Welcome to County Durham’s Safeguarding Adult’s Policies and Procedures.

- The aims of adult safeguarding are to stop abuse or neglect and prevent harm and reduce the risk of abuse or neglect to adults with care and support needs within County Durham.

- Durham County Council, as the local authority, is the lead agency but all public authorities and services in the council area have responsibilities for safeguarding adults.

- These policies and procedures will support professionals who need to prevent and respond to adult safeguarding concerns.

- These policies and procedures reflect the 2014 Care Act which has put safeguarding adults on a statutory footing.

- PLEASE NOTE; these policies are currently under review.
A Duty to Safeguard Adults

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

Safeguarding means protecting an adult’s right to live in safety, free from abuse and neglect and ensuring that people and organisations work together.

The Care Act sets out the safeguarding adult duties for Durham County Council and partner organisations. These duties are overseen by the Safeguarding Adults Inter-Agency Partnership known as the Safeguarding Adults Board (SAB) and will be implemented via this policy and procedural framework. The framework is designed to protect adults with care and support needs from abuse or neglect.

The Care Act has extended safeguarding duties to include new categories of abuse: Modern slavery, Self-neglect and Domestic abuse. These people may or may not have eligible social care needs.

Distinction between Safeguarding and Adult Protection.

The term “Safeguarding” applies to a continuum from low to high risk types of abuse. This framework draws a distinction between safeguarding issues which require minimal intervention and those which require more formal inter-agency statutory intervention which is known as Adult Protection.

All safeguarding concerns will be responded to in the most appropriate and proportionate way.

Where the individual appears to meet the national eligibility threshold for services and significant harm using the Risk Threshold tool, concerns may need to be escalated to adult protection procedures.
Introduction to County Durham Inter Agency Policy and Statement of Commitment.
The Care Act has defined safeguarding in broad terms covering prevention and protection. There is a new legal duty for DCC, as the Local Authority, to ensure that safeguarding enquiries take place to establish the level and circumstances of the risk. Eligibility for social care needs is not a barrier to these enquiries. Safeguarding enquiries must be made for any adult who:
- Has needs for care and support (whether or not the LA is meeting any of those needs) and;
- Is experiencing, or at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

The purpose of the enquiry is to clarify matters and ask other agencies or professionals to make enquiries on its behalf. A Safeguarding enquiry will not necessarily result in formal inter agency procedures with an investigation by police, health or DCC. It can result in many forms of action to assist the adult concerned such as advice, information, redirection to another agency or a care and support package. Interventions must be proportionate and appropriate. Where the actions required to protect the adult can be met by LAs, then the LA should take appropriate action.

Formal inter-agency investigations, known as Adult Protection in this policy and procedure, will only be for people with a greater level of risk and vulnerability due to eligible care and support needs and high risks in accordance with the Risk Threshold Tool.

‘Care and support’ is defined in the Care Act guidance as: ‘The mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent – including older people, people with a disability or long term illness, people with mental health problems, and carers. Care and support includes assessment of people’s needs, provision of services and the allocation of funds to enable a person to purchase their own care and support. It could include care home, home care, personal assistants, day services, or the provision of aids and adaptations.’
Policy and Statement of Commitment

This policy document constitutes a statement of commitment by the Safeguarding Adults Board in respect of the following aims to:

- Stop abuse or neglect wherever possible
- Prevent harm and reduce risk of abuse or neglect to adults with care and support needs
- Safeguarding adults in a way that supports them in making choices and having control about how they want to live
- Promote an approach that concentrate on improving life for the adults concerned
- Raise public awareness so that communities as a whole alongside professionals play their part in preventing and identifying and responding to abuse and neglect
- Provide information and support in accessible ways to help people understand the different types of abuse how to stay safe and what to do to raise a concern about the safety caused the abused
- Support strategic development of adult safeguarding particularly when faced with a particularly challenging safeguarding issue.

This framework is for all organisations working in partnership for the protection of adults at risk 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, whether permanently or temporarily resident within the boundaries of Durham county, to all perpetrators, and in all settings, including people’s 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.
Aims of the Policy

The inter-agency policy and procedural framework are intended to provide support and guidance to achieve the aims of the policy:

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

The policy and procedural framework is based on six key principles:

Empowerment – People being supported and encouraged to make their own decisions and informed consent.
"I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens."

Prevention – It is better to take action before harm occurs.
"I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help."

Proportionality – The least intrusive response appropriate to the risk presented.
"I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed."

Protection – Support and representation for those in greatest need.
"I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want."

Partnership – Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse. "I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me."

Accountability – Accountability and transparency in delivering safeguarding.
"I understand the role of everyone involved in my life and so do they."
Wellbeing Principle

The Wellbeing principle is fundamental to the Care Act. This is reflected in the Safeguarding Adults Partnership by the commitment to ensuring that service users, their families and carers are at the centre of all work. All those involved must ensure that people receiving care and support from Children and Adult Services 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.

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. This approach to wellbeing is fundamental to making safeguarding personal.
Under Section 42 of the Care Act, DCC has a duty to make enquiries itself or ask others to make enquiries where it has reasonable cause to suspect that an adult:

- Has needs for care and support (whether or not the local authority is meeting any of those needs) AND
- Is experiencing or at risk of abuse or neglect AND
- As a result of those care and support needs is unable to protect themselves from either the risk of or the experience of abuse or neglect

This decision to carry out a safeguarding enquiry does not depend on the person’s eligibility for social care needs.

The purpose of a safeguarding enquiry is for the LA to clarify matters and then decide on what course of action (if any) is required to protect the adult in question from abuse or neglect. Other agencies and professionals have a duty to co-operate (Care Act Section 6 and 7).

The enquiry could begin and end with a conversation with the subject of the concern who is given advice, information or redirected to another agency or with provision of a care package. Alternately Adult Protection procedures may be required for people who are more vulnerable because they have care and support needs* which meet the eligibility threshold and are experiencing significant levels of risk in accordance with the RISK THRESHOLD TOOL. The Risk Threshold Tool is designed to assist professionals when deciding on the level of risk and whether the LA needs to undertake a safeguarding enquiry.

*Care and support’ is defined in the Care Act guidance as:

‘The mixture of practical, financial and emotional support for adults who need extra help to manage their lives and be independent – including older people, people with a disability or long term illness, people with mental health problems, and carers. Care and support includes an assessment of people’s needs, provision of services and the allocation of funds to enable a person to purchase their own care and support. It could include care home, home care, personal assistants, day services, or the provision of aids and adaptations.’
Where someone is 18 or over but is still receiving children’s services and a safeguarding issue is raised, the matter should be dealt with through adult safeguarding arrangements. The level of needs is not relevant, and the young adult does not need to have eligible needs for care and support under the Care Act, or be receiving any particular service from the local authority, in order for the safeguarding duties to apply – so long as the conditions set out in paragraph 14.2 are met.14.6.

Local authority statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting, other than prisons and approved premises where prison governors and National Offender Management Service (NOMS) respectively have responsibility.

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

The Care Act defines abuse as:

Physical abuse includes assault, hitting, slapping, misuse of medication, restraint or inappropriate physical sanctions.

Domestic violence includes psychological, physical, sexual, financial, emotional, “honour violence”

Sexual abuse includes indecent exposure, sexual harassment, inappropriate touching, exposure to pornography or witnessing sexual acts, indecent exposure, and sexual assault or sexual acts to which the adults has not consented or was pressured into consenting.

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

Financial or material abuse includes fraud, theft, internet scamming, coercion in relation to wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Modern slavery includes human trafficking, forced labour, domestic servitude, Gang-masters.

Discriminatory Abuse includes forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion.

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

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

Self-neglect covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding.
Who Abuses and Neglects Adults?

Anyone can abuse or neglect including:

- Spouses/partners
- Other family members
- Neighbours
- Friends
- Acquaintances
- Local residents
- People who deliberately exploit adults they perceive as vulnerable to abuse
- Paid staff or professionals and
- Volunteers and strangers

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.

Increasingly we are seeing human traffickers and slave masters who deceive, coerce and force individuals in to a life of abuse, servitude and inhumane treatment.
Types of Abuse and How to Recognise them

Our website provides an overview of the forms of abuse in 'What is Abuse'. 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 described under each heading are linked to the different types of abuse.

None of these indicators are conclusive to an act of abuse having taken place, and investigation required to determine if abuse has occurred.

General signs that abuse may have taken place, or may still be on going include;
- difficulty experienced by professionals 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
- Where one or more agencies – e.g. Police or welfare, raise concerns
Psychological

There is a psychological element to all forms of abuse. This includes emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber bullying, isolation, or unreasonable behaviour. They can also be very aggressive shouting, swearing or making racist comments. Other examples of psychological abuse are:

- withdrawal of the adult from a valued activity, or deprivation of normal contact
- making a person feel ashamed of involuntary behaviour, or ridicule appearance due to a disability
- Indifference such as denying or failing to recognise the adult’s choice, opinion, privacy, dignity, or 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:

- Feeling insecure, low self-esteem, depression or tearfulness; lack of 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
- The adult showing deference or submission to the perpetrator
Domestic Violence

Domestic violence includes psychological, physical, sexual, financial, emotional, ‘honour-violence’

Domestic abuse

In 2013, the Home Office announced changes to the definition of domestic abuse: ‘Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse by someone who is or has been an intimate partner or family member regardless of gender or sexuality.’

Includes; psychological, physical, sexual, financial, emotional abuse, so called ‘honour-based’ violence, female genital mutilation, forced marriage. Age range extended down to 16.

Many people think that domestic abuse is about intimate partners, but it is clear that other family members are included and that much safeguarding work that occurs at home is, in fact, concerned with domestic abuse. This confirms that domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.
Physical

Physical abuse is the physical ill-treatment of an adult, which may or may not cause physical injury includes assault, hitting, Scratching or pinching, punching, slapping, Shaking, Kicking, Restraint, Inappropriate, physical sanctions, 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:

- sanctions such as forced isolation; or 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
- A person being taken to many different places to receive medical attention.
Modern Slavery
Encompasses slavery, human trafficking, forced labour and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment.

A serious challenge to identifying victims is the widespread misperception that modern slavery is an issue of immigration. This is wrong. Modern slavery is a breach of human rights and potentially is the gravest crime. Signs that the person may be the victim of modern slavery are numerous. However some of the common ones are identified below:
The person may be:
• Foreign extraction and appear to be an illegal immigrant/Fearful of trafficker/fearful of police or authority
• Appear to be under control of Gang master/Constantly being moved to avoid detection
• Unable to speak without controlling person present
• Use of inducements/promises of better life/ Entrapments of accommodation & work
• Employed in agriculture, car wash, nail bars, factories, illicit drug, grooming
• Communication problems /unable to speak English
• Unpaid/paid very little /Wages used for debt/No control over money/bank cards/ mobile phone
• Lack of awareness of being trafficked/ Victims have little or no freedom/Person kidnapped
• Collected and dropped off at work- long hours. No health and safety in work place
• Fear of deportation/not in possession of ID or Passport docs/Forced to engage in criminal activity
• Forced marriage/ sexual exploitation//Abuse of partner/ or family

The person may be exhibiting signs of:
Psychological trauma
• Fear of telling others about their situation/Lack of memory of recent events, withdrawn/unkempt/Isolated
• Appears anxious, hesitant or confused/Hesitant to talk to strangers, no eye contact /rarely interact
• Fear of violence, death or serious injury /Belief of threat on their lives or family

Physical
• Self harm/Poor physical condition/Malnourished/Evidence of bruising/Untreated conditions/Signs of neglect
• Limited access to medical or dental care/Undergo unnecessary operation/organ harvesting

Poor Living conditions
• Living at work place or lives in premises of multiple occupation
• Living in lock ups/sheds/containers/Lives in dirty, cramped cold conditions
• Unfamiliar with neighbourhood or where they work/Constantly wears same clothes
Sexual abuse includes indecent exposure, sexual harassment, inappropriate touching, exposure to pornography or witnessing sexual acts, indecent exposure, and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.

Sexual abuse can involve physical contact, and others that do not. It can include an isolated incident of assault, or sexual acts within an on-going 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.
- Being touched in a sexualised manner on the breasts, genitals, anus or mouth, or masturbation of either or both persons.
Sexual (Continued)

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
- 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
- any sudden changes in behaviour, particularly incontinence or confusion
Financial or Material

Financial or material abuse includes fraud, theft, internet scamming, coercion in relation to wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits 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 via a Direct Payment may be considered to be at higher risk of financial abuse. Practitioners need to consider the arrangements carefully and put measures in place to avoid abuse e.g. Appointing Suitable Persons Procedure under the Mental Capacity Act 2005.

Financial or material abuse may also 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
- preventing the adult’s access to his or her funds or possessions

Financial abuse is the main form of abuse by the Office of the Public Guardian both amongst adults and children at risk. It can occur in isolation, but as research has shown, where there are other forms of abuse, there is likely to be financial abuse occurring. Although this is not always the case, everyone should also be aware of this possibility.

Potential indicators of financial abuse include change in living conditions, lack of heating, clothing or food, inability to pay bills/unexplained shortage of money, unexplained withdrawals from an account, unexplained loss/misplacement of financial documents, the recent addition of authorised signers on a client or donor’s signature card, or sudden or unexpected changes in a will or other financial documents. *This is not an exhaustive list, nor do these examples prove that there is actual abuse occurring. However, they do indicate that a closer look and possible investigation may be needed.*
Financial or Material ( Continued )

Most financial abuse is also capable of amounting to theft or fraud and so would be a matter for the police to investigate. It may also require attention and collaboration from a wider group of organisations, including shops and financial institutions such as banks.

Where the abuse is by someone who has the authority to manage an adult’s money, the relevant body should be informed, for example, the Office of the Public Guardian for deputies and Department for Work and Pensions (DWP) in relation to appointees.

If anyone has concerns that a DWP appointee is acting incorrectly they should contact the DWP immediately. In addition to a name and address the DWP can get things done more quickly if it also has a National Insurance number. However, people should not delay acting because they do not know the adult’s National Insurance number. The important thing is to alert DWP to their concerns. If DWP know that the person is also known to the local authority then they should also inform them.

Signs that financial or material abuse may be taking place;

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

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Neglect and Acts of Omission

Includes ignoring medical, emotional, or physical needs, failure to provide health, care, support or educational services, withholding medication, adequate nutrition and heating. Neglect can be the deliberate withholding of, or failure to provide a necessary care and support for an adult. Passive neglect is a general failure to fulfil those obligations. Both can constitute ill treatment when the results are impairment of, or avoidable deterioration in physical or mental health, or physical, intellectual, emotional, social or behavioural development.

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

The Mental Capacity Act 2005 contains a criminal offence of ‘wilful neglect’, which if proven in a court of law may result in prosecution. Neglect and acts of omission may include:

- Ignoring medical or physical care needs to extent that their health and well-being is impaired
- Administering too much, too little, or the wrong type of medication
- Failure to allow the adult access to appropriate health, social care or education services
- Withholding the necessities of life, such as adequate nutrition, heating or clothing
- Failure to intervene in situations assessed to be dangerous to the adult or others especially when the person lacks capacity to assess risk

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

- Malnutrition/dehydration/unexplained rapid or continuous weight loss or weight gain
- Poor physical condition e.g. skin ulcers, pressure sores, pale or sallow complexion hypothermia
- Poor hygiene, incontinence odour, dirty fingernails, old food residue in-between teeth, broken or missing dentures or stained clothing, dirty or soiled bedding, inadequate clothing
- No access to necessary aids e.g. walking aids, hearing aids, spectacles or dentures
- Missed medical appointments
- Exposed to unacceptable risk
- A carer’s or care worker’s reluctance to involve relevant professionals in the person’s care.

Neglect could be due to a carer being overstretched or under-resourced—the carer may seem very tired, anxious or apathetic.

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Self Neglect

Self-neglect covers a wide range of behaviour including neglect of one’s personal hygiene, health or surroundings and includes behaviour such as hoarding. Impact and typical characteristics of self-neglect may be:

- Poor standards of personal care
- Evidence of urine or faeces from adult or animal in the home
- Evidence of significant hoarding
- Home filthy, verminous, not habitable
- Lacks mental capacity
- Evidence of physical, mental or learning disability or illness
- Refuses important health care
- Non co-operative with services
- Substance misuse- heavy use of drugs or alcohol or both
- No support from family or others– very isolated
- Victim of crime, anti-social behaviour or abuse
- Perpetrator of crime, anti-social behaviour
- Risk of fatality or serious harm
- Fire Risk
- Self- neglect has a serious impact on the safety of others

Many of these situations may be resolved by safeguarding enquiries. However Adult Protection procedures will have to be considered for cases where there is imminent/ high risk of fatality or harm or harm to others.
Discriminatory Abuse

Discriminatory Abuse includes forms of harassment, slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion.

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. It may include other types of abuse;

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

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
- The person may be made to dress differently
Organisational Abuse

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

Key indicators are an abusive regime or culture which denies an adult or group of adults care, support, and dignity, or an individual’s needs and choices are ignored or trivialised in order to make an institution or organisation easier to manage and/or to save the organisation’s resources. Organisational abuse may include any one or combination of the forms of abuse especially neglect or omission.

Sometimes a number of adults will experience the abuse, e.g. hate crime against particular groups. Sometimes several family members may mistreat an adult who is dependent upon them in some way. Other examples are;

- 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
- Bad practice in services not being reported and going unchecked and unchallenged
Organisational Abuse (Continued)

Organisational 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
- unsafe and unhygienic living environment

Institutional abuse at Winterbourne View 2012 identified abuse of people who have learning disabilities within a large private hospital setting. The Social Care Institute for Excellence have since produced resources including a report *Arranging Services for People with a Learning Disability and Behaviour that Challenges* and a film *Challenging behaviour and learning disabilities: improving services* which looks at working together to prevent abuse. SCIE’s Learning Together model for Safeguarding Adult Reviews (SARs) training course identifies SAR process. Mencap published *Out of Sight* which identifies concern regarding the standard of care for people who have a learning disability and commissioning of services.
Policy Feedback

This inter-agency policy and procedural framework has been drawn-up in consultation with representatives from the Safeguarding Adults Board with a commitment to work in this way. This will be reviewed regularly on the basis of feedback and comments from partnership agencies. Any necessary updates to the policy, procedures and supplementary good practice guidance will be made available to the partner agencies. Stakeholders, including service users, carers and the public, may forward their views about the policy and procedures by writing, telephoning or e-mailing Children and Adults Services’ Safeguarding Adults Team.

County Durham Safeguarding Adults Inter-agency Partnership
Children and Adults Services
Priory House
Durham
DH1 5RR

Tel: 03000 268 198
E-mail: safeguardingadults@durham.gov.uk.

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. 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.
The Role of the Safeguarding Adults Board

The Safeguarding Adults Board is a statutory requirement and has three core duties:

1. It must publish a strategic plan for each financial year that sets how it will meet its main objective and what the members will do to achieve this. The plan must be developed with local community involvement and the SAB must consult the local Health Watch organisation. The plan should be evidence based and make use of all available intelligence from partners to form and develop its plan.

2. It must publish an annual report detailing what the SAB has done during the year to achieve its main objective and implement its strategic plan. The report must identify what each member has done to implement the strategy as well as detailing the findings of any safeguarding adults review and subsequent action.

3. It must consider holding Safeguarding Adults Review in accordance with Section 44 of the Care Act.

The Local Authority, DCC, is the lead agency for safeguarding adults but works in partnership with the Police, CCG, NHS Foundation Trust, Prisons, Probation, Housing, CQC and DWP who are all represented within the SAB.

Accountability for leading the development of the Safeguarding Adults Board resides with the Local Authority and the Independent Chair.

The Board also includes representatives from other 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.

SAB has well established links with other local strategic partnership i.e. Safe Durham Partnership, the Domestic Abuse Services partnership and the Strategic Safeguarding Board (Children).

All partnerships work together to ensure that they comply with Safeguarding Adult Policies and Procedures. The County Durham Partnership (CDP) framework is made up of the CDP Forum, CDP Board, five thematic partnerships and 14 Area Action Partnerships. There is a strong track record of working in partnership across County Durham, which is evident throughout the partnership framework. The Safe Durham Partnership, Health and Wellbeing Board, Children and Families Trust and Area Action Partnerships have the close links with Safeguarding Adults. All partnerships help make Durham a safer place to live.
The Role of the Safeguarding Adults Board

The Safeguarding Adults Board (Continued)

[Image: County Durham Partnership Framework.pdf] provides more detail with regard to partnerships.
Board Members

Durham County Council has established a multi-agency partnership to lead Safeguarding Adults work and this includes representation from all the appropriate statutory agencies:

Chair - Representative of the Independent Sector
Safeguarding Adults, Children and Adult Services, Durham County Council
Durham Local Safeguarding Children’s Board, Durham County Council
Clinical Commissioning Groups
County Durham & Darlington NHS Foundation Trust
Tees, Esk & Wear Valley NHS Foundation Trust
Durham Constabulary
Durham Probation
Care Quality Commission
Her Majesty’s Prison Service, Durham
Housing
Independent and Voluntary Sector Representation
Victim Support
Healthwatch
Legal
Commissioning

Accountability for leading the creation and maintenance of the partnership is located within the Local Authority. The Safeguarding Adult Board is scrutinised by cabinet before being presented to the Overview and Scrutiny Committee. A diagram of the whole process is shown below (see next page).
Roles and Responsibilities

Interface Between Board Members

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**Reporting and Interface Arrangements**

- Cabinet
- Corporate Management Team
- Children and Adults Management
- Adult Care Management Team
- Multi-Agency Partners (Management Boards)
- Safer Durham Partnership
- Vulnerability Delivery Group
- Local Safeguarding Children’s Board

**Links with Wider Safety Partnerships**

**Glossary**

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Denotes linkage between chair/s members of respective groups

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**Index**
Links between SAB and Wider Safer Durham Partnership

The Safeguarding Adults Partnership is endorsed by and has close links with Safer Durham Partnership. The Head of Children and Adult services provides representation on both the Safeguarding Adults Board and the Safe Durham Partnership.

Safeguarding Adults is a priority aspect of the Joint Strategic Needs Assessment. The Joint Strategic Needs Assessment identifies priorities for promotion of regeneration, health and citizenship and the partnerships required to achieve this. This includes the promotion of safety and safeguarding for people with a chronic or terminal illness.

Service frameworks for working with older people identifies a zero tolerance approach to abuse and references the safeguarding adults policies and procedures.

Tees, Esk and Wear Valley Mental Health services have a safeguarding adults protocol.

The new Locate website which takes over from the Durham Information Guide has a link to staying safe processes including safeguarding adults.

The strategic plan for safeguarding is reviewed annually by the Safeguarding Adults Board and an annual report is published.
Joint Systems

Each partner agency will have its own internal ‘safeguarding adults/adult protection’ guidelines, which should be consistent with the inter-agency policy and procedure, and clearly describe the responsibilities of all of the workers who operate within them.

Where appropriate, those partner agencies should use the inter agency tools e.g. **Risk Threshold Tool** which identify risk of abuse and neglect into their assessment practice and risk management protocols. 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
- 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
- Make appropriate referrals where there are safeguarding concerns regarding adults and children

Each partner organisation/agency must have a ‘speaking out’, or ‘whistle blowing’ policy and procedure 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.
Complaints

If anyone has any reason to believe that concerns about safeguarding adults issues have not been properly addressed by Children and Adult Services, they may make a formal complaint by contacting the department’s Complaints Officer or any Children and Adult Services 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 Children and Adult Services Complaints Officer can be contacted at:
Telephone no: 03000 269007
E-mail: complaints@durham.gov.uk
Or for more advice on the complaints process, visit the Durham County Council Website complaints section.

Customer Services
Durham County Council
Crook Civic Centre
Crook
County Durham
DL15 9ES

You can also use the online complaints form.
Roles and Responsibilities

Agency 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 in the following links, where individual agencies other than Children and Adult Services can insert their own procedural guidance.

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Roles and Responsibilities diagram:

- Alerter
- Children and Adult Services
- Section 42 Enquiries
- Social Care Direct (SCD)
- Emergency Duty Team (EDT)
- Lead Officer
- Investigative Team
- Investigative Responsibilities
- Assessing Officer
- Practice Officers
- Executive Officer
- Health and Safety Staff Care
- Financial Support
- The Police
- Assessing Capacity
- Crown Prosecution Service (CPS)
- Prosecution
- Advocates
- Care Quality Commission (CQC)
- Clinical Commissioning Groups (CQC)
- Health and Safety Executive
- Coroner
- Office of the Public Guardian
- Human Resources and Safeguarding
- Disclosure and Barring Service (DBS)
- Equal Access to the Criminal Justice System
- Drug and Alcohol Services and Safeguarding
- Multi Agency Risk Assessment Conference (MARAC)
- Potentially Dangerous Persons Protocol
- Serious Vulnerably Individuals Protocol
- Multi Agency Public Protection Arrangements
- Local Multi Agency Problem Solving (LMAP) - Anti Social Behaviour
- Witness Intermediary
- Support for Victims
- Care Home—Keeping People Safe
- Pharmacists
- Other Contributors
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Alerter

An alerter is any person who has concerns about an adults’ safety or believe the adult 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 designated officer or line manager.

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 in order that an appropriate response may be made.

Employees (including Children and Adults Services 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 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. Each partner agency and service provision - including Children and Adults Services 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. This is known as the Designated Adult Safeguarding Manager. The designated person will usually be a Manager.

On receipt of information about suspected or alleged abuse, the designated person or post holder is responsible for following his or her individual agency’s guidelines to determine whether or not to refer the case to Social Care Direct to undertake a safeguarding enquiry. 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, the designated person should seek advice from Social Care Direct. The Safeguarding Lead Officer team or Senior Children and Adults Services Manager may also be consulted in exceptional circumstances where concerns are complex and the best course of action unclear.

Referrals must be made to Social Care Direct and in the case of a registered service; the CQC should also be notified. They will then liaise with the Lead Officer from Children and Adult Services or relevant allocated Lead Officer.
Children and Adults Services

Durham County Council’s Children and Adults Services have a duty under Section 42 of the Care Act to respond to any safeguarding concern that is brought to its attention. This means making initial enquiries and deciding on the appropriate response according to the level of risk (Risk Threshold Tool). Adult Protection referrals will be taken for an “adult at risk” where there are serious concerns regarding abuse and neglect and the individual appears to meet the Durham SAB threshold for Adult Protection.

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. 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.

Section 42 Enquiries with or without consent

Referrals should be made even where the victim is unable to consent (due to lack of capacity) or unwilling to give their consent. In the latter case, the LA is still required to undertake enquiries—to the best of their ability with or without the victim’s consent and co-operation. Finding that they victim does not want to be involved, is an enquiry. However the decision to take further steps based on public interest causing a fuller enquiry to be taken is a decision for the council. The referral can still be followed up lawfully where there may be a criminal act, abuse involving coercion or harassment or when there is a possibility that others may be being abused.
Social Care Direct (SCD)

Social Care Direct is County Durham’s single point of contact for responding to adults at risk. SCD are required to make initial enquiries or ask others to make enquiries regarding any actual or suspected abuse brought to its attention whether or not the person has eligible care and support needs. Following enquiries, a decision will be made regarding the most appropriate response. SCD will expect other professionals and organisations to co-operate with these enquiries and share information (duty to co-operate section 6 & 7 Care Act and sharing information statutory guidance 14.34).

Once SCD have clarified matters, they must decide what action may be needed. SCD will decide on the most appropriate and proportionate response on the basis of the circumstances and level of risk (Risk Threshold Tool). Where the actions required to protect the adult can be met by Local authority, the Local authority should take appropriate action. The responses will typically range from:

- Provision of advice and information or redirection to the appropriate agency e.g. Police, Housing, NHS, DWP
- Referral for social care assessment
- Care and support plan
- Referral for Adult Protection due to serious concerns arising from risk, vulnerability and care and support needs.
- Minimal/Low Risk issues which can be addressed via care management or care co-ordination. SCD will use Safeguarding Enquiry (Section 42) referral to identify these issues which will be followed up by front line staff.

Where the concern meets the threshold for an inter-agency investigation under Adult Protection procedures, an appropriate referral will be logged onto the Social Services Information Database (SSID):

- Adult Protection (Individual Victim)
- Section 42 Establishment Referrals (concerns arising in Care Homes or Agencies or other Establishments requiring further investigation)

SCD will pass the referral to the relevant Lead Officer (Children and Adult Services Manager or equivalent) responsible for making an Adult Protection decision.
Emergency Duty Team (EDT)

The Emergency Duty Team (EDT) are an out of hours service and will respond to all safeguarding and adult protection concerns out of hours. EDT will take any appropriate and immediate steps to safeguard the individual.

Depending on the situation, EDT will make safeguarding enquiries or initiate an adult protection investigation. Where they are unable to complete the work due to time restraints, they will pass the matter on to the relevant Lead Officer to continue in the next working day.

For further information see the EDT roles and responsibilities described in the section 'Responding to Abuse'
Lead Officer

Lead Officers are responsible for the management of Adult Protection procedures. On receipt of a referral for Adult Protection a Lead Officer is responsible for overseeing and supervising the response to allegations of neglect and abuse. The Lead Officer will ensure that all appropriate agencies are involved in the investigation, provision of support, and maintaining good standards of practice. They will also provide the first line of negotiation if differences arise between agencies.

The Lead Officer may or may not be an employee of Children and Adults Services, but will hold an appropriately senior post within his or her organisation. For Children and Adults Services employees this means at Manager Level or equivalent. From referral point the main responsibilities cover:

- Responding to the referral immediately and ensuring the alleged victim is safe
- Making an initial decision regarding the level of risk and appropriate level of intervention and involvement
- Decision regarding whether or not to invoke adult protection procedures within 5 working days
- Recording the decision about the level of urgency
- Taking responsibility for co-ordinating the strategy process
- Making appropriate decisions about when to hold a strategy meeting—both telephone, face to face and other methods
- Ensuring each agency carries out actions agreed in the strategy discussion, and reports back any changes to the plan, or anything that could change the plan
- Lead Officer co-ordinates an update strategy meeting (strategy review) if required
- Lead Officer ensures that comprehensive records are kept of any multi agency processes and outcomes that they manage, and this information is stored securely
Lead Officer (Continued)

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 the inter-agency intervention where referrals to the Disclosure and Barring Service (DBS) 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 about the DBS 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.

All services with care management and care co-ordination functions are required to have identified Lead Officers to oversee safeguarding processes within their area. Lead Officers will need to be separately identified within each individual organisation’s procedural guidance.
Roles and Responsibilities

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 Children and Adult Services, 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.

Adult Protection in Prison settings or Approved Premises

- Prison authorities will be responsible for investigating adult safeguarding incidents for prisoners. They will adhere to their instructions issued by NOMs in respect of safeguarding in prisons.

- Probation Services will be responsible for investigating adult safeguarding incidents in Approved Premises. They will adhere to their instructions issued by NOMs in respect of safeguarding in prisons.
Investigative Responsibilities

The Police will conduct an investigation where there is an indication of a 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.
Assessing Officer/ Social Worker/ Care Manager/ Care Co-ordinator/ Case Worker

The primary approach for social work in adult protection work must be person centred and focusing on the outcomes that people want.

Once SCD has screened the concern and decided to take an adult protection referral, the individual will normally require a social worker or equivalent social care practitioner to undertake the assessment of need.

The Assessing Officer may be a Social Worker, a Care Manager/ Co-ordinator or another qualified professional, from a multi-disciplinary integrated or specialist team. They will be responsible for carrying out an assessment of the level of risk and needs. This may involve the arrangement of suitable advocacy support for person who has substantial difficulties in understanding or participating in the assessment. The Assessing Officer will record the outcome of the assessment using the appropriate electronic format, and share this with the Manager, Lead Officer and investigative team. He or she may also be involved in drawing-up a safeguarding plan with the adult and communicating with the adult concerned appropriate information via the Lead Officer.

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.
Practice Officers - Safeguarding Adults

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 Children and Adult Services commissioning / contracts, monitoring and quality assurance processes and provide specialist training.

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 Children and Adult Services commissioning/contracts teams and the Care Quality Commission 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.
Executive Officer

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 Children and Adult Services 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 within their organisations will be involved in the safeguarding process. An Executive Officer will normally be appointed as ‘Executive Lead Officer or chair’ 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. It may also be necessary to make a referral for a Safeguarding Adults Review where the criteria are met.
Health and Safety and Staff Care Team

The Health and Safety and Staff Care Team are involved in:-

1. Ensuring that Children and Adult Services 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.

2. 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).

3. Providing advice and support to people who have disabilities, employed by Children and Adult Services, their Managers and the service as a whole.

4. Identification and resolution of disability discrimination issues with regard to Children and Adult Staff Care.

5. Optimisation of attendance at work by Children and Adult Services employees, including the development of policies and practices around issues of staff welfare.

6. Ensuring that Children and Adult Services employees are aware of ways in which they can gain access to counselling and support services where needed (this may be required following involvement in particularly complex and upsetting safeguarding work).

7. The team will work proactively with Children and Adult Services 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.
Financial Protection Team

DCC’s 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 Appointee ship’. 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.

The Financial Support Team may play an important role in financial investigations, as directed by the Lead Officer / Police investigation when safeguarding procedures are invoked.
The Police

In some instances abuse may result in 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). Police will make an informed decision with regard to attendance.

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

Adult Protection adults referrals must be reported to Social Care Direct who will allocate a Lead Officer. Where there are no emergency concerns or forensic evidence to preserve then the Lead Officer will notify the Police Vulnerability Unit of the allegation, as part of initial response / risk management. If it is suspected that there is an on going crime, threats to the safety of the victim, or it is necessary to preserve evidence that may be lost if there is a delay, the Police should be contacted directly. Social Care Direct may offer advice with regard to police contact. Out of hours, such incidents should be reported to the Emergency Duty Team in Social Care Direct’s absence.
Assessing Capacity in Safeguarding - Whose responsibility?

**Responsibility for completing Mental Capacity Tests and Best Interest Decisions in Safeguarding Procedures**

**Inter-Agency procedures for Adult Protection**
The policy and procedure make it clear that joint working is essential to achieve the best outcomes for victims. The main agencies are the Police, Probation, NHS and Adult Social Care. Joint working, in practice, translates into information sharing, joint investigations, care and protection for the victim. The procedure also provides guidance to ensure that action is taken to deal with the perpetrator including disciplinary procedures, referrals to Disclosure and Barring Service (DBS) and criminal prosecution as well as care and protection when they are also service users.

Many of the service users who are the focus of adult protection procedures either as victims or perpetrators have difficulties communicating & understanding the world around them due to profound learning disabilities, dementia, substance misuse, stroke or brain injury or other mental health problems. They need their family or professionals such as Social Workers to help them make important decisions & act in their best interests as set out by the Mental Capacity Act (MCA). The Lead Officer will normally invite the Care Manager (CM) or Care Co-ordinator (CC) for the victim and perpetrator (where perpetrator has community care needs) to the initial strategy to be involved in the safeguarding investigation. This is good practice because they often know the person well & are best able to understand their circumstances and communicate with them.

**Police involvement in safeguarding procedures**
In line with the procedures, the Police will also be involved in a safeguarding strategy to determine if a criminal investigation is needed & whether a crime has been committed. The Lead Officer and the Police will both need to know whether the victim has capacity to understand and agree to the safeguarding referral and investigation and provide evidence if necessary. The police need to know whether the potential victim has the capacity to understand whether they have been abused. This may determine whether a criminal investigation will be conducted or not.
Assessing Capacity in Safeguarding - Whose responsibility?

**Responsibility for completing Mental Capacity Tests and Best Interest Decisions in Safeguarding Procedures (Continued)**

The ‘Victim’ Mental Capacity Test
Where this is in doubt, a capacity test needs to be carried out regarding the victim. The purpose is to ascertain whether the subject of the safeguarding referral has the mental capacity to:

- consent to a safeguarding referral?
- understand and participate in a safeguarding investigation and interview processes
- capacity to understand gravity of criminal justice process and their participation in it?

The Lead Officer will consult the Police and agree the best way to do this to ensure that the victim or evidence is not compromised in anyway. If the Police are concerned that the victim may disclose important information during the MCA Test which may be used as evidence in the future, the police can decide to attend the MCA Test to assist the CM/CC.

The capacity test should be carried out according to section 3 of the Mental Capacity Act 2005 and Children and Adult Services policy and procedures. If the CM or CC assesses that the person lacks capacity to consent to and to participate in the safeguarding investigation, there should be a best interests decision about whether it is in their best interests to proceed with the safeguarding investigation.

The Care Manager or Care Co-ordinator must make a careful record of the capacity test by describing the questions, the person’s responses and the decision regarding capacity and best interests. They will inform the Police of their findings who will then decide what action to take next.

Based on this initial information, the police may decide to undertake a formal interview in accordance with Achieving Best Evidence (ABE) guidelines. They may seek the evidence of an expert witness to establish whether the person has capacity if they feel that the case is complex (e.g. allegation of sexual abuse) and likely to be recommended for court proceedings. Under these circumstances, this can be done by a psychiatrist or psychologist or doctor.
Assessing Capacity in Safeguarding - Whose responsibility?

**Responsibilities of Interviewing Alleged Perpetrator**

If the police wish to interview and investigate a service user who is also an alleged perpetrator e.g. person with a learning disability or dementia, they must adhere to the Police and Criminal Evidence Act 1984 (PACE) procedures and decide whether the person is:

- Fit to be detained?
- Fit to be interviewed?

The Police and Criminal Evidence Act 1984 (PACE) codes of practice state that an “appropriate adult” must be present during the questioning of a person whom a police officer has been told in good faith or whom an officer suspects may be mentally ill or someone with a learning disability or incapable of understanding the significance of questions put to them. This “appropriate adult” can be a relative, guardian or other person responsible for the person’s care and custody, or social worker. The role of the appropriate adult is active not passive. They should advise the person being questioned and observe whether or not the interview is being conducted properly and fairly. They should also facilitate communication with the person being interviewed. The police are responsible for making the capacity decision with information from professionals such as social worker. They can direct that further capacity tests be obtained using experts such as: psychiatrist, psychologist, force medical officer or doctor.

In practice, however, they will initially seek the views of staff who know the service user well to ask if they believe them to have the mental capacity to understand the safeguarding incident and determine if the perpetrator be brought into the criminal justice system or not. Where a CM or CC or other professional informs the police that the person has, for example, a severe learning disability or severe dementia they may decide at the initial stages not to bring the perpetrator in to the criminal justice system.
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. The CPS will determine whether the case fulfils both the evidential test and the public interest test. This means that there needs to be enough evidence to secure a prosecution and it is in the public interest to do so.
Prosecution

Health and safety offences are usually prosecuted by the Health and Safety Executive (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) |
Advocacy
DCC must ensure that individuals have access to independent advocacy to support them as part of adult protection process. This will primarily arise where the individual lacks capacity and has “substantial difficulty” in being fully involved in the adult protection process. Lead Officers should consider: the person’s ability to understand, retain, use or weigh up relevant information and their ability to communicate their views, wishes and feelings. Arrangements for an independent advocate to facilitate the involvement of a person MUST be made if the following 2 conditions are met:
• That if an independent advocate were not provided then the person would have substantial difficulty in being fully involved in these processes
• There is no appropriate individual available to support the person’s wishes who is not paid or professionally engaged in providing care or treatment to the person or their carer

**Independent Mental Capacity Advocate (IMCA)**
Where a person lacks capacity, representation from family may not be appropriate and there are safeguarding concerns an IMCA be employed to represent the views of the person concerned. The IMCA referral form can be found via the safeguarding adults’ website via the link. Please see section on IMCAs in Capacity and Consent.

**Independent Domestic Violence Advocate (IDVA)**
The IDVA service works in partnership with criminal justice and other partner agencies as part of the Multi Agency Risk Assessment Conference (MARAC) process. IDVAs in County Durham are placed within the police domestic abuse units and are accessed via MARAC /Police /Domestic Abuse services.

**Independent Mental Health Advocates (IMHA)**
People who are treated under the Mental Health Act now have the right to independent mental health advocacy (IMHA). This applies to hospital patients and those who are on a Supervised Community Treatment Order. This advocate can be accessed via the consultant in charge of the patients care.

**Independent Sexual Violence Advocate (ISVA)**
In County Durham we currently have two ISVAs who are employed by the police. ISVAs can be accessed via the Police Domestic Abuse Service /the Sexual Advice Referral Centre (SARC).

**Representational Advocacy** to be offered to adults who have substantial difficulty in engaging with assessment and care processes.

**Contact Details for advocacy services:**

<table>
<thead>
<tr>
<th>Skills for People (IMCAs)</th>
<th>Rethink Mental Illness (IMHAs)</th>
<th>Learning Disability Advocacy Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key House</td>
<td>Unit 15 Crook Business Centre</td>
<td>Citizens Advice County</td>
</tr>
<tr>
<td>Tankerville Place</td>
<td>New Road</td>
<td>Durham</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>Crook</td>
<td>17-19 Upper Chare</td>
</tr>
<tr>
<td>NE2 3AT</td>
<td>County Durham</td>
<td>Peterlee</td>
</tr>
<tr>
<td>Tel: 0191 281 8737</td>
<td>DL15 8QX</td>
<td>SR8 1BW</td>
</tr>
<tr>
<td>Fax: 0191 212 0300</td>
<td>Tel: 01388 766 310</td>
<td>Tel: 0191 586 4786</td>
</tr>
</tbody>
</table>
Care Quality Commission

A nominated member of staff will represent the Care Quality Commission (CQC) on the Durham Inter-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. 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.

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 Children and Adult Services. 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 attend Executive strategies but will not normally attend individual strategies unless it is suspected that:

- There has been a breach of the Care Standards Act or Regulations
- 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
- 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.

Care Quality Commission Website
Clinical Commissioning Groups (CCGs)

Please use the Risk Threshold Tool to determine whether you need to make a Safeguarding or Adult Protection Referral via Social Care Direct on 03000 267979.

CCG Safeguarding Arrangements

An accountability and assurance framework has been made to ensure that both children and adults at risk are safeguarded, the arrangements for this have been described in detail in the document Arrangements to Secure both Children's and Adult's Safeguarding in the Future NHS. CCGs and the NHS Children’s Board (NHS CB) will be statutorily responsible for ensuring that the organisations from which they commission services provide a safe system that safeguards children and vulnerable adults. Local authorities will have the same responsibilities in relation to the public health services that they commission. Both CCGs and the NHS CB will have a statutory duty to be members of Local Safeguarding Children Boards (LSCBs) and Safeguarding Adults Boards (SABs), working in partnership with local authorities to fulfil their safeguarding responsibilities.

In addition to the distinct responsibilities that the NHS Children’s Board will have as a commissioner of primary care and other services, the Board will also be responsible for developing overall NHS policy on safeguarding, providing oversight and assurance of CCGs’ safeguarding arrangements and supporting CCGs in meeting their responsibilities. This will include working with the Care Quality Commission (CQC), professional regulatory bodies and other national partners. This will mean that the NHS CB and CCGs will work closely together – and in turn will work closely with local authorities, LSCBs and SABs – to ensure that there are effective NHS safeguarding arrangements across each local health community, whilst at the same time ensuring absolute clarity about the underlying statutory responsibilities that each commissioner has for the services that they commission, together with a clear leadership and oversight role for the NHS CB.

The Care Act sets out requirements with respect to safeguarding vulnerable adults, including membership of Safeguarding Adults Boards. The NHS CB has an accountability framework which sets out how the NHS CB and CCGs will work together to minimise risk, improve outcomes for children and vulnerable adults, develop and sustain effective partnerships, and ensure they are able to access the necessary clinical expertise and advice.

GP Safeguarding Adults Toolkit

Safeguarding Vulnerable Adults - a Toolkit for General Practitioners offers generic guidance to GPs with regard to safeguarding consideration. These policies and procedures will provide more specific information about policies and processes within County Durham.
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 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. For Durham County Council’s guidance on Health and Safety at Work follow the link.
Coroners

Coroners are ‘Independent Judicial Officers’, and are often Lawyers or Doctors. Coroners are supported by the work of Coroners’ Officers, who receive reports of death and make enquiries on the Coroner’s behalf. Coroners investigate all deaths that are potentially not due to natural causes, or which need an inquiry for some other reason. In law, the categories that the Coroner must investigate are listed as: ‘violent or unnatural deaths, sudden deaths of unknown cause and deaths which have occurred in prison.’ (Coroners Act 1988)

A death should be referred to the Coroner if;
- the cause of death is unknown
- the deceased was not seen by the certificating 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
- the death occurred during or shortly after detention in Police or prison custody

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.

If a person is subject to a Deprivation of Liberty Safeguards Authorisation then the managing authority i.e. the Care Home Manager, Hospital Ward Manager, should inform the Coroner of the death.
Roles and Responsibilities

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, affairs, health care and personal welfare of adults who lack capacity.

The OPG’s Safeguarding Vulnerable Adults Policy covers any person;
- Who has a Deputy appointed by the Court
- Is a donor of a registered Enduring Power of Attorney (EPA) or Lasting Power of Attorney (LPA)
- 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 investigative process by working in partnership with the local authority; and the police where a crime has been committed.

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. 0300 456 0300
E-mail: customerservices@publicguardian.gsi.gov.uk

For urgent requests and reporting concerns contact:
Tel. 0207 664 7274
Roles and Responsibilities

Human Resources and Adult Protection

If the allegation of abuse or neglect involves a member of staff or paid carer, the strategy meeting will be attended, where appropriate, by:

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

Any information required by the employers should be requested directly from the organisation from which it is sought and the information released will depend on each of the individual organisational protocols. Representatives of organisations attending Adult Protection Strategy meetings should be reminded that they should not disclose any information shared at the meeting without the express permission of the chair, however, this would not apply to information obtained directly from individual organisations outside of that meeting.

Adult Protection records, including strategy minutes, are not to be shared for the purposes of HR investigations as these records pertain to the victim of the abuse. Where disciplinary action is being taken against the staff member the employing organisation should seek guidance from the Adult Protection Lead Officer regarding the timely sharing of information and the content of information to be shared. The chair may produce a report covering the specific details relating to the employee and would not share information relating to the victim.

Where there is a Police Investigation, then this takes precedence over any HR investigative process and contact should be made with the Lead Officer regarding the timing of HR investigation. During the process of criminal investigation best evidence must be achieved to gain credibility for court purposes. In achieving best evidence information must be contemporaneous, in other words, as soon as possible after the event and also in the words of the witness/witnesses. Any questioning for HR purposes could destroy evidence by asking what may be seen as leading or suggestive questions. It could alert the perpetrator to concerns and enable them to develop responses. It would make criminal prosecution very difficult, if at all possible and could therefore enable someone to continue with abusive practice in a different environment.

For further information regarding the sharing of information for HR purposes please see Human Resources and Information Sharing within the Information Sharing section.
Disclosure and Barring Service (DBS) (Previously ISA)

The primary role of the Disclosure and Barring Service (DBS) is to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups including children. The DBS was established under the Protection of Freedoms Act 2012 and merges the functions previously carried out by the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). The DBS searches police records and, in relevant cases, barred list information, and then issues a DBS certificate to the applicant and employer to help them make an informed recruitment decision. DBS checks are only available where an employer is entitled to ask exempted questions under the Exceptions Order to the Rehabilitation of Offenders Act (ROA) 1974. The Exceptions Order acts as the gateway for access to the DBS checking service and lists those occupations, professions and positions considered to be exempt from the ROA.

The checking service currently offers two levels of DBS check; standard and enhanced. The order allows for applications to be submitted to a standard level. To qualify for the higher level of DBS check, the position must also meet one of the criteria set out in The Police Act 1997 (Criminal Records) Regulations. The DBS recognises that information released on DBS certificates can be extremely sensitive and personal. Therefore a code of practice for recipients of DBS certificates has been developed to ensure that any information they contain is handled fairly and used properly.

The legislative changes that amend the Safeguarding Vulnerable Groups Act 2006 (SVGA) and the Police Act 1997 regulations, which the DBS checking service is based on, were introduced through the Protection of Freedoms Act 2012 (POFA). The disclosure and referral to the DBS occurs at the end of the safeguarding process when a person is deemed unfit to work with vulnerable people and their employment is to be considered for termination. The DBS do not investigate abuse but base the decision to bar, on the safeguarding minutes and supplied documentation. All information forwarded to the DBS should be discussed with the Lead Officer and strategy minutes should not be forwarded without their consent. A full version of documentation needs to be forwarded along with a redacted version, with information that cannot be shared with the perpetrator taken out. The DBS share all the information sent with the perpetrator unless a redacted version is supplied.

The Department has published Regulated Activity (adults) which provides information on the scope of regulated activity in relation to adults, as defined in the Safeguarding Vulnerable Groups Act 2006 (SVGA) which has been amended by the Protection of Freedoms Act 2012 (PoFA). Regulated activities are the activities that the DBS can bar people from doing. It is a criminal offence for a barred person to seek to work, or work in, activities from which they are barred. It is also a criminal offence for employers or voluntary organisations to knowingly employ a barred person in regulated activity. Regulated Activity (adults) sets out the scope of the barring regime for adults from 10 September 2012. For people who work in these roles the Criminal Records Bureau can provide an Enhanced Criminal Records Certificate with information about whether the individual is barred from working in regulated activity.
Disclosure and Barring Service (DBS)  (Continued)

There are six categories with the definition of regulated activity for adults:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Healthcare</td>
<td>Doctors, nurses, healthcare assistants</td>
</tr>
<tr>
<td>2. Personal care</td>
<td>Washing and dressing, eating, drinking and toileting</td>
</tr>
<tr>
<td>3. Social Work</td>
<td>Social work required in relation to Health or Social Services</td>
</tr>
<tr>
<td>4. Assistance with Household Affairs</td>
<td>Cash, bills, shopping</td>
</tr>
<tr>
<td>5. Assistance with Conduct Affairs</td>
<td>Power of Attorney, Deputies appointed under Mental Health Order</td>
</tr>
<tr>
<td>6. Conveying of an Adult</td>
<td>Must be for health, personal or social care due to age, illness or disability</td>
</tr>
</tbody>
</table>

Who has a duty to refer:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Regulated activity providers</td>
<td>Employers or voluntary organizations who are responsible for the management or control of regulated activity and make arrangements for people to work in regulated activity</td>
</tr>
<tr>
<td>2. Personnel suppliers</td>
<td>An employment business, employment agency or an educational institution that makes arrangements with a person with a view to supplying that person to employers to undertake regulated activity.</td>
</tr>
</tbody>
</table>

Who has a Power to Refer:

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Local Authorities</td>
<td>As defined in section 1 of the of the Local Authorities Goods and Services Act 1970</td>
</tr>
<tr>
<td>2. Keepers of Registers</td>
<td>Regulators as defined in our legislation, also known as competent bodies e.g. the General Medical Council</td>
</tr>
<tr>
<td>3. Supervisory Authorities</td>
<td>Generally inspectors, defined in our legislation e.g. the Care Quality Commission</td>
</tr>
</tbody>
</table>

Protection of Freedoms Act 2012 amends the definition of Regulated Activity - Adults - which describes the activities that the Disclosure and Barring Service can bar people from. Further information on DBR is available at - New disclosure and barring services: updated definition of regulated activities. The DBS referral form should be used to make referrals for barring.
Equal Access to the Criminal Justice System

All adults are entitled to equal protection under the law and fair treatment for the criminal justice system, which is a mark of a civilised society and a fundamental right for all.

It is essential that adults at risk are properly represented within the legal system and that all efforts are made to ensure that they receive equal treatment within it. As highlighted in the 2001 report published by MENCAP called *Behind Closed Doors*, there was growing concern that vulnerable people, especially those with learning disabilities, who were abused, did not receive equal and just treatment within the criminal justice process.

Within County Durham we have a number of methods of supporting victims / witnesses through the legal process. The Lead Officer will be able to offer guidance and support.
Substance Misuse and Adult Protection

The term substance misuse is used to describe the misuse of all psycho-active substance including illicit drugs, prescribed and non-prescribed pharmaceutical preparations and alcohol misuse.

When a person misuses and has an addiction to drugs / alcohol, this can lead to self-neglect, self-harm, long term physical health, mental health and cognitive disabilities any of which may not repair should they stop their misuse of substances. Some examples of this may be irreparable liver damage, pancreatitis, irreparable peripheral neuropathy, long term psychosis or mental ill health issues when not misusing substances. Support for these individuals is provided by specialist care co-ordinators and will usually involve more than one service.

The process involves screening, assessment, care co-ordination and treatment review and risk management. Risk management may consist of a variety of interventions, including referral to Domestic Abuse Services or Police investigation.

Consideration should also be given to long-term care and support needs such as physical or learning disability, mental health / long term cognitive problems, sensory impairment, frailty or ill health typically associated with old age. The cumulative risk to the service user created through a combination of such issues cannot be addressed through treatment or therapy programmes alone. These issues increase a person’s vulnerability and the need for social care services.
Substance Misuse and Adult Protection (Continued)

Before adult protection is invoked, other potential responses must be considered for individuals with substance misuse. These are wide including care management and care co-ordination, domestic abuse services and criminal justice remedies. Careful consideration must be given to cases where there is a cumulative risk due to an escalating pattern of concerns, as well as in cases where the users has become increasingly vulnerable as a result of significant and permanent cognitive impairment or psychological damage as a consequence of sustained substance misuse. Consideration will also be given to other multi-agency responses where appropriate, i.e. MAPPA, MARAC, Seriously Vulnerable Persons Procedures, Risk Enablement Panel.

Adult Protection Referral

Adults with serious substance misuse problems may need to be referred for Adult Protection procedures on occasions. This is because these individuals can easily become victims of abuse or violence due to their chaotic lifestyles and high levels of self-neglect compounded by having eligible social care needs. Adult protection procedures will normally be used only in the most complex/ high risk cases which can result in serious injury or fatality and the individual meets the threshold for eligibility.

Practitioners should always consider the risk to the child. Hidden Harm identifies what is expected of practitioners in terms of working together to prevent child abuse and protect children from harm. LSCB website
Multi Agency Risk Assessment Conference

A forum where multiple agencies get together to provide a co-ordinated response for those at the highest risk of domestic abuse.

Durham MARAC/DASH referral form

Independent Domestic Violence Advocate (IDVA)

The IDVA service works in partnership with criminal justice and other partner agencies as part of the Multi Agency Risk Assessment Conference (MARAC) process. IDVA’s in County Durham are placed within the police domestic abuse units and are accessed via MARAC / Police / Domestic Abuse services.

Please refer to your own organisational policies for further advice regarding Domestic Abuse.
Potentially Dangerous Persons Procedure

The Potentially Dangerous Persons Procedure provides guidance on the identification, referral and management processes for Potentially Dangerous Persons (PDPs).

The definition of a PDP is as follows: "a PDP is a person who has not been convicted of, or cautioned for any offence placing them into one of the three Multi Agency Public Protection Arrangement (MAPPA) categories, but whose behaviour gives reasonable grounds for believing that there is present a likelihood of them committing an offence or offences that will cause serious harm".

Serious harm is defined in the National Offender Management Service MAPPA Guidance 2007 as "(harm) which is life-threatening and/or traumatic and from which recovery, whether physical or psychological, can be expected to be difficult or impossible".

Very high risk of serious harm is defined in the MAPPA Guidance as "there is imminent risk of serious harm. The potential event is more likely than not to happen imminently and the impact would be serious".

Violent and sexual offences recognised as meeting the threshold of serious harm are outlined in Section 224 of the Criminal Justice Act 2003 (Schedule 15) and provide a guide to the offences which could qualify for referral of a Potentially Dangerous Person. You can make a referral to Multi Agency Public Protection Arrangement via this link when a person has a history of criminal offences and it is deemed that there is imminent risk of serious harm.
Roles and Responsibilities

Seriously Vulnerable Individuals Protocol

The purpose of the Seriously Vulnerable Individuals Protocol is to offer a framework to staff when dealing with cases of vulnerable adults who are currently not open cases and who do not want, or are deemed not to require an assessment of need, but who are at risk of serious or significant harm, often because of their behaviour or lifestyle choices.

This often presents as a culmination of events leading to significant cause for concern. Open cases or new cases accepted for assessment, or new cases where there is an immediate safeguarding issue, will be risk assessed as part of the ongoing care management/care co-ordination processes by the caseworker, and concerns dealt with via the Adult Protection route when appropriate.
Multi Agency Public Protection Arrangements

Multi-agency Public Protection Arrangements are statutory arrangements for managing sexual and violent offenders. If someone has a history of offending behaviour and is considered a severe and imminent risk to the public a MAPPA referral can be made.

For further information regarding MAPPA follow this link.
Local Multi Agency Intervention Service

The Multi-Agency Intervention Service (MAIS) address local concerns about crime and ASB. They focus on emerging and long-term problems that can't be effectively resolved by any single organisation. Issues such as hate crime and Anti-social behaviour which can target people who have Learning Disabilities and Mental Health problems are examples of issues that will the MAIS will deal with. For more information follow this link to the website http://www.durham.gov.uk/article/3882/Multi-Agency-Problem-Solving-Groups
Witness Intermediary Scheme

An intermediary is part of the court’s special measures and helps vulnerable witnesses to assist police investigations and criminal prosecutions and is part of the National Policing Improvement Agency (NPIA).

The Witness Intermediaries Scheme matches communication specialists to the special needs of witnesses. It offers support to witnesses who need help to communicate their evidence, including people with a mental disorder or learning disability, or with a physical disability or physical disorder.

"Intermediaries play an important role in improving access to justice for some of the most vulnerable people in society, giving them a voice within the criminal justice process. They help children and adults who have communication difficulties to understand the questions that are put to them and to have their answers understood, enabling them to achieve their best evidence for police and the courts. "In some cases the work of the intermediary can be crucial in successfully detecting and prosecuting a crime. For further information regarding Intermediaries please follow the link to The Advocate’s Gateway website. The safeguarding adults’ website has a leaflet explaining this called The Vulnerable Witness."
Support for Victims

Victims or their representatives will be provided with a leaflet that explains the support that a victim or carer can expect if adult protection procedures are required. This is called the 'Victim and Carers leaflet'. There is also a local victim support protocol and this is called Delivering Change for Victims and Witnesses. It is based on national policies for victims, the national policy is called, The Victims Charter: Standards of service for victims of crime.

The Safeguarding Adults Website has a Users and Carers section which contains useful information on reporting abuse, domestic abuse, Disclosing and Barring and practical support. There are also three easy read documents describing the safeguarding adult processes such as Staying Safe, Stop Abuse Now and What happens when abuse is reported?
Care Home - Keeping People Safe

The Care Home Pack is a practical guide for care providers and has been produced by the Safeguarding Practice Team. This guide provides advice and information on how to improve the care of residents, dealing with like; depression, stress, incontinence, constipation, diabetes and epilepsy to improve their quality of life.

The County Durham and Darlington Passport for Manual Handling describes good moving and handling practice.

There is also a Skin Damage Protocol which gives guidance to staff in all sectors in County Durham when they are concerned that a pressure ulcer (or other skin damage) may have arisen because of poor practice or neglect and therefore have to decide whether to make a safeguarding referral within County Durham’s Inter-Agency Safeguarding Adults Procedural Framework.
Roles and Responsibilities

Pharmacists and Hospital staff—Preventing and Responding to Abuse with Medicine

Medicines can be used as a form of abuse /control. Physical Abuse could be withholding medicines, force feeding medicines, wrongly administering medicines, failing to provide medication and /or care and unnecessary administration of medicine. Medication can be used as a form of punishment or reward, withholding.

1. Care homes need to have access to pharmacists in overseeing all aspects of medicines in use the care home
2. Care homes that provide services to people with dementia, mental health problems or other specialist issues need to have access to pharmacists with expertise in these specialties to assist with ensuring that the residents receive the most appropriate medicines and staff are well trained in medicines’ management
3. For those who live at home and receive support via the Local Authority there will be joint work between the pharmacy in providing practical assistance and services, the GP in prescribing and the care worker in making sure that the person gets the appropriate support to take the tablet. Pharmacies may provide a domiciliary service into people’s own homes. Staff involved in administering medication should be adequately trained
4. Hospital Trusts need to develop pharmacy outreach services that are part of the multitude of community based hospital services
5. If homecare systems are used then the hospital pharmacy service needs to retain management responsibility for the clinical aspects of medicines optimisation

To ensure that this happens:

- All hospital staff must be trained to recognise abuse
- Pharmacy staff are involved with the clinical care of the patient and have access to information on all aspects of the treatment
- The hospital pharmacy may have access to pharmacists who have specialised knowledge in that area of care
- Pharmacy staff with concerns regarding the use of medicines can take those concerns to the Chief Pharmacist
- The Chief Pharmacist has responsibility to resolve the issues and has access to others who can assist or provide a second opinion. If the matters are not resolved they can take the issue up with other hospital Trust Officials
Other Contributors

It may be necessary for the Children and Adult Services Manager or Lead Officer to call on the skills and expertise of others. For example, the Mental Capacity 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.
Prevention in the Community

Prevention is a fundamental to the success of this policy framework. All organisations and agencies have to play their part. There are a large range of services that deal with crime and disorder, leisure, regeneration, health and well-being which need to work within this framework. Commissioners, regulators and licensing bodies of mainstream services will need to ensure that individuals and agencies from whom services are procured implement appropriate safeguards and responses to safeguarding adults’ issues.

Organisations must also ensure access to mainstream community resources such as accessible leisure facilities, safe town centres and community groups that can reduce the social and physical isolation which in itself may increase the risk of abuse and neglect.

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), Potentially Dangerous Persons Protocol (PDP))
Minimising the Likelihood of Abuse

DCC must co-operate with each of their relevant partners, as described in Section 6 (7) of the Care Act, and those partners must also cooperate with the local authority, in the exercise of their functions relevant to care and support including those to protect adults. DCC must also co-operate with any other agencies or organisations it considers appropriate in the exercise of its adult safeguarding functions including:

- General Practitioners
- Dentists
- Pharmacists
- NHS hospitals
- Housing and health care providers

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

Partners should ensure that they have the mechanisms in place that enable early identification and assessment of risk through timely information sharing and targeted multi agency intervention.
Prevention of Abuse within Services

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 (Children and Adult Services and the Clinical Commissioning Groups 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.

People whose care and support needs are met by the council can choose to purchase support services from non-regulated providers via a Direct Payment. Where this option is to be considered, commissioners from Children and Adult Services 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.

Children and Adult Services – as the commissioner of the Direct Payment will use safeguarding and Adult Protection procedures wherever necessary in these cases. Formal monitoring, auditing and review arrangements are implemented by Children and Adult Services in all cases where people are in receipt of a Direct Payment.

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

- A clear, well-publicised policy within its organisation to prevent abuse and neglect
- This policy must be consistent with this inter-agency policy
- A 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
- 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 Health and Care Professions Council (HPCP), the General Medical Council (GMC) and other professional registering bodies
Prevention of Abuse within Services (Continued 1)

- A protocol linked with Adult Protection procedures by which staff and volunteers can raise concerns, along with protection for staff who speak out (‘whistle-blowers’) in accordance with guidance produced by ‘Public Concern at Work’
- A commitment to implementing the Children and Adult Services 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
- 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
- Effective quality assurance and governance processes that are cross-referenced with safeguarding adults issues
- A clear policy and procedure for dealing with staff disciplinary and grievance issues

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 Disclosure and Barring Service registration checks are required
- Provision of robust induction and relevant on-going training to ensure that all staff and volunteers are able to identify and report concerns of abuse or neglect
- 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
- Referral to the Disclosure and Barring Service (DBS) of Managers, staff or volunteers whose employment is covered by the Department of Health list (for DBS 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 DBS: 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 service users’ finances and risk assessment and risk management, all of which must be referenced with safeguarding adults’ procedures.
Prevention of Abuse within Services (Continued 2)

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 adult protection 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 management/care co-ordination, the care programme approach, the risk enablement panel, the Potentially Dangerous Persons Protocol, Multi Agency Public Protection Arrangements, Multi Agency Risk Assessment Conference 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 adult protection procedures and to the commissioning body (organisation purchasing the service) and relevant regulatory bodies; 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.
Positive Risk Taking

Positive Risk Taking is a fundamental principle that professionals must promote to ensure that people who require services have more control over their assessment, care and support planning. These principles are embedded in DCC’s personalisation policy and practices. "With effective personalisation comes the need to manage risk for people to make decisions as safely as possible" and "As we pick up the pace on personalisation, we need to ensure that this includes the most vulnerable members of our society, including those who may lack capacity. Learning to Live with Risk looks at enabling people to take risks, encouraging choice and control whilst effectively managing these risks. Risk enablement panels are to address complex risk situations in which there are different views held between a service user, family, carers or professionals. This policy is designed to support and promote the resolution of risk at the lowest level appropriate.

Positive risk taking is a key element of making safeguarding personal and the six safeguarding principles by achieving the outcomes that people want.

The approach taken will be person-centred and will include the service user’s view of risk as well as that of their families and carers.
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).
- Develop 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.

On the website [www.safeguardingdurhamadults.info](http://www.safeguardingdurhamadults.info) within the 'Training' section you will find a variety of training linked to Safeguarding Adults. The Training Prospectus gives descriptions of the various aspects of training, both accredited and non accredited and you can also obtain dates, times and venues for the training and book a place for yourself (Non accredited). Within the accredited section you will find National Occupational Standards and identify what you need to know in relation to various aspects of safeguarding. This allows you to identify any gaps in your knowledge and fill them with the relevant training.
Alerter

Alerter Training is mandatory training for anyone in contact with someone who may be deemed an 'Adult at Risk'. The safeguarding website has Dates Times and Venues and provides information for those people undertaking accredited and non accredited training. People can also download the workbook from the website. National Occupational Standards for safeguarding can be checked within the accredited element of the website.
Managing the Alert

Managing the Alert is training to enable a person to consider cumulative risk and determine whether a safeguarding adult referral is required. Information regarding dates, times and venues and further information can be found on the website www.safeguardingdurhamadults.info
Investigation

This module aims to give candidates an understanding of the investigation process including legal frameworks and the role of the police. Candidates will consider the various roles and responsibilities of participants within the investigation and interview process. They will understand the importance of good information and evidence gathering including achieving best evidence, reporting and recording information. Supporting vulnerable and/or intimidated witnesses will be covered. Issues of supporting service users and carers throughout the process and advocacy/intermediary intervention is identified. Risk and risk management identifying and minimising harm. Practitioners from Adult Services, Health staff, police officers, managers within independent and voluntary sectors who may be required to undertake a role within an investigation would benefit from this training. See Programme handbook for those undertaking accredited training.

To book you need to select from dates, times and venues and complete the application form.
Prevention of Abuse and Neglect

Lead Officer

This module aims to give candidates an effective working knowledge of the Lead Officers role in co-ordinating, assessing and managing risk within safeguarding adult situations. The module covers issues of convening and chairing multi agency strategy meetings that are effective in identifying abuse, managing the risks, monitoring progress, effective communication including delegation of tasks responsibilities (Written and verbal), ensuring that relevant information is shared with appropriate bodies, meeting legal responsibilities, national policy and local policy, maintaining the service user as central to the process. See Programme handbook for those undertaking accredited training.

For course dates, times and venues follow the link or contact the Safeguarding Adult training and Communications Officer via safeguarding_training@durham.gov.uk.
Mental Capacity Act

This module aims to give candidates an effective working knowledge of the appropriate and timely use of Capacity Assessments, we shall explore capacity assessments as part of the safeguarding adult process. Candidates will identify a selection of tools, methods and models of practice to support ethical decision making throughout the process. Candidates will identify legislative frameworks appropriate to the process. See Programme handbook for those undertaking accredited training.

For dates, times and venues and booking information, follow the link.
Domestic Abuse

This module is a two day course covering basic Domestic Abuse and referral routes, including recognising Domestic Abuse, assessing and managing risk, safety planning and escalating concerns during day one and the relationship between Domestic Abuse and safeguarding on day two.

For dates, times and venues please use the link and complete the application form.
Substance Misuse and Adult Protection

This module is a two day course and aims to clarify reporting procedures for those working within substance misuse services and / or those who work with people who may misuse substances. Risk identification and management, reporting thresholds, multi-agency intervention, models and theories of practice within safeguarding are covered. See Programme handbook for those undertaking accredited training.

For dates, times and venues please use the link and complete the application form.
Financial Abuse

This module aims to give candidates an understanding of what constitutes a safeguarding matter within financial / material abuse situations. Legal powers relating to financial abuse are explored. The impact of financial abuse on the victim is identified and support structures discussed in relation to case studies. See Programme handbook for those undertaking accredited training.

For dates, times and venues use the link and complete the form at the end of the dates.
Risk, Risk Assessment and Risk Management

This module aims to identify what is meant by risk and risk management, identify a variety of assessment tools, identify roles and responsibilities, and recognise the coordinating role of the Lead Officer. See Programme handbook for those undertaking accredited training.

For dates, times and venues follow the link and complete the application form.
Working with Service Users and Carers

This module aims to assist staff in working with service users and carers to ensure that they understand what abuse is, how to report abuse and who they can contact. Staff will learn how to develop an open culture of discussion about abuse within their work environment. Staff will be able to identify key safety measures, contact details and information available to share with service users and carers including easy read documents and support / advice leaflets. See Programme handbook for those undertaking accredited training.

For dates, times and venues follow the link and complete the application form.
Achieving Best Evidence

This module is a two day course and aims to outline risk management, roles and responsibilities within the safeguarding investigation and interview stage. Capacity assessing, methods of communication, special measures including the use of intermediaries and PACE trained practitioners, support and preparation for vulnerable and/or intimidated witnesses, interviewing process and techniques and co-ordinating interviews are all covered.

For dates, times and venues follow the link and complete the application form.
Recording and Minute Taking

This module aims to identify appropriate recording standards, legal frameworks and considerations when recording safeguarding cases. Recording required for strategy and monitoring of actions are covered. Preparation for meetings including support, and debriefing are explored. Language and communication is discussed including the need for clear communication. See Programme handbook for those undertaking accredited training.

For dates, times and venues follow the link and complete the application form.
Service User and Carer Information / Training

We have three easy read documents for service users and carers Staying Safe, Stop Abuse Now and What Happens When Abuse is Reported. The first two documents have some short questions to answer and a certificate will be forwarded when a person demonstrates their understanding.
Responding to abuse and neglect

Covers a wide spectrum of interventions from problems people can resolve themselves with advice to more serious concerns that need escalation for formal inter-agency Adult Protection Procedures. This involves risk management, decision making, co-ordination and involvement of multi agencies and delegation of roles and responsibilities. It is important that we:

- Empower people to address abuse and neglect,
- Protect people to get away from abuse and neglect
- Support Adults at risk to improve their life by feeling safe and secure in their home environment and when in our community
- Enable Adults to access Criminal Justice Processes
- Assess capacity of the Adult at Risk in relation to decisions to be made
- Give Adults a voice through the process by offering appropriate advocacy
- Communicate effectively with the adult at risk and those involved in the process
- Make sure that we share information to protect those at risk.

Common themes when things go wrong include:

- Not recognising abuse
- Not communicating effectively
- Not sharing information appropriately
- Not assessing capacity
- Change of workers with ineffective hand over of information / concern
Responding to Abuse and Neglect

The Process

Do's and don'ts for receiving alert

In all cases, if an adult is in immediate danger, take preventative steps and call 999 for the emergency services

Member of the public

- Has concerns adult is at risk of abuse or neglect
- Contact Social Care Direct (SCD) 03000 26 79 79
- Social Care Direct will accept anonymous referrals. However, this may inhibit any further investigation

Employee within Children and Adults Services

First
- Discuss concerns with your line manager/supervisor

Then
- Manager considers information and refers concern to SCD if necessary
- SCD will respond to safeguarding enquiry and ask others to make enquiries
- SCD will decide on appropriate referral using Risk Threshold Tool: Safeguarding Enquiry or Adult Protection

Do

- Do ensure the person is not in immediate danger.
  If they are, seek police or medical assistance (999)
- Do remember to remain calm
- Do listen carefully if the person discloses abuse
- Do secure the scene if necessary and if possible
- If you suspect financial abuse, consider placing cheque books, bank cards etc into a plastic bag in case they are required as evidence
- Do explain to the person that you have a duty to discuss the issue with your line manager/supervisor
- Do remember, the person may not want their family informed as the family may actually be involved
- Do make a note of the time, date and setting in which the allegation was made, if the event was witnessed and any witnesses to the event (e.g. incident report, patients notes, client case file)
- Do make a note of anyone else who was there at the time
- Do record what was said using ONLY the person’s own words
- The account you record must be legible and include the date and your signature
- Do ensure your written account follows your agency’s guidelines
- Do provide information to the person about the steps that will be taken and reassure them that the issue will be taken seriously
- Do give the person your/SCD contact details so that they can report any further issues or ask any questions
- Do inform the person that they will receive feedback
- Do give your report to your line manager/supervisor to keep in a safe and confidential place

Don’t

- Don’t place yourself or anyone else in danger
- Don’t be judgemental
- Don’t make promises you cannot keep
- Don’t ask detailed or probing questions
- Don’t interfere with, or contaminate potential evidence following physical or sexual assault, for example, by washing, sheet changing, teeth cleaning etc
- Don’t discuss the incident with anyone else except your line manager/supervisor
- Don’t question witnesses except to obtain basic information
- Don’t leave detailed confidential information on answer machines
- Don’t, in any circumstances, discuss the issue with the alleged perpetrator
- Don’t attempt to influence or intimidate potential witnesses
- Don’t conduct your own investigation

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Responding to Abuse and Neglect

Making Safeguarding Personal and Use of Advocacy

The Care Act places a clear duty on Local Authority to provide an independent advocate to facilitate the involvement of a person in their assessment, preparation of their care and support plan and in the review of their care plan.

Lead officers are reminded that they should facilitate involvement of all adults for whom adult protection procedures have been invoked. Arrangements for an independent advocate to facilitate the involvement of a person MUST be made if the following 2 conditions are met:

That if an independent advocate were not provided then the person would have substantial difficulty in being fully involved in these processes, and

There is no appropriate individual available to support the person’s wishes who is not paid or professionally engaged in providing care or treatment to the person or their carer.

When deciding whether the person would have “substantial difficulty” in being fully involved in the adult protection process Lead Officers should consider: the person’s ability to understand, retain, use or weigh up relevant information and their ability to communicate their views, wishes and feelings.

Advocacy enable the LA to comply with the safeguarding principles to involve people in decisions about their care and support and where there is a safeguarding/adult protection enquiry. The chart below illustrates the client experience with the support of an advocate.

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**Alert**
Recognise my experience; tell me why you are concerned

**Referral and decision**
Assess my immediate support and safety needs. Provide me with support and information to support my decision making; share the risks in the adult protection process

**Strategy discussion**
Involve my advocate to represent my views. Work with me and my advocate and others on a plan to maximise my choices and safety. Explore options and choices with me

**The assessment and investigation**
Put a plan in place that is focussed on my rights and choices an the outcomes that I want

**The outcomes**
Tell me and my advocate what you have found out. Help me to understand what my choices are

**Monitor and review**
Meet with me and my advocate to see how it is going. Discuss with me the next steps – keep making sure the plan is effective

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Adapted from ‘Making Connections’ – (Isle of Wight) Ltd. 2011
What is an Alert?

The reporting of concern to your line manager or designated officer is called an 'Alert'. An alert is an appropriate expression of concern about the adult where there appears to be a safeguarding matter. 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 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’ 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.

If you are a student or staff member you report to your line manager or designated officer who will use the Risk Threshold Tool to determine whether a referral is needed. If you are unable to contact your line manager or designated officer and you are concerned then you should not delay in making a referral to Social Care Direct on 03000 267979.

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

- call Social Care Direct on 03000 267979 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.

For further information on reporting your concerns follow the link.
Responding to Abuse and Neglect

Making an Alert

In making an Alert you have a number of questions to ask:
1. Is this person over the age of 18?
2. Does the person appear to have needs for care and support (whether or not the LA is meeting any of those needs)
3. Is the person experiencing or is at risk of abuse or neglect
4. As a result of those care and support needs is the person unable to protect themselves from either the risk of, or the experience of abuse or neglect
5. Under 18 years - Report matter to Children’s Services [Link]

See forms of abuse in Context and definition

Am I concerned?

If you can answer yes to these questions then you should report the matter to your Line Manager or Designated Officer. This may mean that they respond by addressing the matter within your service and record why they have not referred to Safeguarding or they may make a referral via Social Care Direct on 03000 267979. You must always consider the risks to the person and pass on concern to those who can address these risks as soon as possible. Organisations should have someone available who can respond to the Alert immediately/same day.

There are a number of things that you should consider when supporting someone disclosing abuse or identifying potential abuse. The Do's and Don'ts cards on the safeguarding website identify considerations.

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What if I Remain Concerned?

If you work for any agency other than Children and Adult Services 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 on 03000 267979 or speak with someone in the Safeguarding Team for advice on 03000 268198.
Disclosure

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
• 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
• 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
• 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
Recording Abuse

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
- 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.
Responding to Abuse and Neglect

Making a Referral

Using the Risk Threshold Tool you must decide whether to refer your concern to Social Care Direct. Use the Risk Threshold Tool to identify the type and severity of abuse and record what action has been taken to address the presenting risks. If you are making the referral you should state that you have used the Risk Threshold Tool and go through the categories listed identifying your concerns. At the point of referral it is not expected that you can state that abuse has occurred. The purpose of referring is so that the investigation can fill in the gaps of knowledge to find out if abuse has taken place.

Our website gives an overview of issues to consider when reporting abuse. 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 03000 267979
Risk Threshold Tool

The Risk Threshold Tool will help you decide whether you have identified a safeguarding concern and the level of risk. You must consider whether the individual meets the definition:

Does the adult have needs for care and support and

Is the adult experiencing abuse or neglect and

As a result of the care and support need is unable to protect selves from either the risk of or the experience of abuse or neglect?

The Threshold Tool is designed to help professionals differentiate between:

- Referrals for an inter-agency investigation under Adult Protection procedures as the incidents or concern meet the threshold for significant harm and eligible needs

- Non complex, less serious incidents which do not meet the above thresholds.

The tool does not contain any “hard and fast” rules or remove the need for professional judgement, but is designed to support decision making.

Social Care Direct will make enquiries at the point of referral and decide on the appropriate course of action. This response will be proportionate and range from advice, information and redirection to another agency at the low end of risk and vulnerability to the decision to invoke Adult Protection Procedures at the higher end of risk and vulnerability where the person also meets the national threshold for social care eligibility.

Where the threshold for Adult Protection is met, no matter what you decide to do you must always make sure that the person for whom you are concerned is no longer at risk.
Suspected Crime

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

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

When a Team Manager or Lead Officer receives an Adult Protection referral they should consider the circumstances and if there is some reasonable suspicion that something criminal has been committed and there is a need for the police to investigate, the police should be contacted via the 101 telephone reporting system. The basic circumstances of the referral should be passed which will result in an entry on the police logging system. It should be pointed out that it is an adult safeguarding referral and that it should be brought to the attention of the adult protection team.

There are a number of benefits in reporting this way:-

• Victims would be eligible for services and the enhanced entitlements available to vulnerable and intimidated witnesses provided by a number of organisations that operate in the criminal justice system such as the police, the crown prosecution service and Her Majesty’s Courts and Tribunal Service. These services are set out in the ‘Code of Practice for the Victims of Crime’ and would be available at the earliest opportunity.
• It would help ensure that the investigations are recorded correctly and carried out in a timely manner.
• It would provide the police with better information that would enable them to improve their service.
• Most crime is reported this way and there is no reason why incidents involving vulnerable adults should be reported differently.

There are some circumstances where it is clear that the perpetrator clearly lacks ‘the guilty mind’ or the necessary criminal intent in relation to the act committed that would not require being reported this way. That could be where the offender is someone with a profound learning disability or a person with dementia where the solution would lie with Social Work or Care Coordination.

Typical examples of issues that should be reported are where it is suspected that:-

• An assault has taken place by a carer.
• Benefits or allowances have been misappropriated.
• Unexplained withdrawals from an account.
• Sexual touching where the victim cannot consent to it.
• Lack of care resulting a significant deterioration of health.
• An employee suffers inhumane and degrading treatment.
Staff Disciplinary and 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 adult protection investigation would be impeded by the alleged perpetrator’s presence in the workplace
- 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. If you are a Manager within Children and Adult Services (provider or non-provider) who is notified about an allegation of abuse that implicates a Children and Adult Services 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 What is abuse on the safeguarding adults website.

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
- compromise confidentiality protocols
Staff Disciplinary and Suspension (Continued)

He or she must;
• treat the matter seriously
• keep an open mind
• make a written record of the allegation
• 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
• Make a referral for safeguarding adults intervention, applying the principles and timescales set out in this inter-agency procedural framework

The non-provider Children and Adult Services 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 Disclosure and Barring Service and/or to any professional registering body that the person holds membership to.

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

Must report this information to Social Care Direct.

Considered in the context of cumulative risk however, formal intervention may be required. These episodes may need to escalate to adult protection.

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 for Adult Protection procedures.
Provider’s Checklist - dealing with a safeguarding concern

1. Has the safeguarding concern been reported to SCD or EDT in a timely manner?
2. If not explain reasons
3. Provide date and time of incident, background and detail of incident
4. Was this a one off isolated incident?
5. Was the incident witnessed by staff members? If not did anyone else witness it and how long was it before staff intervened
6. Refer to the Risk Threshold Tool to decide on the seriousness of the incident and whether it needs to be reported. Not every incident needs to be reported, however you must provide a rationale for not referring against the Risk Threshold Tool and describe what you have done instead. Unfortunately, it is not possible to have “hard and fast” rules about whether to refer. This will need to be determined by the level of risk, harm and impact of the incident. Referrals should be made using the Risk Threshold Tool
7. The concern will may be logged as a Safeguarding Enquiry (Section 42) either for future reference or further work if the concern is significant but does not need to be escalated for inter agency investigation at this time. In these circumstances, it is essential that the provider works closely with the case worker or appropriate professionals to resolve the concerns e.g. reassessment of needs and risk management.
8. Identify where possible, if the victim has capacity to consent to a safeguarding referral? If yes, have they consented to a safeguarding referral being made? You can still make a referral even if the person has capacity and does not consent. Social Care Direct / Lead Officer will determine whether there is sufficient legislative need to continue with safeguarding or whether others may be affected.
9. Is the victim safe?
10. Identify any action you have taken

If in doubt please contact Social Care Direct on 03000 267979 for advice.

For your record keeping purposes there is a Safeguarding Incident Report Form to document your actions
Receiving the Referral (For details see Lead Officer’s Guidance)

On receipt of a referral as Lead Officer you should;

- Ensure that the adult at risk is safe as far as is possible
- Clarify basic facts, including who is involved in the allegation
- If there is a potential crime – this must be reported to the police via the Police Non-Emergency 101 line and the police vulnerability unit
- Do not investigate or contact the alleged perpetrator
- Check previous history to establish cumulative risk
- Are there issues that would affect others
- Request an assessment to confirm whether the person meet’s DCC’s eligibility threshold if not clear
Responding to Abuse and Neglect

Social Care Direct (SCD) - Receiving the referral and decision making

SCD is the single point of referral in Durham for all reports of suspected or alleged abuse or neglect where the person appears to have needs for care and support and appears unable to protect themselves. Regardless of the time of day or night, Social Care Direct can be contacted on 03000 267979. Staff can e-mail referrals to: Socialcaredirect@durham.gov.uk. Minicom 01429884124

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

In response to any call regarding abuse or neglect, SCD will screen the concern using the Risk Threshold Tool and decide whether it meets the criteria for adult protection or not. Social Care Direct Officer will immediately ask for the name of the referrer, but will also explain that information may be given anonymously. The SCD officer will also ask questions of the referrer based on the Risk Threshold Tool 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) who appears 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—whether the victim and others are safe and what has been done to ensure their safety
- 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
- 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.
SCD Assessing and Responding to the Information

SCD have a duty to respond to all safeguarding concerns irrespective of whether the adult has eligible needs or not. When presented with an concern SCD must ask key questions. Does the adult have:

- Needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing abuse or neglect and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

SCD will make enquiries or ask others to make enquiries and use the Risk Threshold Tool to determine the level of risk. SCD will use the most appropriate & proportionate response which includes the instigation of Adult Protection Procedures. In the main the Adult Protection procedures will be triggered when the above criteria and the council’s eligibility threshold are met.

The Social Care Direct Officer will need to check all available records to determine whether or not the adult(s) at risk or perpetrator(s) are already known. The SCD officer will also 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 (Social Care Direct will check whether the Skin Damage Protocol 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 protection concerns in the following ways:

- Decide an adult protection referral is required on the basis that abuse cannot be ruled out and person is or may be eligible for Community Care Services
- Decide that referral does not constitute an adult protection referral & standard referral is required for an assessment of need e.g. the police's Safeguarding Adult Report Form should be screened carefully and not automatically be considered as safeguarding
- Decide that concern does not constitute an adult protection referral & signpost assistance from agencies such as Victim Support, the Police, Domestic Violence services, Housing agencies or even a refuge
- Decide concerns do not meet threshold for a formal investigation but require a Safeguarding Enquiry to be logged on SSID to ensure that significant information is not lost and ensure further enquiries are made by social care staff as appropriate.
Responding to Abuse and Neglect

Checklist Social Care Direct—To advise and record

- Is the victim safe? What is the impact of the incident on the victim / perpetrator? Are there any injuries or immediate risks to address? Advise.

- Has the concern been raised in the same working day as the abuse? If not why?

- Gather date, time, location, background detail and witnesses to the incident

- Use the Risk Threshold Tool to decide whether incident is an Alert or a Referral and record against the Risk Threshold tool, to provide a rationale for your decision making. If recorded as an Section 42 Enquiry the case worker will need to follow up the concern reassessing, monitoring, reviewing and amending care plans / risk management plans as appropriate.

- Establish / record whether the victim has capacity to consent to the safeguarding referral being made. Can the victim understand what a safeguarding referral is and can they remember the incident?

- When the person does not have capacity to consent identify potential for sharing information with family where appropriate

- Identify any patterns of abuse or incidents involving same persons
Responding to Abuse and Neglect

SCD/EDT: Recording the correct referral arising from a Safeguarding Section 42 Enquiry—Adult Protection Referral or Section 42 Safeguarding Enquiry Referral.

The Social Care Direct/Emergency Duty Officer will obtain a description of the alleged abuse to ensure that the clearest information is obtained for a referral. They must ask for the identity of the potential victim, perpetrator and any witnesses. They will need to record this information along with a brief summary of any consultation that took place with any other manager about how to respond. This will be entered onto the Social Services Information Database (SSID) using the correct referral type for the victim:

- Adult Protection Referral for the individual victim
- Section 42 Establishment Referral where there is no individual victim but relates to a care home /establishment / hospital and there appears to be widespread concerns.
- Adult Protection Record on SSID which will then appear in the Adult Protection Manager’s User In-tray under ‘Ongoing adult protection incidents’ as a flagged indicator.
- All adult protection referrals will be directed to the central Adult Protection team

Safeguarding Enquiry (Section 42) Referral
SCD/EDT will record these referrals when the concerns do not meet the threshold for adult protection but require further enquiries to be made.

Disposal for Section 42 Safeguarding Enquiry Referrals:
- Open cases – caseworker/locality team
- Closed cases- caseworker locality team
- Self funders – locality team
- CHC cases- notify Clinical Commissioning Group
- Out of county placements- notify responsible Local Authority

SCD/EDT will notify the caseworker responsible for the perpetrator. When there is evidence of accumulating and escalating risk, CDD/EDT may take a referral for an assessment of need to ensure that risks are managed.
Adult Protection incidents which result in multiple referrals

There will be times when a single incident affects a number of people. An adult protection referral must be logged for each individual service user. Each individual service user must have an appropriate record e.g. Initial Decision, Strategy, Strategy Review, Closure Debrief.
Repeat Referrals for Individual Service User

- Where a particular individual is subject to repeat adult protection incidents, either because they regularly display behaviours which put other residents at risk or which put him/herself at risk of abuse from other residents, each incident should continue to be reported as an adult protection referral.

- However, when deciding whether or not to invoke adult protection procedures, Safeguarding Lead Officer should consider any risk management or behaviour management plan already in place within the care home, and how well the incident was managed by care staff.

- Often, as a result of general care co-ordination/ care management or as a result of a previous adult protection strategy, a robust arrangement will already be in place to manage aggression/ challenging behaviours/ recurring incidents. Sometimes these incidents are unavoidable & the best solution is to manage the recurring situation according to an agreed plan.

- Where Adult Protection Lead Officer can satisfy themselves that the existing Risk Management/ Behaviour Management Plan has been adhered to, that no alternative action could have minimised or avoided the incident, and that there are no outstanding issues to be investigated, then a decision not to invoke may be appropriate.

- The evidence-based information to support this decision should be recorded within Initial Decision section on SSID.

- Where an incident has occurred and the Risk Management Plan/ Behaviour Plan has not been adhered to, or where there are outstanding concerns over and above those usually managed within the Risk Management/ Behaviour Plan, then a decision to invoke may be more appropriate.

Safeguarding Enquiry (Section 42)

Where the incident or concern does not meet the threshold for an inter-agency investigation, a safeguarding enquiry can be recorded instead. These referrals are not the responsibility of the Adult Protection Lead Officer Team. It is expected that where there is an allocated Care Manager they will make further enquiries and address any concerns identified and minimise risk.
Responding to Abuse and Neglect

SCD - Cumulative Concerns Indicating Serious Risk

Single agencies holding information about adults at risk who:

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

Must report this information to Social Care Direct. Self Neglect, Self Harming and hoarding may need to be considered as adult protection. For further information see Risk Threshold Tool, Self Neglect within the Initial Decision Section.

These episodes in themselves may not constitute adult protection procedures. Considered in the context of cumulative risk however, adult protection intervention may be required.

Social Care Direct will screen the information, determining the level of risk whilst bearing in mind the Adult Protection policy and procedure. The information will be recorded as set out in Social Care Directs Policy and Procedures.
SCD- Allocation to Central Adult Protection Team

SCD/EDT must ensure that each adult protection referral is sent to the Adult Protection team with one hour of the referral being accepted.

It is accepted that this is not usually achievable for EDT who will allocate as soon as possible once the day shift begins. Most cases are already open and allocated to a locality team who retrain case responsibility. However, where the case is new or not known, the Adult Protection Team Manager can be allocated the case initially until a locality team is identified.

The case will be allocated to the team that best matches the needs of the victim - Older Persons, Physical Disability and Sensory Support, Learning Disabilities, Mental Health Services for Older Persons, Adult Mental Health Services and Substance Misuse services.
Out of County

The local authority where the incident has arisen, will be responsible for Lead Officer role. DCC users who are placed in out of county establishments will remain the responsibility of the local team for care management and care co-ordination functions. The ADASS Out-of-Area Safeguarding Adults Arrangements can be accessed via the link.

The Home of Safeguarding Adults Network North East provides contact details for all North East safeguarding teams.
Referrals Regarding Open 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 Adult Protection referral. In practice this is often the existing Team Manager but can be anyone in a relevant allocated role depending on local agreement.

SCD will;
- Notify the local manager who will lead on the investigation
- 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
Emergency Duty Team (EDT) Roles and responsibilities

The Emergency Duty Team (EDT) are an emergency service and provide the important elements of the process to ensure the safety of the individual concerned. On some occasions the EDT officer may deem themselves best placed to manage the adult protection process, however, this may not always be possible or practicable. Where the process is not managed by the EDT worker it will be passed to the relevant Lead Officer in the next working day.

EDT will use the SCD checklist in response to a safeguarding referral

EDT will record (On the SSID adult protection module) the decision against the checklist and Risk Threshold Tool providing clear evidence of rationale and action taken

EDT will ensure that the initial decision and any subsequent Strategy is recorded on SSID. This may not always be possible by 8.30am when the day time manager takes over the case. EDT will fax the Initial Decision and Strategy documentation to the manager for their information who can ask their admin worker to enter the record should they be able to work. The manager could choose to contact the EDT administrator to see if they can enter the records on SSID as soon as possible Tel: 03000262354

EDT will make their decision to invoke/ not based on information available out of hours. This decision should not be changed by daytime staff. Where there is disagreement another referral should be raised.

EDT will inform the referrer of their decision to invoke where appropriate. This decision will often default to the daytime Lead Officer due to the five day time scale
Out of Hours Allocation

Allocation within one hour will of course not be possible for referrals received by the Emergency Duty Team (EDT) during the evening or over the weekend/Bank Holidays. The EDT will take immediate steps to implement the adult protection 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.

EDT and Lead Officers

Lead Officers must complete safeguarding cases initiated by EDT if there is further work to do once their involvement ceases. This will usually be because they have invoked the procedure and a strategy and investigation is required. EDT will pass on all relevant referrals to the relevant Team Managers at the end of their shifts and notify Lead Officers as necessary. EDT will record all relevant information such as Initial Decisions on SSID before 12 noon.

Safeguarding Enquiry (Section 42)
Where the incident or concern does not meet the threshold for adult protection procedures, a safeguarding enquiry can be recorded instead by EDT. These referrals will be passed to the case worker for their attention and input.
Initial Decision and Recording the Rationale

**Record of decision**-making needs to provide a clear account of actions taken and decisions made.
Immediate risks to the adult needs to be identified and immediate actions that have been taken to ensure the victim’s safety is ensured should be recorded. When there is a child or children at risk, a referral needs to be made immediately to Children’s Services and this also has to be recorded.
There needs to be clear evidence in the record of communication that has taken place with key parties, e.g. the police or GP surgery, during the decision making process.

Capacity and consent is not always straightforward due to a variety of reasons:
- User lacks capacity e.g. severe Dementia
- User unwilling but professionals have concern e.g. potential crime, coercion of the victim, impact on others, substantial risk
- Unable to determine capacity

This should not be a barrier to making enquiries but a clear rationale will be required. **The adult protection referral must still be followed up, even if a person has capacity and does not consent as long as it can be justified on the basis of the “public interest” criteria. You should always try to explain your reasons for referral to the potential victim. Use the 8 Golden Rules.**

Mental Capacity also needs to be considered and recorded, including the necessity to complete a Mental Capacity test and instruct an Independent Mental Capacity Advocate (IMCA).

The potential of Domestic Abuse needs to be considered. You can use the Multi-Agency Risk Assessment Conference (MARAC) referral tool to assess the extent of the abuse. You should refer direct to **Domestic Abuse Services** and provide the information gathered in the MARAC referral tool. If you believe that the abuse is serious abuse then a direct referral can be made to MARAC, in addition to Domestic Abuse Services. You should tell services that you have made a MARAC referral. Always consider the safety of the victim first, including safe contact details. Domestic Abuse services will ask if the person consents to the referral; a person’s consent should be sought; however, this does not prevent access to safeguarding. **North Durham MARAC** referral and criteria and **South Durham MARAC** criteria and forms can be found via the links.

The potential risk to others needs to be considered if the potential perpetrator is employed in a caring role. Suspension of the potential perpetrator needs to be considered. When an allegation of abuse concerns a provider, care must be taken when making the initial decision, not to accept the provider’s explanation without evidence that this is the case or considering the need to undertake further checks.
Initial Decision and Recording the Rationale (Continued 1)

Consideration needs to be given to the risks posed by the perpetrator. If you believe that there may be an imminent and serious risk to the public and the person has a history of offending then a referral to Multi-Agency Public Protection Arrangements is required. You can use the link to access the MAPPA referral form.

The rationale for making the initial decision needs to be clearly recorded including details of the risk assessment that has been undertaken using the Risk Threshold Tool to support the decision that has been made. The risk assessment in the recording of the initial decision should not simply be a repeat of the referral information received, but should be clearly described under the nine factors of the Risk Threshold Tool.

Once a decision is made whether or not to invoke adult protection procedures, and having regard to the issues of confidentiality and taking into account the nature of the allegations, the Children and Adult Services Manager will advise the referrer what they intend to do and when they will next update them. The lead Officer may take up to five days to make this initial decision. The referrer will be informed.

When the initial decision is made not to invoke procedures there should be a clearly recorded rationale for this, including who has been consulted to help make this decision, and using information from the risk support tool to justify the decision made. The rationale should refer to the Risk Threshold Tool and identify factors within the tool that the decision was based on. There also needs to be a record of what other actions may be taken instead, for example allocation to the appropriate worker for an assessment or reassessment of need, or signposting to another service. Feedback should be given to the referrer to state why the adult protection procedures were not invoked.

When determining whether to make a decision to invoke adult protection the Lead Officer should consider the added value of a multi-agency response via the safeguarding adult process.

Some repeat referrals are in relation to people who have mental ill health. Should the CPA process identify a set and established pattern of behaviours a person displays when mentally unwell and an aspect of these behaviours in a history of unfounded allegations of abuse, and; If the multi-agency mental health group including the psychiatrist/consultant/psychologist are confident that this is an aspect of mental ill health that has been investigated in the past and unfounded, then the strategy minutes should reflect this and an action can be identified to not bring the same pattern of circumstances to strategy. If anyone is concerned or anything falls outside the usually established pattern of behaviours the referral needs to be invoked. The issues/decisions should be recorded within the assessment/care plan of the individual being explicit about when a referral is not required and that people should refer in any other circumstance or if they feel concerned.
Please ensure that your considerations and decisions are recorded in a defensible manner. It is useful to record relevant things that are not known at the time, as well as those that are. The diagram below may be used to prompt aspect for consideration. For further details see Lead Officer Guidance.

Feedback should be given to the referrer about whether the incident has resulted in adult protection procedures being invoked. This should be recorded in the adult protection case notes. Someone should be allocated to feedback to the victim as appropriate. Where a potential victim lacks capacity in relation to decision making around care provision and risks a person should be allocated to provide feedback to the carer / family. Mental Capacity Act, Best Interest Decisions should be considered and a rationale provided when the assessor feels that it would not be in a person’s Best Interests to feedback to the family.
Adult Protection Lead Officer Team: Functions and Operating Procedures
(For details see Lead Officer Guidance)

The Adult Protection Lead Officer Team are responsible for the management of all adult protection procedures where the location of abuse is within a:

- Care Home - short, long term, including intermediate care
- Supported Living Unit
- Hospitals in County Durham including private hospitals
- Any individual subject to NHS Continuing Health Care (CHC) including those living in their own homes in County Durham
- Shared Lives

Locality Team Managers remain responsible for safeguarding referrals in the following settings in County Durham:

- Own Home (Other than CHC cases)
- Day Care
- Extra Care
- All DCC out of county placements where lead for Adult Protection is with another local authority.
Adult Protection Lead Officer Team: Functions and Operating Procedures for Out of County Referrals

Where an adult protection referral is received for an incident that takes place outside of County Durham, responsibility for care management and care co-ordination will remain with the local team. The Lead Officer role is the responsibility of the local authority where the incident has arisen.

The ADASS Out-of-Area Safeguarding Adults Arrangements can be accessed via the link.
Self-Neglect must be considered within the spectrum of safeguarding and adult protection. The Care Act defines self-neglect as “wide ranging covering; • Neglecting to care for one’s personal hygiene • Neglecting to care for one’s health • Neglecting to care for one’s surroundings • Hoarding. This definition implies that any adult who has needs arising from specified outcomes in relation to; managing and maintaining nutrition, maintaining personal hygiene, being able to make use of home safely and maintain habitable home should be viewed as a potential victim of self-neglect/abuse.

The decision whether an adult protection referral is required in any particular situation will reflect the outcome of safeguarding enquiries regarding the mental capacity, desired outcomes of the adult concerned and the level of risk identified.

Adult Protection procedures must be considered for any complex situation where there is a potential for serious harm or a fatality for the service user or other vulnerable people that they live with. Examples are; • severe self-neglect or self-harming behaviours • suicidal ideation, or repeated suicide attempts, • hoarding, or behaviour which results in lack of food or medical care or fire risks

However, to ensure a proportionate and appropriate response, not all self-neglect cases will be dealt with via formal adult protection interventions. Initial enquiries (Section 42) are essential and will be undertaken initially by SCD. SCD are required to undertake sufficient telephone enquiries in most instances to determine the appropriate response to concerns regarding self-neglect. It is anticipated that the majority of self-neglect cases will continue to be dealt with by staff within the locality and the specialist integrated teams. It is essential that staff and other professionals take a proactive approach to working with these individuals using care management and care co-ordination interventions.

There may be times when a home visit is required to inform SCD’s decision in circumstances where telephone enquiries are unable to clarify the circumstances, mental capacity and views of the adult concerned and level of risk.

Legislation within Children’s Services allows social workers to apply child protection procedures to ensure the safety of the child. However, for Children and Adult services, the relevant legislation to apply to these situations is primarily the Mental Capacity Act 2005.

All managers and staff dealing with cases of self-neglect need to consider the following; Adult service users with mental capacity have the right to refuse an assessment/services, and to make what may be viewed as unwise decisions. We should record whether or not the person has the mental capacity to make this decision.

If a person is assumed to have capacity, there should be recorded evidence to support this assumption (e.g. “during the course of my discussion with Mrs X I observed her ability to understand, retain and weigh up the information and I had no doubts about her ability to make an informed choice”)

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**Back**
Responding to Abuse and Neglect

Self-Neglect - Practice Decisions (Continued)

Where an assumption of mental capacity cannot be made, a mental capacity test should be recorded for each relevant decision to be made using the current Mental Capacity Test toolkit;
Where it is not possible to carry out a formal Mental Capacity Test (e.g. because the service user has refused to engage with Children and Adult Services), an assumption of capacity or otherwise should be made based on information from other professionals/case history. This should also be recorded accurately.

It is essential to see the home environment in order to make an assessment of any associated risks which must include a full picture of the service user, family members and other service user living in the household and the domestic situation. Reviews should be face-to-face and every effort should be made to see the service user at each home visit. It is good practice to try to spend some time one-to-one with the service user to allow them opportunity to express their own views without any influence.

Case conferences and multi-disciplinary meetings are necessary to promote good practice in any case where risk issues are on-going and it is expected that these are organised in a timely manner. Case conference / MDT meetings are a means of sharing concerns with other involved parties – even if the outcome is ‘no further action’. MDT meetings should be held regularly in complex cases where there is a potential for serious harm or fatality.

- The identification of the need for an MDT meeting can be raised by the Care Co-Ordinator / Social Worker or by provider staff. Provider staff should raise the need for an MDT meeting through their line management if needed.
- MDT meetings should be chaired by staff at a senior practitioner level and above e.g. Principal Social Worker; Assistant Manager; Team Manager. Accurate recording of the case conference/ MDT meeting and outcomes is imperative to evidence justifiable decision-making.
- Although confidentiality procedures would normally discourage practitioners from sharing information without the explicit permission of the service user, staff MUST share information even when the service user has not consented if they have concerns that they may be at risk of significant harm.

If a case is to be closed due to a service user continually declining our involvement, the record must show that practitioners have made reasonable efforts to engage the service user; that we have provided the service user with information (in a format which is appropriate to their communication needs) about how to contact us should they feel they need support in the future; that the decision to close a case has been fully discussed between case worker and manager; and that the justification for closing the case has been clearly recorded.
Strategy - Safeguarding (Adult Protection)

The Purpose of Strategy Meetings are to:
(See Lead Officer Guidance for further info)

Developing an Adult Protection strategy should be a multi-agency process involving all the partner agencies given circumstances. An initial strategy must be agreed within five working days of an adult protection referral being recorded by Social Care Direct, but should also, at all times, reflect the level of presenting risk. Low level risk cases may be addressed via telephone strategies; however, if a case is more complex a face to face strategy meeting should be convened. Responsibility for convening the strategy discussion/meeting rests with the Children and Adults manager who has taken the decision to progress a referral of suspected or alleged abuse.

Strategy discussions are to:

- To give and share information
- To assess the level of risk
- To consider the potential of others being abused
- To co-ordinate professionals in carrying out an action plan, assessment and care plan to prevent abuse from occurring and improve life experiences of the individual in need of community care services.
- To ensure support for the victim e.g. Independent Mental Capacity Advocate (IMCA) or an Intermediary
- Support for potential perpetrator as required e.g. an Appropriate Adult
- Support for vulnerable witnesses
- To organise the investigative process
- To provide information as required e.g. reports, chronologies, staff rotas, supervision notes etc. as required.

The first strategy/discussion meeting will concentrate on sharing information between partner agencies, planning how to best support the adult at risk and planning the next stages of the safeguarding investigation and assessment.

Strategies evolve over time, new information comes to light and circumstances change, this may mean that further strategy discussions/meetings may need to take place. The first strategy meeting is usually attended by professionals only to share information and plan investigation. Once the potential of abuse has been established then the victim / as appropriate their representative or both may attend. Strategy meetings may be staged and different people asked to attend at different times. This is in order that victim and perpetrator issues are addressed separately, or to manage confidential information effectively. It is desirable to involve the victim throughout the process. See Person Centred Safeguarding
Strategy Checklist—Prior to Strategy

Prior to Strategy Meeting

Have I given feedback to the referrer? Y  N

Have I sent out the victim and carers or easy read doc to inform the potential victim and carers what happens when abuse is reported? Y  N

Have I invited all persons to the strategy meeting that would offer the right support, information sharing and decision making, for example consideration of Domestic Abuse services? Y  N

Have I considered potential risks to a child and invited relevant service representative? Y  N

Have I requested any reports that may be required prior to the strategy meeting? Y  N

Have I prepared a room, refreshments, copies of reports, name tags as appropriate? Y  N
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Y</th>
<th>N</th>
<th></th>
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<tbody>
<tr>
<td>7</td>
<td>Have I circulated an agenda?</td>
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<td>8</td>
<td>Have I circulated the confidentiality statement and gained signatures of</td>
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<td></td>
<td>attendance and contact details?</td>
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<td>9</td>
<td>Have I circulated the ground rules?</td>
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<td>10</td>
<td>Have I had a round of introductions, attendance and apologies?</td>
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<td>11</td>
<td>Have I identified the purpose of the strategy meeting?</td>
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<td>12</td>
<td>Have I identified the expectations and joint responsibility of decision</td>
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<td>making within the meeting?</td>
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<td>13</td>
<td>Have I made it clear that nothing can be said “Off the record”?</td>
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<td>14</td>
<td>Am I sticking to the agenda?</td>
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<td>15</td>
<td>Have I offered members an opportunity to speak and respond?</td>
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<td>16</td>
<td>Have I paraphrased the information gained from each attendee in summary</td>
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<td>format for the purposes of recording minutes?</td>
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<td>17</td>
<td>Have I allocated an investigation team, led by police where appropriate?</td>
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<tr>
<td>18</td>
<td>Have I allocated someone to provide feedback to potential victim and</td>
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<td></td>
<td>as appropriate carer?</td>
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<td>19</td>
<td>Have I considered the need and timeliness of capacity assessments?</td>
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<td>20</td>
<td>Have I considered the need for support to access criminal justice system</td>
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<td>and victim support?</td>
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<tr>
<td>21</td>
<td>Have I considered the need for an Independent Mental Capacity Advocate or relevant advocate?</td>
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<tr>
<td>22</td>
<td>Have I considered the need to feed back to the potential perpetrator and who will action this?</td>
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<tr>
<td>23</td>
<td>Have I considered the potential need for reassessment of need and timeliness of this in relation to investigation?</td>
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<tr>
<td>24</td>
<td>Have I considered the need for information gathering from wider community resources such as Local Multi-Agency Problem Solving Groups for anti-social behaviour or other?</td>
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<tr>
<td>25</td>
<td>Have I completed an action plan which is specific, concise, identifies person undertaking the action and the time to be completed?</td>
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<tr>
<td>26</td>
<td>Have I considered the potential need to feed back to the Disclosure and Barring Service regarding employed perpetrator?</td>
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<tr>
<td>27</td>
<td>Have I planned and shared the date and time of the next meeting/feedback session?</td>
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</table>
Who should be involved?

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

The first strategy meeting will concentrate on sharing information between partner agencies, planning how to best support the adult at risk and planning next steps. The adult at risk would not normally attend at this stage, however the meeting would consider ways of empowering the adult at risk to play as active a part in the safeguarding process as is realistically possible and to ensure that their views heard. This will require careful planning to ensure that any specialist access or other needs e.g. for interpretation or signing support, can be properly met. Planning also needs to include considering input from family members.

An alleged perpetrator would only be invited to take part in a strategy meeting in very exceptional circumstances, where this is considered in the best interests of all parties and where a satisfactory resolution may be reached. However the initial strategy discussion is likely to include whether the police will investigate further and plan the investigation, so there is likely to be a conflict here. Any alleged perpetrator’s involvement would need to be agreed by all and the strategy planned in stages to prevent problems with police investigation and evidence gathering.

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. The council’s solicitor and other appropriate specialist advisors could also be invited to take part.

Where a care or support service is involved the manager or proprietor if deemed ‘fit’ should also be included in the strategy process. They will only be deemed fit where it is clear that they haven’t taken part in the suspected abuse.

Where executive strategy is instigated and commissioned and registered care service are implicated there is an expectation that the Commissioning Manager and manager or inspector from the Care Quality Commission will play a key role in the executive strategy process. Safeguarding Practice Officers will also attend.

Making Safeguarding Personal: Victim’s expected outcomes
It is essential that the Lead Officer identifies (via the social worker or appropriate practitioner) what the victim or their representative expects as an outcome from the adult protection process. These expectations or wishes will be personal and individual rather than the procedural outcomes. It will be essential at the end of the process to identify and record whether these outcomes have been met.

Making Safeguarding Personal
Chairing

Being a chair person means:

- Setting ground rules
- Being clear and assertive
- Ensuring that people understand why they are attending the strategy including understanding the definition of ‘abuse’ and ‘significant harm’
- Making sure that the agenda is followed
- Ensuring confidentiality
- Involving the subject in the process
- Making sure that everyone has their say
- Encouraging individuals to contribute
- Not letting individuals take over and managing poor behaviour
- Not letting the discussion digress
- Facilitating decision making
- Developing an action plan to keep the individual safe
- Checking that the minute taker has correctly and succinctly recorded the strategy, decisions and recommendations
- Setting a date for review and / or, closure / debrief
Agenda

AGENDA

1. Introductions
2. Apologies
3. Confidentiality statement
4. Purpose of meeting
5. Details of the allegation/concerns
6. Background and wishes of victim
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)
All persons attending this meeting agree that the primary objective is to share information on a need to know basis, in order to safeguard the adult(s) at risk. The meeting and any subsequent intervention will be conducted in the best interests of the adult(s) concerned, and in accordance with the Durham Safeguarding Adults Policy and Procedural Framework.

All attendees agree to abide by the ground rules overleaf and agree that the information shared and any reports/documents provided in this meeting will remain strictly confidential, and may not be shared with any other person or agency without the prior permission of the designated Lead/Executive Officer in accordance with Data Protection.
Strategy Ground Rules

Strategy ground rules should be circulated with the Confidentiality Statement and the agenda. Depending on size, persons attending, potential for conflicting opinion and the emotional subject matter of the meeting content, the ground rules may need adapting, however, a suggested basic format follows:

- Everyone around the table is equal
- Everyone has the right to speak and be listened to
- Only one person will speak at a time (On occasions this may require questions being addressed to the chair and people being offered an opportunity to respond at an appropriate time)
- Participants opinions will be respected
- Plain language will be used and use of jargon avoided. Participants will challenge any jargon that is used and not clearly understood
- No one will discriminate in any way
- Anyone may ask for a break and their absence times will be recorded within the minutes
- Discussion is confidential, however, may need to be shared with identified persons when a crime is disclosed, a person may harm themselves or someone else or when a person is being coerced and harassed within an abusive situation.
- If someone does becomes disruptive within the meeting, the chair may request the person to leave and resume discussion at a later time
- The chair receives recommendations regarding appropriate attendance, however, retains the right to determine appropriate representation for organisations and individuals. Attendance is determined in order that the size of the meeting, timeliness and effectiveness of the meeting is maintained in the best interests of the potential victim.
Invitation to strategy 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

An adult protection referral has been made to Durham County Council’s Children and Adults 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 planning 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 Adult Protection 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
Feedback to Referrer

Feedback to referrer letter – Adult Protection

Dear

Re: delete/complete as appropriate
Adult Protection Referral
Adult(s) - 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 Children and Adults Directorate in respect of name(s) of adult(s) at risk/name of service.

Your concern(s) have been logged as an adult protection 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
Dear

Re: delete/complete as appropriate
Adult Protection referral
Adult(s) - 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 Children and Adults Directorate in respect of name(s) of adult 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 adult protection 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 03000 267979.

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
Lead Officer letter to Disclosure and Barring Service (DBS) regarding concern about a staff member

The Lead Officer should inform the DBS of a person who may require consideration for barring from practice. A DBS template letter can be found on the safeguarding adults website.
Overview of Lead Officer Role in Strategy

- Lead Officers chair strategy meetings that are multi disciplinary meetings convened to address risk, plan investigation, determine whether abuse has occurred and share information.

- Lead responsibility for the development of the investigation / assessment strategy

- Ensure risk assessment leads to appropriate protection action

- To record all decisions, with reasons, and supporting evidence in a timely, accurate manner

- To ensure that a Mental Capacity Assessment is undertaken where necessary by the most appropriate professional.

- To manage the rest of the adult protection process up to and including completion

- To keep referrer informed appropriately

- To ensure consideration is given to preservation of evidence in the strategy development plan.

- To decide how best to engage users and carers

- Overall responsibility for ensuring an adequate protection plan is in place

- Ensure relevant partners are engaged where necessary, e.g. Children
Lead Officer Guidance

Lead Officers will normally be Local Authority or Integrated Team Managers from the area of service that the victim requires; this includes the Adult Protection Lead Officer Team. The Adult Protection Lead Officer Team are responsible for the management of all safeguarding referrals where the abuse is:

- Within a Care Home - short, long term, including intermediate care
- Within a Supported Living Unit
- Within Hospitals in County Durham including private hospitals
- Any individual subject to NHS Continuing Health Care (CHC) including those living in their own homes in County Durham
- Supported Living / Shared Lives

Sometimes Advanced Practitioners or those allocated from Substance Misuse / Community Alcohol Teams will undertake a Lead Officer role. The role of the Lead Officer is one of delegation and co-ordination and not one that would involve undertaking tasks. The Lead Officer must be of the level of seniority where they are able to make decisions and ensure that issues such as staff suspension is enacted upon. The above job roles and titles may change however, the Lead Officer will be of an equivalent status.

The Lead Officer will take responsibility for chairing strategy discussions, initial strategy, strategy review, closure debrief meeting and ensuring that everyone participating understands and agrees to uphold the department’s policy on confidentiality and information sharing throughout the process. 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). The Lead Officer role is one of delegation and co-ordination and should not be one of doing the actions established via the strategy meeting.

Unless circumstances dictate that the police or 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. The Lead Officer is responsible for co-ordinating the appropriate sharing and recording or information relating to the safeguarding incident. Defensible decision making is very important and each document should tell the story of what has happened in relation to the victim, perpetrator and others affected at each stage. Each document can act as a standalone document and should therefore tell the story to date. Legal advice may be required in some circumstances. If a victim has been placed within this Local Authority by another Local Authority suitable representation from the commissioning Authority will be required.
Should a referral to the Disclosure and Barring Service (DBS) be required for the purpose of barring an employee, then this will be conducted at the completion of the adult protection procedure, where abuse has been substantiated. The Lead Officer will instruct the employer with regard to informing the DBS of the outcome. The DBS do not investigate, but base their decision to bar on information offered. The Lead Officer will ensure that a full copy of relevant information is forwarded in addition to a redacted version, considering the safety and confidentiality of the victim and others in the process. Alternatively a report may be submitted. Any reluctance to inform the DBS should be reported by the Lead Officer to the Care Quality Commission. The outcome should be recorded within safeguarding records. The Lead Officer may also give instruction to an employer to report the safeguarding incident to a professional body such as the Health and Care Professionals Council (HCPC).

The Lead Officer will collate all records made by during the adult protection and investigative process. Risk will be monitored and addressed throughout the process and recorded contemporaneously (As soon as possible after the event).

**Adult Protection Lead Officer Posts**

The team of Adult Protection Lead Officers are based in the Safeguarding & Practice Development team at Priory House.

**Referral Process for Adult Protection Lead Officers in the Adult Protection Team**

**New Cases** - SCD will allocate the referral to the Senior Adult Protection Development Officer, SSID User In-Tray and notify the Adult Protection Lead Officer Team.

**Open cases** - SCD will notify Safeguarding Lead Officer Team.

**Lead Officer will comply in full with Adult Protection policy and procedures. He / She will:**

- Notify the existing Team Manager immediately where case is open by telephone with a follow up email.
- Immediately record Lead Officer in Safeguarding module on SSID
- Liaise with Team Manager and relevant professional e.g. social worker
- Make and record Initial Decision within one working day
- Undertake initial strategy- telephone or face to face
- Organise investigations as required
- Complete Strategy Reviews, Closure Debriefs as required
- Ensure all records and mandatory information are recorded and reports distributed
- Seek advice regarding escalation to Executive Strategy
- Provide users and their family with the relevant information leaflet

**The Safeguarding Practice Officers (Nurses, Social Workers and an Occupational Therapist) will continue to support care homes in raising standards of practice. The Safeguarding Practice Officers do not act as Lead Officer in Safeguarding cases and do not look at individual service user issues.**
The Adult Protection Process Chairing Multi-agency Adult Protection meetings.
A Lead Officer can choose to undertake a telephone strategy rather than a face to face meeting where appropriate. It may not be necessary to undertake a strategy review as well as a closure debrief in simple cases. When completing the closure debrief form, state clearly if it is also a strategy review.
Lead Officer Guidance (Continued 3)

**Recording Rationale for Initial Decision**

Record of decision-making needs to provide a clear account of actions taken and decisions made. Immediate risks to the adult at risk need to be identified and immediate actions that have been taken to ensure the victim’s safety is ensured should be recorded. When there is a child or children at risk, a referral needs to be made immediately to Children’s Services and this also has to be recorded. There needs to be clear evidence in the record of communication that has taken place with key parties, e.g. the police or GP surgery, during the decision making process.

Immediate risks to the adult at risk need to be identified and immediate actions that have been taken to ensure the victim’s safety is ensured should be recorded. When there is a child or children at risk, a referral needs to be made immediately to Children’s Services and this also has to be recorded. There needs to be clear evidence in the record of communication that has taken place with key parties, e.g. the police or GP surgery, during the decision making process. Consent needs to be considered and recorded. Mental Capacity also needs to be considered and recorded, including the necessity to complete a Mental Capacity test and instruct an Independent Mental Capacity Advocate (IMCA).

The potential of Domestic Abuse needs to be considered. You can use the Multi Agency Risk Assessment Conference (MARAC) referral tool to assess the extent of the abuse. You should refer direct to Domestic Abuse Services and provide the information gathered in the MARAC referral tool. If you believe that the abuse is serious abuse then a direct referral can be made to MARAC, in addition to Domestic Abuse Services. You should tell services that you have made a MARAC referral. Always consider the safety of the victim first, including safe contact details. Domestic Abuse services will ask if the person consents to the referral; a person’s consent should be sought; however, this does not prevent access to safeguarding. North Durham MARAC referral and criteria and South Durham MARAC criteria and forms can be found via the links. Safeguarding can run in parallel with Domestic Abuse services. Strategy meetings should involve workers from Domestic Abuse services if this is appropriate to the needs of the individual. The potential of Domestic Abuse should be identified with the police vulnerability unit. Recording should identify the identification of potential domestic abuse and any history of domestic abuse.

The potential risk to others needs to be considered if the potential perpetrator is employed in a caring role. Suspension of the potential perpetrator needs to be considered.

When an allegation of abuse concerns a provider, care must be taken when making the initial decision, not to accept the provider’s explanation without evidence that this is the case or considering the need to undertake further checks. Consideration needs to be given to the risks posed by the perpetrator. If you believe that there may be an imminent and serious risk to the public and the person has a history of offending then a referral to Multi Agency Public Protection Arrangements is required. You can use the link to access the MAPPA referral form.
Lead Officer Guidance (Continued 4)

The rationale for making the initial decision needs to be clearly recorded including details of the risk assessment that has been undertaken using the Risk Threshold Tool to support the decision that has been made. The risk assessment in the recording of the initial decision should not simply be a repeat of the referral information received, but should be clearly described in reference to the Risk Threshold Tool.

Once a decision is made whether or not to invoke Adult Protection procedures, and having regard to the issues of confidentiality and taking into account the nature of the allegations, the Children and Adult Services Manager will advise the referrer what they intend to do and when they will next update them. Ordinarily a decision will be made by the end of the next working day and the referrer will be informed.

When the initial decision is made not to invoke procedures there should be a clearly recorded rationale for this, including who has been consulted to help make this decision, and using information from the risk support tool to justify the decision made. The rationale should refer to the Risk Threshold Tool and identify factors within the tool that the decision was based on. There also needs to be a record of what other actions may be taken instead, for example allocation to the appropriate worker for an assessment or reassessment of need, or signposting to another service.

Please ensure that your considerations and decisions are recorded in a defensible manner. You should provide a clear rationale for how and why you have come to the decision, including reference to relevant legislation, policy, or tools utilised. It is useful to record relevant things that are not known at the time, as well as those that are. The diagram below may be used to prompt aspect for consideration.
Responding to Abuse and Neglect

Initial Decision (Continued)

It is a good idea to complete the initial decision form as soon as possible after receiving the information. Titles can be used to complete the Initial Risk Assessment, you may wish to choose your own titles, however the following text outlines some suggestions.

**BACKGROUND** should include the location, time, date, and witnesses.

**ALLEGED VICTIM** should provide a synopsis of the person’s vulnerability including past safeguarding, Mental Capacity in relation to the safeguarding incident, level of disability and any previous safeguarding incidents. It may be possible to gather some of this information from the background history recorded in the care manager’s assessment.

**ALLEGED ABUSE** should outline what occurred when and where, describing the scenario as reported.

**ALLEGED PERPETRATOR** should outline the vulnerability and background of the perpetrator.

**RISK ASSESSMENT** should highlight concern; clarify risks present and how they have been managed. Any changes in behaviour should be acknowledged here and identified as presenting risk for the individual. A statement should be made in relation to the current safety of the victim and how risks have been minimised. Within the section of the form entitled ‘Decide to Invoke Procedure’ it should be stated that using the Risk Threshold Tool the procedures have / have not been invoked for the following reasons, and the categories for consideration on the Risk Threshold Tool should be explicitly described i.e. how vulnerable is the victim, forms of abuse and severity, impact on the victim and others, intent of perpetrator, illegality of actions, risk of repeated abuse on the victim / others.

Safeguarding notes should be used to record action taken. Notes may be recorded in the following format: Your name, job title and method of contact with whom. You may wish to record their contact details. PURPOSE of contact, CONTENT of contact, OUTCOME of contact. It is good practice to forward information to the victim and their family explaining the safeguarding process. There is a victim and carers leaflet and a carers leaflet you can use and / or an easy read booklet called ‘What Happens When Abuse is Reported’. You can record that you have forwarded this information and who to within the safeguarding case notes.

Feedback should be given to the referrer about whether the incident has resulted in safeguarding procedures being invoked. This should be recorded in the safeguarding case notes. Someone should be allocated to feedback to the victim as appropriate. Where a potential victim lacks capacity in relation to decision making around care provision and risks a person should be allocated to provide feedback to the carer / family. Mental Capacity Act, Best Interest Decisions should be considered and a rationale provided when the assessor feels that it would not be in a person’s Best Interests to feedback to the family.
**Purpose of Strategy Meeting**

**Main Points**

- **To ensure that a variety of perspectives are gained from different professionals**
- **Multi Disciplinary information exchange**
- **Gain service user perspectives regarding perspectives safety**
- **Desired Personal Outcomes for Alleged Victim**
- **Determine on the balance of probabilities whether abuse has happened**
- **To assess and minimise risk using all relevant disciplines to prevent the potential of abuse occurring again**
- **To plan and coordinate Adult Protection investigation**
- **To enable sensitive and supportive access to criminal justice**
- **To consider the potential of others being abused**
- **To give and share information relevant to the abuse**
- **To ensure support for the victim e.g. Advocacy**
- **To make decisions and recommendations to protect the individual, improve their experiences and the care provided**
- **Address issues in relation to the perpetrator e.g. disciplinary action or where a perpetrator is vulnerable**
- **Appropriate Adult support**
- **Consider the location of the victim in relation to the perpetrator and the impact this may have e.g. reduce potential contact**
- **To provide and collate information as required for investigation e.g. reports, chronologies, staff rosters, supervision notes**

**Purpose of Initial Strategy Described**

**Glossary**

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Purpose of an Initial Strategy Discussion / Meeting - Described

Developing an Adult Protection strategy should be a multi agency process involving all the partner agencies appropriate to the given circumstances. An initial strategy must be agreed within five working days of the referral being received by Social Care Direct, but should also, at all times, reflect the level of presenting risk. Responsibility for convening the strategy discussion/meeting rests with the Children and Adults manager / Lead Officer who has taken the decision to progress a referral of suspected or alleged abuse. When an Executive Strategy meeting is convened in respect of an establishment, individual adult protection strategy meetings are still required to be held to address individual victim risks / needs.

The first strategy/ discussion meeting will concentrate on sharing information between partner agencies, planning how to best support the adult at risk and planning the next stages of the safeguarding investigation and assessment.

The rights and safety of staff who ‘speak out’ or use their agency’s whistleblowing procedures also needs to be taken into account. All planned strategies must aim for minimal interruption to the services being provided to the adult at risk and any other individual / groups involved or affected by the safeguarding work.

For Person Centred Safeguarding please see Person Centred section.

Please see Strategy Checklist
Preparation for the Adult Protection Strategy (See checklist)

The strategy discussion/meeting could potentially involve any or all of the multi-disciplinary safeguarding partners. The first strategy meeting will concentrate on sharing information between partner agencies, planning how to best support the adult at risk and planning next steps. The victim would not normally attend at this stage, however the meeting would consider ways of empowering the adult to play as active a part in the safeguarding process, as is realistically possible and to ensure that their views heard. This may involve use of an Independent Mental Capacity Advocate, other advocate or care manager / professional allocated for information sharing. This will require careful planning to ensure that any specialist access or other needs e.g. for interpretation or signing support, can be properly met. Planning also needs to include considering input from family members. An advocate or representative from the family may attend the initial strategy and feedback to the victim and other family members as relevant.

An alleged perpetrator would only be invited to take part in a strategy meeting in very exceptional circumstances, where this is considered in the best interests of all parties and where a satisfactory safeguarding resolution may be reached. However the initial strategy discussion is likely to include whether the police will investigate further and plan the investigation, so there is likely to be a conflict here. Any alleged perpetrator’s involvement would need to be agreed by all and the strategy planned in stages to prevent problems with police investigation and evidence gathering.

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. The council’s solicitor and other appropriate specialist advisors could also be invited to take part.

Where a care or support service is involved the manager or proprietor if deemed ‘fit’ should also be included in the strategy process. They will only be deemed fit where it is clear that they haven’t taken part in the suspected abuse.

Where executive strategy is instigated and commissioned and registered care service are implicated there is an expectation that the Commissioning Manager and manager or inspector from the Care Quality Commission will play a key role in the executive strategy process. Safeguarding Practice Officers will also attend.
Deciding who needs to be invited: Lead Officer, minute taker, Care Co-ordinator/ Social Worker, nurse, vulnerability police, Care Quality Commission should be invited as appropriate. In addition tissue viability, falls assessor, occupational therapist, physiotherapist, relevant hospital staff, those from care home, finance team, GP, advocate, service user / carer and anyone relevant to the care process and or abuse reported should be considered.

Requesting information: Partners are reminded that they have a duty to assist with enquiries under Section 42, and provide relevant information – preferably in written form. Lead officer can use the attached checklist here which identifies clearly what is needed, by who and when.

Inviting victim and advocate: This should be considered and managed to ensure views are shared. The strategy should ensure that the action plan identifies how information will be communicated with the victim if not in attendance.

You also need to prepare / forward: Date and time, venue / meeting room, health and safety issues, letter of confirmation to referrer, refreshments, place cards, prior discussion where possible with minute taker, attendance list, ground rules and confidentiality statement, agenda.

Being a chair person means:
- Setting ground rules
- Being clear and assertive
- Ensuring that people understand why they are attending the strategy including understanding the definition of ‘abuse’ and ‘significant harm’
- Making sure that the agenda is followed
- Ensuring confidentiality
- Involving the subject in the process
- Encouraging individuals to contribute and making sure everyone has their say
- Not letting individuals take over, not letting discussion digress and managing poor behaviour
- Facilitating decision making
- Developing an action plan to keep the individual safe
- Checking that the minute taker has correctly and succinctly recorded the strategy, decisions and recommendations
- Setting a date for review and/ or, closure/ debrief
Preparation for the Adult Protection Strategy (See checklist) - Clarity of Purpose

The Lead Officer may need to provide a clear understanding about the purpose of the meeting and joint decisions to be made. Not everyone is clear about why they are attending the strategy and what it is that needs to be determined.

Where necessary, remind attendees that the definition of abuse consists of a single act or repeated acts. Significant harm is wide ranging including physical harm, ill treatment sexual abuse, domestic violence and forms of ill treatment which are not physical but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional social or behavioural development.
Adult Protection and Domestic Abuse

Domestic abuse occurs across society regardless of any factors such as age, gender, sexuality, wealth, ethnicity or geography. It is abuse often perpetrated by men against women, can be perpetrated by women against men, or those in same sex relationships. For further information about [Domestic Abuse Services and definitions](#) within County Durham you can use the link.

The potential victim of abuse may be concerned for their safety and reluctant to report abuse or consent to legal process. The police have a number of options that they can consider to support the victim and their family. This may include maintaining the family home. The may also impose a number of conditions on the perpetrator to ensure the safety of the victim/ family/ property.

Any incident of Domestic Abuse should be reported to Domestic Abuse Services or Police wherever possible to seek advice.

Where a person is suffering Domestic Abuse, Adult Protection Procedures must be considered where the victim appears to have eligible needs and there are a high level of risks according to the Risk Threshold Tool. The police should be consulted regarding the potential for Domestic Abuse. The Lead Officer must consider inviting relevant Domestic Abuse services to the strategy meeting. Lead Officer may determine that it is more appropriate to utilise Domestic Abuse services and processes, rather than invoking Adult Protection procedures depending on the circumstances.

The Lead Officer should on initial risk assessment, consider the use of the Multi Agency Risk Assessment tool in assessing the extent of the abuse and potential referral to the Multi Agency Risk Assessment Conference. [Durham MARAC](#) criteria and forms can be found via the links.
Overview of Police Role in Strategy

- To take the lead in any criminal investigation when evidence suggests that a crime may have been committed
- To take steps to obtain and preserve evidence
- To make resources available to contribute to the strategy development plan if a crime has been committed
- To provide relevant background information / intelligence
- To give advice on criminal justice processes
- Potentially lead the investigation
- To advise on and provide MAPPA / MARAC interface
- To take an active role in the protection plan where appropriate.
- To plan the witness interviews.
- Advise on achieving best evidence interview where necessary
- To consider use of special measures, including the use of intermediaries
- To plan proactively targeting perpetrators as necessary
- Timeliness of police action should be action planned to prevent costly processes.
Health Role in Strategy

- To advise on health issues
- To access specialist resources
- Potentially lead the investigation where appropriate
- To provide relevant background information
- To contribute to strategy development
- To establish links with clinical governance's processes / critical incidents
Provider Role in Strategy (Not a definitive list)

- To provide risk management plan to ensure continued safety of the victim
- Provide relevant background information and where appropriate chronology of events
- To provide full documentation
- To be assigned as part of the investigation team by the Lead Officer
- To suspend / appropriately redeploy staff, where allegations of abuse have been alleged
- To implement protection plan where appropriate
- To report back when required
- To maintain documentation of investigations and action
- To share information with appropriate persons as instructed by the Lead Officer
- To instigate HR processes
- To liaise with the family as directed by the Lead Officer
Care Quality Commission Role in Strategy

- CQC to take any action necessary to ensure compliance with regulations in registered health and social care services,

- To undertake statutory regulatory role, including urgent action, if necessary, to safeguard people.

- To advise other partners on regulatory status and history, and contribute to strategy.

- To attend strategy meetings (but generally only when concerns relate to a registered person or to a failing service).

- To participate, or take a lead role, in the investigation where inspection of a service for compliance with regulations is considered a necessary part of the process.
Commissioning Role in Strategy

- To provide background information, in particular any reports of monitoring activity and enforcement of contract conditions. Details of any support to providers to enhance performance.

- Support investigations with information, service reviews, contract action when required.

- Collate and analyse performance, quality and needs information.

- To take action under the contract where serious quality concerns have been expressed with regards to commissioned services.
Minute Taking - Introduction

The following identifies many of the issues the minute taker may need to consider when recording an Adult Protection Strategy/ Executive Strategy meeting. The list is not exhaustive but attempts to provide a comprehensive framework from which to work.

Sometimes we are fortunate enough to have a minute taker and on other occasions this may not be possible. The minute taker may not be familiar with issues of abuse and may find the process disturbing. Giving information about the nature and content of the allegation may assist the minute taker.

Minutes are taken during a Strategy Meeting or Executive Strategy Meeting to evidence how decisions have been reached and actions have been met. The minutes need to be comprehensive, accurate and specific; therefore, you are not expected to create a word for word account of what is being discussed. This could be a formal document used in legal process. Please do not use a persons full name but use the initials of the person concerned.

Within Strategy Meetings there are many reasons why records need to be accurate:

- It is a legal requirement
- For accountability
- To explain and justify actions
- To give reasons for decisions made
- To act as an aid memoire
- To safeguard against allegations
- A tool for monitoring, reviewing and evaluating work
- The basis for risk assessment and care planning
- Records may be needed in a Court of Law

Written records are a way of communicating:

- The objectives – what work is being undertaken
- The methods – how work is being done
- Monitor, review and evaluate – what work has been carried out and its effectiveness
- The needs of and the cumulative risks to the individual
- Incidents and events
- Professional opinions and perspectives
- The reason underpinning decision making

Record any disputes / disagreements
Minute Taking - Preparation

Context – It’s extremely helpful for a minute taker to have context of the meeting. A few minutes discussion prior to the meeting helps to give the minute taker an idea of the direction the meeting will go in and also introduces them to terms and names they may otherwise not know. (Hearing an unusual term or name and struggling to spell it can often mean missing the rest of the conversation).

A good minute taker will prepare themselves, briefed by the chair, ahead of the meeting. Make sure that you understand the agenda and review related documents. See glossary for information about terms used. It may be a good idea to add to this glossary as you come across terms that you do not understand.

- Compile details of participants to be invited: Name; Address; Contact Details; Agency.
- Ensure invitations are sent with sufficient notice of the meeting date. Always liaise with the Safeguarding Manager (Lead Officer) before sending an invitation to a service user or carer. Ensure letters are marked “Private and Confidential” and use a standard letter template.
- Anything faxed should be sent to a safe haven fax machine and email should be on a confidential system such as GCSX, PNN.
- Obtain background to the case from the Safeguarding Manager. It may be possible to pre-populate some of the information being discussed prior to the strategy meeting, onto the relevant documentation.
- Collate and photocopy any Safeguarding Reports to be presented at the meeting, ensuring enough copies and that pages are numbered.

Plan your time to ensure a pre-briefing and a de-briefing with the minute taker. Briefing and de-briefing may be of a formal or informal nature.

- Pre-briefing: meet with the Lead Officer to agree the structure of the meeting and anticipated content. The relevant template for minutes will be of use in this task.
- Clarify with them what arrangements will be in place to ensure you are able to keep track of the meeting and that the minute taker can maintain accurate notes. For example, the minute taker may need to signal to the Chair in some way if they need a moment to clarify or catch up with points of discussion. The minute taker will need to clarify dates and times of actions required, you should agree how this will be achieved with the minute taker e.g. Lead Officer to summarise action points at the end of the meeting.
- Speak with the minute taker to confirm that the standard letter confirming receipt of the Adult Protection Referral is to be sent out.
Minute Taking - Preparation (Continued)

You may need to consider:

- waiting room or area
- pens and paper for participants
- seating arrangements and name labels on tables
- refreshments, though please remember that once the meeting begins the
  minute-taker should not leave the meeting.
- does anyone have any access difficulties

Reference to the use of the Risk Threshold Tool should be used in the Adult Protection

**Agenda** – if the chair, the minute taker and members of the meeting understand
the proposed agenda and the chair ensures that discussion fits as tightly as
possible to the sections then the discussion recorded will be more accurate and
flow better. If discussion strays it looks confusing in the notes but is also
confusing for the minute taker

**Introductions/ signing in sheet / confidentiality statement** – the chair will
circulate a signing in sheet including a confidentiality statement, prior to
introductions and starting the meeting. The minute taker can familiarise
themselves with the attendees and ensure that all attendees can read and concur
with the confidentiality statement. Chairs often know everyone except perhaps
the provider – minute takers often know no-one which makes taking notes
difficult. It is therefore important that the minute taker takes this time to
establish who is in attendance

**Reports** – any report being tabled at the meeting should be copied to the minute
taker beforehand. When people read directly from an update sheet or report they
speak unnaturally fast and minute takers cannot pick up what’s being said. If
they have the same sheet to refer to they can mark that with relevant points to
note in the meeting instead.
### Lead Officer Minute Taking – During and After the Meeting

<table>
<thead>
<tr>
<th><strong>Do</strong></th>
<th><strong>Do Not</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Make sure that you control the meeting so that the minute taker listens to one person at a time and records accurately</td>
<td>Allow people to talk over each other, whisper with each other or keep reiterating the same point</td>
</tr>
<tr>
<td>Arrange breaks if the meeting is going to be lengthy</td>
<td>Allow meetings to be overly long and tiring, prepare well</td>
</tr>
<tr>
<td>Bring people together who have views and perspectives on the care provision and support of an individual. Record any controversial or contentious points</td>
<td>Destroy any notes made, or records that were created to develop chronologies of events. The Crown Prosecution Service (CPS) may require these as evidence. The CPS must meet evidentially the ‘Burden of proof’ as ‘Beyond a reasonable doubt’ and they will consider the case that the defence will make. If they think that the defence will challenge recorded evidence, the case may not go to court.</td>
</tr>
<tr>
<td>Disagreements should be clearly and objectively recorded in a neutral manner</td>
<td></td>
</tr>
<tr>
<td>Position the minute taker so that they can easily and discreetly communicate with you</td>
<td>Allow off the record statements</td>
</tr>
<tr>
<td>Follow the structure of the relevant template. The <a href="#">Adult Protection Strategy Meeting Minutes Document</a> can be found on the Safeguarding Adults Website.</td>
<td>Repeat information, instead make use of reports and reference them.</td>
</tr>
<tr>
<td>Seek chronologies of events – If a case goes to court accurate, concise and chronological data will be required.</td>
<td>Leave gaps or inconsistencies in information without an explanation – Assessments, Care Plans, Mental Capacity Act Assessments, Risk Assessments, monitoring outcomes, action plans and other recording should all be consistent and clear.</td>
</tr>
<tr>
<td>Action the sharing of information with the victim / perpetrator, giving times and assigning relevant people</td>
<td></td>
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**Lead Officer Minute Taking Before and After the Meeting (Continued)**

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Contemporaneous notes are notes that are recorded at the time or shortly after an incident. They should be in order of events and could include diary notes, notebook recording, minutes or case file entries.

It is imperative that all notes are kept. If the police pass a case to the Crown Prosecution Service any original notes are needed for the evidential test to be carried out. The Crown Prosecution service must be satisfied that there is enough evidence to ‘provide a realistic prospect of a conviction’ against each defendant on each charge. Evidentially the burden of proof is ‘Beyond a Reasonable Doubt’. They must consider what the defence case may be and how that is likely to affect the prosecution case. They must balance factors for and against prosecution carefully and fairly. A prosecution case will usually take place; however, unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour. (Crown Prosecution Service 2006)

Do not discard any original hand written notes supplied in favour of typing them up.

**Minute taking - Facts**
Records need to relate to the facts of the case. A fact is not based on feelings guesses, assumptions, or our own conclusions.

**Minute taking - Opinions**
It is fine to minute the professional opinion of a person experienced and qualified in their field. Opinions should be substantiated with a rationale to explain how they came to the opinion.

**Minute taking - Hearsay**
Sometimes information from a third party is relevant. It is always important to check with the Lead Officer if you are unsure about documenting this in the final minutes of the meeting.

**Minute taking - Confidentiality**
The minutes should include that the limits of confidentiality has been explained. The sign-in sheet has a confidentiality statement that people read and sign on arrival to the meeting. A standard paragraph may be maintained in all minutes and / or read out by the Lead Officer at the beginning of the meeting. If people require reminding of the need to share information within the Safeguarding Process or of issues relating to confidentiality this needs to be documented. Any restrictions on access to information recorded should be identified.

**Minute taking - Action Planning**
All actions should be clearly documented with the name of the person responsible for the action, the date they are to complete the action. Any guidance from the Lead Officer about when to carry out the action and should be carried forward to the next meeting to be addressed, should the person responsible not have given feedback that the action is complete. The outcomes of all actions should be clearly recorded.
Lead Officer Minute Taking - During and After the Meeting

Structure
The strategy forms on SSID and in paper version provide guidance for information required.

Beginning – Agenda; Date and Time (Meeting and incident); Confidentiality statement; Persons invited and present, apologies; Reason for referral to safeguarding; Lead Officers details including contact; Why persons are excluded at points within the meeting; Victim information; Allegation; Purpose of the meeting; Roles of persons present in relation to victim; Potential Perpetrator details; Consent / capacity issues identified.

Middle – Providing titles such as

BACKGROUND
ALLEGED VICTIM
ALLEGED ABUSE
ALLEGED PERPETRATOR
STRATEGY DISCUSSION

Can assist in ensuring that the recording is clear and concise. Minutes include risk assessment and actions to keep person safe; Organisation feedback; Lead Officer Summary; Actions (SMART); Victim wishes / feelings; Facts; Professional opinions; Lessons Learnt.

End – Summary of key points; Conclusions; Actions and actions met; name and title of person completing the minutes, Signature; Date and time of written record.

Action Planning is an important part of the process and should be specific, measurable, achievable, realistic and timely. The persons responsible for the action is to be identified and a time scale given. The action plan should make it clear that issues of risk are being addressed. The action plan should also include assessment and communications issues. Timely assessment and communication is important to not impede police investigation. The Lead Officer needs to be explicit in the timeliness of assessment, capacity assessment, feedback.
Defensible decision making means providing a clear rationale based on legislation, policy, models of practice or recognised tools utilised to come to an informed decision. This decision is based on the information known at that particular time. It is important to accurately and concisely record your decision making processes, in order that you can explain how and why you came to the decision at that time. Often additional information comes to light at a later date which may discredit your decision and on reflection a person can be asked to account for their actions. Accurate, timely, concise, specific, appropriate recording will support your decision making and provide justification for actions taken.

Within care services we do not wish to be risk averse but consider all issues relevant to the decision being made. Learning to Live with Risk outlines the criminal and civil law context in which social workers and their employers work with risk. Essentially ... if an organisation or individual can demonstrate that their decision and the processes involved in reaching it were, as a matter of fact, consistent with contemporary professional practices, then they have not been negligent. It is also essential to remember that, regardless of deployment arrangements, Approved Mental Health Practitioners (AMHPs) retain accountability to the Director of Adult Services.

The Department of Health (2010) also outline the elements of a defensible decision, which they define as, if an objective group of professionals would consider:

- All reasonable steps have been taken
- Reliable assessment methods have been used
- Information has been collated and thoroughly evaluated
- Decisions are recorded, communicated and thoroughly evaluated
- Policies and procedures have been followed
- Practitioners and their managers adopt an investigative approach and are proactive.

Adult Protection is an aspect of service that requires true defensible decision making, paying particular regard to positive risk taking Learning to Live with Risk contains a specific section on working with the Mental Capacity Act and outlines the five underlying principles contained within it. Essential to working within the Act is ‘... a person who has the mental capacity to make a decision, and choses voluntarily to live with risk is entitled to do so.’ (pg7) This document also presents a risk decision model which can assist in the process and recording of defensible decisions in this context. It looks at the balance of the impact and the likelihood of negative and positive outcomes. Core to this model is that: Risks need to be shared – no one person should take full responsibility (pg9) (the end of this document contains additional information on shared decision making systems).
Defensible Decision Making - Parallel Social Work, Risk Assessment and Recording (Continued)

This concept of a shared responsibility for safeguarding is enshrined in national standards for this area of work. The Association of Directors of Adult Services developed standards which supported the implementation of the No Secrets Guidance that emphasises the role of partnership in delivering effective adult protection services. This work has now been supplemented by the development of cross-organisational standards and suggested probes for effective peer review of adult safeguarding services. See idea.gov.uk. A national competence framework for social workers working in safeguarding has also been produced.

Working with the Human Rights Act
Concern has been expressed that under the Human Rights Act those who are able to access legal support to promote their right to a family life are able to access services at the expense of those who are less vocal, leading to an inequity of service provision. At the root of this is sometimes a fear of legal challenge and being unclear of how human rights legislation impacts on what can be argued is defensible social work decision making. Cornwall have developed a very useful examination of adult protection issues in the context of the Human Rights Act. See cornwall.gov.uk

The Equality and Human Rights Commission have also produced a useful overview of the definition of a right to a family life and provide case law examples of how this has been interpreted in social care decisions.

Judicial Review
Judicial review is a type of court proceeding in which a judge reviews the lawfulness of a decision or action made by a public body. In other words, judicial reviews are a challenge to the way in which a decision has been made, rather than the rights and wrongs of the conclusion reached. If a decision is to be defensible it has to be within a legal framework, supported by national and local policy and a description regarding how the decision was made.

Another important factor in supporting social workers to work effectively with risk is the sharing of information to de-mystify some areas of practice. Focus groups repeatedly raised concerns around the threat of judicial review of decision making. It would appear that the fear of possible judicial review is leading to defensive practice which it could be argued is out of proportion to the actual risk of a review. There has been an increase in the number of reviews which are being undertaken but the success rate remains stable, Sarah Pickup, vice-president of the Association of Directors of Adult Social Services, argues in a Community Care article:

... the relatively stable success rate of challenges showed councils were making tough decisions properly despite the short timescales.
Responding to Abuse and Neglect

Investigation

The purpose of any Adult Protection 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 including care management.

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.

In the vast majority of cases, the investigative process will be completed within 28 days from the conclusion of the strategy meeting, although in complex cases it may take longer to finalise. If an investigation is required, then roles and responsibilities must be jointly agreed at the strategy stage, along with timescales. Wherever there is doubt about grounds to proceed with an investigation, or duties/powers to intervene, Children and Adults Managers should consult with their line-manager, the Safeguarding and Practice Development Manager and / or the Council’s Solicitor.

Where the alleged abuse implicates a care service or organization, 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.
Investigation (continued)

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 Children and Adult Services. 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 and/or Commissioning Services may choose to lead the investigative process.

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. Consent should be sought to share third party medical records with anyone other than the person to whom the record was intended.

- 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 at the Sexual Abuse Referral Centre (SARC)) - 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.
Police Involvement and Capacity Assessing

When the police are involved in Adult Protection cases, the question of who is responsible for the Mental Capacity test and best interest decision arises.

Victim
In respect of the victim, the main purpose is usually to decide whether the victim has the mental capacity to:
- Consent to a safeguarding referral?
- Understand and participate in a safeguarding investigation and interview processes?
- Understand the gravity of the criminal justice process and their participation in it?

Due to the importance of joint working, social care staff e.g. Care Manager or Care Coordinator can do the capacity test as they usually know the user best. The Lead Officer will agree with the Police over the best way to do this to ensure that the victim or evidence is not compromised in any way. If the person lacks capacity, the Care Manager/Care Coordinator must make a best interests decision about whether it is in the best interests of the person to proceed with the safeguarding investigation. They will inform the Police of their findings who will then decide what action to take next. The Police may wish to seek further evidence from an expert witness to establish whether the person has capacity if they feel that the case is complex (e.g. allegation of sexual abuse) and likely to be recommended for court proceedings. Under these circumstances, this can be done by a psychiatrist, psychologist or doctor.

Alleged Perpetrator
In terms of the Alleged Perpetrator, who may have a learning disability or a mental health problem, the PACE procedures must be adhered to. The Police have the responsibility to decide if the person is
- Fit to be detained?
- Fit to be interviewed?

In practice, the Police will seek the views of professionals who know the service user well to ask if they believe them to have the mental capacity to understand the safeguarding incident and determine if the perpetrator be brought into the criminal justice system or not. They can direct that further capacity tests be obtained using experts such as a psychiatrist, psychologist, force medical officer or doctor where they feel this is necessary.
Conducting Interviews with the 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

- 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

- An appropriately trained person may also support the victim with witness profiling
Achieving Best Evidence Interviewing

Achieving Best Evidence Interviewing means that we are seeking to find a way of providing credible, admissible evidence to the court. The collection of this evidence is dictated by Criminal Justice procedures and should be collected by the police in prescribed methods. Any evidence gathered may be scrutinised in a criminal court, where the burden of proof is beyond a reasonable doubt. Failure to gather accurate information to a satisfactory level may compromise the evidence. Evidence can be deemed inadmissible or discredited in a number of ways. This can include:

- Where a vulnerable person is interviewed by persons (Other than in a police interview) who may ask leading questions
- Where vulnerable witnesses are questioned inappropriately by persons other than the police
- Where records are not kept or maintained contemporaneously (at the time of the event)
- Forensic evidence is not preserved or maintained

Achieving Best Evidence is a way of ensuring that vulnerable or intimidated witnesses have the best chance of presenting credible evidence within the criminal justice process. For more information follow the link.
Witness Profiling

Witness Profiling begins when investigation suggests that a crime may have taken place. The Social Worker identified to undertake the witness profile will work intensely for around ten weeks with the victim. The amount of involvement with the witness can vary; in some cases it may be as little as one or two hours per week.

The first meeting is used to establish a relationship with the victim and their carers. Family make-up, services received and provided are discussed. An outline of the work is given including the fact that the evidence can not be discussed at any point, that is for the jury to hear. The next subsequent meetings will look at victim preconceptions of court and their role in the process. Feelings and anxieties about giving evidence in court are discussed. The next visit will address process of the trial, details of the people involved in a trial, how long the person may be expected to be in court. The following meeting, courtroom protocol and behavior may be discussed. A visit to the court room may take place to familiarize the witness and they may meet some of the people involved in their case. The waiting area is also shown to the witness. The witness supporter may assist the witness to practice taking the stand, addressing the judge, answering questions and taking the oath.

Throughout the process the witness profile is developed, testing the witnesses response to stress situations, questioning and challenges. Information is gathered from a variety of professionals and people involved with the witness to create a profile of understanding, communication needs, access needs, responses and behaviors displayed and relevant to the trial process. Psychology, psychiatry, speech and language, physiotherapy, occupational therapy information may be required. The profile may be shared with the judge, barristers and maybe even the jury in order that people understand in advance the needs of the individual and how to make the most credible evidence. Special measures required may also be identified and requested. The process could be developed still further to assist interviewing at the pre-charge stage.

The work is clearly defined with a start and an end date and this is regularly reinforced with the witness. It has been the experience of Liverpool staff that an ending is really important and acknowledgement of the end of court visits, meetings with the Social Worker undertaking the profile and the police. Throughout the process services are maintained in order that the witness can return without difficulties or breaks.
Interviewing the Alleged Perpetrator

Interviews should always be carried out by two (or sometimes more) interviewers. In the case of a Police investigation, this involves Police Officer’s and may involve representative (s) from one of the other partner organizations, e.g. a Social Worker or Nurse.

Alleged perpetrators who are employees, volunteers or students on placement, may be permitted support or representation at interview, but not during police interviews, where a solicitor would support them. Representation may be from for example, a trades union representative, if this is in accordance with the employing/placing agency’s safeguarding and human resources procedures.

Alleged perpetrators may also be enabled to invite a supporter. Supporters should never be involved as witnesses in the case. Supporters should never answer questions put to the suspect.

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.

An Appropriate Adult supports the potential perpetrator and a witness supporter is someone who supports the victim or witnesses. An Appropriate Adult is usually a family member or friend over the age of 17 however, a Social Worker or similar who is trained in the Police and Criminal Evidence Act (1984) may also be an Appropriate Adult. A witness supporter can be anyone deemed to know the person well enough and be an effective support, usually a Social Worker. There is no particular specialist training to be a witness supporter. For further information regarding the interviewing of suspects see Police and Criminal Evidence Act (1984).

Interview records must be signed and dated by all concerned. Consideration must also be given to any support, access or other specialist needs that an interviewee might have and how these can be met. Special Measures may be considered by the judge in proceedings.
Subsequent Allegations

If at any point during the investigative process - or indeed any other stage in the implementation of these adult protection 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/adult protection 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.
Compiling a Report

At the end of the investigation a summary of all information gathered should be recorded in the form of a concise report for the Lead Officer to share appropriately. 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 Children and Adult Services 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
- Recommendations about when and in what circumstances the case should be reviewed/revisited

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 DBS. 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; Sharing and Confidentiality.
Investigating one adult at risk who abuses another.

The abuse by one ‘adult at risk’ of another adult service user within a service setting will normally need to be considered as a safeguarding enquiry.

Incidents of this nature are sometimes approached in terms of the perpetrator’s challenging behaviour and therefore not always 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, adult protection procedures will need to be considered.

Some service providers respond 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 adult 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 adult protection processes, each incident must still be recognised as an abusive act and properly addressed. This may for example involve the drawing-up of adult protection plans for both adults. Additionally, all abusive acts regardless of whether they progress to investigation must be logged as safeguarding enquiries for screening, monitoring and service development purposes.

Perpetrators who are also eligible for services may have needs that require addressing through the strategy process. The perpetrator may require an appropriate adult to support them through legal proceedings.

Where an incident is dealt with internally, the incident must be recorded according to agency procedures. In many cases it will need to be reported to SCD who will record it as a section 42 safeguarding enquiry. Social Care Direct should also be informed and will decide what action to take and the practitioner responsible for the perpetrator must also be informed, as well as other relevant bodies.
Cross Boundary Investigations

Where Durham is ‘host Authority’ to an adult at risk

County Durham have adopted the ADASS Out-of-Area Safeguarding Adults Arrangements for further information please follow the link

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 Adult Services will take the initial lead on referral and overall responsibility for co-ordinating Adult Protection arrangements. With regard to Executive Strategies the Chair must consider informing the relevant Local Authority of anyone potentially at risk and placed within County Durham from out of area. The chair should also consider informing other relevant Local Authorities should there be possible media interest.

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. Adult Services 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 Adult Services 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.

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 Adult Services 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 Children and Adult Services may be allocated to act in a liaison/advisory capacity.
Investigation - Social Work Role

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 Adult Protection 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. **Adult Protection care-plans must be agreed within four weeks of the assessment being completed.**

Where a case is already open at the point of an adult protection 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 Children and Adult Services 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
- 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.**
Closure and Debrief

In the majority of cases, the Adult Protection process is concluded in one meeting followed by a Closure Debrief which is mandatory. However, where reviews are needed; it may be pragmatic to combine the Strategy Review and Closure Debrief when it becomes obvious that the safeguarding work can be concluded at the review. This is acceptable as long as:

- The Lead Officer makes it clear that the Closure Debrief actually includes a Strategy Review by stating this explicitly in the meeting and in the minutes.
- Separate Strategy Reviews are still recorded for more complex cases.

The closure debrief meeting is held to ensure that the potential victim is safe, all actions agreed have been carried out, the investigation is concluded with an agreed outcome, the Social Worker/ Care Manager/ Care Co-ordinator is informed of the outcome in order that main issues can be transferred to the assessment and care plan for review 6 weeks from the closure debrief meeting and as required up to 6 month following the closure of the adult protection closure debrief meeting. Feedback to perpetrator and victim is allocated to relevant persons. All relevant bodies have been informed. The minutes of the closure debrief meeting should tell the whole story of what has happened, what has been investigated, what has been achieved and what is left to be achieved via care / criminal justice processes.

Lessons learned from the adult protection episode are important and can be very informative when looking for themes and concerns within the process during auditing. Feedback about the victim and as appropriate the family’s experience of safeguarding should be sought wherever possible. Appropriate supervision, appraisal, one to one or other methods of debriefing and feedback should be offered to any staff members affected by the incident and relevant services such as counselling sought as appropriate.

The Closure Debrief form can be found on the safeguarding website for purposes of recording and guidance.
What is an Executive Strategy?

An Executive Strategy Meeting (ESM) is held where there are:
- Serious concerns about the quality of service that brings into question a provider’s ability to provide safe care to its service users
- Serious concerns relating to large scale abuse within an institutional setting or the same organisation (e.g. domiciliary care agency)
- Failure/s to comply with the standards contained within a Local Authority contract

The purpose of the ESM is for the Local Authority to take appropriate action to protect individuals from abuse, neglect and inadequate care. The process is overseen and chaired by a Strategic Manager in Adult and Health Services (AHS) who will ensure that all relevant matters are investigated thoroughly and fairly and ensure good standards of care are delivered.
Executive Strategy Guidance for Chairs and Lead Officers—Introduction

This guidance provides a consistent approach to ensure clarity in respect of:

- Processes and timescales for the ESM process
- Standards for minute taking to provide an accurate record for accountability purposes
- ESM records which enable the Chair to respond to future enquiries, complaints, questions
- Any provider/individual, subject to allegations, can be confident they are treated fairly and have the right to information regarding the allegations and the opportunity to provide their own views and evidence

2. Background

ESMs are a well-established process in County Durham. However, the policy has been updated to reflect changes arising from the 2014 Care Act. The ESM is primarily used to focus on concerns of Organisational Abuse defined by the Care Act: Care and Support Statutory Guidance (Department of Health: 2014): https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

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

Organisational abuse can occur in any setting providing health, care or support services. It occurs when the routines, systems and regimes of an establishment result in poor or inadequate standards of care or practice, which affects the whole establishment and results in, or puts adults at significant risk of, abuse or neglect.

Organisational abuse may be indicated by patterns of reported abuse or neglect – which can be one or a combination of the different types of abuse defined in paragraph 14.17 of Care and Support Statutory Guidance (DH:2014) – for an establishment, or where a single concern is so serious that it warrants closer inspection of the establishment as a whole.
Executive Strategy—PRINCIPLES

The ESM policy reflects the safeguarding principles set out in the Care Act:
Empowerment – presumption of person-led decisions and informed consent
Protection – support and representation for those in greatest need.
Prevention – it is better to take action before harm occurs.
Proportionality – the least intrusive response appropriate to identified risks
Partnership – local solutions through services working with their communities.
Accountability – transparency in delivering services, including safeguarding.

The ESM is not intended to be a punitive measure. While poor or unsafe practice is challenged, this policy is designed to provide support and guidance to assist providers to deliver safe care. All agencies and individuals involved in a large-scale enquiry through the ESM must collaborate to facilitate openness, and trust, in order to deliver actions for improvement.

The ESM, therefore, works with all stakeholders on the basis of the:

• 2014 Care Act which states that any Local Authority has a duty to improve an individual’s independence and wellbeing and ensure there is a range of high quality and appropriate services to meet need Care Act Factsheet - General Responsibilities.
• Duty to Co-operate: Care Act sections 6 and 7 describe a general duty to co-operate between the LA and relevant agencies – Housing, Public Health and Children’s Services.
• Duty of Candour: this is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there has been significant harm and includes agencies registered with CQC.
• Principles of natural justice: these govern the ESM to ensure procedures are fair and decisions are made objectively. This means a fair hearing for the provider and impartial decision-making on the basis of clear evidence.
• Information sharing undertaken with regard to confidentiality and data protection legislation and local policy (see Collaborative Working and Information Sharing Procedure)
• The rights of any person(s) alleged to be causing harm will be respected. If that person(s) is also an adult at risk, they must receive support and their needs must be addressed.
• The safety, dignity and wellbeing of the person(s) alleged to have been harmed is paramount. Actions to safeguard adult(s) at risk from abuse will always be given a high priority to ensure they receive all appropriate protection under the law.

NB Action taken during an ESM does not affect the obligations on partner organisations to comply with their statutory responsibilities such as notification to regulatory authorities under the Health and Social Care Act 2008 or to comply with employment legislation.
Executive Strategy—Thresholds

Any concerns about an individual must be reported to Social Care Direct. Most safeguarding concerns do not require escalation to ESM. Individual adult protection cases can run in parallel with the ESM in accordance with the statutory Section 42 criteria:

(a) has needs for care and support (whether or not the [local] authority is meeting any of those needs)
(b) is experiencing, or is at risk of, abuse or neglect
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.”

And the inter-agency Risk Threshold Tool ([Risk Threshold Tool](#))

Most quality and/or contractual concerns do not require escalation to ESM and can be managed through levers available to commissioners, procurement and regulators (such as monitoring). However there are exceptions where concerns go beyond lower level quality and contractual issues and lower-level individual safeguarding concerns which require the initiating of ESM.
Executive Strategy—Identification of Concerns

Patterns or concerns leading to ESM may be identified through a number of different mechanisms as illustrated below (not-exhaustive):

- A number of separate referrals about different individuals using the same service that increases concern about wider practice issues
- Contract monitoring processes by the Council or CQC
- Complaints monitoring by the Council
- Monitoring of performance data by SAB sub-group.
- Analysis of soft intelligence recorded on the SSID Establishment Notes system.
- Allegation from a whistle-blower about the management/ regime of a service.
- Information gathered during regular Information Sharing meetings between the Council, Clinical Commissioning Group and CQC
- Quality monitoring by Practice Improvement Officers

Criteria for Executive Strategy Meeting

**ESM must be considered when any or all of the following factors are present:**

- Institutional Abuse is alleged or suspected
- Multiple Abuse is alleged or suspected
- Organised Abuse is alleged or suspected
- Poor standards of care or serious issues that bring into question a provider’s ability to provide safe care to service users
- Where an Adult at Risk has died and abuse or neglect is suspected- Strategic Manager Safeguarding and Access will consider the need for an ESM or a SAR [Safeguarding Adults Review](#)
- The alleged perpetrator holds a senior position within a care setting/ organisation
- There are large numbers of victims to be interviewed/ supported
- Cases where one partner agency does not have resources alone to carry out the full extent of safeguarding required
- Cases which may attract significant media attention
- Accumulation of significant concerns regarding the quality of care provided by an establishment or organisation that indicate that service users are vulnerable and are at a high risk of suffering harm
- 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
- Care Quality commission identify serious safeguarding concerns
- Failure/s to comply with standards contained in LA contract
Escalating Concerns Which May Require ESM

All staff working with adults with care and support needs should be aware of the following examples that may indicate the ESM threshold has been reached:

- A pattern of ‘serious incidents’ at the establishment rather than one-off incidents
- Multiple adults allegedly abused/are at risk of abuse in or from the establishment
- Multiple staff members/volunteers are suspected to be involved in abuse
- Repeated safeguarding allegations made against the same staff member/volunteer
- Reports of serious crime involving staff/volunteers, (e.g. sexual assault, theft etc.)
- AP investigation or S42 enquiry highlights serious broader concerns about care
- Unauthorised Deprivations of Liberty or inappropriate restrictions
- Medication errors leading to risk of harm for multiple adults
- Injuries, or unexplained deterioration in condition, or behaviour/demeanour of adults where poor care practice or neglect is suspected (e.g. under-staffing etc.)
- Increased attendances from the establishment to A&E (for example), or attendances by ambulances/police (for example) to the establishment
- Missed visits by a Home Care agency
- Increases in the numbers of complaints received by an establishment etc.
- CQC inspection where key standards around safety are not met
- Evidence of an inability to learn on the part of the establishment from previous Adult Protection investigations or Section 42 Establishment enquiries, or usual quality/contractual improvement processes
- Accumulation of significant concerns regarding the quality of care that indicate services users are at high risk of suffering harm or neglect
Overview of Four Key Stages of Executive Strategy Meeting

STAGE 1: Decision to hold ESM

- Concerns & allegations brought to attention of Strategic Manager
- Strategic Manager decides to hold ESM based on initial evidence
- Consultation with legal Services where appropriate re Embargo/suspension
- Immediate steps taken to protect adults in receipt of services e.g. embargo
- Completion of Decision Making form by Strategic Manager (Appendix 1) to document concerns & rationale for decision to hold ESM
- ESM ruled out by Strategic Manager if alternative action more appropriate

STAGE 2: ESM Convened and held in 2 parts

- Chair Appointed
- Stakeholder invite letter & request for written chronology (Appendix 2)
- Provider letter re ESM notification & request for written chronology (Appendix 3)
- First Part - information sharing, risk status decision (RAG) and proposed Action Plan with leads and timescales
- Second Part – Provider attends & informed of concerns/allegations
- Provider has right of reply & opportunity to provide information in mitigation or any actions already taken. Chronology and/or report will assist provider
- Provider informed of actions, timescales and proposed Action Plan
- Confirmed Actions and ESM Action Plan amended, if necessary after provider input
- ESM status logged on tracker system- key dates and progress
- Letter to provider with outcome of ESM e.g. breach of contract and action taken to manage risks e.g. Embargo/Suspensions.
- Ensure all host or placing authorities are informed (See ADASS Out of Area Adults Arrangements June 2016)
STAGE 3: ESM Action Plan

- ESM Action Plan developed to address provider concerns
- Responsibility for plan allocated to Safeguarding Practice Improvement Officer or Commissioning Officer or co-produced
- Provider given copy in order to start to implement plan
- Practice Improvement Officers and/or Commissioning Officers and/or CCG Safeguarding Lead Nurses as required to implement plan
- Other agencies will take responsibility for identified actions in the Action Log contained in the Minutes pro forma Appendix 6. This will identify actions required by other agencies e.g. CCG Pharmacist
- **Chair considers Stakeholder Communications once Action Plan in place**
- Service users; carers; Operational teams; case workers
- Elected members/Executive group members/Media relations
- Decide what information should be disclosed and consider wider implications

STAGE 4: ESM concluded

- ESM concluded once Chair is satisfied that all risks have been addressed
- The Chair must be satisfied that all actions are completed or in hand by all relevant agencies e.g. police, CCG
- Stakeholders satisfied that a balanced investigation has taken place
- Referrals made to appropriate bodies i.e. DBS
- Formal Debrief arranged where necessary ESM status updated on ESM tracker
- Ensure that all host or placing NHS or Local Authorities are informed of events and decisions
DETAILED OVERVIEW OF FOUR STAGES OF ESM

STAGE 1: Decision to hold ESM - Initial Evidence, Decision Making and rationale.

When concerns emerge, they must be brought to the immediate attention of an appropriate Strategic Manager. The decision to hold an ESM is made by the relevant Strategic Manager in discussion with senior colleagues i.e. Strategic Manager Commissioning Service.

Where concerns primarily relate to a number of specific incidents of abuse and harm to service users as a consequence of care practices and poor service delivery, the ESM will be led by a Strategic Manager in Adult and Health Care.

Where concerns primarily relate to the general quality of service standards and there are no serious adult protection allegations of harm to individuals, the ESM will be led by a Strategic Manager Commissioning.

The Strategic Manager must decide on any immediate action to safeguard adults involved. This may include:

- Consideration of immediate removal of victims to safe environment
- Embargo/suspensions
- Initial allegations and actions will be recorded in the ESM Initial Evidence and Decision Making form (Appendix 1)
- Initial Evidence and Decision Making Form enables the Strategic Manager to identify the relevant ESM criteria and rationale for the decision. There are no hard and fast rules, and each case is considered on its own merit
- Strategic Manager may consult LA legal services where necessary especially where an Embargo or Suspension is being considered

Alternatives to ESM

Escalation to ESM should not be disproportionate to the risk presented, nor duplicate work already in progress. The Strategic Manager must consider the option of an alternative plan to resolve matters before escalation to ESM i.e. undertaking further investigations or organising a meeting with provider e.g. Provider Planning Meeting chaired by Commissioning (See role of Commissioning Service).
STAGE 2: Convening Executive Strategy Meeting

Where the Strategic Manager decides that the threshold for the ESM is met, a Chair will be appointed to convene the meeting and invite senior representatives from other relevant partner agencies to attend to ensure there is a full and fair investigation (standard letter Appendix 2). These will typically include:

- **Police** – also discussion on how to conduct the ESM in a way that will not jeopardise any criminal investigation and **criminal offences e.g. Section 20 of Criminal Justice and Courts Act 2015 (see Criminal Investigation section)**
- **Commissioning Services Manager** - where registered care services are implicated
- **Safeguarding Adults Practice Improvement Officer (PIO)** – where Practice Improvement Officer is already involved, they will provide information about their involvement. Otherwise PIO will attend and complete actions identified in the ESM
- **Local Authority legal representative** - where potential exists for litigation against the local authority or where the subject of the ESM is liable to request the presence of a legal representative
- **Care Quality Commission**- CQC will be invited to attend where a registered provider is subject to the ESM and the need to monitor/audit outcomes in relation to the service
- **Authorised deputies attend the meeting** with the permission of the Chair
- **Representatives** from CCG/other health providers involved with the service
- **Notifying host and placing authorities** for relevant LA’s or NHS body (See ADASS Guidance for Out of Area Safeguarding Adults Arrangements June 2016.)
- **NB** It is expected that those attending bring to the meeting detailed information about their involvement and any concerns identified and share this with the group.

**Exclusions**

Anyone suspected of acting incorrectly or who may adversely influence the outcome of any investigation should not be invited (e.g. home owner). 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 Executive Strategy Meeting

**Conflicting Governance**

When considering an ESM, consideration should be given as to whether any other group/meeting should take precedence

- An Incident Coordination Group (for a death in a health care setting),
- Police Gold Command Group (where there may be serious systematic failings that would lead to a serious loss of confidence in the police and their partner agencies)
- Mental Health Homicide Review or Domestic Violence Homicide Review
- Safeguarding Adults Review

And whether any group needs to be informed of the issues under investigation.

**When considering the above it is important to note that the ESM is required to address immediate issues rather than a retrospective Lessons Learned activity.**
Provider Notification Regarding ESM

The Chair will contact the provider subject to the ESM, in writing (see example), providing adequate notice to attend the meeting, and information to ensure they understand the reason for the ESM and the process. The Chair will share as much information as possible without compromising any subsequent lines of enquiry. The letter will indicate that the threshold for ESM has been met and any potential breaches of contract.

Preparatory Information for the ESM

Invite letters to the stakeholders and provider will request a written chronology with sufficient detail: dates, times of incidents. In addition the Chair may request additional information;

- Documentation held by an organisation such as care plans, policies and procedures, incident reports etc.
- Incidents and documentation held by Police, TEWV, CCG, NEAS
- Details such as time, date and venue of events and meetings

The ESM must try and establish the facts in respect of any allegation. The Chair may also ask a Practice Improvement Officer and/or Commissioning Officer to visit prior to the ESM to gather further information to enable them to develop an action plan in a timely manner.
Invite Letter and Notification to Provider regarding Executive Strategy Meeting

To the Manager
Add name and address of the provider

Dear

An Executive Strategy Meeting has been convened under County Durham Interagency policy and procedure for (name of provider)

We would like you to attend an executive strategy meeting on:

Date:

Time:

Venue:

The strategy has been convened because a number of Adult Protection practice concerns have been identified in respect of name of provider. These include issues relating to (insert details)

Please discuss this letter with senior managers or owners in your organisation as appropriate. A copy of the letter has also been sent to them. It is recommended that they attend the meeting as their attendance may be beneficial to discuss actions necessary by the provider following the executive strategy meeting. You may also wish to invite another member of staff to attend with you. However if this member of staff is implicated in possible abuse it would not be appropriate for them to attend.

The strategy meeting will be chaired by (insert name) who will act as contact in the process. Relevant partner agencies will also be invited to attend. This may include representatives from Children and Adult Services, the Care Quality Commission, the Police and local NHS services.

The Chair will summarise the concerns highlighted and any previous discussion between professionals. Please bring a written chronology and/or report which is sufficiently detailed i.e. times, dates, accurate details of incidents and persons involved. You will have an opportunity to share information with the group and ask questions. Actions required following the strategy will also be discussed, including the involvement of an investigation team in developing and implementing an action plan and consideration of any enforcement action that may be deemed necessary. You will receive a copy of minutes of the executive strategy following the meeting, including the dates for any subsequent executive strategy meetings, which will be convened to monitor progress.

If you wish more information on the executive strategy process we have included a leaflet with this letter on the role of Safeguarding Practice Officers. Their role involves development of action plans and working closely with provider services to address key areas of concern and report back to the executive strategy. The leaflet gives further details on the executive strategy process and the work that safeguarding practice officers undertake with providers when executive strategy is convened.

If you have any questions prior to the meeting please contact (insert name)

Yours sincerely,

Chair of Executive Strategy Meeting
During the Meeting

**Executive Strategy Meetings – Part One and Two**

**ESM Part One- Main areas for attention for Chair and stakeholders**

Part One will exclude the service provider and consist of formulating the allegations/concerns, information sharing (some of which may not be appropriate to share with the service provider), establishing the level of risk and identifying actions to address the issues outlined. The Chair will also consider any conflicts of interest, the known views of the provider and how to involve them. The main focus will be to determine:

- Whether concerns are valid.
- Level and impact of risk to adults receiving care from the provider
- Whether safe for all/ specific adults to continue to be supported by the provider
- Removal of residents and risks associated with those actions
- Protective action including suspension or embargo of placements or services,
- Lifting of suspensions or embargoes that have already been put in place
- Monitoring to confirm risk is reduced and change can be sustained
- Termination of contract and decommissioning service
- Enforcement or cancellation of registration (CQC)
- Ensuring that service users’ needs can still be met if a business fails
- Notifying other agencies e.g. the CCG or LA who commission the service such as a Care Home or Independent Hospital whether local or out of area (ADASS Safeguarding Adults Policy Network 2016).

**Provider Engagement in ESM**

As already stated, working with the provider in a transparent and fair way is integral to the effectiveness of the ESM. An agreed improvement plan can only be reached through open and constructive dialogue, and a willingness to work together. An ESM should offer support and guidance for establishments – not be punitive.

The provider should receive as much detail as possible about the concerns, present their own case, respond to evidence presented, and play a leading role in developing and implementing their improvement plan. The provider should bring a written chronology and or/report with them to ensure the best quality information is shared.

Action taken under ESM in respect of providers must always be proportionate to the risk identified and take into account any action they have already taken/ is taking to make improvements (e.g. voluntary embargo or management support by the establishment’s organisation). This must be balanced against an establishment’s responsibilities to prevent abuse and neglect, protect adults at risk, and be accountable to the people they support and organisations that have contracted them.

The Chair must consider how and when best to include the provider on a case by case basis and establish regular lines of communication (e.g. meetings) with the provider as part of the communications strategy.
Criminal Investigation

Where there is a possibility of a criminal offence, this must be discussed with the police representative. There are a number of possible criminal offences that can be considered. However Section 20 Criminal Justice and Courts Act 2015 may be particularly relevant as it includes:

- Ill treatment or wilful neglect: care worker offence
- Ill treatment or wilful neglect: care provider offence
- Penalties are a remedial order or a publicity order instead of or as well as imposing a fine

Any police investigation will normally take precedence due to the higher standards of evidence required for the criminal justice system.

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 would only be overridden where there are matters of pressing public interest. After consultation with the police, the ESM chair will 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. Where criminal prosecution is ruled out, it should be made clear if there is still be a need to continue investigations into issues of a non-criminal nature.
ESM Part Two

The Chair will summarise the allegations/concerns and any appropriate information for the provider before receiving the service provider’s response and finalising the action plan. The Executive Strategy process should result in a fair and impartial investigation and report. The ESM must take into consideration any information provided by an individual or organisation by way of defence or mitigation.

As well as the ESM Action Plan, the provider will also receive a formal letter stating the outcome of the ESM and any relevant decisions regarding Embargo, Suspensions or Termination of Contract etc.

**NB** Where someone has been excluded from the Executive Strategy Meeting as they are subject to criminal prosecution in respect of the allegations, the employer/service provider may not be informed of the meeting if it is considered doing so may frustrate the investigation. Such exclusions must be documented within the minutes with supporting reasons.
OVERVIEW OF PROCESS FOR CONDUCTING EXECUTIVE STRATEGY MEETING

**Part One:** the Chair will:

- Share agenda (standard agenda appendix 4) in advance where possible to ensure all items are addressed:

- Decide whether to exclude anyone for the whole or part of the meeting. The reason for exclusion should be recorded in the minutes of the meeting. In the majority of cases exclusions will only take place at the first meeting.

- Explain reason for convening with brief outline of the allegations / concerns.

- Confidentiality Statement - provide an overview of the confidentiality statement to the meeting and ensure members of the meeting are familiar with the contents and sign it accordingly (appendix 5)

- All allegations/concerns (also reviewed in subsequent meetings) should be identified and recorded clearly and concisely in the minutes (appendix 6).

- Stakeholder Information Sharing including contractual and legal matters. This is an opportunity for the exchange of information from the partner organisations. All communications should go through the Chair. If any information is confidential and cannot be shared with a service provider for specific reasons, the stakeholder should state this prior to sharing.

- The Chair will identify proposed actions for all relevant parties on the Action Log see Appendix 6 Minutes template.

- The actions will be allocated to an individual with responsibility for completing it with agreed timescale

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

- Risk Status - the Chair will ask attendees to consider the level of risk for the service user(s) using the RAG rating (traffic light system). The risk status is then formally recorded as: Green, Amber, Red

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<td>RED</td>
<td>There is evidence of a significant risk to service users due to abuse or unsatisfactory practice. which is likely to result in serious harm, breach of contract and organisational failure</td>
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<tr>
<td>AMBER</td>
<td>There is evidence that individuals are at some risk of abuse or unsatisfactory practice which is likely to result in some harm, contractual weaknesses and organisational failings</td>
</tr>
<tr>
<td>GREEN</td>
<td>No evidence of risk to any service user</td>
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Responding to Abuse and Neglect

ADDITIONAL POINTS TO NOTE

Part Two

- Chair’s Summary - following the sharing of information the Chair should, with the assistance and agreement of the meeting, summarise the information.
- This summary will form the basis of the disclosure to the service provider in the second part of the meeting.
- Provider will have the right to reply and any relevant information, actions taken and mitigation should be taken into consideration.
- Following provider comments the action list should be finalised and timescales for the completion of confirmed.
- Confirm Actions in Action Log (Appendix 6 Minutes Template).
- Review of Actions from previous ESM if relevant - the Chair will ensure the agreed actions from the previous meeting are reviewed.
- A Practice Improvement Officer and/or Commissioning Officer will draft an Action Plan based on the Actions and Risk Status identified in the ESM and work jointly with the Commissioning Service and CCG Safeguarding Team as needed.
- Depending on previous involvement by the Practice Improvement Officer and/or Commissioning Officer, this Action plan may already have been developed.
- These actions will be reviewed in subsequent meetings to monitor progress and note any amendments or additions as necessary.
- The Chair should reflect on any lessons learned such as systematic and procedural failings.
- Letter to provider with outcome of ESM such as breach of contract an action taken to manage risks e.g. Embargo/Suspensions
ADDITIONAL POINTS TO NOTE

Where an Executive Strategy Meeting focuses on an individual, contemporaneous notes are required. These are notes that are recorded at the time or shortly after an incident. They should be in order of events and could include diary notes, notebook recording, minutes or case file entries.

It is imperative that all notes are kept. If the police pass a case to the Crown Prosecution Service any original notes are needed for the evidential test to be carried out. The Crown Prosecution service must be satisfied that there is enough evidence to ‘provide a realistic prospect of a conviction’ against each defendant on each charge. Evidentially the burden of proof is ‘Beyond a Reasonable Doubt’. They must consider what the defence case may be and how that is likely to affect the prosecution case. They must balance factors for and against prosecution carefully and fairly. A prosecution case will usually take place; however, unless there are public interest factors tending against prosecution which clearly outweigh those tending in favour. (Crown Prosecution Service 2006)

- The Chair must consider informing the relevant Local Authority of anyone potentially at risk and placed within County Durham from out of area. The chair should also consider informing other relevant Local Authorities should there be possible media interest. A record should be made of the decision and actions.

Original hand written notes should never be discarded in favour of typing them up.

**Action Planning**

- All actions should be clearly documented with the name of the person responsible for the action.
- The timescale for completion and guidance from the Chair should be carried forward to the next meeting to be addressed.
- The outcomes of all actions should be clearly recorded (including those outstanding).
- Any actions carried forward and completed will be represented in grey on the action plan in subsequent meetings, those actions not completed will be carried forward in bold for the next action plan.
- It is the responsibility of the chair to ensure that all actions are identified and marked completed or still requiring action.
- In the next meeting the chair will first seek confirmation about whether actions have been met. Later in the process the Chair will ask for an update and will gather further information regarding barriers to achieving the action or successful completion of the action.
Structure

**Understanding the process** – If the minute taker understands the process of the meeting then recording will be structured too.

**Summarise** – If the chair provides a clear summary at the end of each agenda item it gives the minute taker a chance to capture anything they may have missed and gives them a point of reference to check the accuracy of what they have noted. This should not deviate from the structure of the meeting.

**Beginning:** Agenda, Date and Time (Meeting and incident), Confidentiality statement, Persons invited and present, apologies, Reason for referral to safeguarding, Chairs details including contact, Why persons are excluded at points within the meeting, Victim information, Allegation, Purpose of the meeting, Roles of persons present in relation to victim, Potential Perpetrator details, Consent/ capacity issues identified

**Middle:** Minutes include risk assessment and actions to keep person safe, Organisation feedback, Chair Summary, Actions (SMART), Victim wishes/ feelings, Facts, Professional opinions. Discussion prior to action planning and after risk analysis should include ‘Communications’ such as media relations, information sharing with Local members and absent stakeholders, information sharing with service users, relatives and providers and restrictions on information sharing.

**End:** Summary of key points, Conclusions, Actions and actions met, Name and title of person completing the minutes, Signature, Date and time of written record. Lessons Learnt.
Responding to Abuse and Neglect

Structure

After the Meeting

POINT TO NOTE

Direct Feedback – when minutes haven’t turned out as the chair expects, it’s important for them to give direct feedback to the minute taker and to advise of the expectation for future meetings rather than having someone else amend the notes. The minute taker should use this as a process for offering their feedback to the chair too (and minute takers should be encouraged to do so). This should be done constructively. Similarly, if the notes were excellent then positive feedback should be given so a minute taker knows what they’ve done right and can learn and improve where needed.

Following the meeting the following should take place:

• The minute taker and Chair should meet to check and clarify notes made and ensure agreement on the discussion and actions. This is also an opportunity for a minute taker to discuss any emotional impact the meeting may have had.

• Any additional papers circulated at the meeting should be forwarded to the minute taker for further circulation.

• A first draft of the notes and action sheet should be produced as soon as possible after the meeting (and within established performance timescales). (Appendices 6 & 7). They should be distributed only following sign off by the chair and should include a copy of the acceptance of minutes agreement (Appendix 8).

• If applicable the minute taker and chair should liaise regarding circulation of minutes to service users and/or carers, ensuring any information not shared at the meeting is not included.

• Notes should be circulated using a secure email network or other agreed secure method and should be marked private and confidential.

• Timescales should be adhered to for circulating minutes and responding to any amendments subsequently requested. (Ideally 7 working days however the performance target states 10 working days).

• Any hand-written notes of the meeting should be retained until the final version has been agreed by the Chair and all participants and then scanned for future reference.

At the very end of the process the chair should fill out the Completion of Executive Strategy form and add to the safeguarding file.
During Executive Strategy

**Legal Requirements of Minutes**

- New information or cumulative risks should be presented to meeting participants and clearly recorded in chronological order of events.
- All documentation must follow the Durham Adult Protection Policies and Procedures (Local Guidance).
- Minutes need to be accurate and concise. If a case were to enter legal proceedings, the protocol is that all information relevant to the case will be gathered and compiled in chronological order. It is important that assessments, care plans, risk assessments, monitoring outcomes, action plans and other documentation all correspond and consistently reflect the same information.
- Where relevant the record must show that concerns regarding the risk to the victim were discussed openly and factually and include how the victim will be safeguarded from any risks presented. Any disputes should be recorded.
- Where relevant the minutes should include actions regarding the sharing of information with the victim/perpetrator and the seeking of the victims’ views. This needs to be timely so that it does not impede any investigative process. Times and dates of action should be clearly recorded.
- In the event that people leave or arrive at the meeting in stages, (this may be because only some information can only be shared with them) this should be recorded clearly within the notes. This is particularly important if anyone is asked to withdraw from the meeting while legal advice is given.

Executive Strategy Minutes must clearly identify actions and subsequent meeting arrangements (dates, times etc.)

**Key Learning Points**

- Preparation prior to the meeting is important: Sit, think, plan, draft
- Remember that records could be used as evidence in a court of law
- Original and / or handwritten reports received should be kept, even if they are later typed up or put into the minutes
- It is important to maintain the structure of the meeting and minutes: beginning, middle and end
- Access to read and record should be clearly outlined
- Recording of injuries and evidence supplied is important
- Recording of other documentation supplied is important
- Actions must always have outcomes recorded and addressed before the safeguarding process is concluded
Executive Strategy

The Importance of Robust Minutes from Executive Strategy Meetings

Minutes are taken during an Executive Strategy Meeting to evidence how decisions have been reached and actions have been met. They must be comprehensive, accurate and specific however, a verbatim account of the discussion is neither expected nor required.

Within Safeguarding Adult Executive Strategy Meetings the reasons why records need to be accurate include:

- Legal requirement.
- Accountability.
- Evidence and justify actions and outcomes.
- Record reasons for decisions made.
- To act as an aid memoir.
- To safeguard against allegations.
- A tool for monitoring, reviewing and evaluating work.
- The basis for risk assessment and care planning.
- Records may be needed in a Court of Law.

Written records are a way of communicating:

- The objectives – what work is being undertaken.
- The methods – how work is being done.
- Monitor, review and evaluate – what work has been carried out and its effectiveness.
- The needs of and the cumulative risks to the individual.
- Incidents and events.
- Professional opinions and perspectives.
- The reason underpinning decision making.
- Record any disputes / disagreements.
Letter re Executive Strategy

Dear (stakeholder)

An Executive Strategy Meeting has been convened under County Durham Interagency policy and procedure for (name of provider). You are invited to attend on:

Date:
Time:
Venue:

The strategy has been convened because a number of Adult Protection and practice concerns have been identified in respect of (name of provider). These include issues relating to (bullet point main issues)

The meeting will be chaired by (name of chair), who will act as contact in the process. Relevant partner agencies are invited to attend Executive Strategy Meetings to share information, help plan the investigative process and understand their organisation’s role within this process.

It is essential that you bring to the meeting any information your organisation has about your involvement with the provider and any concerns identified. This information should be sufficiently detailed i.e. times, dates, accurate details of incidents and persons involved. You will be asked to share this information with the multi disciplinary group.

If you are unable to attend please send a suitably briefed representative who can deputise for you. If it is not possible to send a representative to the meeting please provide a detailed report outlining your organisations involvement with the subject of the meeting, which can be shared with other participating partner organisations.

Please confirm your attendance/representation at least one full working day prior to the meeting.

Representatives from the provider organisation will also be invited to join the meeting at a later time at which point the chair will summarise concerns, previous discussion and plans for the investigative process including enforcement action required. The provider will also be given the opportunity to share information with the executive strategy group.

A copy of the minutes will be circulated following the Executive Strategy Meeting and will include the date of any subsequent meeting convened to monitor progress.

If you have any questions prior to the meeting please contact (name of lead offer and tel. no).

Yours sincerely
Chair of Executive Strategy
Letter Inviting Provider
Executive Strategy

To the Manager
Add name and address of the provider

Dear

An Executive Strategy Meeting has been convened under County Durham Interagency policy and procedure for name of provider: We would like you to attend an executive strategy meeting on:

Date:
Time:
Venue:

The strategy has been convened because a number of Adult Protection practice concerns have been identified in respect of name of provider. These include issues relating to (insert details)

Please discuss this letter with senior managers or owners in your organisation as appropriate. A copy of the letter has also been sent to them. It is recommended that they attend the meeting as their attendance may be beneficial to discuss actions necessary by the provider following the executive strategy meeting. You may also wish to invite another member of staff to attend with you. However if this member of staff is implicated in possible abuse it would not be appropriate for them to attend.

The strategy meeting will be chaired by (insert name) who will act as contact in the process. Relevant partner agencies will also be invited to attend. This may include representatives from Children and Adult Services, the Care Quality Commission, the police and local NHS services.

The Chair will summarise the concerns highlighted and any previous discussion between professionals. You will have an opportunity to share information with the group and ask questions. Actions required following the strategy will also be discussed, including the involvement of an investigation team in developing and implementing an action plan and consideration of any enforcement action that may be deemed necessary. You will receive a copy of minutes of the executive strategy following the meeting, including the dates for any subsequent executive strategy meetings, which will be convened to monitor progress.

If you wish more information on the executive strategy process we have included a leaflet with this letter on the role of Safeguarding Practice Officers. Their role involves development of action plans and working closely with provider services to address key areas of concern and report back to the executive strategy. The leaflet gives further details on the executive strategy process and the work that safeguarding practice officers undertake with providers when executive strategy is convened.

If you have any questions prior to the meeting please contact (insert name)

Yours sincerely,
Chair of Executive Strategy Meeting
Executive Strategy Meeting
In respect of concerns relating to (name of care home)
held on (date) at (time)

Agenda

Part 1  Multi Agency Discussion
1. Identification of Chair
2. Context and Focus of Meeting
3. Introductions and apologies
4. Any exclusions
5. Confidentiality Statement
6. Review of actions from action sheet (subsequent meetings only)
7. Overview of allegations / Concerns (reviewed in subsequent meetings)
8. Stakeholder Information Sharing/updates (including contract and legal status)
9. Chair’s Summary
10. Risk Analysis
11. Stakeholder Communications (service user/carer, elected members, media relations, executive group members etc.)
12. Determine proposed actions and timescales (reviewed in subsequent meetings)

Part 2  Provider Engagement
13. Introductions and apologies
14. Context and focus of meeting
15. Summary of Issues
16. Provider’s response
17. Confirmation of Actions and Timescales
18. Lessons learned
Responding to Abuse and Neglect

Executive Strategy Meeting In Respect of......

Date:

Confidentiality Agreement

All persons attending this meeting agree that the primary objective is to share information on a need to know basis, in order to safeguard the adult(s) at risk. The meeting and any subsequent safeguarding intervention will be conducted in the best interests of the adult(s) concerned, and in accordance with the Durham Safeguarding Adults Policy and Procedural Framework.

All attendees agree that the information shared in this meeting will remain strictly confidential, and may not be shared with any other person or agency without prior permission of the designated Lead/Executive Officer.

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<tr>
<th>Name</th>
<th>Job Role</th>
<th>Agency and Contact Details</th>
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**Apologies**
Chair
(name of Chair) was identified as the Chair of the Executive Strategy process in respect of (name of care home)

Context and Focus of the Meeting
(name of chair) explained that this meeting had been convened under the Executive Strategy Process for Safeguarding Adults after concerns were raised around care practices within (name of care home)

Introductions and Apologies
Members of the meeting introduced themselves and clarified their roles for the purposes of the meeting.

Exclusions
N/A (Where necessary the chair will make a decision about whether to exclude anyone for the whole of part of the meeting).

Confidentiality Statement
(name of chair) made the group aware that all information shared within the meeting was to remain strictly confidential and that information should not be shared outside of this meeting without the agreement of the Chair. Members of the group were then asked to sign the confidentiality agreement.

Review of actions from action sheet (to be reviewed in subsequent meetings)

Overview of allegations and concerns (to review in subsequent meetings as appropriate)

(name of chair) gave an outline of the allegations and concerns raised which included:

Stakeholder Views and Information Sharing/updates
(name of chair) asked the group to take it in turn to update the meeting about key information held in respect of (name of provider) and any associated concerns.

Safeguarding/Adult Protection
Commissioning
CQC
Health
Police
Chair’s Summary

(name of chair) summarised the issues discussed as follows:

Risk Analysis

(name of chair) advised the group of the categories of risk pertaining to executive strategy. In light of the information shared the group then considered the risks prior to deciding the risk status.

It was agreed to formally record the status of this case as:

Green  Amber  Red

Stakeholder Communications

The Chair should consider the wider communications issues including the following:

Service user/carer
Elected members
Media relations,
Executive group members

The chair should give specific direction on what information should be disclosed and consideration should be given as to the wider implications of sharing it.

Proposed actions and timescales (review in subsequent meetings)

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<tr>
<th>No</th>
<th>Action to be taken</th>
<th>Timescale</th>
<th>Lead</th>
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### Executive Strategy Meeting Action Sheet in respect of ........

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<th>Action no.</th>
<th>Date Actioned / Date of meeting</th>
<th>Action to be taken</th>
<th>Timescale</th>
<th>Chair</th>
<th>Status (completed, ongoing etc)</th>
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Executive Strategy Meeting Action Sheet in respect of ..........

**Minutes are to be circulated with an email (wording as below) stating that any amendments should be forwarded to the minute taker by a specified date.** There will also be a statement on the minutes identifying that minutes are accepted as an accurate and true record unless contact is made by the identified date, with amendments:

‘Attached are the minutes of the executive strategy meeting held on dd/mmm/yyy at Location regarding identity of person / establishment for your information and attention. The next meeting is scheduled for dd/mmm/yyy at Location where you will have an opportunity to agree or amend the minutes. If you are unable to attend and require amendments to be made to the minutes will you please forward those amendments to email address within seven day of receipt of this email so your proposed amendments can be brought to the attention of the chair at the next meeting’.

**Also the chair could remind everyone at the end of the meeting that**

‘The minutes of this meeting will be circulated. If you are unable to attend the next meeting you can make representations regarding any proposed amendments by sending an email to email address by dd/mmm/yyy. This will enable them to be can be considered by the chair at the next meeting when the minutes are agreed.'
Decommissioning

Decommissioning a residential service following safeguarding executive planning intervention - joint working protocol

This protocol sets out the process to be followed by Durham County Council Children and Adult Services and partner safeguarding agencies, e.g. Clinical Commissioning Groups (CCGs) 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 Children and Adult Services Decommissioning 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.

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
Decommissioning

**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.

**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.

**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 CCG must similarly be contacted.
Decommissioning Process

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 CCG will liaise with other placing CCGs 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 de-briefing meeting.

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.
Decommissioning

Impact on stakeholders – areas for consideration

- Service users, their families and supporters
- Self-funded placements
- Information sharing
- Consultation
- Disagreement
- Staff support needs

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 Coordinator 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.
Decommissioning

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.

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.

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.

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.
Decommissioning

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.

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.
Achieving Best Evidence / Video Interviews

The video interviewing of witnesses is a ‘Special Measure’ which is part of the Achieving Best Evidence protocol(s). For further information regarding Achieving Best Evidence please follow the link.

During safeguarding process and police interview services should not investigate unless the Lead Officer has instructed someone to be part of the investigative team. Where police are involved this will usually be police led. Investigation needs to be carried out by the police who have extensive training to ensure that evidence is credible. Personal investigation outside of that directed by police or the Lead officer could destroy evidence or make it less credible.

Over view of Care Act
"Until now it’s been almost impossible for people who need care, carers, and even those who manage the care system, to understand how the previous law affecting them worked. Over nearly 70 years it has been added to again and again and is out of date and confusing. The Care Act has created a single, modern law that makes it clear what kind of care people should expect." Care Minister Norman Lamb

Introduction
The Care Act 2014 builds on recent reviews and reforms, replacing numerous previous laws, to provide a coherent approach to adult social care in England. Part one of the Act (and its Statutory Guidance) consolidates and modernises the framework of care and support law; it set out new duties for local authorities and partners, and new rights for service users and carers.

What does the Act aim to achieve?
- Clearer, fairer care and support
- Wellbeing – physical, mental and emotional – of both the person needing care and their carer
- Prevention and delay of the need for care and support
- People in control of their care.

A new emphasis on wellbeing
The new statutory principle of individual wellbeing underpins the Act, and is the driving force behind care and support.

Prevention
Local authorities (and their partners in health, housing, welfare and employment services) must now take steps to prevent, reduce or delay the need for care and support for all local people.

Integration
The Act includes a statutory requirement for local authorities to collaborate, cooperate and integrate with other public authorities e.g. health and housing. It also requires seamless transitions for young people moving to adult social care services.

New criminal offence: Ill treatment and Wilful neglect Criminal Justice and Courts Act

**Department of Health Consultation document**

1. In November 2013, the Government accepted the recommendation of the National Advisory Group on the Safety of Patients in England that a new statutory criminal offence of ill-treatment or wilful neglect of patients should be created. The Government committed to consulting on detailed proposals as soon as possible, with the aim of legislating as soon as Parliamentary time allowed.

2. Since then the Department of Health has been working to develop a set of proposals, on which we began a public consultation on 27th February 2014. The consultation document set out the background to the proposals and asked for views on a number of different issues. The consultation period ran until 31st March. This document summarises the responses received to each of the questions we asked, and sets out how we will be proceeding on each issue following the consultation.

3. This document talks about “the offences”, as, in light of the comments received from respondents to the consultation, the legislation will set out two offences, one relating to individuals, and a separate one relating to organisations.

- an act to make provision about how offenders are dealt with before and after conviction
- to create offences involving ill-treatment or wilful neglect by a person providing health care or social care
- to create an offence of the corrupt or other improper exercise of police powers and privileges
- to make provision about offences committed by disqualified drivers
- to create an offence of disclosing private sexual photographs or films with intent to cause distress
- to amend the offence of meeting a child following sexual grooming
- to amend the offence of possession of extreme pornographic images
- to make provision about the proceedings and powers of courts and tribunals
- to make provision about judicial review
- for connected purposes.

See [http://www.legislation.gov.uk/ukpga/2015/2/section/20/enacted](http://www.legislation.gov.uk/ukpga/2015/2/section/20/enacted)
A Vision for Adult Social Care: Capable Communities and Active Citizens

November 2010 the government launched a new initiative "A vision for adult social care: Capable communities and active citizens". The Vision sets out how the Government wishes to see services delivered for people; a new direction for adult social care, putting personalised services and outcomes centre stage. In February 2012 this was updated by Building Safe, Active Communities. The main themes are:

- **Personalisation:** individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their own care.

- **Partnership:** care and support delivered in a partnership between individuals, communities, the voluntary and private sectors, the NHS and councils - including wider support services, such as housing.

- **Plurality:** the variety of people’s needs is matched by diverse service provision, with a broad market of high quality service providers.

- **Protection:** there are sensible safeguards against the risk of abuse or neglect. Risk is no longer an excuse to limit people’s freedom.

- **Productivity:** greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services. A focus on publishing information about agreed quality outcomes will support transparency and accountability.

- **People:** we can draw on a workforce who can provide care and support with skill, compassion and imagination, and who are given the freedom and support to do so. We need the whole workforce, including care workers, nurses, occupational therapists, physiotherapists and social workers, alongside carers and the people who use services, to lead the changes set out here.
ADASS Making Safeguarding Personal 2013-14

**Making Safeguarding Personal 2013-14 Report Findings**

Making Safeguarding Personal is a sector led initiative in adult safeguarding. It has arisen in response to findings from peer challenges, the response to the ‘No Secrets’ consultation and other engagement with councils and their partners. It aims to develop an outcomes focus to adult safeguarding work and a range of responses to support people to improve or resolve their circumstances. This should result in safeguarding being done with, and not to, people.

Behind Closed Doors

*Behind Closed Doors* is a report by MENCAP that highlighted the issues around the need for appropriate representation of vulnerable people within the criminal justice system. The report focussed on those people who have a learning disability.
Safeguarding Adults: best practice for the NHS

Published by DoH in March 2011. A set of documents produced by the department of health to remind health services of their duties to safeguard adults. They assist NHS commissioners, health service managers and practitioners in preventing and responding to neglect and abuse, focusing on patients in the most vulnerable situations. The documents include good practice principles and examples.
The British Medical Association has published a toolkit that provides practical advice to doctors on promoting and protecting the wellbeing of vulnerable adults. Although principally aimed at GPs, any professional working in health care settings with vulnerable adults will find it useful.

- Download Safeguarding vulnerable adults – a toolkit for general practitioners

The term “vulnerable adults” covers an extremely wide range of individuals, some of whom may be incapable of looking after any aspect of their lives and others who may be experiencing short periods of illness or disability with an associated reduction in their ability to make decisions.

The toolkit highlights the obligation doctors have to protect vulnerable adults, including identifying abusers, identifying systemic healthcare failures and reporting poor performance by health professionals. It includes examples of good practice and signposts key guidance, relevant legislation and useful names and addresses.

The guidance covered includes:

- What is safeguarding?
- Which adults may be vulnerable?
- What part does mental capacity play in safeguarding?
- What information can be shared about vulnerable adults?
- What constitutes abuse and neglect?
- When should concerns about patient safety be reported?

http://dementiapartnerships.com/safeguarding-vulnerable-adults-a-toolkit-for-general-practitioners/

This guidance does not cover doctors’ responsibilities to protect or disclose personal information about patients. See our publication, Confidentiality (2009) for further information.
Crime and Disorder Act

The Crime and Disorder Act Within this Act S 115 identifies that we should share information where a crime may have been committed.
Serious Crime Act 2015

- Protection of Children and Others and Law on Domestic Abuse - controlling or coercive behaviour in an intimate or family relationship
- Offences including ill treatment and wilful neglect: care worker offence

Link to Serious Crime Act 2015 Overview
Link to Serious Crime Act 2015 Explanatory Notes
Criminal Justice and Courts Act

Criminal Justice and Courts Act 2015

Criminal Justice Offences involving ill-treatment or wilful neglect by Care worker
Section 20 makes it an offence for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully neglect that individual. The offence will apply in England and Wales. Please see links to explanatory notes for details about these offences

Link to the Criminal Justice and Courts Act Overview
Link to the Criminal Justice and Courts Act Explanation Section 1
Link to the Criminal Justice and Courts Act Explanation Section 20
Link to the Criminal Justice and Courts Act Explanation Section 21

Crown Prosecution Service

The Criminal Justice Act - Hearsay and representation in Court

CPS descriptions

Link to the Criminal Justice and Courts Act Explanation Section 22
Link to the Criminal Justice and Courts Act Explanation Section 23
Domestic Violence and Criminal Justice system

There are several useful pieces of legislation to assist in adult protection matters:

The Domestic Violence, Crime and Victims Act 2004

The Domestic Violence, Crime and Victims 2004

Particular interest to Safeguarding Lead Officers in terms of the relationship between the Domestic Abuse and Safeguarding decision making process. This Act enables police to intervene with victimless prosecution where coercion from perpetrator is an issue in Domestic Abuse situations.

The police have powers to initiate specific protective actions such as Domestic Violence Protection Orders (DVPO)

Click below to view the Government’s website on Domestic Violence Protection Notices; Domestic Violence Protections Orders

Serious Crime Act 2015

Covers Domestic abuse and Controlling or Coercive behaviour in an intimate or family relationship


See PART 5
Protection of Children and Others

Overview of Act
Draft Communications Data Bill 2012

The Draft Communication Data Bill

The purpose of this Bill, is to protect the public and bring offenders to justice by ensuring that communications data is available to the police and security and intelligence agencies in future as it has been in the past. The Government is committed to ensuring that we strike the right balance between protecting the public and safeguarding civil liberties.
The Equality Act

The Equality Act 2010 describes the expectation of equitable standards of practice. Equitable practice prevents abuse.
Codes of Practice - Equality Act

Equality Act Codes of Practice are available for a variety of purposes.
designated adult safeguarding manager (DASM)

In accordance with the care act, each member of SAB must have a designated adults safeguarding manager who must respond to allegation and concerns about a person who may have harmed or pose a risk to adults. The DASM is responsible for the management and oversight of individual complex cases and coordination where allegations are made or concerns raised about a person, whether an employee, volunteer or student, paid or unpaid. DASMs should keep in regular contact with their counterparts in partner organisations. They should also have a role in highlighting the extent to which their own organisation prevents abuse and neglect taking place.

- The DASM should provide advice and guidance within their organisation, liaising with other agencies as necessary. The DASM should monitor the progress of cases to ensure that they are dealt with as quickly as possible, consistent with a thorough and fair process.
- The DASMs will work with care and support providers and other service providers e.g. housing and NHS trusts to ensure that referral of individual employees to the DBS and, or, Regulatory Bodies (e.g. CQC, HCPC, GMC, NMC) are made promptly and appropriately and that any supporting evidence required is made available.
- The DASMs will ensure that systems are in place to provide the employee with support and regular updates in respect of the adult safeguarding investigation. Particular care must be taken to not breach the right to a fair trial in Article Six of the European Convention on Human Rights as incorporated by the Human Rights Act 1998.
- DASMs should ensure that appropriate recording systems are in place that provide clear audit trails about decision-making and recommendations in all processes relating to the management of adult safeguarding allegations against the person alleged to have caused the harm or risk of harm and ensure the control of information in respect of individual cases is in accordance with accepted data protection and confidentiality requirements.
- The local authority DASM will need to work closely with the children’s services Local Authority Designated Officer (LADO) and other DASMs and LADOs for both adults and children in the region or nationally to ensure sharing of information and development of best practice.
- There may be times when a person is working with adults and their behaviour towards a child or children may impact on their suitability to work with or continue to work with adults at risk. This may be referred to the DASM from a LADO, if it is not, then information should be shared with the LADO. Each situation will be risk assessed individually.
- There may also be times when a person’s conduct towards an adult may impact on their suitability to work with or continue to work with children. All these situations must be referred to the LADO.
- Unless it puts the adult at risk or child in danger, the individual should be informed that the information regarding the allegation against them will be shared. Responsibility lies with the person receiving the information to obtain the consent of the individual to share information. The person with the allegation against them should be offered a right to reply, wherever possible seek their consent to share, and be informed what information will be shared, how and who with. Each case must be assessed individually as there may be rare cases where informing the person about details of the allegations may increase the risks to the adult or child.
- Decisions on sharing information must be justifiable and proportionate, based on the potential or actual harm to adults or children at risk and the rationale for decision-making should always be recorded.
- When sharing information about adults, children and young people at risk between agencies it should only be shared:
  - where relevant and necessary, not simply all the information held;
  - with the relevant people who need all or some of the information; and
  - when there is a specific need for the information to be shared at that time.

Senior managers

- Each agency should identify a senior manager to take a lead role in the organisational and in inter-agency arrangements, including the SAB. In order for the Board to be an effective decision-making body providing leadership and accountability, members need to be sufficiently senior and have the authority to commit resources and make strategic decisions. To achieve effective working relationships, based on trust and transparency, the members will need to understand the contexts and restraints within which their counterparts work.
Designated Adults Safeguarding Manager (DASM) for Durham County Council

Under the Care Act 2014 every Safeguarding Adults Board is required to have a Designated Adults Safeguarding Manager (DASM). Durham County Council’s DASM will be undertaken as a joint role by the Local Authority Designated Officer for Children and Adult Services (LADO). The DASM role and function is based on the Care Act statutory guidance.

LADO role in Child Protection cases where perpetrator is an adult who works with adults
The LADO will be responsible for responding to Notifications of Alleged perpetrators of child abuse that also may present a risk to vulnerable adults as a result of their employment working with vulnerable adults. The LADO will be responsible for co-ordinating these investigations.

DASM role in Adult Protection cases
Within Adult Care Services, the Safeguarding Lead Officer (SLO) is responsible for undertaking investigations in accordance with inter agency safeguarding procedures for any alleged perpetrator including family members, friends and those who work in settings which provide care and support to vulnerable adults. These include individuals who are Employed or Volunteers or Students and work in the following types of settings:

• Care Homes, Supported Living, Shared Lives, Domiciliary Care, Durham County Council
• NHS settings (including hospital, private hospitals, dentists, podiatry etc)
• Colleges/Universities

The SLO will continue to manage Adult Protection investigations. However, the SLO will be required to refer some specific alleged perpetrators to the DASM. This is where the allegation has met the threshold for serious concerns which could result in dismissal because the adult has:

• Behaved in a way which has harmed the adult
• Possibly committed a criminal offence against or related to an adult
• Behaved towards an adult in a way which indicates that he is/she is unsuitable to work with children.

DASM Process for Safeguarding Lead Officers
Where the above criteria are met, the SLO will complete the Allegation Notification form and submit it to the DASM. If accepted, the DASM will co-ordinate the necessary actions required in respect of the employee under investigation:

• Ensuring that all HR processes are completed by the employer
• Ensuring that disciplinary action is taken as required
• Ensuring referral is made to the correct regulatory body: CQC, DBS, HCPC, GMC, NMC and any supporting evidence is made available

The SLO will continue to conclude their investigation alongside the DASM. The DCC DASM will:

• Obtain relevant information regarding the alleged perpetrator from the SLO & SSID.
• Record their input within the Adult Protection record on SSID using the notes field.
• Seek any additional information they need from the SLO.
• Update the case within the Adult Protection record on SSID to ensure that relevant information is recorded in respect of the outcome for the alleged perpetrator
• Update their own Alleged Perpetrator Data base.

Interface between DCC DASM and DASM from other organisations
Each statutory member of the Safeguarding Adults Board must have a DASM to take responsibility for the alleged perpetrator within their own organisation e.g. Police, NHS, Probation, Health Watch.

The DCC DASM will maintain links with other DASMs in County Durham as well as establishing regional and national links to ensure information sharing and the development of best practice.

Interface with SAB
The DASM will maintain full records regarding their interventions and provide reports to SAB as requested so that they are aware of the outcomes for the Alleged Perpetrators.
Hidden in Plain Sight

Several serious cases of abuse of disabled people – such as Fiona Pilkington and her daughter, Francecca, who died in 2007 after suffering years of harassment have been reported in the media over the last few years. This inquiry shows that harassment of disabled people is a serious problem which needs to be better understood.
Human Rights Act

Human Rights Act 1998 a positive duty upon ‘public bodies’ to act compatibly with the 1950 European Convention on Human Rights. This includes a duty to intervene proportionately to protect the rights of citizens. Article 2: ‘The right to life’, Article 3: ‘Freedom from torture’ (including humiliating and degrading treatment), Article 8: ‘Right to family life’ (one that sustains the individual).
In Safe Hands

*In Safe Hands* was the implementation of the safeguarding adult procedures in Wales looking at improving the care and provision of services for those people deemed vulnerable.
Guidance on Investigating Domestic Abuse - NPIA

The NPIA Guidance on Investigating Domestic Abuse is primarily focussed on police investigation however, practitioners may benefit from knowledge of the process.
Legal and Policy Context for Safeguarding Adults

Social Care Institute for Excellence produced a document in 2009 which now is under review: Safeguarding Adults at Risk of Harm: A Legal Guide for Practitioners

This guide is due to be reviewed, and the link may not work once updated. In which case please follow the link below to the Social Care Institute for Excellence main website where the new document can be accessed using the search facility.

Main SCIE Website
Mental Capacity Act

The Mental Capacity Act 2005 describes the rights of individuals to make decisions for themselves and how we can assess a person's capacity and make a Best Interests decision when they are unable to. S44 of the Act was amended to enable prosecution for Wilful Neglect.
The Mental Capacity Act 2005, covering England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. The Act received Royal Assent on 7 April 2005 and will come into force during 2007. The legal framework provided by the Mental Capacity Act 2005 is supported by this Code of Practice (the Code), which provides guidance and information about how the Act works in practice.
National Counter Terrorism Strategy

**PREVENT—National Counter Terrorism Strategy**

The Prevent Strategy is a cross-Government policy that forms one of the four strands of CONTEST: the United Kingdom’s Strategy for Counter Terrorism. It includes the anti-radicalization of vulnerable adults and children. CONTEST as a counter-terrorism strategy is organized around four work streams, each comprising a number of key objectives;

- **PURSUE**: To stop terrorist attacks
- **PREVENT**: To stop people becoming terrorists or supporting terrorism
- **PROTECT**: To strengthen our protection against a terrorist attack
- **PREPARE**: To mitigate the impact of a terrorist attack.

**What do we mean by the term terrorism?**

Although there is no generally agreed definition of terrorism internationally, in the United Kingdom the Terrorism Act 2000 defines terrorism as;

- The use or threat of action designed to influence the government or an international governmental organisation or to intimidate the public, or a section of the public
- made for the purposes of advancing a political, religious, racial or ideological cause

And it involves or cause;

- serious violence against a person
- serious damage to a property
- a threat to a person’s life
- a serious risk to the health and safety of the public
- or serious interference with or disruption to an electronic system.

**What do we mean by the term radicalisation?**

Radicalisation refers to the process by which a person comes to support terrorism and forms of extremism leading to terrorism.

There is no obvious profile of anyone likely to become involved in extremism or a single indicator of when a person might move to adopt violence in support of extremist ideas. The process of radicalisation is different for every individual and can take place over an extended period or within a very short time frame.

**What do we mean by the term prevention?**

Prevention means reducing or eliminating the risk of individuals or groups becoming involved in terrorism. Prevent involves the identification and referral of those susceptible to violent extremism into appropriate interventions. These interventions are aimed to stop the vulnerable being radicalized.

Extremists will always target the vulnerable in a bid to spread their firmly held, but flawed, ideologies, but we must tackle them at source and prevent people being brainwashed into terrorism.

Our [E-Learning](#) package provides more information about the PREVENT strategy and allows you to complete a quick quiz.
Prevent Strategy (Continued)

The Prevent agenda requires all partner organizations to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who may be at a greater risk of radicalization and making safety a shared endeavor. The County Durham Inter Agency Safeguarding Adults Board fully endorses and supports this national and local strategy.

Since 2010, when the Government introduced the PREVENT Strategy reviewed the strategy there has been an awareness of the specific need to safeguard vulnerable adults and children from violent extremism and terrorism which results in: holding extreme views including views justifying political, religious, sexist or racist violence, or to steer them into a rigid and narrow ideology that is intolerant of diversity and leaves them vulnerable to future radicalisation.

This work is overseen by the Safe Durham Partnership, through its priority partnership ‘CONTEST Silver group’ in County Durham. It meets bi-annually and is chaired by Deputy Chief Constable. It reviews the group’s collective response to the PREVENT duty and statutory expectations as set out in Section 26 (General Duty) and Sections 36 to 38 (Channel) of the Counter Terrorist and Security Act 2015.

‘Prevent Duty Guidance: for England and Wales’ outlines the statutory duty and sets expectations of all specified authorities. The organisations listed below are deemed ‘specified authorities:

Durham County Council  
Durham Constabulary  
Prisons  
Probation  
ARCC Community Rehabilitation Company  
All NHS Trusts & Foundation Trusts  
Schools  
Further Education  
Durham University

Each specified authority must take a risk based approach to the Prevent Duty. This includes:

- Ensuring staff understand the risk and why people may be vulnerable to radicalisation
- Ensuring staff understand how to obtain support for people who may be being exploited by radicalising influences
Public Interest Disclosure Act

The Public Interest Disclosure Act protects workers to 'Blow the Whistle' about wrongdoing.
Raising the Bar

Raising the Bar looked at the needs of vulnerable victims and witnesses.

This Report makes 48 recommendations under six headings:

(i) Training: A comprehensive modular programme of training in handling vulnerable witnesses, victims and defendants should be put in place for all criminal and family practitioners, both new and experienced. It is suggested that it should be led by the Bar Council in partnership with the Inns of Court and Criminal Bar Association, with training programmes approved and moderated by the Advocacy Training Council.

(ii) Practitioners: A range of recommendations for practitioners, including the provision of ‘Toolkits’ for advocates setting out common problems and solutions, and recommendations on areas such as pre-trial visits, the use of leading questions, disclosure, agreed notes for the jury, PCMH6, etc.

(iii) The Judiciary: Suggestions for the consideration of the Judiciary include the possibility of the JSB developing generic directions regarding vulnerable witnesses, victims and defendant.

(iv) Trial Management: Recommendations on trial management, such as taking breaks every 45 minutes for child witnesses and giving more consideration to the needs of young offenders travelling long distances to court.

(v) Police: Recommendations include better and continuous training for the Police in handling ABE interviews, practical exercises and the early involvement of the CPS in ABE interviews.

(vi) Other Recommendations: Other recommendations include a possible requirement for similar compulsory training for solicitor advocates, wider dissemination of the HMCS ‘Going to Court’ DVD, and training for Witness Service volunteers. Further consideration should also be given to the provision of special advocates for vulnerable witnesses.
Safeguarding and the Law: Legal and Ethical Context

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
- 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.

The Social Care Institute for Excellence (SCIE) have a legal guide called Safeguarding and the Law, follow this link for more information.
Safeguarding Vulnerable Groups Act

Self-Neglect and Adult Safeguarding

The Care Act 2014 (the Act) identifies safeguarding as a legal duty of the Local Authority and requires the Local Authority to make enquiries, or cause others to do so, if it believes an adult is experiencing or at risk of, abuse or neglect.

These safeguarding duties apply to any adult who:
- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or at risk of, abuse or neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of abuse or the experience of abuse or neglect

Self-Neglect is identified by The Act as a new category of abuse. Self-neglect differs for other categories of abuse as the adult concerned is also self-perpetrating.

Self-neglect is defined as, “wide ranging covering:
- Neglecting to care for one’s personal hygiene
- Neglecting to care for one’s health
- Neglecting to care for one’s surroundings
- Hoarding

County Durham Safeguarding Adults Board (SAB) has recognised the need to provide a proportionate response to all safeguarding concerns and has agreed that in County Durham the multi-agency process previously known as “safeguarding” will now be called “adult protection”. The decision whether an adult protection referral is required in any particular situation will reflect the outcome of enquiries regarding the mental capacity, desired outcomes of the adult concerned and the level of risk identified.

Self-neglect concerns should only require an adult protection referral in exceptional circumstances, as there are other, more appropriate responses available to safeguard the adult concerned. E.g. Provision of a care and support package, multi-agency/multi-disciplinary planning meeting or CPA.

The following information and flow-chart overleaf describe the agreed response to concerns regarding self-neglect.

Social Care Direct will enter all self-neglect referrals onto SSID and record “self-neglect” as a stated issue. Social Care Direct will undertake telephone enquiries to determine the appropriate response to all concerns regarding self-neglect.

Social Care Direct will allocate the referral to the appropriate locality team when:
- A social work assessment is required
- A home visit is required to clarify the capacity and views of the adult concerned or where there is a need to determine an objective level of risk. E.g. Use of a hoarding clutter scale.

The 2014 Care Act has now brought Self-Neglect into the safeguarding framework. However, not all self-neglect concerns need to be treated as Adult Protection. The appropriate response will often be Care Management or Care Co-ordination to access an assessment or services. Self-neglect may also be a potential indicator of abuse by a perpetrator who is not the subject of the concern.

Useful documents:
- Self-neglect policy and practice: building an evidence base for adult social care
- Self-neglect policy and practice: key research messages
- Self-neglect policy and practice: research messages for managers
- Self-neglect policy and practice: research messages for practitioners
Sexual Offences Act

The Sexual Offences Act is an Act to make new provision about sexual offences, their prevention and the protection of children and vulnerable adults from harm from other sexual acts, and for connected purposes. [20th November 2003]
County Durham and Darlington Sexual Violence Strategy

The County Durham and Darlington Sexual Violence Strategy
Speaking Up for Justice

*Speaking up for Justice* - Report highlighted the treatment of vulnerable or intimidated witnesses in the criminal justice system and the need to obtain ‘best evidence’. This resulted in their eligibility for special support measures under Part 2 of the Youth and Justice and Criminal Evidence Act 1999 supported by the Home Office Action for Justice and Achieving Best Evidence guidance.
The Protection of Freedoms Act 2012

The act includes the following provisions:

- DNA retention - adopting the protections of the Scottish model for the retention of DNA and fingerprints
- fingerprinting of children in schools - introducing a requirement on schools and colleges to obtain the consent of parents before taking fingerprints (and other biometrics such as iris scanning) from children under the age of 18 years
- further regulation of closed circuit television/automatic number plate recognition systems – introducing a statutory code of practice and the appointment of a surveillance camera commissioner with responsibility for reviewing and reporting on the operation of the code
- the use of the Regulation of Investigatory Powers Act 2000 by local authorities
- stop and search powers
- pre-charge detention
- powers of entry – there are some 1,200 separate powers of entry contained in a mix of primary and secondary legislation. The act creates three order-making powers to; (1) enable a minister of the crown (or the Welsh ministers) to repeal unnecessary powers of entry and associated powers, (2) consolidate a group of existing powers, or (3) attach additional safeguards to the exercise of such powers, including in particular provision requiring prior authorisation by a magistrates’ court. Provisions are also made for a code of practice governing the exercise of powers of entry
- prohibiting wheel clamping – creating a new criminal offence to immobilise, move or prevent the movement of a vehicle without lawful authority. We are also changing the law so that parking providers and other landowners may seek to recover unpaid parking charges from the registered keeper of a vehicle
- reform of the vetting and barring scheme and criminal records regime – introducing legislative provisions to implement the outcome of the reviews of the vetting and barring scheme and the criminal records regime, so as to scale them back to common-sense levels
- disclosure of decriminalised convictions for consensual gay sex – changing the law so that historical convictions for consensual gay sex with over-16s no longer have to be disclosed
- freedom of information – extending the freedom of information regime to cover companies wholly owned by two or more public authorities
- right to data – creating an obligation on departments and other public authorities to proactively release datasets in a reusable format
- Office of the Information Commission – changes to the appointment and accountability arrangements to enhance the independence of the Information Commission
- human trafficking - give effect to the criminal law aspects of EU Directive of 5 April 2011 on preventing and combating trafficking in human beings and protecting its victims (Directive 2011/36/EU)
- serious fraud trials – repealing provisions removing the right to trial by jury
Think Local Act Personal

The Association of Directors of Adult Social Services, the Local Government Association and the Department of Health have produced a partnership agreement ‘Think Local, Act Personal’, which is a sector-wide statement of intent that makes the link between the government’s new vision for social care and Putting People First and provides the way forward for personalisation and community-based support.

It asserts that councils, health bodies and providers need to work more collaboratively to personalise and integrate service delivery across health and adult social care; and make vital public funding go further. It also recognises the contribution that individuals, families, carers and communities make in providing care and support - both to those who are publicly funded and those who either pay for themselves or rely on family carers.
The Localism Act 2011

The Localism Act was introduced to Parliament on 13 December 2010, and was given Royal Assent on 15 November 2011, becoming an Act.

This Act will shift power from central government back into the hands of individuals, communities and councils. We are committed to this because over time central government has become too big, too interfering, too controlling and too bureaucratic. The Government believe that this has undermined local democracy and individual responsibility, and stifled innovation and enterprise within public services.

Government want to see a radical shift in the balance of power and to decentralise power as far as possible. The Government believe that Localism isn't simply about giving power back to local government. This Government trusts people to take charge of their lives and we will push power downwards and outwards to the lowest possible level, including individuals, neighbourhoods, professionals and communities as well as local councils and other local institutions.

- for services which are used individually, this means putting power in the hands of individuals themselves
- where services are enjoyed collectively, they should be delivered by accountable community groups
- where the scale is too large or those using a service are too dispersed, they should be delivered by local institutions, subject to democratic checks and balances, enabled by full transparency

The Localism Act includes five key measures that underpin the Government’s approach to decentralisation.

- Community rights
- Neighbourhood planning
- Housing
- General power of competence
- Empowering cities and other local area
Youth Justice and Criminal Justice Act 1999 (S16 and 17) and Intimidated Witnesses

**Vulnerable Witnesses** are defined by Section 16 of the above Act as:

- All child witnesses
- Any witness whose quality of evidence is likely to be diminished because they;
  - Suffer from a mental disorder as defined by the Mental Health Act
  - Have a significant impairment of intelligence and social functioning (e.g. Learning Disability)
  - Have a physical disability or are suffering from a physical disorder - however this will not be all persons with a disability and the witness should be consulted with this regard

Intimidated Witnesses (S17 YJCEA 99): are defined by Section 17 of the Act as those whose quality of evidence is likely to be diminished by reason of fear or distress. In determining whether a witness falls into this category the court takes account of;

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

Also falling into this category are;

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

Registered Intermediaries (RIs) have been facilitating communication with vulnerable witnesses in the criminal justice system in England and Wales since 2004. A criminal investigation by the police takes priority over all other enquiries, although a multi-agency approach should be agreed to ensure that the interests and personal wishes of the adult will be considered throughout, even if they do not wish to provide any evidence or support a prosecution. The welfare of the adult and others, including children, is paramount and requires continued risk assessment to ensure the outcome is in their interests and enhances their wellbeing.

If the adult has the mental capacity to make informed decisions about their safety and they do not want any action to be taken, this does not preclude the sharing of information with relevant professional colleagues. This is to enable professionals to assess the risk of harm and to be confident that the adult is not being unduly influenced, coerced or intimidated and is aware of all the options. This will also enable professionals to check the safety and validity of decisions made. It is good practice to inform the adult that this action is being taken unless doing so would increase the risk of harm.
The Care Act 2014

This act has reformed the law relating to care and support for adults and the law relating to support for carers, to make provision about safeguarding adults from abuse or neglect, to make provision about care standards, to establish and make provision about Health Education England, to establish and make provision about the Health Research Authority, and for connected purposes.

Please follow this link to the Care Act
Duty of Candour

Duty of Candour Regulation 20 and Adult Protection
Health and Social Care Act (Regulated Activities) Regulations 2014:

From 1 April 2015, a new statutory Duty of Candour was placed on all organisations registered with Care Quality Commission (CQC).

The aim of this regulation is to ensure that providers are open and transparent with people who use services and other ‘relevant persons’ (people acting lawfully on their behalf) in relation to care and treatment.

The regulation sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body.

Background

The introduction of Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust which recommended that a statutory duty of candour be introduced for health and care providers. This is further to the contractual requirement for candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of a regulated activity. In interpreting the regulation on the duty of candour we use the definitions of openness, transparency and candour used by Robert Francis in his report: “Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, chaired by Robert Francis QC”

See presentation by NHS Litigation Authority


- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.
Duty of Candour (continued)

Legislation

Regulation 20 has been introduced under The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations. It defines what constitutes a notifiable safety incident for health service bodies and all other providers (such as primary medical and dental practices, adult services. This applies to providers when they are providing care and treatment to people who use services in the carrying on of a regulated activity only.

To meet the requirements of Regulation 20, a registered provider has to:

- Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the provider’s knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing, and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person.

This regulation will encourage a culture of openness and transparency within health and social care services, at all levels within organisations. In our provider guidance we also reference the NPSA Being Open Framework as key national guidance which outlines the action organisations can take to create a culture which supports staff to be open. The framework provides detailed guidance on communicating about incidents with patients, people who use services, their families and carers.

The Duty applies to a ‘notifiable safety incident’ which means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that:

- Appears to have resulted in:
  - The death of the service user, where the death relates directly to the incident rather than to the natural course of the service users illness or underlying condition.
  - An impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days.
  - Changes to the structure of the service user’s body.
  - The service user experiencing prolonged pain or prolonged psychological harm.
  - The shortening of the life expectancy of the service user.

- Requires treatment by a health care professional in order to prevent:
  - The death of the service user.
  - Any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in paragraph (a) above.

Interface with Adult Protection

There will be “notifiable safety incidents’ which also meet the threshold for adult protection will need to be investigated under the inter agency procedures. The Duty of Candour requirements do not replace Adult Protection procedures. Where an adult protection investigation is required, providers will need to work closely with the Lead Officer to avoid any confusion or duplication for the service user.
Background

The sharing of personal information between organisations is vital to ensure co-ordinated and seamless provision of services that are protective and supportive. Some forms of abuse are criminal offences, police investigations and therefore information must be shared. When things go badly wrong in the failure to safeguard an adult or vulnerable child or vulnerable parent or carer, inadequate sharing of information is often a significant factor. This policy is consistent with the principles set out in the Caldicott Review published 2013.

- Information will only be shared on a “need to know” basis when it is in the interests of the adult
- Confidentiality must not be confused with secrecy
- Informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement
- It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.
Sharing Information and Duty to Co-operate

The Care Act sets out a duty for the LA and partner organisations to co-operate under Section 6 and 7. This includes assessments for an adult’s care and support needs and safeguarding enquiries. It reinforces the need for agencies to work in partnership and share relevant information to assist the LA in the exercise of its functions.

Protocol for Collaborative Working and Information Sharing between Professionals to protect vulnerable adults and children establishes the need to share information to protect children and adults at risk of abuse. It has the agreement of all local partner agencies. When it is necessary to share information, in the first instance consideration should be given to obtaining informed consent from the individual in question. Being open and honest about why, what, how and with whom information will be shared will often encourage people to consent to the sharing of personal information. It is better if individuals understand why personal information needs to be shared. If this is not possible or inappropriate or other vulnerable adults are at risk, it should be borne in mind that a person’s right to confidentiality is not absolute and the Lead Officer will need to decide if the person’s lack of or refusal to consent can be overridden. On the one hand, it is about not excessively and unnecessarily interfering with people’s private lives and on the other it’s about protecting people even at the cost of confidentiality, e.g. in the interests of public safety, police investigation or implications for a regulated service.

Striking this balance reflects very much the proportionality approach required in safeguarding generally. Confidentiality must not be confused with secrecy. It is inappropriate for agencies (and practitioners) to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other vulnerable people may be at risk.

The Protocol contains a brief user friendly leaflet to assist with making decisions in this area.

This leaflet contains a guide on Information Sharing broken down into 8 golden rules.
8 Golden Rules

i) Remember that the Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately.

ii) If there are concerns that an adult may be at risk of serious harm or a child at risk of significant harm, then it is your duty to follow the relevant procedures without delay. Seek advice if you are not sure what to do at any stage and ensure that the outcome of the discussion is recorded.

iii) Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

iv) Seek advice if you are in any doubt, without disclosing the identity of the person where possible.

v) Share with consent where appropriate and, where possible, respect the wishes of those who do not consent to share confidential information. You should go ahead and share information without consent if, in your judgement, that lack of consent can be overridden in the public interest, or where an adult or child is at risk of serious or significant harm. You will need to base your judgement on the facts of the case.

vi) Consider safety and well-being: Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

vii) Necessary, proportionate, relevant, accurate, timely and secure: Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

viii) Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.
Information Disclosed

The information disclosed should be:

- clear regarding the nature of the problem and the purpose of sharing the information
- Based on fact not assumption
- Restricted to those who have a legitimate need to know
- Relevant to specific incident
- Strictly limited to the needs of the situation at the time
- Recorded in writing with reasons stated
Disclosing Personal Information

The Data protection Act governs the processing of personal information and in particular what it defines as ‘sensitive personal information’ such as information about a person’s racial or ethnic background, physical or mental health or condition, sexual life or information about their involvement in the criminal justice process. In some cases explicit consent from the individual whose record it is will be required. However, with safeguarding in mind, there are various justifications for sharing such information without that consent:

- To protect the vital interests of the data subject, where either he or she cannot give consent or it is not reasonable for the data controller to obtain it, or to protect the vital interests of someone else, where consent by or on behalf of the data subject has been unreasonably withheld
- The information is already made public by the individual
- For the purpose of legal proceedings, and administration for justice
- For exercising statutory functions.

If information is sought that is held in another person’s record a redacted version of the record may be produced that only contains personal information about the applicant.
Making and Recording Decisions

From a legal and good practice point of view, when a professional makes a decision to either override or respect a person’s confidentiality, they should provide clear reasoning as to how they came to the decision. It is important that a clear and comprehensive record of the rational used either not to share or to override consent should be made. This record will be important should the decision be challenged at some later date.
People Lacking Capacity

If a person lacks mental capacity to decide about their own personal information, the Mental Capacity Act 2005 Code of Practice states that certain other people may nevertheless be able to request access to that information. This would be somebody with a lasting power of attorney, an enduring power of attorney or who is a deputy appointed by the Court of Protection. In the absence of these arrangements, a capacity test and best interests decision is required.
Sharing Information without Consent

Practitioners should not seek consent when they are required by law to share information through a statutory duty or by a court order. Consent does not need to be sought if doing so would;

- Place a person (the individual, family member, staff or a third party) at increased risk of significant harm if a child, or serious harm if an adult
- Prejudice the prevention, detection or prosecution of a serious crime
- Lead to an unjustified delay in making enquiries about allegations of significant harm to a child, or serious harm to an adult
Information Sharing and Confidentiality

Public Interest Criteria for Sharing Information without Consent

Includes;

- When there is evidence or reasonable cause to believe that an adult is suffering, or is at risk of suffering, serious harm
- To prevent the adult from harming someone else
- The promotion of welfare of the adult
- Detecting crime
- Apprehending offenders
- Maintaining public safety
- Administration of justice

When considering whether disclosure is in the public interest, the rights and interests of the individual must be taken into account. A fair balance between the public interest and the rights of the individual must be ensured.
Individuals Seeking Information about Themselves

Adults at Risk or alleged perpetrators of harm may wish to see information held about them by organisations such as local authorities and the NHS. The request has to be made under the ‘subject access’ provisions of the Data Protection Act 1998. (See Children and Adults Services procedure for Access to Person Information for Service Users).
Accessing Personal Information about Someone Else

In the context of safeguarding, a person might be seeking information about somebody else. This could be a concerned family member, a friend, alleged perpetrator or even the person about whom safeguarding concerns have arisen. The request could be about details and names of staff involved in an incident, care plans, reports of investigations, minutes of meetings and so on. The information sought might be of an impersonal nature about, for instance, an agency’s safeguarding procedures. Either way, the request comes under the Freedom of Information Act 2000, which applies to public bodies subject to a number of exemptions such as information that may be used in legal proceedings or investigations, Health and Safety or information that is or will be in the public domain. Some of the exemptions are absolute and some need to be qualified balancing public interest against the refusal to disclose.

Written requests for information under the FOI Act must be dealt with within 20 working days. Requests must be in writing, must contain a name and address and must describe the information you want in enough detail to identify it. For more information about Freedom of information visit the County Council web site at:-

http://www.durham.gov.uk/foi where an online application form can be obtained, or send your request in writing to:

Freedom of Information/Officer
Assistant Chief Executives Office,
Durham County Council,
Room 4/140, County Hall,
Durham DH1 5UF
Seeking Information about People who are Deceased

Sometimes requests are made in relation to deceased persons. For example, a family may suspect a safeguarding issue preceded or led to a relative’s death. Such a request would come under the Freedom of Information Act 2000 or sometimes under the Access to Health Records Act 1990 (this gives a right of access to information by a dead patient’s representative or any person who might have a claim arising out of the patient’s death). Matters may not be straightforward under the 2000 Act, because the duty of confidence to a person (for example, the victim) survives death. That is, there could be a legally actionable breach of confidence (for example, by a relative or personal representative), even after the person has died. Legal advice should be sought.
Allegations of Abuse on Employees Personnel File

Children and Adult Services 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.
Human Resources and Information Sharing

Where disciplinary action is being taken against a staff member the employing organisation should seek guidance from the Safeguarding Adult Lead Officer regarding the timely sharing of information and the content of information to be shared. The chair may produce a report covering the specific details relating to the employee and would not share information relating to the victim.

If information that is personal to the victim / service user needs to be shared then the Safeguarding Adult Lead Officer should seek consent. In most cases the wishes of the victim / service user should be met, however, there are exemptions in the various provisions of the Data Protection Act. The most important of these within Safeguarding relate to national security, the prevention of crime, disclosures required by law and certain statutory provisions relating to health, education and social work. A well documented rationale should be provided where consent from the victim / services user has not been given and information is shared. If a victim is deceased an appropriate representative should be contacted for consent to share information. Representatives could be the Personal Representative (under probate), appointee or advocate previously involved with the individual. If no suitable representative is available a Best Interests Decision should be made under the Mental Capacity Act 2005.
Collaborative Working and Information Sharing Between Professionals to Protect Vulnerable Adults and Children

**Collaborative Working** is a multi-agency protocol in Durham which 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
- 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

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. When young people are subjects of child protection arrangements or other forms of support within Children’s Services because they are identified as being at risk of harm and the practitioner has reasonable suspicion that there is risk to a child or young person, it is essential that they share the relevant information about the risk with relevant persons.

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.
Safeguarding and Consent

If you are concerned that someone has;

- Needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing or at risk of abuse or neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

You should make a referral to Social Care Direct on 03000 267979. It is always best to get consent from the person concerned. However, even if the person does not consent, you should still pass on your concerns. It is the Lead Officers responsibility to consider the different legal frameworks and what action is to be taken.

For further information see Public Interest Criteria for Sharing Information without Consent within the Information Sharing Section.

There is further information on 'Assessing Capacity in Safeguarding - Whose responsibility?' within the Roles and Responsibilities section and also within this section the police role in relation to capacity assessment.

Lack of consent is not a barrier to making enquiries but a clear rationale will be required. The adult protection referral must still be followed up, even if a person has capacity and does not consent as long as it can be justified on the basis of the "public interest" criteria. You should always try to explain your reasons for referral to the potential victim. Use the 8 Golden Rules.
Mental Capacity Act 2005

The Mental Capacity Act 2005 came fully into force on 1 October 2007. It affects anyone who is unable at any particular time to make some or all decisions because of a temporary or permanent impairment in the function of their mind or brain.

It provides a way to assess whether or not individuals are able to make specific decisions for themselves. It also gives adults the right to make decisions about how decisions should be made if they lose capacity in the future. Further information on the Mental Capacity Act 2005 can be found via this website link.
Mental Capacity Act - Codes of Practice

The Mental Capacity Act Codes of Practice provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. The Act received Royal Assent on 7 April 2005 and will come into force during 2007. The legal framework provided by the Mental Capacity Act 2005 is supported by this Code of Practice (the Code), which provides guidance and information about how the Act works in practice.
5 Statutory principles of the Mental Capacity Act

1. There is a presumption of capacity
2. Must take all practicable steps to help a person make a decision
3. A person may make an unwise decision but still have capacity
4. Anything done must be in that person’s best interests
5. Must take the least restrictive option for that person’s rights and freedoms
Deciding if a person lacks capacity

If you are concerned about someone’s health or wellbeing, you may need to know if they are capable of making their own decisions. Some people might need someone else to make decisions for them. Every day people make decisions about lots of things in their lives from what to wear or what to eat to making decisions about medical treatment or financial matters. The ability to make specific decisions is called mental capacity.

Some people have difficulties making some decisions either all or some of the time. This could be because of a temporary condition such as infection, illness, accident or the influence of alcohol or drugs, or they may have a learning disability, dementia, a mental health problem, or it could be the result of a head injury or stroke. The Mental Capacity Act 2005 sets out the legal rights for supporting vulnerable people who are not able to make their own decisions. It makes clear who can take decisions, in which situations, and how they should go about this. It also enables people to plan ahead when they may lose capacity.

An assessment of a person’s Mental Capacity should be made at the time a particular decision needs to be made, usually by the person who needs the decision to be made. All assessment start with the assumption that a person has the capacity to make the decision in question. An assessment should never be based simply on their age, appearance, condition, behaviour or any other superficial judgement. You need to check whether you are choosing the best time to assess a person’s capacity and must provide every opportunity to have the person understand the decision being made to the very best of their ability. This may mean doing the test at a more appropriate date or time of day. You need to consider whether you or someone else could work with the person to get them to understand the decision to be made better and make the decision when this work is complete, managing risk in the meanwhile. When assessing a person’s capacity you have to consider:

• Does the person understand the decision that they need to make and why they need to make it?
• Does the person understand what might happen if they do or do not make this decision? In other words can the person understand and weigh up the information relevant to the decision?
• Can the person communicate their decision (Talking, sign language, pictorial images or other means such as assistance from a Speech and Language Therapist)?
• Is there a need for a more thorough assessment by a specialist such as the GP, consultant, psychiatrist, psychologist?

Is the question that you are considering too large and can it be broken into smaller components to make easier decisions for the person concerned? You must not treat the person as unable to make a decision just because they make decisions you don’t agree with. 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 and a Best Interests Decision made. The Mental Capacity Act - Codes of practice gives further guidance and information.
Best Interests Decision

An essential foundation of the Act is to ensure that any decision made, or action taken on behalf of someone who lacks capacity to make the decision or act for themselves is made in their best interests and not on the basis of any unjustified or prejudicial assumption.

The Act requires that any Best Interest Decision or act must be the least restrictive option to the person in terms of their rights and freedom of actions.

The Act recognises the right of the capacitated individual to make what may be considered to others, an unwise decision.

The decision maker needs to consult with all other professionals and anyone else involved with the person in order to make a Best Interests Decision. Where the decision maker needs to balance a range of views simultaneously or there are several interrelated decisions to be made, a meeting may be the most appropriate forum.

It is recognised however, that consultation in an emergency situation may not always be possible.

The views of all parties consulted, including the person deemed as lacking capacity to make the particular decision, need to be considered and recorded as part of the Best Interest decision making process.
Independent Mental Capacity Advocate (IMCA)

The Independent Mental Capacity Advocate (IMCA) provides independent safeguards for those people who lack the capacity to make specific decisions at the time that the decision is to be made, they have no one other than paid staff to support or represent them and no one to consult with about their needs. The IMCA establishes and represents independently the best interests of the person concerned. The Making decisions: Independent Mental Capacity Advocate Service booklet accessed via this link provides further information about the service. In some circumstances the Local Authority has a duty to refer to the IMCA service. A referral to the IMCA would be undertaken in the following circumstances:

- The Local Authority or the NHS propose to take or have taken protective measures in relation to a person who lacks capacity to agree to those measures.
- The protective measures have been taken after receipt of an allegation or evidence that the person lacking capacity is being or has been abused or neglected by another OR is / has abused another person.

In safeguarding cases only the person does not have to be unrepresented to qualify for an IMCA.

A referral under this power should only be made where there has been a recommendation by the Safeguarding manager that the circumstances of the case are such that a referral would be of particular benefit to the person and where there is no other advocate involved. The Social Care Institute for Excellence in conjunction with Adult Directors of Social Services have developed practice guidance for those who undertake safeguarding work and may need to employ an Independent Mental Capacity Advocate. The Practice guidance is called: Practice Guidance on the involvement of Independent Mental Capacity Advocates in Safeguarding Adults and can be accessed via this link.

Within County Durham we use Skills for People as our IMCA service:
- Skills for People
- Key House
- Tankerville Place
- Jesmond
- Newcastle Upon Tyne
- NE2 3AT
- 0191 281 8737
- Or you can email: information@skillsforpeople.org.uk

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Risk and 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 Children and Adult Services ‘Guidance on Risk Management’ document. The guidance is to be read in conjunction with the ‘Risk Procedure’.
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 an adult protection 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 to best protect the individual concerned.

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, a Children and Adult Services Manager, taking into consideration all of the information available at that time, has to decide whether to proceed to an adult protection 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. Seek further advice from the Police and the Council’s Solicitor as appropriate.

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 record. Risk management plans for adults at risk must be documented using the required format for your service. Disagreements 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 overarch ing 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, on-going discussion, interim meetings and the results of any re-assessment or planning need to be properly documented. In all aspects of risk and risk management consideration should be given to the capacity of the individual concerned and Capacity Assessments directed by the Lead Officer.
Risk Enablement Panel

For some cases a referral may need to be made to the Risk Enablement Panel. Cases can be referred to the risk enablement panel if the person concerned is in receipt of services or would meet eligibility criteria regarding eligibility for service provision.

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.
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 Children and Adult Services 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.
Acting on the Risk Assessment

The results of the assessment will need to be recorded and kept with the safeguarding record, 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 Children and Adult services to ensure the best interests of service users are kept central to any planned outcomes.

See decommissioning process.
In the Event of Multiple or Organisational Abuse

Where an Adult Protection 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.

For further information see Executive Strategies within the Responding to Abuse section
In the Event of a Death

In the event of the death of an adult where adult protection concerns already exist or are raised around the time of death, the decision making Children and Adult Services 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, may need to be convened.

If a person is subject to a Deprivation of Liberty Safeguards Authorisation then the managing authority i.e. the care home manager, hospital ward manager, should inform the coroner of the death.

Following an investigation reviews may take place such as a Domestic Homicide Reviews or a Safeguarding Adult Review. For more information on Safeguarding Adult Review section.
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)

- 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

- 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
Adult Protection Assessment, Care-Planning and Review

The adult protection 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 adult protection assessment process must be completed within a maximum of four weeks from referral.

Based on the outcome of the Adult Protection assessment, the Assessing Officer will work with the adult to draw-up an adult protection 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 an adult protection 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 Children and Adult Services 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
- 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 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 adult protection 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.
Domestic Abuse

Domestic abuse occurs across society regardless of any factors such as age, gender, sexuality, wealth, ethnicity or geography. It is abuse often perpetrated by men against women, can be perpetrated by women against men, or those in same sex relationships. It may be a serious crime. For further information about Domestic Abuse Services and definitions within County Durham you can use the link.

In County Durham the Partnership has adopted the definition suggested by Government following the national consultation which took place during 2012. This being:

“any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional”

This definition also includes so called ‘honour’ based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to any one gender or ethnic group. The Safe Durham Partnership recognises that domestic abuse can be experienced by anyone irrespective of sexuality or gender. This can be in straight (heterosexual), same sex (lesbian or gay) and bisexual relationships equally. The gender of the victim and perpetrator will affect and influence the behaviour involved in the abuse. Both men and women including those of the trans communities can and do experience domestic abuse.

Although domestic abuse affecting those aged under 18 is also a child safeguarding issue the Safe Durham Partnership will support the County Durham Children and Families Board in tackling these issues.

The Serious Crime Act 2015

- Protection of Children and Others and Law on Domestic Abuse- controlling or coercive behaviour in an intimate or family relationship
- Offences including ill treatment and wilful neglect: care worker offence
Disability can be a factor which increases the victim’s vulnerability to abuse.

Where a person is suffering from Domestic Abuse and appears to meet the eligibility threshold, Adult Protection investigation must be considered. Lead Officer should consult with Domestic Abuse Services and invite relevant representatives to the strategy meeting. The police should be consulted regarding the potential for Domestic abuse. The potential victim of abuse may be concerned for their safety and reluctant to report abuse or consent to legal process. The police have a number of options in law that they can consider to support the victim. Often the victim is afraid of losing their home. The law now supports them maintaining their home and removing the perpetrator of abuse.

The Lead Officer / concerned person should on initial risk assessment consider the use of the Multi Agency Risk Assessment tool in assessing the extent of the abuse and potential referral to the Multi Agency Risk Assessment Conference. Durham MARAC criteria and forms can be found via the links.

'Honour-based violence (HBV) is a crime or incident which has or may have been committed to protect or defend the honour of the family and/or the community.'

Forced Marriage is not an arranged marriage but a marriage where one or both parties are forced to marry against their wishes.

If you have any concerns regarding potential forced marriage or honour based violence you should follow your organisations policies and procedures. For guidance and advice you can contact the Choice Helpline on: 0800 5999 365

For professionals working with lesbians, gay men, bisexuals or transgender people suffering domestic abuse information can be found on the Victim Support - North East website.
Forced Marriage

There is a clear distinction between a forced marriage and an arranged marriage. In arranged marriages, the families of both spouses take a leading role in arranging the marriage but the choice whether or not to accept the arrangement remains with the prospective spouses. In forced marriage, one or both spouses do not (or, in the case of some vulnerable adults, cannot) consent to the marriage and duress is involved. Duress can include physical, psychological, financial, sexual and emotional pressure.

Parents who force their children/young person to marry often justify their behaviour as protecting their children, building stronger families and preserving cultural or religious traditions. They often do not see anything wrong in their actions. Forced marriage cannot be justified on religious grounds; every major faith condemns it and freely given consent is a prerequisite of all religions. Often parents believe that they are upholding the cultural traditions of their home country, when in fact practices and values there may have changed. Some parents come under significant pressure from their extended families to get their children married. In some instances, an agreement may have been made about marriage when a child is in their infancy. Many young people live their entire childhoods with the expectation that they will marry someone their parents select—some may be unaware that they have a fundamental human right to choose their spouse. Some of the key motives that have been identified are:

- Controlling unwanted sexuality (including perceived promiscuity, or being lesbian, gay, bisexual or transgender) - particularly the behaviour and sexuality of women
- Controlling unwanted behaviour, for example, alcohol and drug use, wearing make-up or behaving in a “westernised manner”
- Preventing “unsuitable” relationships, e.g. outside the ethnic, cultural, religious or caste group
- Protecting “family honour”
- Responding to peer group or family pressure
- Attempting to strengthen family links
- Achieving financial gain
- Ensuring land, property and wealth remain within the family
- Protecting perceived cultural ideals
- Protecting perceived religious ideals which are misguided
- Ensuring care for a child or vulnerable adult with special needs when parents or existing carers are unable to fulfil that role
- Assisting claims for UK residence and citizenship
- Long-standing family commitments.

While it is important to have an understanding of the motives that drive parents to force their children to marry, these motives should not be accepted as justification for denying them the right to choose a marriage partner and enter freely into marriage. The Area Command Vulnerability Detective Inspector, and/or the Senior Investigating Officer in cases of major crime for Durham Constabulary, will assume responsibility for the co-ordination and management of victim and witness care issues in respect of investigations into HBV/FM related criminality. Partner agencies need identify a named person whose responsibility it is to ensure that cases of forced marriage and honour based violence are handled, monitored and recorded properly.

Please contact:
Choice Helpline on: 0800 5999 365
Durham Police on 101, Textphone 18001 101
In an emergency 999
Call in to a local police station
Crimestoppers on 0800 555 111. All calls are free and confidential.
Online via True Vision website www.report-it.org.uk
Honour Based Crime

The term “honour crime” or “honour-based violence” embraces a variety of crimes of violence (mainly but not exclusively against women), including assault, imprisonment and murder where their family or their community is punishing the person.

They are being punished for actually, or allegedly, undermining what the family or community believes to be the correct code of behaviour. In transgressing this correct code of behaviour, the person shows that they have not been properly controlled to conform by their family and this is to the “shame” or “dishonour” of the family.

Welchman and Hossain state “The term crimes of honour encompasses a variety of manifestations of violence against women; including murder termed “honour killings”, assault, confinement or imprisonment and interference with choice in marriage where the publicly articulated justification is attributed to a social order claimed to require the preservation of a concept of honour vested in male family and or conjugal control over women and specifically women’s sexual conduct – actual, suspected or potential.”

Please contact:
- Choice Helpline on: 0800 5999 365
- Durham Police on 101, Textphone 18001 101
- In an emergency 999
- Call in to a local police station
- Crimestoppers on 0800 555 111. All calls are free and confidential.
- Online via True Vision website [www.report-it.org.uk](http://www.report-it.org.uk)
Genital Mutilation

Female Genital Mutilation (FGM), previously known as ‘Female Circumcision’, is a collective term for procedures which include the partial or total removal of the external female genitalia, for cultural or other non-therapeutic reasons. The age at which FGM is carried out varies, but is commonly between 4 and 10 years. The procedure can cause severe pain and shock and a number of girls die as a direct result of the procedure through blood loss or infection. Damage to the external reproductive system can cause severe long term health consequences such as uterine, vaginal and pelvic infections, difficulties in menstruation and urination, sexual dysfunction, infertility and complications in pregnancy and childbirth. Girls who have undergone the procedure may also suffer from mental health or psychological problems.

FGM is a criminal offence in the UK. Under the Female Genital Mutilation Act 2003 it is also illegal for a UK national or permanent resident to carry out FGM abroad, or to aid, abet or procure the carrying out of FGM abroad, even in countries where the practice is legal. Local authorities can exercise their powers under section 47 of the Children Act 1989 if there is reason to believe that a child is likely to suffer or has suffered FGM.

Please contact:
- Choice Helpline on: 0800 5999 365
- Durham Police on 101, Textphone 18001 101
- In an emergency 999
- Call in to a local police station
- Crimestoppers on 0800 555 111. All calls are free and confidential.
- Online via True Vision website www.report-it.org.uk
Hate Crime

A hate crime is a criminal offence which is perceived, by the victim or any other person, to be motivated by a hostility or prejudice based on a person’s disability or perceived disability, race or perceived race, religion or perceived religion, sexual orientation or perceived orientation; who is transgender or perceived to be transgender.

You might have been a victim of hate crime if you think that you have been targeted based on prejudice or discrimination because of your actual or perceived:

- race, ethnic origin, or nationality
- religion
- sexual orientation
- disability
- gender identity.

Hate crimes and incidents can often be misinterpreted as acts of anti-social behaviour. However it is important to consider the definitions above to establish whether the act was motivated by a hostility or prejudice based on a person’s actual or perceived race, religion, sexual orientation, disability or transgender.

To report a hate crime or hate incident contact:

Please contact:
- Choice Helpline on: 0800 5999 365
- Durham Police on 101, Textphone 18001 101
- In an emergency 999
- Call in to a local police station
- Crimestoppers on 0800 555 111. All calls are free and confidential.
- Online via True Vision website www.report-it.org.uk
Links with Safeguarding Children

The adult at risk may live in the same house, as part of the family unit, or have significant contact with a child or children. The adult may have parental responsibility, a legal order, extended family relationship or social network. If this is the case then a structured collaborative working arrangement via multi agency meetings will be necessary. Durham County Council staff will need to follow Collaborative Working (replaces The Protocol for Working Together in the Delivery of Services to Adults and Children) as this clearly sets out that the welfare of the child is paramount, even when this conflicts with the interests of the parent or the carer. The safeguarding of vulnerable members of the community is a collective responsibility and all practitioners have a duty of care and responsibility to identify those who may be at risk and act appropriately. The management of risk including that involving the risk to both individuals (be they adults or children) and the risk to the wider community is a shared responsibility. As such all organisations and those employed by them have a professional duty to participate in the identification, assessment and management of risk.
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;

1. 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’

2. 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’

3. The 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

4. 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.’
The Responsibilities of Workers Providing Services to Adults

A worker providing services to an adult must make a referral to Children’s 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.
Think Family

Intensive, whole family approaches, working across Adult, Children’s and Health Services to provide joined up, coherent support to the whole family have been piloted. They are designed to provide seamless support to families. Consideration must be given to the complex situation of the whole family and the safety of individuals within the family.

The Think Family strategy sets out how the partners of County Durham will work together to meet the needs of the most vulnerable, challenged and challenging families in the County. By working together, partners will create a coherent system of support to the whole family, with benefits across the strategic agenda.

Within Safeguarding we are keen to ensure that no family member is left in an unsafe situation. We are looking to deliver training and guidance to staff across Children and Adult Services regarding approaches to the whole family. If you suspect a child or an adult who is or may be eligible for community care services to be at risk please contact 03000 267979
Serious Incident Procedures

A serious incident in the context of this procedure refers to an incident, episode or series of incidents which:

- had a major adverse effect on a service user or carer, or resulted in serious harm to him/her (sometimes referred to as a high impact event) or
- involved a substantial risk of such adverse effect or harm (sometimes referred to as a high risk or near miss event) which in either case
- involved to a significant extent (fulfilling social services responsibilities), typically where an assessment had been carried out, services were provided or commissioned, and where staff actions or omissions may have been linked to the incident.

Examples could be instances of unexpected death or serious injury or harm, and where service users were found to have been at serious risk of such occurrences.

The Senior Manager will make the decision to:

- Implement Serious Incident Procedure
- Inform Safeguarding and Practice Development Manager
- Identify scope/terms of reference of the investigation
- Assign a Lead Officer to conduct investigation
- Convene a debriefing meeting
- Ensure recommendations are implemented and lessons learned where necessary
- Ensure Progress/Evidence of the completion of recommendations is provided to monitor the outcomes of the Serious Incident Review

The Lead Officer will:

- Make necessary arrangements to obtain written records relevant to the case
- Analyse and summarise the written information Interview staff/partner agencies
- Identify chronology of events and root causes Complete report for ACMT
- Oversee the progress and monitoring of actions

The Serious Incident Review Procedure can be found on the Durham County Council intranet along with appropriate forms for completion.
Safeguarding Adult Review

Introduction

Under the Care Act 2014, the County Durham Safeguarding Adults Board (SAB) has a duty to undertake a Safeguarding Adult Review (SAR) when an adult in County Durham dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

A SAR must also be undertaken when an adult in County Durham has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In the context of a SAR, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

The adult who is the subject of any SAR does not have to be in receipt of care and support services for the SAB to arrange a review in relation to them.

The Purpose of SAR

The purpose of carrying out a SAR (previously known as a Serious Case Review) is not to hold any individual or organisation to account. Other processes exist for that including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council. However if during the course of the review, serious issues relating to an agency or individual involved in the case may come to light, action may be needed by the relevant agency.

The purpose of the SAR is to:

- Understand what has happened and why
- Learn lessons from the way professionals and agencies worked together
- Identify what the agencies and individuals might have done differently that could have prevented harm or death.
- Prevent similar harm occurring again in the future
- Improve future practice by acting on the learning.
- Review and improve the Safeguarding Adults Procedures.
- Identify good practice as well as poor

View Safeguarding Adults Review Procedure
Safeguarding Adult Review (SAR) (Continued)

1) At the conclusion of an internal agency investigation involving adult protection concerns, 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 Safeguarding and Practice Development Manager (SPOC) who would refer the case to the Independent Chair and Safeguarding Adults Review Panel.

3) The Safeguarding Adults Review Panel (made up of SAB representatives) will review the evidence. The SAB chair will make the final decision if the case meets the criteria for SAR.

4) If it is agreed the case will be subject to SAR the case would be entered on the Safeguarding Adults Review Register by the Safeguarding Adults Manager within 5 working days of receipt of the notification. A SAR lead will be appointed.

5) The SAR Lead will draw up terms of reference within 4 weeks,

6) The SAR Lead 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 within 6 months. See SAR Procedure for Timescales Appendix 7

7) Following agreement by the Board partner agencies would disseminate and implement the action plan.

8) Agencies would report on progress in respect of implementation of the action plan on a six monthly basis to the Serious Incident Sub Group.

9) The Safeguarding Adults Development Officer will monitor and report on progress to the Board until the action plan is discharged by the Board.

Some examples of serious case reviews that have shaped the Safeguarding Adult Process:

The Stephen Hoskin Serious Case Review describes the need for multi agency working and low level reporting

The Winterbourne View Serious Case Review was an example of Institutional Abuse on a grand scale.

The Serious case Review for Gemma Hayter looked at the need to identify 'Mate Crime' and ant social behaviour.

The Fiona Pilkington Serious Case Review looked at the need to identify Hate Crime and the holistic needs of a family rather than the individuals within.
Sexual Exploitation - Adult at Risk

**Sexual Exploitation**

Those wishing to exploit people sexually, target people who are vulnerable, perhaps as a result of a disability, mental health problem, learning disability or as a result of disengagement from home, education and work. Many people who are exploited may be abusing drugs and may have a history of being missing from home. Many may have been brought up in care.

The person may have been groomed for many years and might believe the person exploiting them to be their partner. It is common for victims not to recognise that they are being abused. Commonly, but not always, those exploiting the more vulnerable, are people who are older. It may be difficult for a person to believe that they are being exploited and a multi agency response is required to assess the risks and identify support. Safeguarding procedures may be a useful starting point to consider.
Prostitution and Adults at Risk

Prostitution

Prostitution of adults 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 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 or adult protection 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.
Self-Harm and Self-Neglect (including hoarders)

Self-harm and self-neglect are serious issues that a person will require support with, often requiring the support of a multi-disciplinary meeting to address safeguarding concerns. In some instances self-harm and self-neglect may be an indicator of abuse and a person may, in discussion, talk to you about issues of abuse.

Adult protection procedures must be considered for complex cases where there is a potential for serious harm or fatality due to self harm and self-neglects. Cases where there is a potential for serious harm or fatality can include an increase in self harming behaviours; harm to others, suicidal ideation e.g. detailed planning of suicide or unsuccessful suicide attempts.

Legislation within Children’s Services allows social workers to apply child protection procedures to ensure the safety of the child. However, for Children and Adult services, the relevant legislation to apply to these situations is the Mental Capacity Act 2005.

All managers and staff dealing with cases of self-neglect are asked to consider the following;

Adult service users with mental capacity have the right to decline assessment/services, and to make what may be viewed as unwise decisions. We should record whether or not the person has the mental capacity to make this decision.

- if a person is assumed to have capacity, there should be recorded evidence to support this assumption (e.g. “during the course of my discussion with Mrs X I observed her ability to understand, retain and weigh up the information and I had no doubts about her ability to make an informed choice”)
- where an assumption of mental capacity cannot be made, a mental capacity test should be recorded for each relevant decision to be made using the current Mental Capacity Test toolkit
- where it is not possible to carry out a formal Mental Capacity Test (e.g. because the service user has refused to engage with AWH), an assumption of capacity or otherwise should be made based on information from other professionals/case history. This should also be recorded accurately.

Please see Hoarder Guidance and Self Neglect and Hoarding Threshold Tool
Self-Harm, Self-Neglect including Hoarding (Continued)

Good practice is to view full case histories and that of close family members/other service users within the household to ensure a full picture of the service user and the domestic situation. Any children residing within the household should be considered for potential neglect and referral routes appropriate to the situation utilised.

It is also good practice to see the service user/family in their home environment in order to make an assessment of any associated risks.

Reviews should be face-to-face and every effort should be made to see the service user at each home visit. It is good practice to try to spend some time one-to-one with the service user to allow them opportunity to express their own views without any influence.

Case conferences and multi-disciplinary meetings are necessary to promote good practice in any case where risk issues are on-going and it is expected that these are organised in a timely manner. Case conference / MDT meetings are a means of sharing concerns with other involved parties – even if the outcome is ‘no further action’. MDT meetings should be held regularly in complex cases where there is a potential for serious harm or fatality.

- The identification of the need for an MDT meeting can be raised by the Care Co-Ordinator / Social Worker or by provider staff. Provider staff should raise the need for an MDT meeting through their line management if needed.

- MDT meetings should be chaired by staff at a senior practitioner level and above e.g. Principal Social Worker; Assistant Manager; Team Manager. Accurate recording of the case conference/ MDT meeting and outcomes is imperative to evidence justifiable decision-making.

- Although confidentiality procedures would normally discourage practitioners from sharing information without the explicit permission of the service user, staff MUST share information even when the service user has not consented if they have concerns that they may be at risk of significant harm.

- If a case is to be closed due to a service user continually declining our involvement, the record must show that we made reasonable efforts to engage the service user; that we have provided the service user with information (in a format which is appropriate to their communication needs) about how to contact us should they feel they need support in the future; that the decision to close a case has been fully discussed between case worker and manager; and that the justification for closing the case has been clearly recorded.
Glossary of Terms

**Abuse** includes physical, domestic, sexual, psychological, financial, material, modern slavery, discriminatory, organisational, neglect, acts of omission, self-neglect.

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

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

**Adult Protection Procedures**—formal inter agency intervention for adults with care and support needs (because of a mental or physical illness or impairment) who are at risk of abuse or neglect and are unable to protect themselves from harm.

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

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

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

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

**CAADA** (Co-ordinated Action Against Domestic Abuse) is a national charity supporting a strong multi-agency response to domestic violence.

The **CAAADADASH** (Domestic Abuse, Stalking and Harassment and Honour-based violence) risk identification checklist (RIC) was developed by CAADA and the Association of Chief Police Officers (ACPO).

**Capacity** is the ability to make an issue specific decision about a particular matter, at the time the decision needs to be made.

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

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

**Case conference** is a multi-agency meeting held to discuss the outcome of the investigation and to put in place a protection or safety plan. Used by children’s safeguarding services within County Durham.

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

Glossary of Terms (Continued 1)

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

**CMHTs** (community mental health teams) are made up of a team of professionals and support staff who provide specialist mental health services to people within their community.

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

**CPA** (Care Programme Approach) was introduced in England in the joint Health and Social Services Circular HC (90)23/LASSL (90)11, ‘The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services’, published by the Department of Health in 1990. This requires health authorities, in collaboration with social services departments, to put in place specified arrangements for the care and treatment of people with mental ill health in the community.

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

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

**DASH** (Domestic Abuse, Stalking and Harassment and ‘Honour’-based violence) risk identification checklist (RIC) is a tool used to help front-line practitioners identify high-risk cases of domestic abuse, stalking and ‘honour’-based violence.

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

**EDO** (emergency duty officer) is the social worker on duty in the emergency duty team (EDT).

**EDT** (emergency duty teams) are social services teams that respond to out-of-hours referrals where intervention from the council is required to protect a vulnerable child or adult, and where it would not be safe, appropriate or lawful to delay that intervention to the next working day.

**Eligibility Threshold** is a national system used for deciding whether people with social care needs meet the eligibility criteria and how much help they need to promote their wellbeing. It applies to all the local authorities in England. Its aim is to help social care workers make fair and consistent decisions about the level of support needed, and whether the local council should pay for this.

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

**IDVAs** (independent domestic violence advisers) are trained support workers who provide assistance and advice to victims of domestic violence.

**IMCAs** (independent mental capacity advocates) were established by the Mental Capacity Act 2005. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions, including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.
Intermediary is someone appointed by the courts to help a vulnerable witness give their evidence either in a police interview or in court.

Investigation is a process to gather evidence to determine whether abuse took place. This is co-ordinated by the Safeguarding Lead Officer.

Investigating officer is the member of staff of any organisation who investigates the allegation of abuse. This is often a professional or manager in the organisation who has a duty to investigate and may be in conjunction with the police.

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

Lead Officer is primarily a manager within Adults, Wellbeing and Health who co-ordinates the Safeguarding Adult strategy meeting, investigation, review, debriefing process and lessons learned from safeguarding.

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

Line manager is the person within an organisation to whom the alertor is expected to report their concerns. They may also be the Designated Officer within an organisation. It is the line manager who will in most cases make the referral and take part in the Safeguarding Adults process.

MAPPA (Multi-agency Public Protection Arrangements) are statutory arrangements for managing sexual and violent offenders.

MARAC (Multi-agency Risk Assessment Conference) is the multi-agency forum of organisations that manage high-risk cases of domestic abuse, stalking and ‘honour’-based violence.

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

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

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

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

PALS (Patient Advice and Liaison Service) is an NHS body created to provide advice and support to NHS patients and their relatives and carers. Person causing the harm is the person or adult who is alleged to have caused the abuse or harm.

Public interest – a decision about what is in the public interest needs to be made by balancing the rights of the individual to privacy with the rights of others to protection.

QIPP (quality, innovation, productivity and prevention) is a Department of Health initiative to help NHS organisations to deliver sustainable services in better, more cost-efficient ways.
Glossary of Terms (Continued 3)

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

Red Sigma – Police computer operating system within County Durham that provides real-time access to intelligence. It allows officers to check incidents, crimes and intelligence simultaneously.

Referral – an alert becomes a referral when it is passed on to a Safeguarding Adults referral point (Social Care Direct 03000 267979) and accepted as a Safeguarding Adults referral.

RIC (risk identification checklist), please see DASH above. Safeguarding Adults is used to describe all work to help adults at risk stay safe from significant harm. It replaces the term ‘adult protection’.

Safeguarding Adults Manager / Co-ordinator – this is the typical title of the manager in a local authority who supports the work of the Safeguarding Adults Partnership Board (SAPB) and advises on Safeguarding Adults cases in the borough. The role varies from borough to borough, and may have a different title.

SAB (Safeguarding Adults Board) represents various organisations in a local borough who are involved in safeguarding adults.

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

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

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

SOCA (Serious Organised Crime Agency) is a non-departmental public body of the government and law enforcement agency with a remit to tackle serious organised crime.
Strategy discussion is a multi-agency discussion between relevant organisations involved with the adult at risk to agree how to proceed with the referral. It can be face to face, by telephone or by email.

Strategy meeting is a multi-agency meeting with the relevant individuals involved, and with the adult at risk where appropriate, to agree how to proceed with the referral.

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

Wilful neglect is an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for him/herself.
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