious personal injury, whether physical or psychological.

In a safeguarding context, the statutory safeguarding agencies who have a duty to act co-operatively to protect life and limb and public interest (the Police, the Probation Service, the CQC, Adults Wellbeing and Health, Health Trusts and Strategic Health Authorities and other voluntary and statutory agencies including Registered Social Landlords accommodating MAPPA offenders) have to share information about particular offenders who present significant risk.

In practical terms this could involve:

Attending strategy or executive meetings perhaps where they are already involved in a case, or where they have a clear responsibility;

Sharing information about particular offenders and about broader issues so as to enable the lead safeguarding agency and other 'duty to co-operate' agencies to work together effectively;

providing advice about cases in which they are not involved and have no direct responsibility, but where assistance may enable the lead safeguarding and other agencies to assess and manage risk more effectively; and

Advising on broader, non case-specific issues, which may affect the operation of MAPPA more generally.

In work on individual safeguarding cases, at the point of the strategy discussion/meeting it may well be necessary for the decision making Adults Wellbeing and Health Manager/Lead Officer to check with the other agencies to determine whether the adult(s) at risk, the alleged perpetrator(s), or the setting are known, and under what circumstances previous involvement has been necessary. If the partner MAPPA agencies do have information that can be legitimately shared, then a representative should be invited to participate in the strategy and possibly investigative processes.

One or more of the following may be contacted: Accident and Emergency departments, the Care Quality Commission, GPs, the Police Vulnerability Unit, Adults Wellbeing and Health Integrated and Promoting Independence Teams, Mental Health Teams, Substance Misuse Teams, Learning Disabilities Services, Children's Services and Local Authority Contracts Teams. Information may also be obtained from the Probation Service and other voluntary or statutory organisations that are providing services to the adult at risk and his or her family or carers.

18.6 Potentially Dangerous Persons (PDP)

A PDP is a person who has not been convicted of, or cautioned for, any offence that is relevant to serious harm, but whose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing such an offence.

18.7 Multi-Agency Risk Assessment Conference (MARAC)

MARAC is the means by which the ongoing safety needs of high or very high risk victims of domestic abuse are addressed. The subject of a MARAC meeting is the victim, although there is no requirement for a formal complaint to have been made by the victim to the Police, or for charges to have been brought against the perpetrator.

The purpose of MARAC - in a single meeting - is to combine the relevant up-to-date risk information provided by each of the participating agencies with a comprehensive assessment of the victim's needs, and to link those directly to the provision of appropriate services for the victim, the perpetrator and any children that may be affected.

In a safeguarding context, any worker who is concerned about a victim of domestic abuse who is also an adult at risk can make a referral to MARAC. The worker will need to use the MARAC referral form, which is also a risk assessment tool. Responsibility for determining the level of risk - and therefore whether the referral will progress to a MARAC meeting - lies with the MARAC Co-ordinator.

Although it is preferable to have the victim's consent to refer, an over-riding duty exists under common law in the interests of protecting life. Consent does not need to be obtained and indeed should not be sought from the perpetrator; this could seriously increase risk to the victim. See the appendices for a link to the MARAC referral form.

18.7.1 Referring Domestic abuse

The Safeguarding Adults Board is committed to providing an effective response to domestic abuse to safeguard victims and children. It is important when dealing with victims of domestic abuse that all staff appreciates the difficult and unique position of victims regarding their relationship with the abusive partner, for example they could be their carer. Victims should never be told there is nothing anyone can do to help them and it needs to be remembered that an inappropriate response could put the person at further risk.

If domestic abuse is identified as an issue, a MARAC risk assessment should be completed. If there is significant concern for the individual then the case needs to be referred to the MARAC Coordinator, (for contact details and a copy of the risk assessment see appendix 2). If consent has been given a referral should be made to the [local domestic abuse outreach service](#).

For cases where there is no significant concern, with consent a referral is to be made to the local domestic abuse outreach service. It would be helpful to have completed a MARAC risk assessment in order to ascertain the level of risk; however, this is not a requirement for a referral to be made to the domestic abuse services.

18.8 Recording safeguarding adult's information

Upon receipt of a complaint or allegation, each partner organisation will be responsible for identifying protocols for collating all relevant service user and agency records into an individual safeguarding case file, and for recording all subsequent safeguarding action that is taken (this may be kept on the main service user file, however see 'storage of information below'). Where a service provider receives the alert, this information must be made available to Adults Wellbeing and Health as a matter of priority. In accordance with the protocol referred to above, it may also be shared with other protection agencies, for instance the Police, the Care Quality Commission or the Probation Service.

It is absolutely essential that all decisions reached throughout the safeguarding process be recorded in detail, along with an account of how they were reached (what factors were considered in the process and what risk assessment strategies were used). Safeguarding decisions may be legally challenged at a later date and since every professional will be held accountable for his or her actions they must be able to justify the basis for their decision making.

From a legal perspective, the Human Rights Act 1998 incorporates into law a distinct and different approach to thinking about rights, responsibilities and remedies, and in light of this the importance of keeping detailed records is crucial.

Adults Wellbeing and Health and its partner agencies as appropriate must therefore keep written records of the following:

- the initial statement of concern (the allegation) as shared by the alerter with Social Care Direct or an appropriate designated postholder or person;
- the Adults, Wellbeing and Health Manager's decision as to whether the concern constitutes a safeguarding matter;
- the Manager or Lead Officer's records of any strategy discussions/meetings or executive planning meetings that take place, along with the minutes of any such meetings where agreed actions/outcomes must be clearly identified; and
- all subsequent interventions, including assessments, investigations, interviews, follow-up strategy and de-briefing meetings, safeguarding planning meetings and plan reviews and action required/taken by the statutory bodies/employers in respect of the alleged perpetrator(s).

All alerts and subsequent interventions must be entered onto the appropriate Adults Wellbeing and Health database.

All records must be contemporaneous, accurate and factual - they may well be relied upon at a later date in court.

All written and electronic records must be kept from the point the allegation or disclosure is made, every entry must be dated and timed and the name of the person making the record must be written in full. Initials are not acceptable.

All records must include factual information, e.g. times, dates, names, locations etc.

And

All contacts with the adult at risk, the perpetrator and any other persons linked with safeguarding process must be logged in detail. The procedural framework describes exactly what information needs to be recorded and what forms to use. Rough notes must also be kept on file, as these too may be required as evidence.

N.B. Staff need to be given clear direction about what information to record (and in what format) through each step of the safeguarding process. Adults Wellbeing and Health must use the designated SSID forms. The forms may also serve as useful prompts for the other safeguarding partner agencies. Careful consideration must also be given to the law governing the gathering, recording and sharing of information. For this reason, interviewing and recording techniques should form part of each partner agency's safeguarding training strategy.

18.9 Storage of information

Within each partner organisation, all records pertaining to service users and to safeguarding work in individual cases must be stored and accessed in accordance with the Data Protection Act 1998 and accompanying organisational policies and procedures. It may however be inappropriate to document certain information in the place normally used for service user records if a suspected perpetrator or his or her associates have access to those records (in a residential care home for example). In such circumstances alternative and separate secure storage and access will need to be arranged.

18.10 The media

Staff must never under any circumstances disclose information to the media. If approached, all workers must report to their Manager as a matter of priority. Members of safeguarding or investigative teams should report media contact/enquiries to the Lead Officer, who in turn will take senior management advice and liaise with the press office.

In the event of a death or multiple or organised abuse, the Executive Lead Officer will liaise with the DCC's Media Team to prepare an appropriate official press release. All such media contacts will need to be co-ordinated by the Executive Lead Officer in conjunction with a senior Manager within Adults Wellbeing and Health and the Council's multi-agency media team.

18.11 Safeguarding investigative interviews and 'Achieving Best Evidence' (ABE)

All safeguarding adults criminal investigations will be led by a Police Officer, assisted by another appropriate professional, usually from a

social care or health background. Both the Police Officer and supporting worker will first of all need to have completed specialist training in the 'Achieving Best Evidence' interview process, and will be expected to follow the guidance referred to below.

The guidance

The first edition of 'Achieving Best Evidence in Criminal Proceedings: Guidance on Interviewing Victims and Witnesses', and 'Using Special Measures' (Office for Criminal Justice Reform) was issued in January 2002 following the implementation of the *Speaking Up for Justice* report, which in turn led to the introduction of 'special measures' into the Youth Justice and Criminal Evidence Act 1999.

The second edition (published in 2007) reflects more recent developments, including reform of the law of evidence on bad character and hearsay in the Criminal Justice Act 2003, the 'Code of Practice for Victims of Crime', and the national roll-out of Police/Crown Prosecution Service Witness Care Units, which aim to ensure that witnesses are better informed, better prepared and better supported throughout court proceedings. The Intermediaries special measure, additionally, has been the subject of a pilot in eight pathfinder areas.

The guidance considers preparing and planning for interviews with 'vulnerable' witnesses, decisions about whether or not to conduct an interview, and decisions about whether the interview should be video-recorded or whether it would be more appropriate for a written statement to be taken following the interview. It covers the interviewing of witnesses both for the purposes of making a video-recorded statement and also for taking a written statement, their preparation for Court and any subsequent Court appearance. It applies to both prosecution and defence witnesses, and is intended for all persons involved in relevant investigations, including members of the legal profession.

18.12 Special measures

The Courts can exercise **discretionary** powers to apply special measures to encourage and support 'vulnerable' or intimidated witnesses to give their best evidence in criminal proceedings. Special measures include submission of video recorded 'evidence in chief' and cross examination, use of communication aids and Intermediaries to overcome physical difficulties with understanding and answering questions, live links with the Court, removal of wigs and gowns, clearing the public gallery, restrictions on the cross-examining of defendants in rape trials and other cases, and restrictions on evidence relating to the complainant's previous sexual history.

18.13 Appropriate Adult

Where an alleged perpetrator is also an adult at risk, then he or she must not be interviewed alone, especially if there is any possibility that a criminal offence may have been committed. In accordance with the Youth Justice and Criminal Evidence Act 1999, all interviews with that person carried out as part of the investigative process should involve the support of an 'Appropriate Adult'.

Anyone acting in this capacity must have the necessary specialist skills to fulfil the role, e.g. be a British Sign Language interpreter, a Makaton user or someone who speaks the chosen language of the alleged perpetrator if English is his or her second language.

Essentially, the Appropriate Adult must not have witnessed the alleged abuse, since acting in this capacity would clearly represent a conflict of interest.

18.14 Adults who are exposed to serious risk to life and limb, but whose circumstances are not readily recognisable as requiring safeguarding intervention

Following the serious case review conducted on behalf of Cornwall County Council in response to the death of Steven Hoskins, there is an identified need for safeguarding adults partner agencies to be alert to the fact that some adults may be exposed to serious risk to life and limb, even when there is no apparent evidence of safeguarding adults concerns. Only when agencies begin to share their disparate and seemingly low-risk pieces of information about such adults, does it become clear that a multi-agency safeguarding response is required.

Therefore, single agencies holding information about adults who:

- have a number of emergency care episodes relating to assault/having taken an excess of drugs and/or alcohol; and/or
- make repeated calls to the Police to any one address or for any one person; and/or
- attract a number of complaints from neighbours, or concern from social landlords in respect of poor tenancy standards; and/or
- Make repeated referrals to Adults Wellbeing and Health with concerns about issues including bullying, unpaid rent, stolen money etc.

Must share this intelligence with Social Care Direct.

Social Care Direct, in turn, will log the information and screen it in the context of the emerging picture building up in relation to the individual

concerned. At the stage when the individual's SSID history indicates a significantly high level of risk that cannot be managed through standard care management interventions or via the risk enablement panel, then the case will be referred to the safeguarding adults procedural framework.

18.15 Monitoring safeguarding work

Each of the partner organisations is responsible and accountable for meeting national guidance and legislative requirements in relation to implementing safeguarding adults work, whether through working in partnership or through its own actions.

By ensuring robust systems are in place for the monitoring of its safeguarding work, the Durham Safeguarding Adults Board will be able to determine whether those requirements are being met. Monitoring should be regarded as a shared responsibility and the results of all monitoring exercises and analysis of quantitative and qualitative safeguarding data should be used by the partners to:

- inform senior Managers and Elected Members;
- inform the Department of Health;
- learn from experience so that procedure and practice can be revised and improved;
- monitor the workloads of staff employed by the statutory bodies;
- identify possible resource implications in managing safeguarding work effectively and enable the most appropriate targeting of resources;
- put together a case for allocation of additional resources;
- develop safeguarding training and access and involvement strategies across the full range of sectors and services;
- plan and develop new and innovative specialist protective and independence promoting services, e.g. recovery services; and
- Raise the profile of safeguarding adults work.

18.16 Data collection/analysis

The partners can each make a valuable contribution by keeping, and at regular intervals sharing with the Safeguarding Adults Board, intelligent information about:

- numbers of referrals according to each geographical location, service user group, age range, gender, ethnic group etc.;
- whether and how these proceed;
- the outcomes of safeguarding interventions;
- the numbers and types of incidents that are not pursued or logged as safeguarding referrals, but are dealt with using other individual agency procedures, e.g. clinical incidents, complaints or disciplinary matters;
- vulnerable victims of crime where these are identified in generic crime statistics and/or analysed within community safety initiatives;
- enforcement work and cancellation of registrations actioned by the regulatory bodies;
- numbers and outcomes of relevant disciplinary or professional misconduct hearings; and
- Numbers, types and outcomes of complaints made about the way safeguarding matters have been handled.

18.17 Supervision and case audit

As part of the monitoring process staff supervision and case audit processes will need to include safeguarding adults work as a permanent and ongoing theme. Identification of practice shortfalls and gaps in knowledge will need to be appropriately addressed on both an individual practitioner basis, and through the development and delivery of a comprehensive multi-agency safeguarding adults training strategy.

18.18 Obtaining feedback from people who have experienced abuse and accessed safeguarding adults services

The Durham Safeguarding Adults Board is committed to developing sensitive mechanisms for obtaining the views of adults at risk, and where appropriate their supporters, about individual experiences of safeguarding adults interventions. The feedback will be evaluated by the Safeguarding Adults and Practice Development Team and used to further shape and improve multi-agency safeguarding work.

Protocols and tools will be inserted here as they are developed.

SECTION 19 - APPENDICES

Appendix 1

List of relevant legislation and guidance

The following list (which is not exhaustive) provides an overview of some of the key legislation and other law and guidance that shapes the way safeguarding adults work is carried out. The original legislation and guidance can be easily found on the internet at the following websites:

Department of Health (for health and social care policy including 'No Secrets')

www.dh.gov.uk

Office of Public Sector Information (for legislation, some of it amended since originally enacted)

www.opsi.gov.uk

British and Irish Information Legal Institute (for legal cases)

www.bailli.org

Department of Constitutional Affairs (for mental capacity law)

www.dca.gov.uk

Crown Prosecution Service (for guidance of prosecution matters etc.)

www.cps.gov.uk

Ministry of Justice (for criminal issues, vulnerable witnesses, multi agency public protection etc.)

www.justice.gov.uk

Office of the Public Guardian (for Lasting Power of Attorney and Court of Protection)

www.publicguardian.gov.uk

N.B. Sometimes a direct search (using a search engine such as 'Google') finds the relevant document more readily than a search on the particular website.

- Access to Health Records Act 1990
- Caldicott Report 1997
- Care Standards Act 2000 and Protection of Vulnerable Adults List

- Care Homes and Domiciliary Care Agencies Regulations 2002
- Carer's (Recognition and Services) Act 1995
- Carers and Disabled Children Act 2000
- Carers (Equal Opportunities) 2004 Act
- Chronically Sick and Disabled Persons Act 1970
- Common Law Duty of Confidentiality
- Corporate Manslaughter and Corporate Homicide Act 2007
- Crime and Disorder Act 1998
- Criminal Procedures and Investigations Act 1996
- Criminal Violence Act 2003 (MAPPA)
- Data Protection Act 1998
- Disability Discrimination Act 1995
- Disabled Persons (Services, Consultation and Representation) Act 1986
- Domestic abuse Crime and Victims Act 2004
- Employment Rights Act 1996
- Enduring Power of Attorney Act 1995
- Fair Access to Care Eligibility Criteria
- Family Law Act 1996
- Freedom of Information Act 2000
- Forced Marriage (Civil Protection) Act 2007
- Health Act 1999
- Health Services and Public Health Act 1968
- Health and Social Care Act 2001
- Home Office Circular 19/2000 Domestic abuse
- Housing Act 1985 (Part III Homelessness)
- Housing Act 1996
- Human Rights Act 1998
- Investigating Patient Safety Incidents Involving Unexpected Death or Serious Untoward Harm, Department of Health Memorandum of Understanding, February 2006
- Learning from Complaints: Social Services Complaints Procedure for Adults (DH, August 2006 - issued as Section 7 Guidance under the Local Authority Act 1970)
- Local Authority Social Services Act 1970
- Mental Health Acts 1959, 1983 and 2007 (The 2007 Act amends the 1983 Act, the Domestic abuse, Crime and Victims Act 2004 and the Mental Capacity Act 2005 in relation to mentally disordered persons; to amend section 40 of the Mental Capacity Act 2005; and for connected purposes)
- Mental Capacity Act 2005 and Deprivation of Liberty (DoL) safeguards
- National Assistance Act 1948, amended in 1951
- National Guidance Document Achieving Best Evidence in Criminal Proceedings 2001
- National Health Service and Community Care Act 1990
- National Health Service Act 1977
- No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse 2000

- Police and Criminal Evidence Act 1970 and 1984
- Power of Attorney Act 1971
- Protection from Harassment Act 1997
- Public Health Acts 1936 and 1961
- Public Interest Disclosure Act 1998
- Regulation Of Investigatory Powers Act 2000
- Regulation Of Investigatory Powers Act 2000
- 'Safeguarding Adults: a National Framework of Standards for Good Practice and Outcomes in Adult Protection Work' (Association of Directors of Social Services 2005)
- Safeguarding Vulnerable Groups Act, 2006
- Sexual Offences Acts 1956, 1967, 1993 and 2003
- Social Security (Claims and Payments) Regulations 1987
- Theft Act 1968
- Youth Justice and Criminal Evidence Act 1999

Additional Durham County Council policy and procedural guidance

Links to the following Council policy and procedural documents may be found on the Durham County Council Intranet:

[DCC Confidential Reporting Code](#)

[Complaints policy and procedures \(REP/025\)](#)

Serious Incidents Procedure for Adults at Risk (A/CM/049)

Protocol for working together in the delivery of services to adults and children (A/CM/048)

Multi-Agency information sharing protocol

Durham Local Safeguarding Children's Board procedures for dealing with allegations against staff and paid carers

Durham Council's policy statement regarding the Regulation of Investigatory Powers Act 2000

Advocacy – appointing an Independent Mental Capacity Advocate (A/CM/052 Appendix 6)

Appendix 2

Templated Documentation and Sample Forms

SS680 Lead Officer notes
SS355 Safeguarding adults initial decision form
SS356 Safeguarding adults strategy form
SS357 Safeguarding adults strategy review form
SS358 Safeguarding adults closure & debrief form

MARAC referral form
MARAC risk assessment document

Appendices

Flowchart 1: The alert and referral to Social Care Direct
Flowchart 2: Receiving the referral - the Adults, Wellbeing and Health Manager's decision
Flowchart 3: Managing the safeguarding case
Safeguarding Adults Risk Support Tool
Safeguarding Adults – a step by step summary of the procedure
Strategy meeting invitation letter
Confidentiality agreement
Strategy meeting/executive planning meeting agenda
Strategy debrief/executive planning debrief agenda
Feedback to referrer letters – safeguarding and non-safeguarding
Key legislation, safeguarding guidance and protocols used by the statutory agencies

Appendix 3

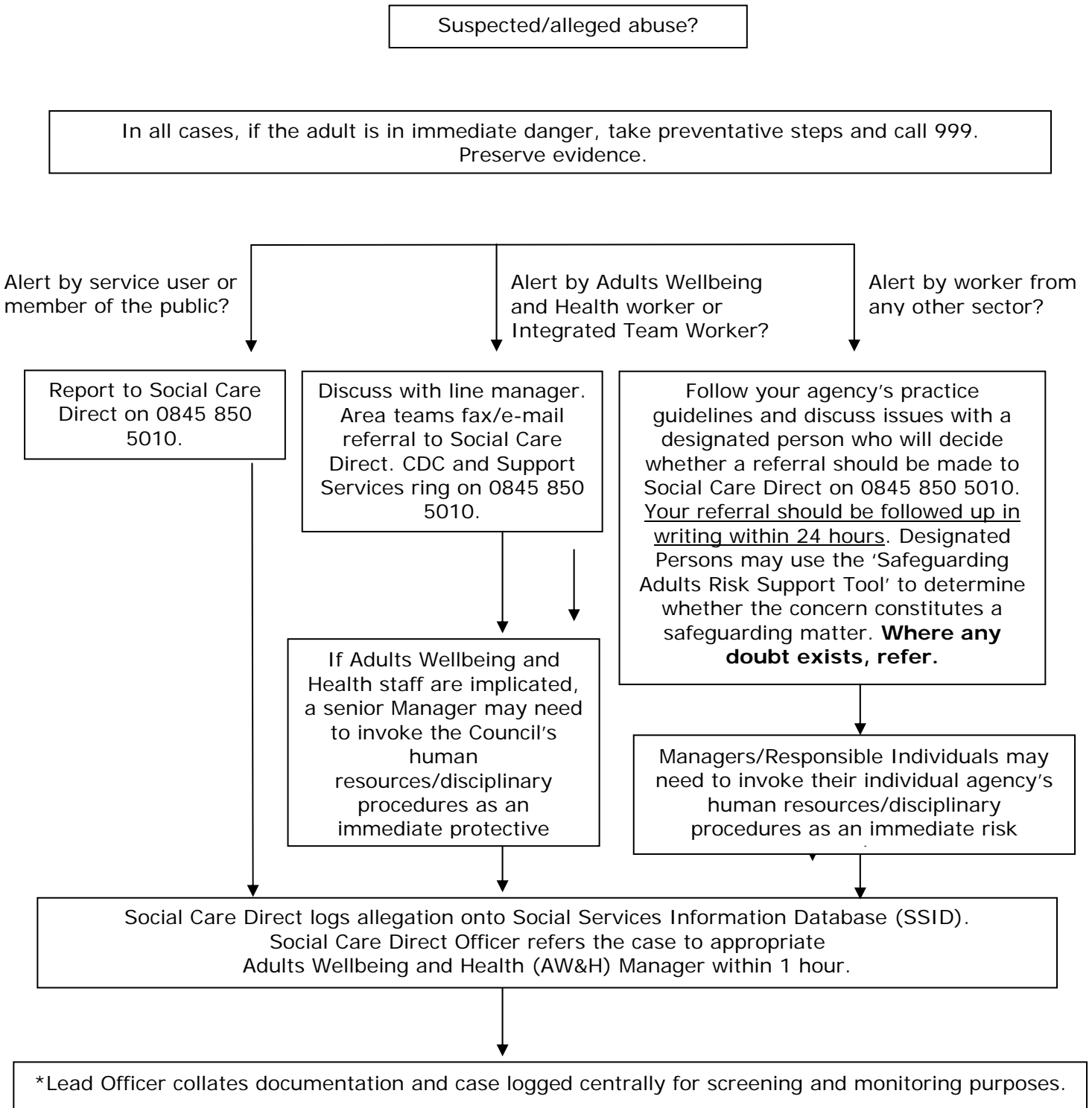
Introduction to County Durham Inter Agency Procedural Framework and Flowcharts

These inter-agency procedures provide a clear framework to guide all those involved in safeguarding adults work, through each of its necessary stages according to ADASS good practice guidance. Concerns that do not constitute abuse or neglect, and as such fall out with the safeguarding framework, should be dealt with using the most relevant alternative procedures, e.g. complaints, staff supervision/training etc.

Some allegations and issues of concern may prove very complex, e.g. may involve one or more adults at risk and several partner agencies. These will require the implementation of the complete safeguarding process.

Less complex cases on the other hand may require a less formal approach, but one that nonetheless ensures that proper consultation takes place and results wherever possible in positive safeguarding outcomes. Therefore, at any stage in the safeguarding process the Lead Officer (with senior management authorisation and sometimes legal advice) may take the professional decision that an allegation of abuse has been addressed or resolved and that intervention is complete. This decision, as with all other cases, will be communicated to those who 'need to know', including the referrer.

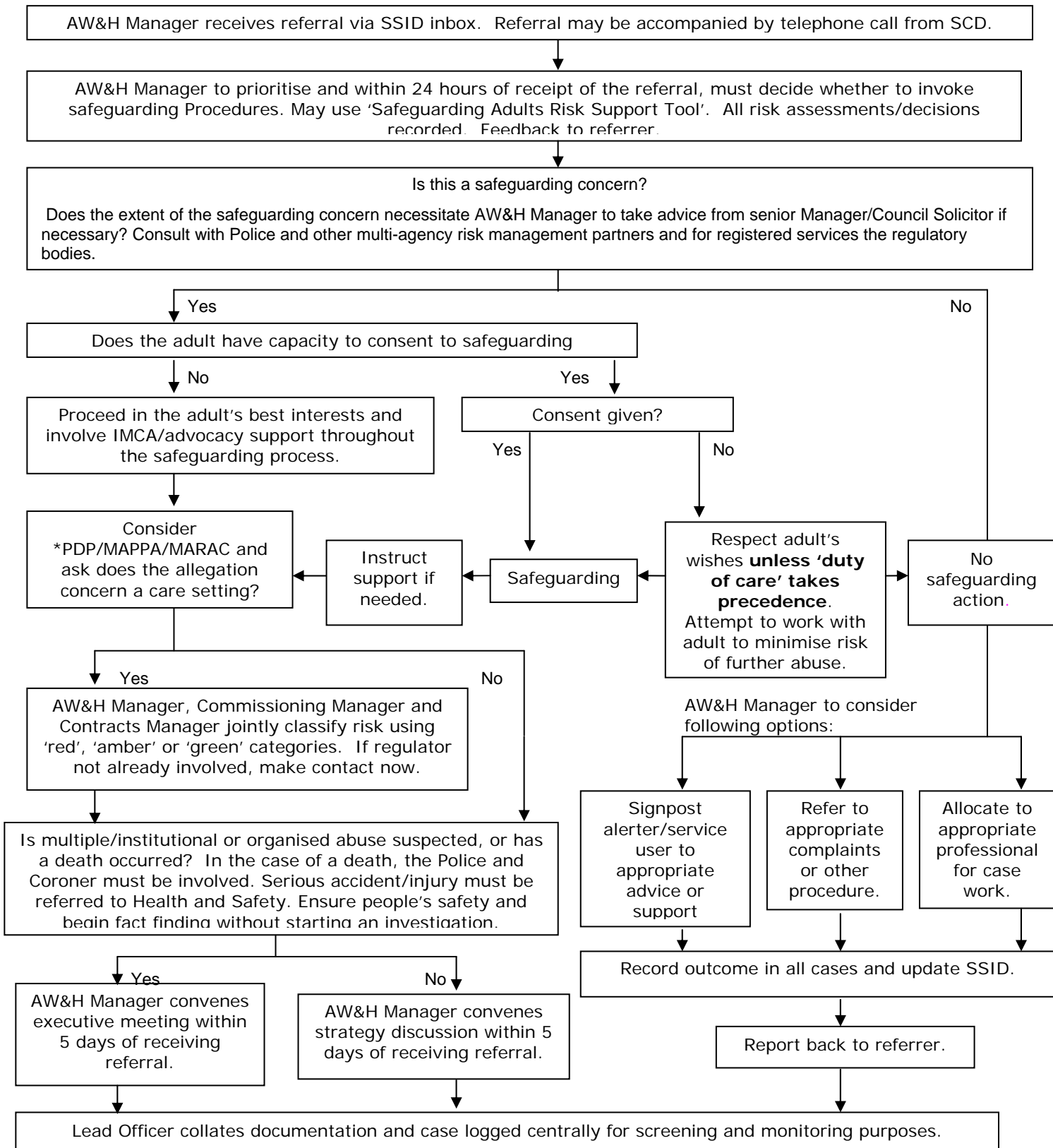
Flowchart 1: The alert and referral to Social Care Direct



*The Lead Officer will be an Adults Wellbeing and Health Manager or appropriate senior social care or health professional
 P&PS - Policy and Procedures
 SSID – Social Services Information Database

Remember to observe human resources policies and procedures in parallel with any

Flowchart 2: Receiving the referral - the Adults, Wellbeing and Health Manager's decision



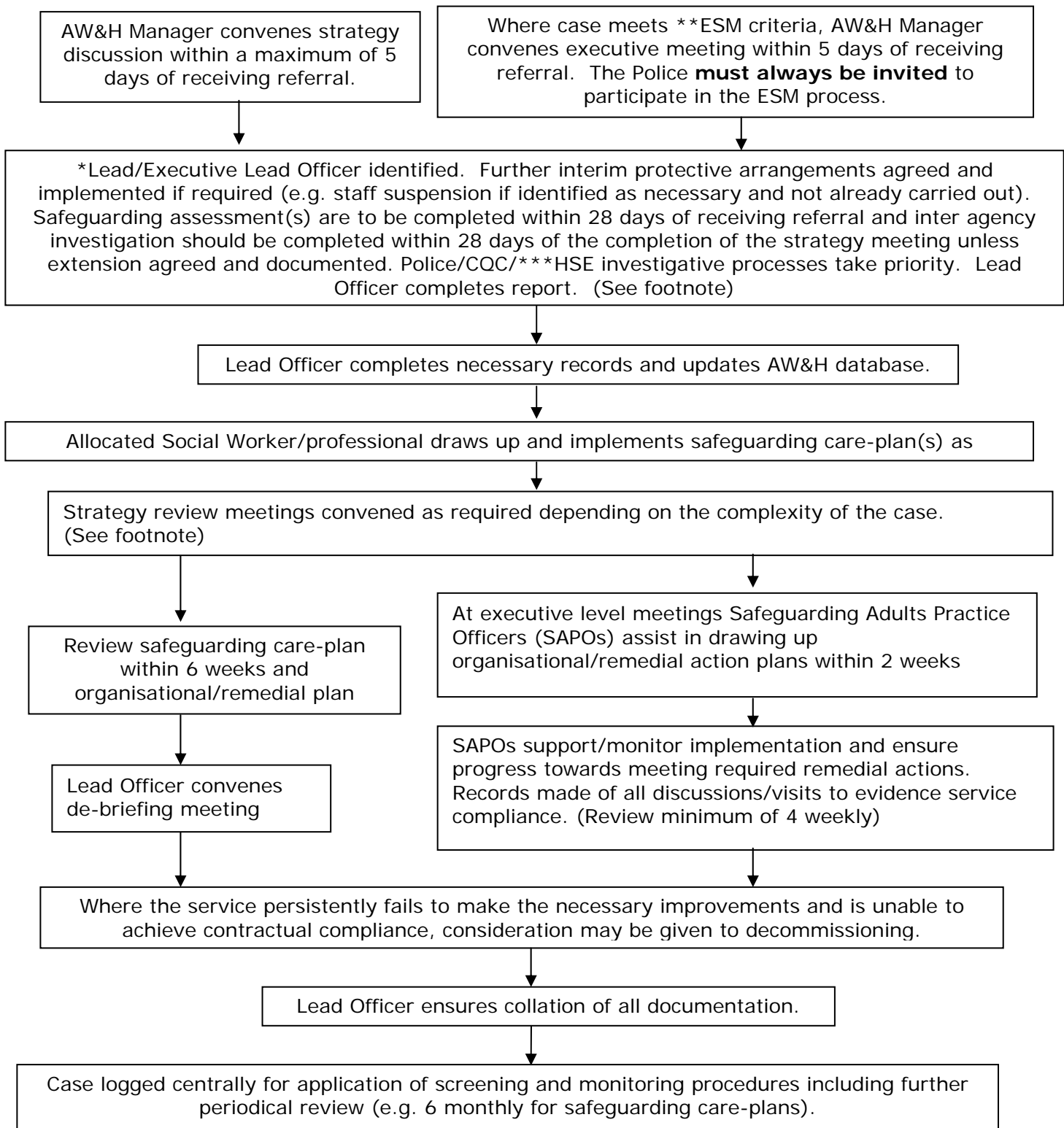
*PDP - Potentially Dangerous Persons

MAPPA – Multi Agency Public Protection Arrangements (contact the Public Protection Unit on (0191 3839083)

MARAC – Multi Agency Risk Assessment Conference (contact the MARAC Co-ordinator on (0191 3752072)

Remember to observe human resources policies and procedures in parallel with any safeguarding action

Flowchart 3: Managing the Safeguarding Case



*The Lead Officer will be an Adults Wellbeing and Health Manager or appropriate senior social care or health professional

** ESM – Executive Strategy Meeting
 ***HSE – Health and Safety Executive

Footnote:
 Remember to observe human resources policies and procedures in parallel with any safeguarding action and ensure appropriate remedial action is taken, including referral to ISA and professional registering bodies as necessary. Police pursue prosecution if appropriate. (These steps may take place at any stage)

Safeguarding Adults – a step by step summary of the procedure

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
1. Identifying the concern	Immediately	<p>A concern may centre around single or repeated acts, which constitute abuse or neglect.</p> <p>Upon suspicion or disclosure that abuse or neglect is occurring/has occurred, concerns should be shared through the appropriate channels as described below.</p> <p>For staff employed by any of the safeguarding partners, the responsibility to share such concerns is part of their 'duty of care'.</p> <p>Where an adult is in immediate danger, action should also be taken to protect the safety of that person, e.g. by calling for emergency medical assistance.</p> <p>Immediate protective action should not incur irresponsible risk for the person identifying the concern.</p>	Anyone in contact with or having knowledge of an adult(s) 'at risk'.	<p>Section 1 Aims of the policy Working with adults at risk</p> <p>Section 5 Suspected or alleged abuse or neglect in services provided by the Health Trusts</p> <p>Section 15 Legal and ethical context</p> <ul style="list-style-type: none"> • Key legislation and Confidentiality • Definitions and categories of abuse (all sub-parts) <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health key individual and team roles – Alerter

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
2. Alert and referral to Social Care Direct	Immediately – the main objective should always be to act in the adult’s ‘best interests’ and prevent further harm.	<p>Service users, carers and members of the public (including adults at risk) should report suspicions/allegations of abuse to Social Care Direct on 0845 8505010.</p> <p>Employees, students on placement and voluntary workers should report concerns to the designated person or postholder (usually a Manager) identified within each agency’s own safeguarding guidelines.</p> <p>Where another worker is implicated whistle blowing or ‘speaking out’ procedures should be used to alert an appropriate person to the situation.</p> <p>Where the designated person may be implicated in the abusive practice, an alert should be made to Social Care Direct, and for registered services the CQC.</p> <p>A written record must be made as soon as practicably possible.</p> <p>N.B. Where a Social Worker or other lead practitioner employed by Adults Wellbeing and Health receives an alert or is party to a disclosure, then he or she must e-mail or fax the details to Social Care Direct and immediately report the matter to his or her Manager. In-house provided services ring Social Care Direct in the usual way.</p> <p>Where a criminal offence is suspected, the Police must also be contacted.</p>	Anyone who suspects or knows that abuse has occurred and needs to report this so that safeguarding action can be taken.	<p>Section 2 Aims of the policy Working with adults at risk</p> <p>Section 4 Suspected or alleged abuse or neglect in services provided by the Health Trusts Safeguarding Adults Risk Support Tool</p> <p>Section 16 context</p> <ul style="list-style-type: none"> • Key legislation and guidance • Confidentiality • Whistle blowing or ‘Speaking out’ <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health • Key individual and team roles – Alerter • Designated post holders • The Police • The Care Quality Commission

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
<p>3. The designated person receives an alert and makes a referral to Social Care Direct</p>	<p>Within 1 working day of the alert being received.</p>	<p>Upon receipt of an alert via safeguarding or 'speaking out' procedures, the designated postholder must review the information provided and make a decision about whether the reported concerns constitute abuse. The Safeguarding Adults Risk Support Tool might be useful here.</p> <p>Where the possibility of abuse cannot be ruled out, a referral must be made to Social Care Direct on 0845 8505010, and followed up with a written report including precise factual details of the allegation. In the case of any uncertainty about how to proceed, a formal pre-referral consultation process is available from the Safeguarding Adults and Practice Development Team.</p> <p>If a crime is suspected, no attempts should be made to question the adult at risk or any other witnesses. This will be done as part of a formal Police investigation.</p> <p>Provider services should refer to their organisation's internal human resources/suspension/staff disciplinary procedures to protect the interests of the adult(s) at risk and any staff members concerned. Contact should also be made with the regulatory bodies.</p> <p>Allegations against staff employed by the statutory safeguarding agencies/adult placement carers must be dealt with in accordance with the procedure described in this framework. Managers within Adults Wellbeing and Health should seek advice from an appropriate senior Manager about taking steps to invoke the Council's disciplinary procedures.</p> <p>Implicated staff/volunteers that also have contact with children through their work should be referred to the Council's nominated 'Senior Manager', or in the case of familial contact, Children's Services.</p>	<p>The designated postholder/ person within any of the safeguarding partner organisations, or any care service to whom alerts must be reported. Alternatively a Social Worker or practitioner to whom the adult is already known.</p>	<p>Section 2 Aims of the policy Working with adults at risk</p> <p>Section 5 Referral Safeguarding Adults Risk Support Tool Suspension, staff disciplinary procedures and support for implicated staff Allegations against Adults Wellbeing and Health employees Allegations against adult placement carers Allegations against employees of other statutory safeguarding agencies Allegations of adult abuse/neglect which implicate workers or adult placement carers who may also have access to children</p> <p>Section 16 Legal and ethical context</p> <ul style="list-style-type: none"> • Key legislation and guidance • Confidentiality • Whistle blowing or 'Speaking out' <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health • Key individual and team roles – Designated post holders • Social Care Direct • The Police • The CQC

STEP	TIMESCALES	ACTION	BY WHOM	GUIDANCE REFERENCE
4. Social Care Direct	Referral to be passed to Adults Wellbeing and Health Manager within 1 hour of receipt.	<p>In response to any call regarding a safeguarding matter, the Social Care Direct Officer will:</p> <ul style="list-style-type: none"> • gather and record as much information as possible about the alleged abuse; • check all available records to determine whether any parties are already known; • decide upon the most appropriate immediate response; and • Enter the referral onto the Social Services Information Database (SSID). <p>Where both the victim and the alleged perpetrator are 'adults at risk', a separate safeguarding referral for the latter is not required. A standard referral should instead be completed. The exception to this would occur when both adults are victims, and it is not possible to determine which is the primary perpetrator. Using an incorrect party coding will distort safeguarding performance data.</p> <p>In the majority of cases referrals will be allocated to an Adults Wellbeing and Health Manager for decision making, but where it is clear that the identified adult is not 'vulnerable' or exposed to critical or substantial risk, the referrer may need to be signposted to a more appropriate agency. It is the SCD Officer's responsibility to ensure that each safeguarding referral is sent to the appropriate Adults Wellbeing and Health Manager for decision making.</p> <p>N.B. Where a Social Worker or other lead practitioner employed by Adults Wellbeing and Health receives an alert or is party to a disclosure, then he or she must e-mail or fax the details to Social Care Direct and immediately report the matter to his or her Manager. Alerters (whether professional or members of the public) should not be expected to make the same alert twice.</p>	Social Care Direct Officer/Social Care Direct Team Manager or Social Worker, other lead practitioner	<p>Section 2 Aims of the policy</p> <p>Section 7.1.18 Social Care Direct Recording referrals for alleged perpetrators who are 'adults at risk' Adults who are exposed to serious risk to life and limb whose circumstances are not readily recognisable as safeguarding concerns</p> <p>Templated documentation</p> <p>Section 16 Legal and ethical context</p> <ul style="list-style-type: none"> • Key legislation and guidance • Confidentiality <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health and Assessing Officer • Key individual and team roles – Social Care Direct

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
<p>5. Receiving the referral - decision making by the Adults Wellbeing and Health Manager</p>	<p>On the same day that the referral is received.</p> <p>The referrer must be advised of action to be taken within one working day of making contact with Social Care Direct.</p>	<p>The Adults Wellbeing and Health Manager (AWHM) must decide whether and how to invoke the safeguarding procedures. He or she must:</p> <ul style="list-style-type: none"> • consider the referral information in its context; • consider the reliability/credibility of the information received; and • Carry out an initial risk assessment. <p>Decision making must take place in consultation with the identified adult at risk. Unless circumstances dictate otherwise, the adult's consent to take part in a safeguarding assessment is required. Issues of capacity must be taken into account. Referrers must be advised about how their concerns will be addressed by the end of the next working day. Decisions must be recorded on SSID. Advocacy/other support as required must be sourced for the adult at risk.</p> <p>The AWHM must ensure that the adult is kept safe throughout the safeguarding process and make contact where necessary with the Police, CQC, and the multi-agency risk management partners*. In the event of a death, the Coroner's Office must be informed and. Serious injury/accidents must be reported to the Council's Health and Safety and Staff Care Team, who will refer to the Health and Safety Executive if necessary. Where a child (ren) may be at risk, a referral made immediately to the Child Protection Team.</p> <p>The appropriate safeguarding partners should be invited to take part in a safeguarding strategy discussion/meeting or executive planning meeting as appropriate. A robust record must be kept of all discussions, risk assessments, decisions (to proceed or otherwise) and actions. SSID entries must be kept up-to-date.</p> <p>*For MAPPA call (0191) 3839083 For MARAC call (0191)3752072</p>	<p>An Adults Wellbeing and Health Manager</p>	<p>Section 2 Aims of the policy</p> <p>Section 4.1.8 False allegations Decision Risk/protection Allegations of adult abuse/neglect which implicate workers or adult placement carers who may also have access to children Adults who are exposed to serious risk to life and limb whose circumstances are not readily recognisable as safeguarding concerns Templated documentation</p> <p>Section 16 Legal and ethical context</p> <ul style="list-style-type: none"> • Key legislation and guidance • Confidentiality • MAPPA/PDP • Capacity and consent • Place of safety • Advocacy and support <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health • Key individual and team roles – Social Care Direct and Adults Wellbeing and Health Manager

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
6. Disagreement	Disagreement to be passed to a senior Manager on the same day as it is raised. Resolution/ Compromise to be reached as soon as is practicably possible (urgency influenced by presenting level of risk).	<p>Where a referrer disagrees with the Adults Wellbeing and Health Manager's decision, the referral must pass to a more senior Manager who will review the referral and give a second opinion. If the situation cannot be resolved to the referrer's satisfaction, then he or she may make representation to the appropriate responsible Manager with a safeguarding lead, or access the Council's complaints procedures.</p> <p>Disagreements may also occur between the partner safeguarding agencies at any stage throughout the safeguarding process. These must be referred to the appropriate responsible Manager with the safeguarding lead, who will make an objective judgement about how best to proceed.</p> <p>The best interests of the adult(s) at risk must always be kept central to any judgements made.</p> <p>All disagreements must be fully recorded – and SSID entries must be kept up-to-date – and include details about agreed compromises (if any) and outcomes. Compromises will not be considered where these may jeopardise the safety of the adult or run counter to legislative or good practice guidance and/or individual/collective professional codes of practice.</p>	Adults Wellbeing and Health in conjunction with an appropriate senior Manager and/or the appropriate responsible Manager with the safeguarding lead	<p>Section 2 Aims of the policy Complaints</p> <p>Section 6.1.23 Disagreement Templated documentation</p> <p>Section 16 Legal and ethical context</p> <ul style="list-style-type: none"> • Key legislation and guidance • Confidentiality <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health • Key individual and team roles – Adults Wellbeing and Health Manager and appropriate responsible Manager with a safeguarding lead

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
7. Strategy discussion/meeting or executive strategy meeting	<p>Strategy discussions/ meetings must be concluded and a strategy plan agreed within A maximum of 5 days following receipt of the safeguarding referral.</p> <p>The same timescales apply for executive planning meetings and agreements.</p>	<p>In urgent cases, a strategy discussion may take place over the telephone, by e-mail or 'virtual' meeting. In more complex cases a face-to-face meeting may be more appropriate. In the case of multiple/institutional abuse or the death of an adult, an executive strategy meeting (senior level strategy) should always be convened.</p> <p>If a strategy meeting has taken place as a virtual meeting or by telephone, e-mail or fax it should be recorded on the SSID system as an initial strategy meeting and subsequent meetings should be recorded as reviews.</p> <p>The strategy discussion/meeting could potentially involve any or all of the multi-disciplinary safeguarding partners, including the adult at risk. Where an alleged perpetrator works for more than one care/support service, each employer should be invited. Issues of mental capacity and support needs will have to be considered. An alleged perpetrator should only be invited to take part in strategy discussions/meetings in very exceptional circumstances. Care service Managers/Responsible Individuals (Proprietors) should be included as full partners if deemed 'fit'. Safeguarding Adults Practice Officers will participate in executive level meetings, and occasionally in standard strategy meetings. The Police must be invited to all executive planning meetings.</p> <p>The process should enable multi-agency partners to plan investigative and other interim protective interventions and identify individual and collective tasks, responsibilities and timescales for action. Strategies evolve over time and in some cases a series of discussions/meetings may need to take place.</p> <p>The content of all strategy discussions/meetings must be recorded using the appropriate proforma, and SSID entries must be kept up-to-date. This will be the responsibility of the Lead Officer.</p> <p>Feedback should be offered to the referrer if appropriate</p>	<p>Strategy meetings should be convened by the Adults Wellbeing and Health Manager who receives the referral and takes the decision to proceed.</p> <p>A Lead Officer will need to be appointed to chair a strategy meeting. In the case of executive strategy meetings the Lead Officer will need to be employed at Executive Officer level.</p>	<p>Section 2 Aims of the policy</p> <p>Section 5 Ongoing involvement of designated person/Registered Manager Suspension, staff disciplinary procedures and support for implicated staff Allegations against Adults Wellbeing and Health employees Allegations against adult placement carers Allegations against employees of other statutory safeguarding agencies Allegations of adult abuse/neglect which implicate workers or adult placement carers who may also have access to children Safeguarding strategy and executive meetings Risk/protection Templated documentation</p> <p>Section 15 Legal and ethical context</p> <ul style="list-style-type: none"> • Key legislation and guidance • Confidentiality • Advocacy and support <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health • Key individual and team roles – all roles and additional contributors including the Independent Mental Health Advocate

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
8. Risk management/ protection	Ongoing from the point of decision making. Risk assessments will need to be kept under review throughout the safeguarding process and after safeguarding care-plans and/or organisational/ Remedial plans have been implemented.	<p>Safeguarding work throughout each stage of the procedures must be underpinned by a robust and shared risk management approach. The results of every risk assessment undertaken and all subsequently agreed risk management plans/actions must be recorded on each safeguarding file. Disagreements too should be noted. The Safeguarding Adults Risk Support Tool might be useful here as a guide.</p> <p>Where a care service is involved, an assessment of the presenting level of risk to service users (classifications at green, amber or red) will need to be carried out in conjunction with the relevant senior Manager (Safeguarding Adults Practice Officer in executive strategies) the Council's Contracts Manager and the CQC. The classification will determine the nature of any subsequent action.</p> <p>In some cases it may be necessary for employers to implement their individual organisation's human resources/suspension/disciplinary procedures as an immediate protective action.</p> <p>If at any stage in the safeguarding process it becomes evident that an adult(s) at risk or child (ren) may be exposed to significant harm, immediate protective measures should be considered.</p> <p>SSID entries must be kept up-to-date.</p>	The Adults Wellbeing and Health Manager, the Assessing Officer and potentially other safeguarding partners.	<p>Section 2 Aims of the policy</p> <p>Related Documents Risk/protection Safeguarding Adults Risk Support Tool Suspension, staff disciplinary procedures and support for implicated staff Allegations against Adults Wellbeing and Health employees Allegations against adult placement carers Allegations against employees of other statutory safeguarding agencies Allegations of adult abuse/neglect which implicate workers or adult placement carers who may also have access to children Templated documentation</p> <p>Section 16 Legal and ethical context</p> <ul style="list-style-type: none"> • Key legislation and guidance • Confidentiality • Place of safety • Advocacy and support <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health • Key individual and team roles – Adults Wellbeing and Health Manager, Safeguarding Adults Practice Officer, Assessing Officer and potentially other key players including the Council's Contract Manager • The Police • The CQC

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
9. Safeguarding assessment (runs parallel with step 10)	To be completed within 28 days of referral.	<p>The safeguarding assessment process will usually run parallel to any investigative action being implemented by the partner agencies, and will need to be carried out in a setting, manner and language appropriate to the level of understanding and cultural background of the adult concerned. The assessment must be preceded by a test of the adult's contextual mental capacity, if this has not already been established.</p> <p>Based on the outcome of the safeguarding assessment the Assessing Officer will work with the adult to draw-up a safeguarding care-plan. This will normally include strategies for minimising risk of further harm and preventing abuse.</p> <p>An initial review of the safeguarding care-plan should be held no later than six weeks after the date of it being agreed. Subsequent reviews should take place at least six-monthly until concerns diminish and a decision can be taken by the multi-disciplinary team that the case can be closed. SSID entries must be kept up-to-date.</p> <p>There will be a number of complex cases where it will be impossible to meet the completion deadline of 28 days; however, there will be some cases such as those where there is a police investigation or where there are HR issues to resolve which may prolong the completion date. In those cases the managers / lead officers can end the investigation and close down the safeguarding case if :-</p> <ul style="list-style-type: none"> • All reasonable steps to protect the user have been taken. • There are no concerns about the user's safety in the foreseeable future. • User's needs have been assessed as necessary. <p>Cases should not be closed if major problems are anticipated or significant further work or updates are required.</p>	Assessing Officer	<p>Section 2 Aims of the policy Working with adults at risk</p> <p>Sections 6 and 16 Safeguarding assessment, care-planning and review Templated documentation</p> <p>Section 16 Legal and ethical context</p> <ul style="list-style-type: none"> • Key legislation and guidance • Confidentiality • Capacity and consent • Place of safety • Advocacy and support <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health • Key individual and team roles – Assessing Officer

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
<p>10. Investigation and reporting (runs parallel with step 9)</p>	<p>The investigative process must proceed within 48 hours of the strategy discussion/meeting or executive strategy meeting.</p> <p>The investigation must be completed within 28 days of the completion of the strategy meeting, although in complex cases a time extension may be permitted (e.g. where a criminal investigation is taking place). The reasons for the extension must be fully recorded and communicated to the adult at risk and his or her supporters, and where appropriate, the referrer.</p>	<p>The purpose of the safeguarding investigation is to:</p> <ul style="list-style-type: none"> • find out if and how an identified adult or adults has/have experienced abuse and who perpetrated it; • identify the presenting risks to the adult and any others affected by the alleged abuse; and • Determine how these can be minimised to an acceptable level through recommendation or application of a range of remedial measures to be set out in an organisational/remedial plan. <p>Evidence will be required to substantiate any findings and to satisfy legal, regulatory and disciplinary proceedings.</p> <p>If a criminal act is suspected then the Police investigation will take precedence. Where allegations of abuse or neglect concern a registered service and it is suspected that a breach of Regulations may have occurred or fitness is in question, then the CQC may lead the investigative process.</p> <p>At the end of the investigation a summary of all information gathered should be recorded in the form of a concise report. Where Adults Wellbeing and Health staff take responsibility for this task, the report can be documented using the case note recording facility. SSID entries must be kept up-to-date and include a chronology of events/interventions.</p>	<p>The investigative team</p>	<p>Section 10 Investigation Additional considerations for investigations Allegations of adult abuse/neglect which implicate workers or adult placement carers who may also have access to children Templated documentation</p> <p>Section 16 Legal and ethical context Key legislation and guidance</p> <ul style="list-style-type: none"> • Confidentiality • Place of safety • Advocacy and support <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health • Key individual and team roles – the investigative team and potentially all others including additional contributors • The Police • The CQC

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
<p>11. Debriefing meeting, organisational/remedial planning and safeguarding case review</p>	<p>De-briefing meetings must be held within 5 days of completion of the safeguarding assessment/ Investigative processes being completed.</p> <p>Organisational/ Remedial plans must be drawn-up within four weeks of the completion of the investigative process.</p> <p>An initial review of such plans must be held no later than six months after the de-briefing meeting and earlier if the risk increases or circumstances dictate.</p>	<p>The outcome of all investigations, including those conducted at Executive Officer level, will need to be shared at a de-briefing meeting. This will enable the safeguarding partners to consider the reported outcome of the investigation and assessment and any associated recommendations. Decisions can then be jointly taken about how the ongoing needs of the identified adult(s) will be met within pooled resources and how remedial actions can best be achieved and outcomes reviewed.</p> <p>At this stage, any organisational/remedial plans to supplement the adult's safeguarding care-plan will need to be drawn up and agreed – often in executive strategy cases with the support of the Safeguarding Adults Practice Officers. Organisational/remedial planning may include referral to the ISA/professional registering bodies of any workers proven responsible for the alleged abuse, or even decommissioning of a service, along with identified timescales for action and multi-disciplinary review. In complex cases where the risk of ongoing abuse remains a significant factor, the nature and frequency of each review will vary. The review should involve as many of the original safeguarding partners as is deemed necessary.</p> <p>Records will need to be kept of the meeting and subsequent reviews and SSID entries kept up-to-date. These will be subject to inter-agency information recording, storage and sharing protocols. Copies of these and the investigation report will need to be sent to the appropriate responsible Manager with a safeguarding lead for monitoring purposes.</p>	<p>De-briefing meeting to be arranged by the Lead Officer/Executive Lead Officer. All previously involved strategy members are to be invited, including the adult at risk and his/her carers and/or supporters if appropriate.</p>	<p>Sections 10 and 13 Post investigation Referral to the ISA Templated documentation</p> <p>Section 15</p> <p>Legal and ethical context</p> <ul style="list-style-type: none"> • Key legislation and guidance • Confidentiality • Advocacy and support <p>Roles and responsibilities</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health • Key individual and team roles – potentially all including additional contributors • The Police • The CQC

STEP	TIMESCALES	ACTION	BY WHOM	REFERENCE
12. Monitoring	Ongoing	<p>Each of the partner organisations is responsible and accountable for meeting national guidance and legal requirements in relation to implementing safeguarding adults work, whether through working in partnership or through its own actions.</p> <p>By ensuring robust systems are in place for the monitoring of its safeguarding work, the multi-agency partners will be able to determine whether those requirements are being met. Monitoring should be regarded as a shared responsibility and will include the collection and analysis of key data, implementation of quality monitoring tools such as 'serious case review', and annual review and revision of the inter-agency safeguarding policy and procedural guidance. The Durham Safeguarding Adults Board will ensure that suitable mechanisms are put in place to facilitate sharing of 'lessons learned' from its safeguarding work.</p>	The appropriate responsible Manager with a safeguarding lead and other safeguarding partners.	<p>Section 1 Quality and development Complaints</p> <p>Section 14.9 Monitoring safeguarding work Templated documentation</p> <p>Section 14 Roles and responsibilities:</p> <ul style="list-style-type: none"> • Adults Wellbeing and Health • Key individual and team roles – the appropriate responsible Manager with a safeguarding lead

Type of Abuse	Examples of alerts that might fall out with safeguarding procedures and be addressed by other means	Less Serious	The Extent of the Abuse		Extremely Serious
Physical Medication	<ul style="list-style-type: none"> Staff error causing no/little harm, e.g. friction mark on skin due to ill-fitting hoist sling Minor events that still meet criteria for 'incident reporting' Adult does not receive prescribed medication (missed/wrong dose) on one occasion - no harm occurs 	<ul style="list-style-type: none"> Isolated incident involving service user on service user Inexplicable marking found on one occasion Recurring missed medication or administration errors that cause no harm 	<ul style="list-style-type: none"> Inexplicable marking or lesions, cuts or grip marks on a number of occasions Recurring missed medication or errors that affect more than one adult and/or result in harm 	<ul style="list-style-type: none"> Inappropriate restraint Withholding of food, drinks or aids to independence Inexplicable fractures/injuries Assault Deliberate maladministration of medications Covert administration without proper medical authorisation 	<ul style="list-style-type: none"> Grievous bodily harm/assault with weapon leading to irreversible damage or death Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death
Sexual	<ul style="list-style-type: none"> Isolated incident of teasing or low-level unwanted sexualised attention (verbal or touching) directed at one adult by another whether or not capacity exists 	<ul style="list-style-type: none"> Verbal sexualised teasing or harassment Being made to look at pornographic material against will/ where valid consent cannot be given 	<ul style="list-style-type: none"> Recurring sexualised touch or isolated/recurring masturbation without valid consent Voyeurism without consent Being subject to indecent exposure 	<ul style="list-style-type: none"> Attempted penetration by any means (whether or not it occurs within a relationship) without valid consent 	<ul style="list-style-type: none"> Sex in a relationship characterised by authority, inequality or exploitation, e.g. staff and service user Sex without valid consent (rape)
Psychological	<ul style="list-style-type: none"> Isolated incident where adult is spoken to in a rude or other inappropriate way – respect is undermined but no or little distress caused 	<ul style="list-style-type: none"> Occasional taunts or verbal outbursts which cause distress The withholding of information to disempower 	<ul style="list-style-type: none"> Treatment that undermines dignity and damages esteem Denying or failing to recognise an adult's choice or opinion Frequent verbal outbursts 	<ul style="list-style-type: none"> Humiliation Emotional blackmail e.g. threats of abandonment/ harm Frequent and frightening verbal outbursts 	<ul style="list-style-type: none"> Denial of basic human rights/civil liberties, over-riding advance directive, forced marriage Prolonged intimidation Vicious/personalised verbal attacks
Financial	<ul style="list-style-type: none"> Staff personally benefit from the support they offer service users e.g. accrue 'rewards' points on their own store loyalty cards when shopping 	<ul style="list-style-type: none"> Adult not routinely involved in decisions about how their money is spent or kept safe - capacity in this respect is not properly considered 	<ul style="list-style-type: none"> Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of interest Adult denied access to his/her own funds or possessions 	<ul style="list-style-type: none"> Misuse/misappropriation of property, possessions or benefits by a person in a position of trust or control Personal finances removed from adult's control 	<ul style="list-style-type: none"> Fraud/exploitation relating to benefits, income, property or will Theft
Neglect	<ul style="list-style-type: none"> Isolated missed home care visit where no harm occurs Adult is not assisted with a meal/drink on one occasion and no harm occurs 	<ul style="list-style-type: none"> Inadequacies in care provision that lead to discomfort or inconvenience - no significant harm occurs e.g. being left wet occasionally Not having access to aids to independence 	<ul style="list-style-type: none"> Recurrent missed home care visits where risk of harm escalates, or one miss where harm occurs Hospital discharge without adequate planning and harm occurs 	<ul style="list-style-type: none"> Ongoing lack of care to extent that health and well-being deteriorate significantly e.g. pressure wounds, dehydration, malnutrition, loss of independence/confidence 	<ul style="list-style-type: none"> Failure to arrange access to life saving services or medical care Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk
Institutional (any one or combination of the other forms of abuse)	<ul style="list-style-type: none"> Lack of stimulation/ opportunities for people to engage in social and leisure activities Service users not given sufficient voice or involved in the running of the service 	<ul style="list-style-type: none"> Denial of individuality and opportunities for service users to make informed choices and take responsible risks Care-planning documentation not person-centred 	<ul style="list-style-type: none"> Rigid/inflexible routines Service users' dignity is undermined e.g. lack of privacy during support with intimate care needs, pooled under-clothing 	<ul style="list-style-type: none"> Bad practice not being reported and going unchecked Unsafe and unhygienic living environments 	<ul style="list-style-type: none"> Staff misusing their position of power over service users Over-medication and/or inappropriate restraint used to manage behaviour Widespread, consistent ill treatment
Discriminatory	<ul style="list-style-type: none"> Isolated incident of teasing motivated by prejudicial attitudes towards an adult's individual differences 	<ul style="list-style-type: none"> Isolated incident of care planning that fails to address an adult's specific diversity associated needs for a short period Recurring taunts 	<ul style="list-style-type: none"> Inequitable access to service provision as a result of a diversity issue Recurring failure to meet specific care/support needs associated with diversity 	<ul style="list-style-type: none"> Being refused access to essential services Denial of civil liberties e.g. voting, making a complaint Humiliation or threats on a regular basis 	<ul style="list-style-type: none"> Hate crime resulting in injury/emergency medical treatment/fear for life Hate crime resulting in serious injury or attempted murder/honour-based violence

N.B. These examples provide a limited illustration of the types of abuse that can occur, along with an indication of the possible range of severity. The list is not in any way exhaustive and should not be used as a definitive guide. If you are in any doubt about whether a concern constitutes a safeguarding matter, then you should make a referral to Social Care Direct on 0845 850 50 10.

Invitation to strategy/ESM and information gathering letter

Dear

Re: Adult(s) at risk - name(s) and address (es)/date(s) of birth
and/or
Service name and address

A safeguarding adults referral has been made to Durham County Council's Adult Wellbeing and Health Directorate in respect of name(s) of adult(s) at risk/name of service.

You are invited to attend a multi-agency strategy meeting/executive strategy meeting, which is being held at venue, on date and time. The purpose of the meeting, which will be conducted in the best interests of the adult(s) concerned and in accordance with the Durham Safeguarding Adults Policy and Procedural Framework, is to share information about the adult(s) at risk, the alleged perpetrator(s) if known, and anything else that may have a bearing on the presenting risk or that might influence the safeguarding process. The meeting will facilitate a shared decision about how best to proceed; this will include consideration of the need for any immediate protective interventions and enable the planning of investigative and other processes.

Please confirm your attendance to the above telephone number. If you are unable to attend, then we would be grateful if you could delegate a suitable representative to attend on your behalf. They should bring along to the meeting any relevant information. Alternatively, you could fax a summary of the information to insert contact name and fax number; which should be marked 'highly confidential'. Information will be used in accordance with Durham County Council's multi-agency information sharing and 'working together' protocols.

Yours sincerely

Name
Designation
Team

Durham Safeguarding Adults Board

Strategy Meeting/Executive Strategy Meeting Agenda

AGENDA

1. Introductions
2. Apologies
3. Confidentiality statement
4. Purpose of meeting
5. Details of the allegation/concerns
6. Background
7. Multi-agency information sharing
8. Decision (reached on the basis of shared risk assessment)
9. Agreeing a strategy (including interim safeguarding interventions, safeguarding assessment/care planning processes/risk assessment and investigative processes)
10. Action planning
11. Arrangements for feeding back to relevant parties
12. Any other business
13. Date of next meeting (if appropriate)

Durham Safeguarding Adults Board

Strategy Debrief/Executive Planning Debrief Agenda

AGENDA

1. Introductions
2. Apologies
3. Confidentiality statement
4. Purpose of meeting
5. Views of the alleged victim/adult at risk (these may be presented by the adult or by a suitable representative on his/her behalf)
6. Update on current situation (addressing outcome of any investigation/risk assessment/safeguarding assessment processes and nature of subsequent safeguarding plans/service remedial plans)
7. Review of previous action plan
8. Views of professionals/others involved
9. Decision (reached on the basis of shared risk assessment)
10. Updated action plan (if necessary)
11. Outcome and lessons learned
12. Arrangements for feeding back to relevant parties
13. Any other business
14. Date of next meeting (if required)

Feedback to referrer letter – safeguarding

Dear

Re: delete/complete as appropriate
Safeguarding adults referral
Adult(s) at risks - name(s)/address (es) and date(s) of birth
and/or
Service name and address

Thank you for the alert you made to Durham County Council's Adult Wellbeing and Health Directorate in respect of name(s) of adult(s) at risk/name of service.

Your concern(s) have been logged as a safeguarding adults referral and will be dealt with in accordance with the multi-agency safeguarding adults procedures. We may not need to make any further contact with you, however if we believe you may be able to offer further assistance and help us with our enquiries, we will be in touch again in due course. If this does become necessary, we would appreciate your continued support.

If you have any queries about the contents of this letter, then please make contact using the telephone number indicated above.

Yours sincerely

Name
Designation
Team

Feedback to referrer letter – not safeguarding

Dear

Re: delete/complete as appropriate
Safeguarding adults referral
Adult(s) at risk - name(s)/address(es) and date(s) of birth
and/or
Service name and address

Thank you for the alert you made to Durham County Council's Adult Wellbeing and Health Directorate in respect of name(s) of adult at risk/name of service.

We would like to reassure you that your concerns have been taken seriously and careful consideration given to the risk(s) you described. The department will not however be progressing this as a safeguarding adults matter.

Delete as appropriate (you could use options 1 and 3 together, 2 and 3 together, or just 3 on its own)

1. We have referred the matter to (insert name of alternative agency), who we hope will be able to offer a more appropriate response.
2. We suggest you contact (insert name of alternative agency to which referrer is being signposted to) who may be able to offer a more appropriate response.
3. If you are concerned that (insert name of adult(s) remains at risk, or the risk has increased since your first contact with the department, and that it is not being properly recognised or managed, then please get back in touch by ringing Social Care Direct on 0845 8505010.

If you have any queries about the contents of this letter, or about our decision in this instance, then please make contact using the telephone number indicated above.

Yours sincerely

Name
Designation
Team

Appendix 11 **Key legislation, safeguarding guidance and protocols used by the statutory agencies**

Primary (preventative) interventions	
Legislation	
Human Rights Act, 1998	Includes 'the right to life' (Article 2), 'the right to freedom from torture' (Article 3, which is absolute) and 'the right to family life – one that sustains the individual' (Article 8). There is a duty on public agencies (including the statutory safeguarding partners) under Human Rights legislation to intervene proportionately to protect the rights of citizens. Any 'adult at risk' should be able to access public organisations for appropriate interventions which enable them to live a life free from violence and abuse.
Mental Capacity Act, 2005 (also provides for tertiary interventions)	<p>Provides a statutory framework to empower and protect vulnerable people who are unable to make their own decisions. It makes it clear who can take decisions, in which situations, and how they should go about this, and it enables people to plan ahead for a time when they may lose capacity. In the context of safeguarding adults, the Act introduces a new criminal offence of 'ill treatment' or 'wilful neglect' of a person who lacks capacity, with a maximum penalty of up to five years imprisonment. Additionally, the Mental Health Act 2007 has introduced the 'Deprivation of Liberty Safeguards' into the Mental Capacity Act 2005; these take effect from April 2009 (see below).</p> <p>The MCA is underpinned by a set of five principles:</p> <ul style="list-style-type: none"> • a presumption of capacity - every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise; • the right for individuals to be supported to make their own decisions - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;

	<ul style="list-style-type: none"> • that individuals must retain the right to make what might be seen as eccentric or unwise decisions; • 'best interests' - anything done for or on behalf of people without capacity must be in their best interests; and • Least restrictive intervention - anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms. <p>Sections 8 to 13 introduce a 'Lasting Power of Attorney' (LPA), repealing the Enduring Power of Attorney Act 1985. LPAs will extend to all or any specific matters concerning the donor's personal welfare, property and affairs. LPAs may be registered while the donor still has capacity, but their powers cannot be exercised until the donor no longer has the capacity. The donee is required to act in the 'best interests' of the donor.</p> <p>Sections 14 to 22 provide a new 'Court of Protection', with the same powers, rights and privileges as the High Court to resolve complex issues (see below). The Sections replace 'Receivers' with 'Deputies'.</p> <p>The Act introduces a new Public Guardian, to replace the Public Guardianship Office, and also the role of Independent Mental Capacity Advocate</p>
Deprivation of Liberty Safeguards (DoL)	<p>The safeguards apply to anyone:</p> <ul style="list-style-type: none"> • aged 18 and over; • who suffers from a 'mental disorder or disability of the mind' – such as dementia or a profound learning disability; • who lacks the capacity to give informed consent to the arrangements made for

	<p>their care and / or treatment; and</p> <ul style="list-style-type: none"> • For whom deprivation of liberty is considered - on the basis of independent assessment - to be necessary in their best interests to protect them from harm. <p>The safeguards cover patients in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.</p> <p>The safeguards are designed to protect the interests of an extremely vulnerable group of service users and to:</p> <ul style="list-style-type: none"> • ensure people can be given the care they need in the least restrictive regimes; • prevent arbitrary decisions that deprive vulnerable people of their liberty; • provide safeguards for vulnerable people; • provide them with rights of challenge against unlawful detention; and • Avoid unnecessary bureaucracy.
Guidance/Protocols	
<p>'No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse' (Department of Health and Home Office 2000)</p>	<p>Issued under Section 7 of the Local Authority Social Services Act 1970, which requires Local Authorities in their Social Services functions to act under the general guidance of the Secretary of State. In the context of 'No Secrets', this means co-ordinating a multi-agency response to ensuring that appropriate policies, procedures and practices (for the protection of vulnerable adults at risk of abuse) are put in place and implemented locally.</p> <p><i>No Secrets</i> does not have the full force of statute. Nevertheless, the compliance of the safeguarding adults partnership with this guidance is necessary, unless local circumstances dictate exceptional reasons to justify a variation.</p>

	<p>At the time of writing, <i>No Secrets</i> is in the process of being 'refreshed' by Government. ADASS has called for safeguarding adults work to be given a statutory footing, and has requested that a legislative framework for intervention be developed, in line with that recently introduced by the Scottish Executive (Adult Support and Protection (Scotland) Act, 2007). The Department of Health consultation period is expected to be complete by April 2009.</p>
<p>'Safeguarding Adults: a National Framework of Standards for Good Practice and Outcomes in Adult Protection Work' (Association of Directors of Social Services 2005)</p>	<p>Constitutes a set of eleven good practice standards, intended to be used as an audit tool and guide by all those implementing adult protection work. This guidance adopts a modern and user-focussed approach to safeguarding work, which reflects the legal, political and philosophical changes which have taken place in the field of adult social and health care since 2000.</p>
<p>'Our Health, Our Care, Our Say', (Department of Health 2006)</p>	<p>Emphasises the importance of people having more control over their lives and access to responsive, preventative services - equally applying to those people who have experienced abuse or who need safeguarding from a risk of abuse.</p>
<p>'Valuing People' (Department of Health 2001)</p>	<p>Has four underlying principles for policy in respect of people with learning disabilities: rights, independence, choice and inclusion. Makes clear that any intervention aimed at safeguarding people must respect and strengthen an individual's rights and freedoms.</p>
<p>'Dignity in Care' Campaign</p>	<p>Launched by the Government in November 2006, this campaign aims to eliminate indignity in health and social care services, and create a care system where there is zero tolerance of abuse. It involves a sustained series of actions, events and policy development. These include:</p> <ul style="list-style-type: none"> • a partnership with Investors in People UK;

	<ul style="list-style-type: none"> • an active programme of service improvement support to be delivered locally by the CSIP; • development of an online practice guide; • the introduction of the 'Queen's Mother's Award for Dignity in Care of Older People'; • the introduction of a Beacon Council Award for Dignity in Care; • a review of national policies including the 'No Secrets' guidance; • complaints reforms; • training and registration of the workforce; and • Improving the care environment.
<p>'Independence, choice and risk: a guide to best practice in supported decision making' (Department of Health 2007)</p>	<p>Provides a risk framework for everyone involved in supporting adults using social care (within any setting and provided by all sectors, including all NHS staff working in multi-disciplinary or joint teams). It aims to:</p> <ul style="list-style-type: none"> • outline a common set of principles as the basis for supporting people in making decisions about their own lives and managing any risk in relation to those choices; • support the principle of empowerment through managing choice and risk transparently, in order to enable a fair appraisal of the decision process if required; and • Highlight how to balance necessary levels of protection and preserve reasonable

	<p>levels of choice and control, in order to help people achieve their potential without their safety being compromised.</p> <p>The framework is intended to complement, rather than replace existing guidance.</p>
<p>'Rights, risks and restraints: an exploration into the use of restraint in the care of older people' (Commission for Social Care Inspection 2007)</p>	<p>This report presents an exploration into the use of restraint in the care of older people. It focuses on the principles of dignity, freedom and respect being necessary to good quality social care, and debates the conflict between observing these principles whilst keeping people safe from harm and supporting individuals whose behaviour may cause difficulties. It describes examples of appropriate and inappropriate restraint and highlights the need for clear policy guidance and staff training.</p>
<p>Secondary (identifying and responding) interventions</p>	
<p>Legislation</p>	
<p>Police and Criminal Evidence Act (PACE) 1984 and PACE Codes of Practice</p>	<p>Together provide the core framework of Police powers and safeguards around 'stop and search', arrest, detention, investigation, identification and interviewing detainees.</p> <p>Section 17 gives the Police powers to enter premises to save life or limb, protect property or to arrest for certain offences.</p> <p>The introduction of the Serious Organised Crime and Police Act 2005 amended Section 24 of PACE to give Police the power to arrest for any offence. Persons other than Police Officers may only arrest in relation to suspected indictable offences (these are the more serious crimes and include murder, manslaughter and rape).</p> <p>PACE also has a power to compel a spouse or partner to attend Court for the purpose of giving evidence.</p>

<p>The Domestic abuse, Crime and Victims Act 2004</p>	<p>Explicitly states that it is a criminal offence to physically or sexually abuse, harm or cause 'deliberate cruelty by neglect' of a child or an adult. This legislation was introduced, in part, to emphasise the crime of abuse between partners within the home and gives the Police and the Courts greater powers to tackle offenders while ensuring victims get the support and protection they need.</p> <p>The definition of vulnerable adult within this Act means 'a person aged 16 or over whose ability to protect himself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise'. This means that the abuse - including neglect - of a vulnerable adult who has capacity may constitute a criminal offence if he or she subsequently dies. The Act also creates a new offence of 'causing or allowing the death of a child or vulnerable adult'; by closing a legal loophole which will help to ensure that offenders who remain silent or blame each other do not escape justice. In other words, where there are one or more potential perpetrators and it isn't possible to prove who did what, and then both (or all) can be convicted.</p>
<p>The Crime and Disorder Act 1998</p>	<p>May be used in relation to hate crimes and any crime where prejudice against an identifiable group is a factor in determining who the perpetrator victimises; this includes crimes that are racially aggravated, homophobic crimes and crimes against faith groups, asylum seekers and disabled people.</p>
<p>The Sexual Offences Act 2003</p>	<p>Offers a number of safeguards for people who may be vulnerable. While many of these relate to children, it covers people 'with a mental disorder impeding choice'. Other sections (38 to 42) specify offences involving care workers, abusive types of relationships and abuse of trust.</p>
<p>Youth Justice and Criminal Evidence Act 1999</p>	<p>Aims to encourage and support vulnerable or intimidated witnesses to give their best evidence in criminal cases by giving the Courts discretionary powers to apply 'special measures'. The special measures apply to all children under 17 years of age at the time</p>

	<p>of the hearing, complainants in sexual offence cases*, persons suffering from a 'mental disorder' (within the meaning of the Mental Health Act) or a significant impairment of intelligence or social functioning, those with a physical disability or other physical disorder, and also persons suffering fear or distress in connection with testifying in the proceedings.</p> <p>*Special measures are usual, rather than discretionary, in sexual offence cases</p> <p>Special measures include submission of video recorded 'evidence in chief' and cross examination, use of communication aids and Intermediaries to overcome physical difficulties with understanding and answering questions, live links with the Court, removal of wigs and gowns, clearing the public gallery, restrictions on the cross-examining of defendants in rape trials and other cases, and restrictions on evidence relating to the complainant's previous sexual history.</p>
<p>Protection from Harassment Act 1997</p>	<p>Section 2 introduces the offence of 'causing alarm or distress'. Section introduces the offence of 'causing fear or violence'. These offences require an offender to have 'harassed' on more than one occasion, however once this has been established the offender may be arrested on any occasion they repeat similar behaviour. These basic offences committed with any proven form of racial motivation or hostility based on race will attract a more severe sentence.</p>

<p>Forced Marriage (Civil Protection) Act 2007</p>	<p>Where a forced marriage has or is about to take place, Courts will be able to make Orders to protect the victim or the potential victim and help remove them from that situation. The Courts will have a wide discretion in the type of injunctions they will be able to make to enable them to respond effectively to the individual circumstances of the case and prevent or pre-empt forced marriages from occurring. Courts will also be able to attach powers of arrest to Orders so that if someone breaches an Order they can be arrested and brought back to the original Court to consider the alleged breach.</p> <p>The Act additionally enables people to apply for an injunction at the County Courts, rather than just the High Courts, and permits third parties to apply for an injunction on behalf of somebody else.</p>
<p>Public Interest Disclosure Act 1998 (Whistle blowing or 'Speaking Out')</p>	<p>The Act sets out a requirement for organisations to have procedures under which staff can raise, in confidence, any serious concerns that they may have and do not feel that they can raise in any other way. These can include situations when an employee believes that:</p> <ul style="list-style-type: none"> • a criminal offence has been committed; • someone has failed to comply with legal obligation; • a miscarriage of justice has occurred; • the health and safety of an individual is being endangered; and • There are or may be financial irregularities.
<p>The Care Standards Act 2000 and associated Regulations</p> <p>(also a primary and tertiary</p>	<p>This Act gives powers to authorised staff of the regulatory bodies to enter and inspect organisations providing care services to vulnerable adults either in the community or residential establishments. All such services/homes must be registered with CQC.</p>

intervention)	Where service providers persistently fail to comply with Regulations, then their registration may be cancelled or they may be prosecuted. Additionally, where Officers of the Commission consider there is serious risk to 'the life, health and/or wellbeing of residents', then they may obtain an order for an immediate closure of a home.
Health and Social Care Act 2008 (again, this legislation falls into all three categories of intervention)	<p>The Act abolishes the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission. The Care Quality Commission for England (CQC) will take over those bodies' functions with extended powers as a Care Standards Registration Authority with effect from April 2009. The Act, which also gives the Department of Health powers to extend the range of sectors in which registration is required, will not be fully implemented until April 2010.</p> <p>In respect of the human rights of service users placed in residential care homes, Section 145 of the Act provides that protection travels with a service user who is placed by a Local Authority. As a result, the home is required to comply with the Human Rights Act 1998.</p>
Mental Health Act 1983 N.B. The Mental Health Act 2007 updates and amends the 1983 Act. (also a tertiary intervention)	<p>Section 115 permits an Approved Mental Health Professional (AMHP) to enter and inspect any premises in which a 'mentally disordered' adult is living, if there is reasonable cause to believe that the patient is not 'under proper care' (has been, or is being, ill-treated or neglected and not kept under proper control, or is unable to care for him or herself and is living alone). Forced entry is not allowed, although obstruction may be considered an offence under Section 129, and the ASW can apply for a warrant under Section 135. The adult need not be named in this warrant and the evidence used to obtain it can be about mistreatment in the past, so allows for accumulation of evidence over a period of time. The warrant permits removal of the adult for up to 72 hours.</p> <p>Section 136 allows for a Police Officer to intervene if the adult is in a public place (e.g. wandering outside of their home).</p>

	<p>Section 13(4) places a duty on Social Services to direct an AMHP to consider making an application for admission under the Act, if requested to do so by the nearest relative. This power could be used if the nearest relative of a mentally disordered adult complains of mistreatment by a third party, provided grounds exist under the Act.</p> <p>Sections 2, 3 and 4 give an AMHP power to authorise the hospital admission of a 'mentally disordered' adult where he or she is satisfied that the criteria for compulsory admission are met as per the provisions of the Act.</p> <p>Section 7 allows for a vulnerable adult to be received into guardianship by the Local Authority if he or she has a mental disorder which falls within the criteria set out in the Act. The guardianship must be necessary in the interests of the welfare of the adult or for the protection of other persons; it gives the guardian three basic powers:</p> <ul style="list-style-type: none">• to say where someone is to live;• to require the adult to attend somewhere for the purpose of medical treatment, occupation, education or housing; and/or• To gain access to the patient at a place in which someone is living. <p>Section 127 (2) makes it an offence for an employee or a Manager of a mental nursing home or hospital, to 'ill-treat or wilfully neglect' a patient who is either:</p> <ul style="list-style-type: none">• currently receiving treatment for mental disorder as an in-patient in that hospital or home; or• A patient receiving treatment as an out-patient. <p>It is also an offence for any Guardian or other person who has care of a 'mentally disordered' adult to ill-treat or wilfully neglect that person.</p>
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<p>Mental Health Act 2007</p> <p>(again also tertiary)</p>	<p>Key amendments to the 1983 Act include:</p> <ul style="list-style-type: none"> • a single definition of mental disorder with fewer exclusions (alcohol and drug dependence remain excluded, but 'sexually deviant' mental disorders are now included); • the introduction of a requirement for appropriate medical treatment; • the introduction of supervised community treatment; • the provision of additional safeguards for patients; • changing professional roles; • improved access to review tribunals; • age-appropriate service for children and young adolescents; and • Changes to place of safety arrangements.
<p>Medicines Act 1968</p>	<p>Provides for an offence in relation to the administration of medicines to one person that have been prescribed for another.</p>
<p>Corporate Manslaughter and Corporate Homicide Act 2007</p>	<p>Introduces a new UK-wide offence for prosecuting companies and other organisations where there has been a gross failing in the management of health and safety with fatal consequences. An organisation will be guilty of the new offence if the way in which its activities are managed or organised causes a death and amounts to a gross breach of a duty of care to the deceased.</p>

Guidance/Protocols	
The Right to Choose: Multi-agency statutory guidance for dealing with forced marriage (Foreign and Commonwealth Office (FCO), 2008)	Issued as statutory guidance under the above Act, the document is targeted at Chief Executives, Directors and senior Managers of organisations responsible for safeguarding and promoting the welfare of children and 'vulnerable adults'. It outlines their responsibilities in relation to developing and maintaining local procedures and practice arrangements to enable front-line practitioners to handle cases of forced marriage effectively. It sets out how cases of forced marriage should be responded to using existing frameworks for safeguarding children and adults and victims of domestic abuse. The document is not intended to be used by frontline practitioners as practice guidance; the FCO has published specific guidance of this type for the different sectors including health and social care and education professionals and the Police.
Tertiary (remedial) interventions	
Removal of an adult at risk to a place of safety	
At the time of writing, an adult can only be compulsorily removed from an abusive situation through the application of either the Mental Health Act 1983 (as amended by the 2007 Act), or the National Assistance Act 1948 (amended in 1951 to allow ex-parte applications). In respect of an adult lacking mental capacity, the New Court of Protection replaces the common law order of declaratory relief where circumstances necessitate this type of action. Careful consideration will need to be given as to whether any such removal might be construed as a deprivation of the adult's liberty. Additionally, since each of these possible legislative routes involve what may be regarded as sanctions against the abused person and not the perpetrator. Advice must always be sought from the Council's Solicitor before embarking on any strategy discussion.	
Legislation	
National Assistance Act 1948 (Section 47, compulsory removal of	Section 47 of the National Assistance Act gives Local Authorities and GPs the power to apply to a Magistrates Court for an order to remove an adult from a situation, to prevent injury to his/her own health, or to prevent serious nuisance. This section

<p>people from their homes)</p>	<p>applies to adults who are:</p> <ul style="list-style-type: none"> • suffering from grave chronic disease; or • being aged, infirm or physically incapacitated, are living in unsanitary conditions; and • Are unable to devote to themselves and are not receiving from other persons proper care and attention. <p>This section of the Act is rarely used but could be considered if there is no alternative and the risk is considered to be very grave. An order will last for up to three months depending on the circumstances in which it is obtained. Only in exceptional circumstances would Section 47 allow a Local Authority to arrange for the provision of residential care for an adult who was the subject of verbal or physical mistreatment. A modification of the Section 47 procedure is provided by the National Assistance (Amendment) Act 1951 to deal with situations in which it is necessary to remove an adult without delay.</p> <p>In relation to financial mistreatment, Section 47 could be used to cover the situation of an adult whose money was being misused to the extent that the other conditions set out above were satisfied. However, this would only assist in cases of financial abuse if it enabled a person who was exploited to be removed from the control of the abuser.</p>
<p>'New' Court of Protection (introduced by the Mental Capacity Act, 2005)</p>	<p>The Court has jurisdiction to deal with decision-making for adults who lack capacity. The new Court is able to take decisions about 'property and affairs' (which is the term used in the 2005 Act to describe the wide financial decision making jurisdiction) and also about 'personal welfare' matters. The term 'personal welfare' comprises both welfare and healthcare matters. The Court also has the power to make a declaration as to whether or not a person has capacity to make a particular decision or in relation to a particular matter. This will replace the current provision of declaratory relief.</p>

	<p>Where ongoing management of a person's property and affairs or welfare is required, a Deputy may be appointed to make any decisions. The Court will define the extent of the Deputy's powers, especially if the adult also has capacity to carry out certain functions for himself. Welfare deputies will be rare.</p>
<p>Section 1 of the Domestic Violence, Crime and Victims Act 2004</p>	<p>The breach of a non molestation order is now a criminal offence and as a result there is a power of arrest. A person in breach can be dealt with in one of two ways. Under a criminal justice route where there is a maximum sentence of 5 years imprisonment or if the applicant returns to court it would be dealt with as a contempt of court</p>
<p>Family Law Act 1996</p>	<p>Sections 33 to 38 refer to Occupation Orders which deal with the occupation of the home and occupation rights by spouses, former spouses with extended matrimonial rights, cohabitants and associated persons. Such Orders can require the respondent (perpetrator) to leave the home, or part of it, not to come near the home, to allow the applicant (victim) to enter, or stay in the home, or part of it, and can also decide what rights the respondent and applicant have to occupy the home.</p>
<p>Appointee ship</p>	<p>The Department of Work and Pensions (DWP) can appoint someone else to receive an adult's benefits and to use that money to pay expenses such as household bills, food and personal items. An Appointee should be a close relative or friend or someone who is regularly in contact with the adult. The person who is willing to act as the Appointee must contact the local DWP office, who will arrange to interview the adult to decide whether they are mentally or physically incapable of acting on their own behalf. The Appointee can give one month's notice of their intention to cease the arrangement and the DWP can end the arrangement at any time if it is not working satisfactorily.</p> <p>Adults who do not have a suitable Appointee can be referred to the Adults Wellbeing and Health Financial Protection Team.</p>

Guidance/Protocols	
Safeguarding Vulnerable Groups Act 2006	<p>The Vetting and Barring scheme was introduced on 12th October 2009 and as a result it is now a criminal offence for anyone who has been barred by the Independent Safeguarding Authority (ISA) to work or apply to work with vulnerable adults in a variety of regulated and controlled activities.</p> <p>It is also an offence to knowingly employ a barred person in those circumstances. This applies to both paid employment and voluntary work.</p> <p>Employers and a variety of professionals are now under a duty to refer anyone working with 'vulnerable adults' to the ISA who they have 'caused harm or pose a risk of harm'.</p>
Investigating Patient Safety Incidents Involving Unexpected Death or Serious Untoward Harm (Department of Health Memorandum of Understanding, February 2006)	<p>The purpose of this protocol is to promote effective working relationships between the National Health Service (NHS), the Association of Chief Police Officers and the Health & Safety Executive (HSE). It will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the Police, or the Police and the HSE jointly.</p> <p>The protocol sets out the general principles for the NHS, the Police and the HSE to observe when liaising with one another. It focuses on investigations in NHS Trusts, although the principles and practices it promotes should apply to other locations where healthcare is provided and the NHS is required to investigate under its performance management and other duties. The protocol is supplemented by detailed guidelines to the NHS. Police officers and HSE inspectors have their own guidelines.</p>
Police 'Gold' Strategy Response Protocol	<p>In the event of a critical incident, the Police sometimes use a system that involves the response of a Gold, Silver or Bronze Strategy Group. A 'Gold Strategy Group' represents the highest level of escalation and can be implemented in response to any major incident.</p> <p>Where a criticism can be levelled at the Police service or other public agency action, the</p>

	<p>lead Chief Officer (or other Chief as appropriate) must declare the matter a critical incident and ensure that this discussion is widely known amongst the team. It is the Chief Officer's responsibility to arrange a 'Gold Strategy Group'.</p> <p>Terms of reference for the group would include:</p> <ul style="list-style-type: none">• identifying and addressing any risks or potential areas of criticism regarding the incident, matters leading up to it, or since it occurred;• addressing any areas of risk with regard to conducting an enquiry;• considering issues for the families or communities;• considering impact to or from any other agency;• considering media issues; and• Identifying learning points.
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