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The following document has been developed by the four local safeguarding adults boards (4LSAB) covering Hampshire and the Isle of Wight to meet the requirements of *No Secrets (2000), Department of Health* and to support current good practice in adult safeguarding.

This document covers all the policy and procedures which apply to the whole of the 4LSAB area. Local procedures and guidance, specific to each local authority area, will be provided separately.

The document is divided into three sections:

**Section 1: Multi-agency Policy**

In this section the Multi-agency Policy provides a framework for all partners that gives priority to adult safeguarding and supports the use of procedures and good practice guidance to help in keeping adults safe from abuse, neglect and exploitation.

**Section 2: Multi-agency Procedures**

In this section the Multi-agency Procedures aim to clarify and support the roles and responsibilities of staff and managers in all agencies who have a responsibility to support an adult and assess and investigate concerns of abuse, neglect and exploitation.

**Section 3: Multi-agency Guidance**

In this section the Multi-agency Guidance provides information and strategies on good practice in adult safeguarding.

The whole document will inform all those who have a role to play in adult safeguarding and each section can be used either as part of the whole document or independently.
Living a life that is free from harm and abuse is a fundamental right of every person. When abuse does take place, it needs to be dealt with swiftly, effectively and in ways that are proportionate to the issues. In addition, the person at risk at the centre of any safeguarding concern, must stay as much in control of decision making as possible. The right of the individual to be heard throughout the process is a critical element in the drive to ensuring more personalised care and support.

In Hampshire and the Isle of Wight, the main statutory agencies - the local authorities, the Police and the NHS organisations - need to work together to both promote safer communities in order to prevent harm and abuse and to deal well with suspected or actual cases. It is our belief that people at risk are best protected when procedures between statutory agencies are consistent across the whole of Hampshire and the Isle of Wight.

All staff, whatever the setting, have a key role in preventing harm or abuse occurring and in taking action when concerns arise. The policy and procedures set out here are designed to explain simply and clearly how agencies and individuals should work together to protect people at risk. The target audience for this document is therefore professionals and front-line workers (including unqualified staff and volunteers).
The Government believes that safeguarding is everybody’s business with Local Authority Social Services, the Police and Health playing a key role in preventing, detecting, reporting and responding to abuse, neglect or exploitation and working with partner agencies to find ways of helping people to protect themselves and ways of protecting those least able to protect themselves.

Safeguarding ourselves from harm and knowing what we can do if we are experiencing harm is every adult’s responsibility. Adults have fundamental rights to determine how they want to live their lives, so we need to strike a balance which supports an individual’s right to make choices and be independent, while providing specialist support when this is needed.

Safeguarding must be built on empowerment so that it does not detract from other qualities of life, such as self-determination and the right to family life. Sometimes people want help to consider the options, information and support available to them, in order to retain control and to make their own choices; a wide range of agencies and organisations have a role to play in considering or providing options and supporting choices.

Safeguards against poor practice, abuse, neglect and exploitation need to be an integral part in the delivery of care and support, as well as commissioning and awarding contracts and monitoring arrangements. This should be achieved through partnerships between local organisations and individuals. Any person at risk of abuse, neglect or exploitation should be able to get in touch with public organisations for appropriate interventions and to know that agencies will work together as needed.

Safeguarding Adults Boards have a critical role to play in terms of leadership and the management of safeguarding services across partners. The Southampton, Hampshire, Portsmouth and Isle of Wight Safeguarding Adults Boards have a responsibility in ensuring that all agencies and organisations work in partnership to safeguard persons at risk in their area.

Adult safeguarding work covers a wide range of activities and actions taken by a large number of people. Adult safeguarding investigations are concerned with those people who due to their circumstances would be defined as ‘persons at risk’ and are experiencing abuse, neglect or exploitation or are likely to be at risk of abuse, neglect or exploitation. No Secrets (DOH, 2000) requires social services departments to take the lead in co-ordinating safeguarding investigations where there are safeguarding concerns about adults who are suffering or at risk of abuse or neglect. However, police or health practitioners may also take the lead for investigations subject to agreement at a multi-agency strategy discussion or meeting.

The purpose of Safeguarding Adults Boards is to develop an overall safeguarding adults strategy, oversee effective inter-agency working and ensure the dissemination of good practice.

The Care and Support Bill will be implemented in 2014 and will place statutory duties upon Safeguarding Adults Boards. A briefing note to explain the changes will be issued at this time.
Aims of the Policy

Person Led Safeguarding

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Aims of the Policy

This Policy aims to make sure that each adult maintains:

- Choice and control
- Safety
- Good health
- Good quality of life
- Dignity and respect.

And ensures that:

- the human rights of persons at risk who are suffering, or who are at risk of, abuse, neglect or exploitation, are respected and upheld
- the needs and interests of persons at risk are always respected and upheld
- a proportionate, timely, professional and ethical response is made to any person at risk who may be experiencing abuse, neglect or exploitation
- all decisions and actions are taken in line with the Mental Capacity Act 2005
- agencies work together as partners to support persons at risk to live safely in their communities, to access mainstream services and specialist services to keep themselves safe from abuse, neglect and exploitation, and to ensure access to criminal justice, victim support services and any therapeutic services needed to support the person to recover from the abuse.

This Policy represents the commitment of organisations to work together to safeguard adults. Each local partnership is committed to adopting this Policy so that there is a consistent framework across Southampton, Hampshire, Isle of Wight, and Portsmouth in how adults are safeguarded from abuse, neglect and exploitation.

Person Led Safeguarding

Person led adult safeguarding follows the principle of ‘no decision about me without me’ and means that the adult, their families and carers are working together with agencies to find the right solutions to keep people safe and support them in making informed choices.

This person led approach to safeguarding leads to services which are: person centred and focused on the outcomes identified by the individual; planned, commissioned and delivered in a joined up way between organisations; responsive and which can be changed when required.

Personalised care and support is for everyone, but some people will need more support than others to make choices and manage risks. Making risks clear and understood is crucial to empowering and safeguarding adults and in recognising people as ‘experts in their own lives’.

Safeguarding is everyone’s responsibility

All organisations have a responsibility to ensure that they foster a culture which enables transparency, reporting of concerns and whistleblowing.
Policy

Partnerships

The local Safeguarding Adults Boards will lead work to ensure that the organisations/agencies that support persons at risk of abuse will:

• explicitly include persons at risk as a key partner in all aspects of safeguarding work. This includes building service-user participation into the Boards: membership; monitoring, development and implementation of its work; training strategy; planning and implementation of their individual safeguarding assessment and plans

• develop a culture that does not tolerate abuse, neglect and exploitation

• raise awareness about adult safeguarding

• prevent abuse, neglect and exploitation from happening wherever possible.

Support and safeguard the rights of people who are harmed to:

• stop abuse, neglect and exploitation

• access services they need, including advocacy and post abuse support

• access justice.

Whilst local authorities have the lead role in coordinating work to safeguard adults, No Secrets recognises that successful responses need multi-agency and multi-disciplinary working, therefore all agencies will work together:

• to promote safer communities to prevent abuse, neglect and exploitation

• to deal well with suspected or actual abuse, neglect and exploitation.

Principles

The Department of Health sets out the Government’s statement of principles for use by Local Authority Social Services, Health, Police and other agencies for both developing and assessing the effectiveness of their local safeguarding arrangements. It also describes, in broad terms, the outcomes for adult safeguarding, for both individuals and agencies, and outlines the next steps. (Department of Health Policy Statement May 2011)

We will use the following principles to benchmark existing adult safeguarding arrangements.

Principle 1

Empowerment - presumption of person led decisions and informed consent

We will actively promote the empowerment, independence and well-being of all persons at risk and respect the right of the individual to lead an independent life based on self-determination and personal choice. We will involve the person at risk from the start, provide access to information, make them aware of the safeguarding procedures and provide support to assist their decision making.

Principle 2

Protection - support and representation for those in greatest need

We will ensure there is an assessment of decision making capacity where it is thought that a person at risk lacks capacity to make relevant decisions about maintaining their safety and, if required, act in their best interests in accordance with the Mental Capacity Act 2005. We will ensure that when the right to an independent lifestyle and choice is at risk, the individual concerned receives appropriate support including advice, advocacy, protection and support from relevant agencies.
Principle 3
Prevention - It is better to take action before harm occurs
The report on the consultation on No Secrets found that prevention should be the foundation of safeguarding services. We will ensure that our safeguarding systems are proactive, rather than reactive, we will ensure the safety of persons at risk by integrating strategies, policy systems and services within the framework of relevant legislation and promotion of human rights.

We will ensure that prevention occurs in the context of person-centred support and personalisation, empowering individuals to make choices and supporting them to manage risks. This should lead to the services that people want to use, with the potential to prevent crises from developing.

Principle 4
Proportionality - proportionate and least intrusive response appropriate to the risk presented
We accept that the right to self-determination can involve risk and will ensure that such risk is assessed, recognised and understood by all concerned. We will seek to minimise risks through open discussion between the individual and agencies. We will ensure that the law and statutory requirements are known and used appropriately so that the person at risk experiencing crime receives the protection of the law and access to the judicial system.

Principle 5
Partnerships - local solutions through services working with their communities
We recognise that communities have a part to play in preventing, detecting and reporting abuse, neglect and exploitation. We will work together as partners to develop opportunities for communities to learn from the experiences of persons at risk.

Principle 6
Accountability - accountability and transparency in delivering safeguarding
We will work together to ensure that:
- the roles of all agencies are clear and that they understand to whom they are accountable
- staff understand what is expected of them and others
- agencies recognise their responsibilities to each other, act upon them and accept collective responsibility for safeguarding arrangements
- we share and receive information, consistent with the Data Protection Act 1998
- the Caldicott Principles on confidentiality and information sharing are applied.
There are three levels of safeguarding work: prevention, early intervention and safeguarding. Prevention and early intervention are approaches that involve a wide range of responses to individuals from across agencies, that aim to prevent things escalating into the safeguarding arena. Safeguarding is carried out in direct response to individuals suffering abuse or neglect.

Some examples can be seen below:

### Prevention
Ways to improve everyone’s general wellbeing, to help communities ‘look out for each other’ and help the public (and the full range of professionals and volunteers) know what to do if they think that someone may be experiencing abuse, neglect or exploitation.

*For example:*
- Community safety leaflets in GP surgeries
- Access to adult safeguarding training for all who have a role in recognising abuse, neglect and exploitation.

### Early Intervention
Everybody who provides services to persons at risk should take specific action to identify and help people protect themselves when they are at risk of, or experiencing, abuse, neglect or exploitation and to find ways of helping people manage risks and access mainstream services.

*For example:*
- Trading Standards, targeting older people around awareness and prevention of Scams and Rogue Traders
- Community Safety Partners identifying persons at risk who are at greatest risk of anti-social behaviour and developing effective responses
- HealthWatch helping persons at risk make complaints about their care, facilitating access to advocacy.

### Specific Safeguarding Interventions
Ensure that, where persons at risk have or may be experiencing abuse, neglect or exploitation and are unable to protect themselves, they are supported to access Multi-agency Adult Safeguarding Procedures.

*For Example*
Ensure that persons at risk are involved in decisions about their safeguarding needs, to find out what has/is happening and to receive support, redress and access to justice if they are victims of crime.

Ensure there are specific actions to make sure people who lack capacity are supported through advocacy so that their best interests are pursued.
Who may be in need of a safeguarding intervention?

Clarity of definition is essential in ensuring safeguarding adults procedures address concerns about those people within the population they are intended to serve. No Secrets 2000 was issued under Section 7 of the Local Authority Social Services Act 1970; as such it requires every local authority to follow the directions in the No Secrets guidance.

“A ‘vulnerable adult’ is a person over 18 years old:

who is or may be in need of community care services by reason of mental or other disability, age or illness;

AND

who is or may be unable to take care of him or herself,

OR

unable to protect him or herself against significant harm or exploitation.

For the purposes of this guidance ‘community care services’ will be taken to include all care services provided in any setting context.” (No Secrets 2000)

The last two parts of the definition are crucial:

• is this person dependent on others for basic needs including protection from abuse (i.e. is or may be unable to take care of him/herself);

  OR

• because of circumstances (e.g. a patient in hospital, living in a care setting, does not have capacity to decide on the specific risks to themselves or others, or is under duress from others) they are unable to protect themselves against significant harm or exploitation.

To be defined as a ‘vulnerable adult’, a person needs to meet the first part of the No Secrets 2000 definition and one of the second two parts, i.e. is unable to take care of him or herself, or is unable to protect him or herself against significant harm or exploitation.

In terms of wider society, the number of people within the population at whom No Secrets is targeted is very small, i.e. those people who are unable to maintain their own human and civil rights and have to rely on others for support or actions to have those rights. As this group are not able to protect themselves, any concerns that ‘significant harm’ is being experienced the alert will need to be raised to initiate safeguarding adults procedures.

An adult who may be at risk of abuse, neglect or exploitation and in need of care and support may therefore be a person who:

• is elderly and frail due to ill health, physical disability or cognitive impairment

• has a learning disability

• has a physical disability and/or a sensory impairment

• has mental health needs including dementia or a personality disorder

• has a long-term illness/condition

• misuses substances or alcohol

• is a carer, (family member/friend) and is subject to abuse

• is unable to demonstrate the capacity to make a decision and is in need of care and support.

It is very important to note that access to the safeguarding process is not dependent on an individual’s eligibility for services under the Fair Access to Care guidance. An individual who meets the No Secrets (2000) definition of a ‘vulnerable adult’ and is suffering or at risk of abuse or neglect is automatically entitled to a safeguarding assessment.

“The Safeguarding Vulnerable Groups Act (2006) recognises that any adult receiving any form of health care is vulnerable. Whilst there is no formal definition of vulnerability within health care, some people receiving health care may be at greater risk from harm than others, sometimes as a complication of their presenting condition
and their individual circumstances. The risks that increase a person’s vulnerability should be appropriately assessed and identified by the health care professional at the first contact and continue throughout the care pathway.”

(Clinical Governance and Safeguarding 2010, Department of Health)

**Table 1: Factors which increase a person’s vulnerability to abuse and exploitation**

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<th>Personal characteristics of a person at risk that can increase vulnerability may include:</th>
<th>Personal characteristics of a person at risk that can decrease vulnerability may include:</th>
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<tr>
<td>• Not having mental capacity to make decisions about their own safety including fluctuating mental capacity associated with mental illness and other conditions</td>
<td>• Having mental capacity to make decisions about their own safety</td>
</tr>
<tr>
<td>• Communication difficulties</td>
<td>• Good physical and mental health</td>
</tr>
<tr>
<td>• Physical dependency – being dependent on others for personal care and activities of daily life</td>
<td>• Having no communication difficulties or if so, having the right equipment/support</td>
</tr>
<tr>
<td>• Low self esteem</td>
<td>• No physical dependency or if needing help, able to self-direct care</td>
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<tr>
<td>• Experience of abuse</td>
<td>• Positive former life experiences</td>
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<tr>
<td>• Childhood experience of abuse</td>
<td>• Self-confidence and high self-esteem</td>
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<table>
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<th>Social/situational factors that increase the risk of abuse may include:</th>
<th>Social/situational factors that decrease the risk of abuse may include:</th>
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<td>• Being cared for in a care setting, that is, more or less dependent on others</td>
<td>• Good family relationships</td>
</tr>
<tr>
<td>• Not getting the right amount or the right kind of care that they need</td>
<td>• Active social life and a circle of friends</td>
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<tr>
<td>• Isolation and social exclusion</td>
<td>• Able to participate in the wider community</td>
</tr>
<tr>
<td>• Stigma and discrimination</td>
<td>• Good knowledge and access to the range of community facilities</td>
</tr>
<tr>
<td>• Lack of access to information and support</td>
<td>• Remaining independent and active</td>
</tr>
<tr>
<td>• Being the focus of anti-social behaviour</td>
<td>• Access to sources of relevant information</td>
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When does self neglect meet eligibility for a safeguarding response?

In the majority of cases where there are concerns of self-neglect by a vulnerable adult, the best route to provide an appropriate intervention is via community care assessments / care programme approach, risk assessment, risk management and review.

The adult safeguarding procedures will apply where a person at risk has been identified as experiencing serious self-neglect which could result in significant harm to themselves or others

and

There are concerns about the person’s capacity to make the relevant decisions,

and/or they have refused an assessment

and

They have refused essential services, without which their health and safety needs cannot be met

and/or

The person has terminated services which had been arranged as a result of an assessment of health or social care needs

and

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

In these circumstances, all agencies must consider a response under the Multi-agency safeguarding Adults Policy and Procedures. Every attempt must be made to include the person at risk in this process and to apply the principles set out in the adult safeguarding procedures.

Refer to the Practice Guidance Self Neglect and Adult Safeguarding

Abuse

Abuse is defined as… “a violation of an individual's human and civil rights by any other person or persons.” (Department of Health 2000)

Abuse of a person at risk may consist of a single act or repeated acts. It may occur as a result of a failure to undertake action or appropriate care tasks. It may be an act of neglect or an omission to act, or it may occur where a vulnerable person is persuaded to enter into a financial or sexual transaction to which they do not, or cannot, consent. Abuse can occur in any relationship and any setting and may result in significant harm to, or exploitation of, the individual. In many cases it may be a criminal offence.

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

Types of abuse

Abuse can be something that is done, or omitted from being done, to a person. It can be:

• physical (e.g. hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions)

• sexual (e.g. rape and sexual assault, or sexual acts to which the person at risk did not, or could not, consent – or had to consent to under pressure)

• psychological (e.g. emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks)

• financial or material (e.g. theft, fraud, exploitation, pressure in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits)
• **neglect and acts of omission** (e.g. ignoring medical or physical care needs, failing to provide access to appropriate health, social care, welfare benefits or educational services, withholding the necessities of life such as medication, adequate nutrition and heating)

• **discriminatory** (e.g. racism, sexism or acts based on a person’s disability, age or sexual orientation. It also includes other forms of harassment, slurs or similar treatment such as disability hate crime).

### Contexts in which abuse might take place

Abuse and crimes against adults may occur in different contexts. Actual or suspected abuse of persons at risk in any of the contexts below will trigger a safeguarding response in accordance with this policy.

#### Institutional abuse

Institutional abuse occurs when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of adults at risk.

#### Hate crime

Hate crime is defined as any crime that is perceived by the victim, or any other person, to be racist, homophobic, transphobic or due to a person’s religion, belief, gender identity or disability. It should be noted that this definition is based on the perception of the victim or anyone else and is not reliant on evidence.

#### Mate crime

Mate crime happens when someone is faking a friendship in order to take advantage of a vulnerable person. Mate crime is committed by someone known to the person. They might have known them for a long time or met recently. A ‘mate’ may be a ‘friend’, family member, supporter, paid staff or another person with a disability.

### Domestic abuse

Domestic violence is defined as “any incident of threatening behaviour, coercive control, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members regardless of gender or sexuality” and that forms a pattern of coercive and controlling behaviour. (Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family; see Association of Chief Police Officers 2004).

If one or both adults (including 16-17 year olds) involved can be regarded as an adult(s) at risk, then the safeguarding procedures should be used. If a person at risk is not involved, then these guidelines will not normally apply.

#### Honour based violence

“Honour based violence is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community.” (Crown Prosecution Service/Association of Chief Police Officers)

It is a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour. Such violence can occur when perpetrators perceive that a relative has shamed the family and/or community by breaking their honour code.

#### Forced marriage

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

#### Female genital mutilation (FGM)

FGM involves procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. The practice is medically unnecessary, extremely painful and has serious health consequences, both at the time when the mutilation is carried out and in later life.
The age at which girls undergo FGM varies enormously according to the community. The procedure may be carried out when the girl is newborn, during childhood or adolescence, just before marriage or during the first pregnancy.

FGM constitutes a form of child abuse and violence against women and girls, and has severe short-term and long-term term physical and psychological consequences.

In England, Wales and Northern Ireland, the practice is illegal under the Female Genital Mutilation Act 2003.

**Human trafficking**

The United Nations definition of human trafficking is: “the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation”.

**Exploitation by radicalisers who promote violence**

Individuals may be susceptible to exploitation into violent extremism by radicalisers. Violent extremists often use a persuasive rationale and charismatic individuals to attract people to their cause. The aim is to attract people to their reasoning, inspire new recruits and embed their extreme views and persuade vulnerable individuals of the legitimacy of their cause.

The Prevent Strategy, launched in 2007, seeks to stop people becoming terrorists or supporting terrorism. It is the preventative strand of the government’s counter-terrorism strategy, CONTEST.

**Carers at risk of harm**

There are times when carers may experience abuse from the person to whom they are offering care and support, or from the local community in which they live. Carers may also be persons at risk and those carers experiencing abuse by the person they offer care to, can expect the same response as any person at risk of abuse.

Carers also have a legal right to an assessment of their needs. A carer’s assessment under carers legislation should be seen as part of the overall assessment process. In some cases both the carer and the supported person can be considered to be at risk of harm. The needs of the person at risk who is the alleged subject of abuse should be addressed separately from the needs of the person alleged to be causing them harm.

**Carers who cause harm**

The vast majority of carers strive to act in the best interests of the person they support. However, on occasion carers may cause intentional or unintentional harm. Cases of unintentional harm may be due to lack of knowledge, or due to the fact that the carer’s own physical or emotional needs make them unable to care adequately for the vulnerable adult.

The carer may also be a vulnerable adult. In this situation the aim of any safeguarding adults work will be to support the carer to provide support and to help make changes in their behaviour in order to decrease the risk of further harm to the person they are caring for.

**Abuse of trust**

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

**Safeguarding concerns between persons at risk**

Abuse can happen between persons at risk, and agencies and services which provide support to adults have a responsibility to protect them from abuse as well as preventing them from causing harm to other adults. It is important the needs of the adult causing the harm are taken into consideration in the safeguarding responses for both parties.
Prisons
Her Majesty’s Inspectorate of Prisons (HMIP) is moving to address the area of safeguarding within prisons. The underlying principle is that No Secrets does not exclude prisoners. The reason for this briefing is to ensure that Directors of Adult Social Services (DASSs) are aware that local safeguarding teams may be contacted by inspectors if they identify possible abuse of adults at risk within prisons.

Personal budgets, direct payments and self-directed care
People who direct their own care and support should be enabled to manage their personal budgets and direct payments in a safe way. A culture that promotes positive risk taking, based on appropriate person centred polices, supports this approach and seeks to enable and empower individuals.

Harm
In determining what justifies intervention and what sort of intervention is required No Secrets (2000) uses the concept of ‘significant harm’. This refers to:

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

and/or

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

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

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

The actual or likelihood of harm may impact upon the person in one or more areas of their life:

- exercising choice and control
- health and well-being, including mental and emotional as well as physical health and well-being
- personal dignity and respect
- quality of life
- freedom from discrimination
- making a positive contribution
- economic well-being
- freedom from harm, abuse and neglect, taking wider issues of housing and community safety into account.

Significant harm varies between individuals. This requires careful assessment using as much information as available before a decision is made as to how to proceed and should include consideration of the possibility of future significant harm. The seriousness or extent of the abuse, neglect or exploitation is often not clear; some incidents may not have caused immediate significant harm but if they were to happen again, could lead to significant harm to the adult, other adults or children. If there are not well managed measures in place to prevent another incident, a situation which has a high likelihood of potential serious abuse, neglect or exploitation could cross the threshold for use of safeguarding procedures.

Not everyone who needs support to live their everyday lives is in need of such services, therefore it is important to target resources on those who do. Resources must also be used proportionately, i.e. some people will need the safeguarding adults procedures to be used to fully protect them, in other situations the safeguarding adults procedures can be used to enable a person to self-protect in the present, or future, circumstances.
Out of Area Referrals

In the case of a safeguarding alert for someone who is temporarily residing in a local authority area where they are not ordinarily resident, the host authority will take the lead for the assessment and co-ordination of the safeguarding investigation. Examples include where someone is receiving hospital or residential care in another local authority. This includes care which is funded by the local authority or health and care which is paid for by individuals.

Where there are repeat referrals of individuals in acute hospital settings the ordinary residence rule will apply and the person’s usual authority will lead rather than the host authority.

Where the nature of the allegation gives rise to a concern that the alleged abuse or neglect may be institutional in nature, the host authority will lead the investigation as a whole service investigation.

Children

Local authorities have specific duties under the Children Act 1989 in respect of children in need (Section 17) and children at risk of significant harm (Section 47).

All those working with adults and children in health, social care and voluntary sector settings have a responsibility to safeguard children when they become aware of, or identify, a child at risk of harm. They should follow Local Safeguarding Children Board (LSCB) procedures which are based on the Government Guidance Working Together to Safeguard Children (WT) (2010).

There is an expectation that health and social care professionals that come into contact with children, parents and carers in the course of their work are aware of their responsibilities to safeguard and promote the welfare of children and young people.

Guidance for all professionals is contained in ‘Working Together’ Chapter 2 (WT sections 2.52 to 2.73).

Children identified as being placed at risk by the activities of their parents or carers should be referred by adult workers into the local children’s safeguarding team. This action is supported by detailed local guidance contained within the 4 LSCB ‘Joint Working Protocol (Safeguarding children and young people whose parents / carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress) adopted across Hampshire, Southampton, Portsmouth and the IOW. This protocol gives information about research and guidance for good practice.

When there are concerns about children and adults at risk of abuse

There must be a ‘think family’ approach to safeguarding adults. Where it is identified through the safeguarding adults process that a child may be at risk, the concern must be referred immediately to Children’s Services.

Where it is identified by Children’s Services in the context of their work with children and families that a person at risk is experiencing abuse, then the concern must be referred to Adult Services.

A decision will be made as to who will lead the safeguarding process, whether it is Adult Social Care or Children’s Services. Regardless of who takes the lead, there should be appropriate representation from both Adults and Children’s Services within this joint process.

Transitions between Adult and Children’s Services

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

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

**Good practice includes:**
- having policies and procedures which support effective transition processes
- shifting the general view of risk as a potential danger for a child, to one of potential opportunity for an adult, but acknowledging there are still potential risks
- managing risks as a phased process with awareness of the psychological and emotional issues
- managing family expectations (being clear about the level of support and resources available)
- taking time to get to know the young person and their family, especially if they have communication difficulties
- acknowledging the rights of adults to take more responsibility for their decisions.

**Mental Health Services**

The term Care Programme Approach (CPA) is used to describe the framework that supports and co-ordinates mental health care for people with severe mental health problems and are receiving treatment from mental health services. It is called an approach rather than a system because it covers:

- An assessment of health and social care needs
- A written care plan agreed with all those involved in the delivery of an individual’s care
- The nomination of a care co-ordinator who acts as the main point of contact overseeing the delivery of an individual’s care
- Ongoing and regular reviews of an individual’s care plan and health and social care needs

Where there is a concern that someone who is known to Adult Mental Health services has been abused or is at risk of neglect or abuse, then safeguarding procedures apply and should run alongside CPA.

**Information sharing**

The Information Sharing Guidance recognises that information sharing between organisations is essential to safeguard adults at risk of abuse, neglect and exploitation.

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

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

- adults have a right to independence, choice and self-determination. These rights extend to control over information about themselves and to determine what information is shared. Even in situations where there is no legal requirement to obtain written consent before sharing information, it is good practice to do so
- the person’s wishes should always be considered. However, when there is a concern of abuse, a general principle is that an incident of suspected or actual abuse can be reported more widely and that in so doing, some information may need to be shared among those involved. Information given to an individual member is subject to the Data Protection Act 1998.

There will be occasions where practitioners believe it key that information is shared without consent or delay, such as in emergency or life threatening situations (Vital Interest, Data Protection Act 1998). However, where similar circumstances arise but not in an emergency situation, the decision to share information without consent should only be made after a risk assessment carried out by the organisation, rather than the individual practitioner. In all cases, the decision and rationale should be fully documented.
Safeguarding Adults Serious Case Reviews

Safeguarding Adults Serious Case Reviews (SCRs) are not designed to re-investigate a case, nor are they to apportion blame. They are voluntarily commissioned by the Safeguarding Adults Boards to establish whether there are any lessons to be learnt about the way in which staff and agencies work together to safeguard vulnerable people.

The review should also establish whether the safeguarding adults procedures are effective or whether they need to be amended. The Board regularly reviews the recommendations of the Serious Case Reviews to ensure that the outcomes inform good practice across all agencies.
APPENDIX: Information sharing – flow chart and key principals (there is also more detailed guidance in Section 3)

Key Principles of Information Sharing:
- identify how much information to share
- distinguish fact from opinion
- ensure that you are giving the right information to the right person
- ensure you are sharing the information securely
- inform this person that the information has been shared if they were not aware of this and it would not create or increase risk of harm.

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

If there are concerns that a child may be at risk of significant harm; or an adult may be at risk of serious harm, then 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.
Section 2
Multi-agency Procedures

This Section provides an overview of what happens within the Multi-agency Safeguarding Adults Procedures if a concern is raised about a person at risk in the context of abuse, neglect or exploitation.

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## Stages of the Safeguarding Process

The 7 stages of the safeguarding process are summarised in the table below.

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<th>STAGE</th>
<th>TIMESCALE</th>
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<tr>
<td><strong>Stage 1: Safeguarding Alert</strong></td>
<td>Immediately, if emergency Or within same working day (this should be within 4 hours).</td>
</tr>
<tr>
<td>A concern that a person at risk is at risk of, or may be being abused, neglected or exploited by a third party or where a person at risk may be causing harm to others.</td>
<td></td>
</tr>
<tr>
<td><strong>Stage 2: Safeguarding Referral</strong></td>
<td>Within 24 hours of receipt of the alert.</td>
</tr>
<tr>
<td>The alert is brought to the attention of Adult Services to determine whether the information provided ‘is an alleged abuse, neglect or exploitation of a person at risk by a third party’ and that ‘the person suffering or at risk of abuse or neglect is unable to take care of him / herself. If an alert meets the criteria, a referral should be accepted. In order to assess whether a referral crosses the threshold for use of the safeguarding procedures, the decision needs to be made as to whether ‘significant harm’ is likely to have occurred or not. Information should be gathered in order to make a decision about how to proceed. This should include a discussion with the person at risk – if possible – to determine the outcomes they wish to see as a result of the safeguarding process. These should be recorded and fed into the discussion. It should be borne in mind that where there are issues of mental capacity, an Independent Mental Capacity Advocate (IMCA) should be involved in these discussions to support the individual, where the person is eligible for an IMCA.</td>
<td></td>
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<tr>
<td><strong>Stage 3: Safeguarding Strategy</strong></td>
<td>Within a maximum of 7 working days from the threshold decision.</td>
</tr>
<tr>
<td>Where the decision has been made that the concerns meet the thresholds for intervention, the responsible Team will ensure that a strategy discussion or meeting takes place to share the nature of the risk and options for safeguarding are identified and a safeguarding response is planned with key agencies and individuals. The purpose of the meeting is to agree an investigation plan which clarifies the main focus of the investigation and who should take the lead roles. If the referral relates to a service provider, it must be considered within the context of any previous alerts/referrals from this service.</td>
<td></td>
</tr>
<tr>
<td><strong>Stage 4: Safeguarding Assessment and Investigation</strong></td>
<td>Within 21 working days of the strategy meeting/discussion</td>
</tr>
<tr>
<td>The person and key parties work together to assess the risks, determine the nature and extent of the harm and to establish what has happened.</td>
<td></td>
</tr>
<tr>
<td><strong>Stage 5: Case Conference/Safeguarding Plan</strong></td>
<td>Within 21 working days of the strategy meeting/discussion</td>
</tr>
<tr>
<td>The findings from the risk assessment/investigation are shared and a plan is agreed to address and reduce the risks of harm. In some situations this plan may need to be formally developed and shared via a case conference. The individual who is suffering or at risk of abuse or neglect should be supported to attend the meeting if this is their choice. Staff must record the conclusion of allegations e.g. substantiated, unsubstantiated and inconclusive.</td>
<td></td>
</tr>
<tr>
<td><strong>Stage 6: Safeguarding Review</strong></td>
<td>Within 3 months of case conference/plan or as agreed at case conference.</td>
</tr>
<tr>
<td>The Safeguarding Plan is reviewed and any changes needed are made, including ceasing the Safeguarding Plan if appropriate.</td>
<td></td>
</tr>
<tr>
<td><strong>Stage 7: Review and Closure</strong></td>
<td>As agreed by all involved</td>
</tr>
<tr>
<td>Subsequent reviews and closure of the safeguarding adults process.</td>
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A quick guide for investigators can be seen at Appendix 4
Stage 1 - Safeguarding Alert

Timescale: Immediate in an emergency or within same working day (this should be within 4 hours)

The threshold criteria used to identify whether an issue should be raised as a safeguarding alert are as follows:

**Is this person a vulnerable adult?**

**Is abuse/neglect by a third party alleged?**

**AND**

**Is this person unable to take care of him or herself?**

**OR**

**Is this person unable to protect him or herself against significant harm or exploitation.**

If the answer is YES, then you have a 'safeguarding alert'

An alert is a concern that a person at risk is suffering, or at risk of, or may be being, abused, neglected or exploited by a third party, or where a person at risk may be being harmed by others usually in a position of trust power or authority.

Alerts may be made to Adult Safeguarding referral points by anyone and should be made when:

- the person is a person at risk and there is a concern that they are being or at risk of being abused, neglected or exploited
- the person is a person at risk and there is a concern that they have caused or are likely to cause harm to others
- the adult has capacity to make decisions about their own safety and wants this to happen
- the adult has been assessed as not having capacity to make a decision about their own safety, but a decision has been made in their best interests to make a referral
- a crime has been or may have been committed against an adult who lacks the mental capacity to report a crime and a ‘best interests’ decision is made
- the abuse or neglect has been caused by a member of staff or a volunteer
- other people or children are at risk from the person causing the harm
  - the concern is about institutional or systemic abuse
  - the person causing the harm is also a vulnerable adult.

If there is an overriding public interest or vital interest or if gaining consent would put the adult at further risk, an alert must be made.

This would include situations where:

- other people or children could be at risk from the person causing harm
- it is necessary to prevent crime
- where there is a high risk to the health and safety of the vulnerable adult
- the person lacks capacity to consent
- the person at risk would normally be informed of the decision to refer and the reasons, unless telling them would jeopardise their safety or the safety of others
- if the person at risk is assessed as not having mental capacity to make decisions about their own safety and to consent to a referral being made, the alerter must make a decision in their best interests in accordance with the provisions set out in the Mental Capacity Act 2005.
Appendix 2 is a quick reference guide for those raising a safeguarding alert.

**Factors to consider when raising an alert**

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

Not all alerts will become referrals, for example, where there is no abuse, or the person requires signposting to another service or a review of their current care.

In order to prevent a delay in raising concerns, alerts should usually be made by contacting:

<table>
<thead>
<tr>
<th>Location</th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southampton</td>
<td>023 8083 3003</td>
</tr>
<tr>
<td>Hampshire</td>
<td>0845 603 5630</td>
</tr>
</tbody>
</table>

**Isle of Wight** 01983 814980

**Portsmouth** 023 9268 0810

**Immediate action by the person raising the alert**

- Make an immediate evaluation of the risk and take steps to ensure that the adult is in no immediate danger.
- Where appropriate, dial 999 for an ambulance if there is need for emergency medical treatment.
- Consider contacting the Police if a crime has been or may have been committed and do not disturb or move articles that could be used in evidence.
- Contact Children's Services if a child is also at risk.

The first concern must be to ensure the safety and well-being of the person alleged to have been harmed. However, in situations where there has been or may have been a crime and the Police have been called it is important that evidence is preserved wherever possible. The Police will attend the scene, and agencies and individuals can play an important part in ensuring that evidence is not contaminated or lost.

**Principles of securing evidence**

- Try not to disturb the scene, clothing or the victim if at all possible.
- Secure the scene, for example lock the door.
- Preserve other potential evidence, e.g. documents by locking them away if possible.
- Try not to ask the victim too many questions, but do give them reassurance.
- If in doubt about securing evidence get advice from the Police.

**Medical treatment and examination**

In cases of physical abuse it may be unclear whether injuries have been caused by abuse or some other means (for example, accidentally). Medical or specialist advice should be sought. If medical treatment is needed, an immediate
referral should be made to the person’s GP, Accident and Emergency (A&E) or a relevant specialist health team.

If forensic evidence needs to be collected, the Police should always be contacted and they will normally arrange for a Police surgeon (forensic medical examiner) to be involved.

Consent of the person at risk should be sought. Where the person does not have capacity to consent to medical examination, a decision should be made on the basis of whether it is in the person’s best interest for a possibly intrusive medical examination to be conducted.

Obtaining the consent of the person at risk at alert stage

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

The test of capacity in this case is to find out if the person at risk has the mental capacity to make informed decisions:
• about a safeguarding alert
• about actions which may be taken under Multi-agency Policy and Procedures
• about their own safety or that of others, including an understanding of longer-term harm as well as immediate effects
• an ability to take action to protect themselves from future harm.

Raising an alert when the adult does not want any action

If the person at risk has capacity and does not consent to a referral and there are no public or vital interest considerations, they should be given information about where to get help if they change their mind or if the abuse or neglect continues and they subsequently want support to promote their safety. The referrer must assure themselves that the decision to withhold consent is not made under undue influence, coercion or intimidation. The person at risk will need to be informed that an alert will still need to be raised and as a minimum a record must be made of the concern, as well as the adult’s decisions with reasons. A record should also be made of what information the person at risk was given.

Making a record

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

You should make an accurate record at the time, including:
• date and time of the incident
• exactly what the person at risk said, using their own words (their account) about the abuse and how it occurred or exactly what has been reported to you
• appearance and behaviour of the person at risk
• any injuries observed
• name and details of any witnesses
• if you witnessed the incident, write down exactly what you saw
• the record should be factual, but if it does contain your opinion or an assessment, it should be clearly stated as such and be backed up by factual evidence
• information from another person should be clearly attributed to them.
• name and signature of the person making the record.

When raising an alert, where possible, provide the following information:

Details of the referrer
• name, address and telephone number
• relationship to the vulnerable adult
name of the person raising the alert if different
name of organisation, if referral made from a care setting
anonymous referrals will be accepted and acted on. However, the referrer should be encouraged to give contact details.

Details of the adult(s) at risk
- name(s), address and telephone number
- date of birth, or age
- details of any other members of the household including children
- information about the primary care needs of the adult, that is, disability or illness
- funding authority, if relevant
- ethnic origin, religion and cultural needs
- gender (including transgender and sexuality)
- communication needs of the adult due to sensory or other impairments (including dementia), including any interpreter or communication requirements
- whether the adult knows about the referral
- whether the adult has consented to the referral and, if not, on what grounds the decision was made to refer
- what is known of the person’s mental capacity and their views about the abuse, neglect, exploitation and what they want done about it (if that is known at this stage)
- details of how to gain access to the person and who can be contacted if there are difficulties
- details of any immediate plan that has been put in place to protect the person at risk from further harm.

Information about the abuse, neglect or exploitation
- how and when did the concern come to light?
- when did the alleged abuse occur?
- where did the alleged abuse take place?
- what are the details of the alleged abuse?
- what impact is this having on the vulnerable adult?
- what is the person at risk saying about the abuse?
- are there details of any witnesses?
- is there any potential risk to anyone visiting the person at risk to find out what is happening?
- is a child (under 18 years) at risk?

Details of the person causing the harm (if known)
- name, age and gender
- what is their relationship to the vulnerable adult?
- are they the vulnerable adult’s main carer?
- are they living with the vulnerable adult?
- are they a member of staff, paid carer or volunteer?
- what is their role?
- are they employed through a personal budget?
- which organisation do they work or volunteer for?
- are there other people at risk from the person causing the harm?

Any immediate/subsequent actions that have been taken, for example
- were emergency services contacted? If so, which?
- what is the crime number if a report has been made to the Police?
- have Children's Services been informed if a child (under 18 years) is a risk?
- has the CQC been informed (if a regulated service)?
- have patient safety incident processes been actioned?
What happens when an alert is raised?

Anyone expressing concern, or making a complaint or allegation, will be assured that:

• they will be taken seriously
• their comments will usually be treated confidentially but their concerns may be shared if they or others are at significant risk
• anyone who is perceived to be at risk will be given immediate protection from the risk of reprisals or intimidation
• if they are a staff member they have the right not to be subject to any detriment, or to be selected for dismissal or redundancy on the basis of having made a protected disclosure
• they will be dealt with in a fair and equitable manner
• as far as possible, they will be kept informed of action that has been taken and its outcome

It is the responsibility of the person receiving the alert to confirm the next steps to be taken with the person who has raised the concern.

Appendix 3 provides a framework for those working in NHS organisations and refers to the action to be taken in any NHS setting. The aim of the guidance is to enable NHS organisations in England to develop local robust arrangements to ensure that clinical governance systems and adult safeguarding are fully integrated.

Appendix 1 is a quick guide for Provider Services
Stage 2 - Safeguarding Referral

**Timescale: within 24 hours of the receipt of the alert.**

The alert is brought to the attention of Adult Services to determine whether the information meets the criteria, **‘is abuse, neglect or exploitation by a third party alleged’** and **‘is the person a person at risk or carer’**. If an alert meets the criteria, it will become a formal safeguarding referral. (Page 59 Section 3A)

In order to assess whether an alert crosses the threshold for a response under the safeguarding procedures, the decision needs to be made as to whether 'significant harm' is likely to have occurred or whether there is a risk of significant harm.

Accepting an alert as a referral will place the information about the concern in a multi-agency context and will be assessed in accordance with the Multi-agency Safeguarding Adults Procedures.

A referral begins a process of gathering information, initial assessment of the allegation and initial assessment of the adult’s needs, and a risk assessment to decide whether the Safeguarding Adults Policy and Procedures apply. Within 24 hours information will be gathered by the professional receiving the referral as to whether the referral meets the criteria for a response under the Multi-agency Policy and Procedures and in discussion with the Responsible Manager and partner agencies (where appropriate) will determine the threshold and the level of intervention.

**Information gathering**

As part of information gathering, the following issues will need to be considered.

- What was the nature of the incident and type of harm alleged?
- What is the victim's perspective and wishes for the outcome of the safeguarding process?
- What are the issues of mental capacity, consent and confidentiality?
- Are there any risks presented to others?
- Is there a need for advocacy?
- Are there any communication needs?
- What is the perceived level of risk?
- The setting and geographical location of where the alleged abuse took place.
- Name and relationship to the person alleged to have caused harm to the adult.
- The involvement of any witnesses.
- Any action that has already been taken to safeguard the adult.
- The health and social care support needs of the person at risk and whether this support is provided by the person alleged to have caused harm.
- Are there any children at risk who should be referred to Children’s Services?

There may be other people who can help ascertain the wishes of the vulnerable adult, but contact by adult services/integrated teams should be considered within 48 hours in order to: ascertain their views, wishes, information needs and any immediate support the adult needs to keep themselves safe; and to explain the safeguarding process and gain their consent, (where appropriate based on an individual’s circumstances and/or risks to the person or others).
Inter Authority Safeguarding Adults Protocol

There is an Inter Authority Protocol for the investigation of adult abuse. This agreement was ratified by the Association of Directors of Adult Social Services (ADASS) on 20th February 2004 and is intended for adoption by all Local Authorities/Safeguarding Adults Boards.

This protocol clarifies the responsibilities and actions to be taken by local authorities for people living in one area, but for whom some responsibility remains from their area of origin within England. This protocol should be read in conjunction with Section 3.8 of No Secrets (DoH 2000) and LAC (93) 7 Ordinary Residence which identifies these responsibilities.

Deciding the action to be taken following assessment of the referral

Once the information has been gathered, partner agencies consulted with and the Adult Social Care Team/Integrated Team practitioner has undertaken a risk assessment, consulted with partner agencies, undertaken an assessment of seriousness and consulted wherever possible with the adult, there may be a range of possible courses of action outside of the Multi-agency Safeguarding Procedures:

• when there is enough information to decide that the situation does not involve abuse, neglect or exploitation, in which case another service may be appropriate
• where the adult is not a person at risk who is covered by these procedures, they can then be signposted to other services or resources
• the person at risk has the mental capacity to make an informed choice about their own safety, there are no public interest or vital interest considerations and they choose to live in a situation in which there is risk or potential risk and those risks have been discussed with them and agreed as reasonable and form the part of their assessed support/care needs under self-directed support, care management/ care programme approach

• where it is clear that a criminal offence may have taken place and the person at risk does not have health and social care needs, the Police will take the lead in the investigation as a single agency investigation
• following further discussion and assessment, it may not be necessary to pursue a safeguarding adults intervention, however other actions may be required. For example it may be agreed that the person’s health or social care support plan needs reviewing, that the complaints process within an agency should be followed, or a response under Serious Incident Requiring Investigation procedures is more appropriate, or that a referral to another appropriate agency is required.

Where the Safeguarding Adults Procedures are best placed to achieve a positive outcome for the adult or others at risk, the thresholds guidance and levels of response decision making tool (Section 3) should be referred to, to aid decision making.

A decision on how to proceed will be made by the Responsible Manager within the relevant Adult Social Care/Integrated Team in partnership with other agencies or person involved and all decisions must be recorded.
Stage 3 – Safeguarding Strategy

**Timescale: Within a maximum of 7 working days from the threshold decision**

Where the decision has been made that the concerns meet the threshold for intervention under safeguarding procedures, the responsible Team will ensure that a strategy discussion or meeting takes place to share the nature of the risk and identify options for safeguarding, and that a safeguarding response is planned with the person and key agencies with duties or powers to act. The purpose is to agree the focus of the intervention, lead roles and an action plan.

A safeguarding adults strategy discussion or strategy meeting will take place depending upon the assessed level of seriousness and level of intervention. In some instances a number of strategy discussions may be required and sometimes these will need to take place on the same day to ensure that a risk management plan is in place. If a strategy meeting is required, then this should be held within 7 working days of the threshold decision. Any variations in timescales should be recorded.

An assessment and investigation should not be delayed whilst waiting for a safeguarding adult’s strategy discussion to be convened. Any interim action taken must be agreed by the responsible person within the appropriate Adult Social Care/Integrated Team.

Information at the meeting, where relevant to a service provider, must be considered within the context of any other alerts or referrals raised which relate to this provider. In addition to individual safeguarding processes, an overarching meeting focused on the provider may need to be put in place in line with the Safeguarding in Provider Services process (see Section 3).

**The purpose of the strategy discussion or meeting**

The strategy discussion or meeting aims to:

- agree a multi-agency plan to investigate the allegations and assess the risk to the person at risk who is being harmed or to the person at risk who is harming others, to assess any immediate risks and address any immediate needs
- co-ordinate the collection of information about the abuse, neglect or exploitation through a clear plan of action
- involve the adult and/or their representative in decision making.

The strategy meeting will be chaired by an appropriate Responsible Manager who will act in an impartial and objective way in conducting the meetings and will facilitate the meeting to reach decisions and recommendations with the person at risk wherever possible.

**The strategy discussion or meeting must:**

- consider the wishes of the person at risk in relation to the desired outcome for the process and the potential need/role for an advocate
- consider any special needs of the adult
- consider the need for advocacy
- consider the mental capacity of the adult to be able to support and protect themselves from harm
- consider support for the person at risk who may have caused the harm
- agree an interim risk management plan
- consider the health and social care needs of the adult
- consider the need for legal intervention
- consider the likelihood of media attention
- identify who should be the key worker to support and liaise with the adult
- share judgements about the risks and agree how the adult will be supported and the risks managed
• consider the safety and well-being of other adults/children at risk and whether the concerns meet the thresholds for a safeguarding adults/child intervention
  – If the person at risk is aged under 18 years old, a referral must be made to Childrens Services safeguarding process
  – If the person implicated in the safeguarding investigation works with children or young people under 18, a referral must be made to the Local Authority Designated Officer (LADO), a statutory role put in place under Working Together to Safeguarding Children, 2010

• consider action under any parallel proceedings (e.g. regulatory action, health and safety issues, serious incidents requiring investigation, disciplinary processes etc.)

• agree what kind of assessments/investigations will need to take place, and if so, how they should be conducted, by whom and within what timescales

• agree who needs to be interviewed, when and by whom.

Who should participate in or attend strategy discussion/meetings?

Those who should be involved in the strategy discussion/meetings should be limited to those who ‘need to know’ and who have a lead responsibility to ensure that an assessment and investigation is undertaken and contribute to the decision making process.

The views of the person at risk or their representative should be presented and recorded as part of the meeting discussion, having been sought during the information gathering stage. Those attending from partner agencies/organisations should be of sufficient seniority to make decisions as part of the strategy discussion/meetings concerning their organisation’s role and the resources they may contribute to the assessment/investigation and to the agreed Safeguarding Plan.

Investigations and processes that could be triggered by a referral

A referral can trigger various processes that amount to formal investigation, for example, a criminal investigation, a disciplinary investigation or a response within the NHS under Serious Incident Requiring Investigation procedures.

A list of types of investigations can be found at Appendix 5.
Stage 4 – Safeguarding Assessment and Investigation

**Timescale: within 21 days of the strategy meeting/discussion**

The purpose of a safeguarding adults assessment and investigation is to establish:

- the support/information/services the person at risk needs to keep safe
- whether abuse, neglect, exploitation or a crime occurred and the surrounding circumstances
- the ongoing risks to the person at risk or others identified to be at risk
- any immediate action to prevent further abuse
- the level of understanding of the risks by the vulnerable adult
- whether disciplinary action may be required on the part of the employer
- whether legal interventions are necessary.

The person and other key parties work together to assess the risks, determine the nature and extent of the harm and to establish what has happened.

**Safeguarding assessments and investigations**

There are a number of considerations when planning the assessment and investigation of safeguarding referrals:

- establish what needs to be found out and who might have this information
- ascertain what legal powers are needed
- check out all necessary documentation
- Is a capacity assessment needed (be clear about the ‘question’ for any capacity assessments)?
- is a psychological, psychiatric, speech therapy assessment needed in respect of any person at risk needed, prior to carrying out any interviews?
- plan interviews with relevant colleagues prior to commencing interviews
- interview the person at risk or carers in the appropriate environment, taking into account any need for an independent advocate and/or any language, communication, gender or race issues
- is there a need for a generic Community Care assessment in respect of other areas of need and risk?
- is there a need for the provision of services to keep the person at risk safe and to minimise the risk of harm?
- is there a need for a carer’s assessment
- record interviews
- collate the information.

**Evaluation of the evidence**

There is a need to evaluate the evidence obtained from:

- medical or forensic evidence
- background reports, service records and previous histories
- witness statements from formal/joint interviews
- assessment of the individual’s capacity and witness skills
- circumstantial evidence.
- assessment of the extent and seriousness of the harm and the effect it has had on the person at risk and others in their network.

**Safeguarding assessment interview with the vulnerable adult**

The interview is a key stage in the safeguarding process. Where a criminal offence is identified or suspected then the case details must be reviewed and discussed with the Police, prior to any safeguarding assessment interview.

Effective interviewing requires careful planning based upon good knowledge of the person,
their means of communication, physical needs, etc. There will also inevitably be circumstances in which it will not be appropriate to interview a person because of the extent of their mental impairment, or because the person does not wish to be interviewed.

**Principles of interviewing**

- Arrange for the assessment interview to be undertaken by the most appropriate person
- Ensure that any decision to undertake an assessment interview with the person at risk is discussed with the Police if there is any suspicion that a crime may have been committed. (In the case of a crime, the Police will take the lead in all interviewing of vulnerable victims or witnesses.)
- Obtain consent of the person at risk to undertake an interview
- If necessary undertake an assessment of capacity if there is doubt about the adult’s capacity to give consent to a safeguarding assessment interview, and determine through ‘best interests’ if a safeguarding assessment interview is proportionate
- Discuss issues of confidentiality and information sharing with the person at risk and if there are no others at risk, get permission to share information with other organisations as required
- If there are others at risk, inform the person at risk of the duty to share information to protect others
- If the person at risk has mental capacity, reassure them that no decisions or plans which have an impact on their daily living arrangements will be made without their agreement to that decision
- Where the adult has capacity, ensure their wishes are respected as to sharing of information with relatives and/or carers (unless there is a duty to override their decision)
- Carry out a risk assessment with the person at risk if they have mental capacity to understand the risks and consequences
- Identify who will keep the person at risk informed and what information can be shared with them
- If, during the safeguarding assessment interview, it becomes clear that the situation indicates domestic abuse, the CAADA (Co-ordinated Action Against Domestic Abuse) DASH (Domestic Abuse, Stalking and Honour based violence) risk assessment should be completed. If this indicates that there is a high risk of harm, a referral should be made to the MARAC (Multi-agency risk assessment conference)
- If the person at risk does not have mental capacity to make decisions about their safety, the practitioner must continue to involve them. They must also consult with their personal representative, a court-appointed deputy or attorney, if they are not implicated in the allegation and/or an Independent Mental Capacity Advocate if one has been instructed
- Identify if the person needs advice, support, assistance or services under community care legislation
- If the safeguarding assessment interview reveals that a child or young person is living in the same household or is in regular contact with the person alleged to have caused harm and could be at risk, referral should be made immediately to Children’s Services
- Agree an interim Safeguarding Plan with the person at risk and ensure they know what it is and how they will be supported and kept informed during the assessment and investigation stage, including having an appropriate independent advocate if they wish

During the investigation the practitioner should keep the Responsible Manager informed of the progress of the investigation and of any information that could impact on the continued safety of the person at risk of abuse or others who may be at risk, and indicate changes that are needed to the interim safeguarding Safeguarding Plan.

If the assessments and investigation are likely to be prolonged, another strategy meeting
may need to be held to ensure that the interim safeguarding Safeguarding Plan is providing adequate safeguards for the adult (and other persons at risk at risk of abuse if necessary).

**When the assessment and investigations have been concluded**

The nominated person will notify the Responsible Manager within the Adult Social Care/Integrated Team following consultation with the person and key agencies, that the assessment/investigation has been concluded. The Responsible Manager, in discussion with the person at risk and other agencies, will make a decision whether the outcome of the assessment/investigation requires a Safeguarding Adults Case Conference to be convened to share the findings and agree actions, or whether this can be reasonably achieved through other forms of communication.

If it is agreed that no further action is required under the Safeguarding Procedures, the Responsible Manager must advise the person at risk and/or their representatives, the referrer and all relevant agencies the outcome of the assessment/investigation on a 'need to know basis'.
Stage 5 – Case Conference/Safeguarding Plan

**Timescale: Within 21 working days of the strategy meeting/discussion**

The findings from the risk assessment/investigation are shared and a plan is agreed to address and reduce the risks of harm. In some situations this plan may need to be formally developed and shared via a case conference. One person should be assigned to co-ordinate implementation of the plan. Arrangements will be agreed regarding the monitoring of the plan.

A Safeguarding Adults Case Conference/Safeguarding Plan provides an opportunity to exchange information, analyse risk, recommend responsibility for action and devise a plan for further actions and develop a safeguarding plan with the person at risk and key partners and consider the use of legal interventions.

A Plan can be developed via a Case Conference or where appropriate other forms of communication. The Plan should be developed within 15 working days of the conclusion of the assessments and investigations. An additional period of time may be requested where the assessments and investigations are particularly complex. Reasons for longer delays must be agreed with the responsible Manager and recorded.

**Provision of reports**

The Responsible Practitioner should:

- produce a report that summarises the assessments and investigations undertaken by each partner agency, the wishes/views of the person at risk and the assessment interview
- produce a chronology of significant events, actions and outcomes
- submit reports to the Responsible Manager which will form the basis of the discussion at the Safeguarding Case Conference or Safeguarding planning discussions
- share relevant information from the report(s) with the person at risk and/or their representatives on a ‘need to know basis’
- share relevant information with agencies/organisations who have a ‘need to know’ in order to safeguard the vulnerable adult, to inform the Safeguarding Plan and to inform what action will be taken against the person causing the harm if the allegation is substantiated
- the Report should be sent to the Responsible Manager chairing a Case Conference 3 days before the date of the Conference.

**Purpose of a Case Conference or Safeguarding Planning discussion**

The aims of a Case Conference or Safeguarding Planning discussion are to:

- support the person at risk to take the lead in deciding what should be in their Safeguarding Plan
- support the person at risk to have an active part in the decisions about what measures can be taken to protect them and reduce the risk to their safety, including giving them information about the purpose of the meeting and who will be there
- consult with agencies/organisations who have a key responsibility to contribute to the actions and outcomes of the Conference
- consider the information contained in the investigating officer's report(s)
- consider the evidence and, if substantiated, plan what action is indicated
- plan further action if the allegation is not substantiated
- plan further action if the investigation is inconclusive
- consider what legal or statutory action or redress is indicated
• make a decision about the levels of current risks and a judgement about any likely future risks
• agree a Safeguarding Plan around the vulnerable adult
• agree how the Safeguarding Plan will be reviewed and monitored
• plan action in respect of those responsible for causing/contributing to the harm.

The Conference or Plan discussion should evaluate the evidence and determine outcomes for the person at risk and others, and decide on the balance of probability whether abuse, neglect or exploitation has occurred, and what sanctions, where appropriate, should be taken against those who have caused the harm.

**The meeting/discussion will:**

• receive and consider the information contained in the investigating practitioner’s report and decide what further action is/may be needed
• make a decision with the person at risk and/or their representative about current levels of risk and make decisions about the reduction of future risks
• specify what outcomes have been achieved for the person at risk
• decide what action is appropriate when the allegation was not proved or was unfounded but concerns remain about standards of care.

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

To help support the attendance and effective participation of the person at risk at a Case Conference, the meeting can be divided into two parts:

**Part 1** - for the person at risk and key partners to hear the findings of the assessment/investigation pertaining to the adult’s experiences, make decisions on the findings and develop a risk management plan. The agenda should be set out so that the person at risk may actively participate in the meeting (if appropriate).

**Part 2** - for professionals to share the findings from the assessment/investigation pertaining to others, and make decisions as to actions and outcomes which are not ‘need to know’ for the vulnerable adult.

Alternatively, if it is necessary in order to meet the vulnerable adult’s access and communication needs (if specialist facilities are needed), a separate Conference/Safeguarding Plan meeting could be held in a different venue. If this proves to be necessary, such a meeting should be held as close in time to the first part of the meeting as possible.
Stage 6 - Safeguarding Review

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<th>Timescale: Within 3 months of Case Conference/Safeguarding Plan or as agreed at the Case Conference</th>
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<td>The Safeguarding Plan is reviewed and any changes needed are made, including ceasing the Safeguarding Plan if appropriate.</td>
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The purpose of the review is to ensure that the actions agreed at the Conference and in the Plan have been implemented and the outcomes have been achieved, to decide whether further action is needed, including any service improvements.

**If a date for a review of the Plan has not been fixed at the Case Conference, a review will always take place:**

- if an investigation is still under way at the time of the Case Conference
- if the person at risk has the mental capacity to understand the nature of a review and requests a review
- if the person representing the best interests of the person at risk requests a review
- if the situation is seen as high risk
- where a review is requested by any organisation involved in the delivery of the risk management plan
- as the result of a request by the person co-ordinating the risk management plan.

**The Conference or discussions will also:**

- agree a Safeguarding Plan with the person at risk (or the person representing them or in their best interests, if the person lacks capacity to make the specific decision) and decide which organisation will monitor and co-ordinate the Plan
- agree contingency actions if the Safeguarding Plan does not work
- identify a person responsible to co-ordinate the Safeguarding Plan
- agree how the Safeguarding Plan will be shared with partners, taking into account information sharing considerations

- provide support and services to meet the needs of the person at risk and of a carer, if that is indicated
- determine what additional information needs to be shared and with whom
- set a date for a review unless all organisations agree that a review can take place as part of the care management/CPA, or health and social care process
- establish and agree the reporting mechanism for the outcome of the review
- if there are concerns that the Safeguarding Plan may not lead to a reduction of the risk or where the investigation is incomplete at the time of the Case Conference, arrange a review date no later than three months from the date of the Case Conference.

The Safeguarding Plan will not include actions taken against the person causing harm.
Stage 7- Review and closure

**Timescale: As agreed by all involved**

The safeguarding adults process may be closed at any stage if it is agreed that an ongoing investigation is not needed, or if the assessment/investigation has been completed and a risk management plan is agreed and put in place.

In most cases a decision to close the safeguarding adults process is taken at the Case Conference or at a review.

The safeguarding response under the procedures is formally closed by a Manager/senior practitioner. The Responsible Manager must reach agreement to close the process with the person at risk and all partners that have been involved in the assessment/investigation and risk management plan. The closing process must be signed off by the Responsible Manager.

**Actions at closure**

The Responsible Manager should ensure that, on conclusion of the process:

- all actions are completed or are in progress
- a Safeguarding Plan is in place (if needed)
- all records are completed
- case records contain all relevant information and satisfactorily completed forms
- the person at risk and their representative(s) know that the process is concluded and where/who to contact if they have any future concerns about abuse.

Any new concern of abuse, neglect or exploitation would be considered as a new alert.

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

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

- adherence to the timescales would jeopardise achieving the outcome that the person at risk wants
- it would not be in the best interests of the vulnerable adult
- the complexity of the investigation is such that a longer timescale is unavoidable.

Reasons for any variations in timescales must be recorded. Where this variation concerns the strategy meeting, investigation and Case Conference, the agreement of the Responsible Manager must be sought and an alternative timescale agreed to avoid the process becoming open ended.

Other processes, including Police investigations, HR investigations and complaints investigations, may continue alongside the safeguarding adults process, but should not delay it; for example, a decision that on the balance of probabilities abuse took place can be taken, even if the Police have not concluded their enquiries.
How should persons at risk and others be supported during the safeguarding process?

Responding to an adult making a disclosure

It is important that the adult is given the opportunity to talk and every effort should be made to ensure this takes place in private. The person at risk may not understand that they are being abused and so may not realise the significance of what they are telling you. Some disclosures happen many years after the abuse. There may be good reasons for this, for example the person they were afraid of has left the setting. Therefore, any delay in an individual reporting an incident should not cast doubt on its truthfulness.

Principles of responding to a disclosure:

• assure the person that you are taking them seriously

• listen carefully to what they are telling you, stay calm, try to get a better picture of what happened, but avoid asking too many questions

• do not give promises of complete confidentiality

• explain that you have a duty to tell your Manager or other designated person, (if you are an employee/volunteer), and that their concerns may be shared with others who could have a part to play in supporting and protecting them

• reassure them that they will be involved in decisions about what will happen

• explain that you will try to take steps to protect them from further abuse or neglect.

• if they have specific communication needs, provide support and information in a way that is most appropriate for them

• record the words of the person at risk and accept the statements as fact; record the full details, including the time, date and location that disclosure was made. All written notes must be made as soon as practicable and kept securely

• do not confront the person alleged to have caused the harm as this could place you at risk, or provide an opportunity to destroy evidence, or intimidate the person alleged to have been harmed or witnesses

• do not be judgemental or jump to conclusions

• staff and volunteers should follow their organisational procedures for raising the alert

• families, carers and other significant parties should follow the reporting process as laid out in this Multi-agency Policy and Procedures document

When someone discloses to you, remember you are not investigating.

Do:

• stay calm and try not to show shock

• listen very carefully

• be sympathetic

• be aware of the possibility that medical evidence might be needed.

Tell the person that:

• they did a good/right thing in telling you

• you are treating the information seriously

• it was not their fault

• you must tell your Line Manager and, with their consent, the Manager will contact Adult Services, and the Police if a crime has been committed. The Manager will, in specific circumstances, contact Adult Services without their consent but their wishes will be made clear throughout.

If a referral is made but the person at risk is reluctant to continue with any enquiries, record this and bring this to the attention of Adult Services when reporting the alert. This will enable a discussion of how best to support and protect the vulnerable adult.
Supporting immediate needs

In line with information sharing considerations, the Manager may need to take the following actions:

• make an immediate evaluation of the risk to the person at risk and any others who may be at risk
• take reasonable and practical steps to safeguard the person at risk as appropriate
• consider referring to the Police if the abuse suspected is a crime
• if the matter is to be referred to the Police, discuss risk management and any potential forensic considerations
• consider the support needs of the person alleged to have caused harm if they are also a vulnerable adult
• arrange any necessary emergency medical treatment; note that offences of a sexual nature will require expert advice from the Police
• if there is a need for an immediate Safeguarding Plan, refer to the relevant Adult Services or Emergency Duty Services if out of hours
• consider appropriate action in line with the organisation’s disciplinary procedures if a staff member is suspected to have caused harm.

Where concerns are raised about the potential abuse of a vulnerable adult, it is vital that they are involved, supported and enabled to make decisions about their needs and risks, and make decisions about the benefits and harms of a response under the safeguarding procedures.

The person at risk about whom there is a concern should be supported in a way which does not jeopardise any investigation or criminal prosecution. Decisions about how this will be achieved will be made throughout the safeguarding process, informed by what the person at risk is saying they need and what would be acceptable to them.

The identification of risk should usually be undertaken with the person who has been harmed unless doing so is likely to increase the risk of harm or puts other adults or children at risk.

The person at risk may need a range of support/information:

• practical
• psychological/emotional
• medical
• educational
• community
• social care
• legal/financial.

Preserving evidence

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

Try not to disturb the scene, clothing or victim if at all possible. Secure the scene, for example, lock the door, preserve all containers, documents, locations, etc.

Evidence may be present even if it cannot actually be seen. If in doubt, contact the Police and ask for advice.

The Police will always be responsible for the gathering and preservation of evidence to pursue criminal allegations against people causing harm. However, other organisations and individuals can play a vital role in the preservation of evidence to ensure that vital information or forensics is not lost. The Police are required to obtain oral (spoken) evidence in specific ways. For some vulnerable witnesses this means that their evidence has to be obtained in accordance with the Youth and Criminal Evidence Act 1999, which is designed to help them to give evidence and provides a number of ‘special measures’ to enable them to do this.
Vital interest
If the person at risk has the mental capacity to make informed decisions about their safety and they do not want any action to be taken, this may not preclude the sharing of information under safeguarding procedures with relevant professional colleagues. This vital interest decision is considered to enable professionals to assess the risk of harm to the person and others, and to be confident that the person at risk is not being unduly influenced or intimidated, and is aware of all the options. This will also enable professionals to check the safety and validity of decisions made. It is good practice to inform the person at risk that this action is being taken unless doing so would increase the risk of harm.

Best interest
If the vulnerable lacks capacity to make informed decisions about maintaining their safety and they do not want any action to be taken, professionals have a duty to act in their best interests under the Mental Capacity Act 2005.

Public interest
If the person at risk has the mental capacity to make informed decisions about maintaining their safety and they do not want any action to be taken, where it is assessed that there is potentially harm to others, practitioners may have a duty to share the information with relevant professionals to prevent harm to others in the public interest.

Personal risk taking
The person at risk will have views about what is an acceptable level of risk to them and about balancing the risks in order to achieve safety whilst maintaining their independence and chosen lifestyle.

A person with mental capacity may choose to live in a situation which is considered to be unsafe by professionals; if they think the alternatives they are offered are unacceptable, they have the right to make an informed choice to continue to take these risks. However, they do not have the right to make decisions about the protection that other people may need where they may also be at risk from the same person, service or setting.

The individual needs to be able to make informed choices from the information they are given. In order to do this they may need support in a variety of ways such as the help of a family member or friend (as long as they are not the person alleged to have caused the harm), an advocate, an Independent Mental Capacity Advocate (IMCA) or Independent Mental Health Advocate (IMHA), a language interpreter or other communication assistance or aid.

Choice must not be used as an excuse for inaction. There is a responsibility to help the individual explore their decision and to offer regular opportunities to review that decision. A decision not to work with one agency may still allow contact with others who can maintain awareness of the situation and be proactive if the situation deteriorates.

Whenever an agency makes a decision not to support the person’s choice, the decision will be based on clear evidence and reasoning in the risk assessment and risk management plans. This will be discussed with the person at risk and where appropriate, their carer and/or representative.

Witness support and special measures
If there is a police investigation, the Police will ensure that interviews with the adult who is a vulnerable or intimidated witness are conducted in accordance with Achieving Best Evidence in Criminal Proceedings. Special measures are those specified in the Youth Justice and Criminal Evidence Act 1999 and will be used to assist eligible witnesses. The measures can include the use of screens in court proceedings, the removal of wigs and gowns, the sharing of visually recorded evidence-in-chief, cross-examination and re-examination and the use of intermediaries and aids to communication.

Intermediaries play an important role in improving access to justice for some of the most vulnerable people in society, giving them a voice within the criminal justice process. They help
children and adults who have communication difficulties to understand the questions that are put to them and to have their answers understood, enabling them to achieve their best evidence for the Police and the courts.

The Witness Service provides practical and emotional support to victims and witnesses (either for the defence or for the prosecution). The support is available before, during and after a court case to enable them and their family and friends to have information about the court proceedings, and could include arrangements to visit the court in advance of the trial.

Victim Support
Victim Support is a national charity which provides support for victims and witnesses of crime in England and Wales. It provides free and confidential help to family, friends and anyone else affected by crime, which includes information, emotional support and practical help. Help can be accessed either directly from local branches or through the Victim Support helpline 0845 30 30 900.

Responsibilities to adults who make repeated or unfounded allegations
Where a person who uses services has made repeated allegations of abuse which have each been thoroughly investigated and found to be unsubstantiated, the person who uses services and their social worker/care co-ordinator involved may agree that making repeated allegations is part of the person’s normal behaviour and may be due to their illness. If this situation arises, a robust multi-agency risk management plan must be developed in recognition that similar future allegations may be made. This must consider measures to protect those who are at risk of being falsely accused, which could include staff that need to continue to provide care, treatment and support for the person using services, within their own home, a hospital of residential setting. If a new allegation is subsequently made, and following review presents the same issues as before, then the allegation should be managed and recorded as agreed in the risk management plan. However, all new allegations must still be taken seriously and reviewed and if the allegation presents different issues than specified in the risk management plan, then the concern should be reported as a new Safeguarding Adults Alert.

Responsibilities to those who are alleged to have caused the harm
Adults who are alleged to have abused another adult have the right to be assumed innocent until the allegations against them are proved on the evidence. Whether they are members of staff, a volunteer, a relative or a carer, they also have the right to be treated fairly and their confidentiality respected.

What information is shared with them and when, should be decided at the strategy discussion or meeting. They have a right to know in broad terms what the allegations are that have been made against them, unless the Police advise otherwise. They should be provided with appropriate support throughout the process.

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

If the person causing harm is living within a health or social care setting or supported living unit, the impact of their actions on the environment for residents/patients/tenants should be taken into account.

Risk assessment and risk management
Professionals have a responsibility to support the person at risk through risk assessment which is integral to the whole process of safeguarding and is specifically concerned with the identification of specific risks to a person and others.

A risk assessment must be undertaken when an alert is raised; this should clarify the degree
of risk to the vulnerable adult, other adults and/or children, the public, the worker/volunteer and the organisation. Risk should be constantly re-evaluated throughout the process and wherever possible shared with the person at risk and others to ensure that they and all others involved are appropriately supported and protected.

The risk assessment will seek to determine:

- what is the risk decision?
- what are the potential outcomes from that risk decision (positive and negative) and how serious are these potential outcomes and to whom?
- who could be affected? (the individual; their carers/family; the public; the organisation)
- what is the likelihood or probability that those outcomes will actually occur?

Based on this assessment of level and likelihood of risk (incorporating the views and wishes of all involved parties), a decision must be made as to whether to proceed with the risk decision. If the decision is to proceed, a plan to manage identified risks will be required.

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

Organisations will have in place a range of risk assessment tools in paper and IT formats to assist staff in risk assessment and risk management.

The safeguarding risk management Safeguarding Plan should be put in place and should aim to remove or minimise the risk of harm to the person and others who may be affected, and to maximise benefits and gains. The Plan will need to be monitored, reviewed and amended/revised as circumstances arise and develop.

Involving and supporting families, carers, friends and significant others

Where concerns are raised about the potential abuse of a vulnerable adult, it is important that their carers, families, friends and/or significant others are involved and supported throughout the safeguarding process, where appropriate.

Family, friends and carers who are not implicated in the allegation of abuse can have an important part to play in providing support to the adult. Where appropriate and where the adult has capacity to consent, relevant family, friends and significant others should be consulted in relation to the support needs for the adult.

Where they do not have capacity to give consent for information to be shared or to make a decision relevant to the concern in question, family and friends must be consulted in compliance with the Mental Capacity Act 2005 (see Section 3, Multi-agency Practice Guidance for further information).

It is important not to confuse the role of carer with that of care worker who is someone who is employed and paid to provide personal/practical care to an individual.

Families, friends, carers and significant others raising an alert

Families, friends, carers or significant others are often the first to pick up on concerns, witness abuse, have details of an abuse disclosed to them, note unexplained injuries, or see changes in behaviour that may suggest that something has occurred that has distressed the adult.

Professionals should recognise that making a disclosure can be difficult so it is important to ensure that appropriate information and support is available for them. Carer support organisations may be an appropriate form of support for a carer in these situations.

When an alert is raised by a family member, carer or other significant party, they should be informed about the safeguarding process and where appropriate the decision made / action being taken as a result of the referral. They should be advised of the principles of confidentiality and information sharing. They should be advised that any approach to the adult will be sensitively handled and the adult will be supported to be engaged with and involved in the process, if that is their wish.

Professionals working with the adult should take into account that a family member, carer or
significant other may experience guilt or anxiety in relation to having raised the alert.

Professionals should advise the family member, carer or significant other of issues that may arise for example, things they should not do to prevent any enquiries being compromised.

Families, friends and other significant parties often play an important role in supporting the adult through the safeguarding process and this should be recognised by professionals. Where the family member, carer or significant other is a witness to an alleged crime, they may be unable to support the adult in relation to the interview process and they should be informed of this at the earliest opportunity.

If a referral or complaint is received after a person at risk has died

The referral or complaint could contain an allegation or suspicion that abuse or neglect could have been a contributory factor in the person’s death. The allegation may be made by a family member or friend, a concerned member of staff who is ‘whistleblowing’, or as a result of a report from the coroner. Such a referral will give rise to action under the Safeguarding Adults Policy and Procedures. Further concern will be to ensure that no other adults are at risk from the same source and, if they are, to take steps to ensure their safety. Decisions may also be taken about whether a Serious Case Review (SCR) will be undertaken.
Appendix 1: Quick Guide for Providers of Services

Disclosure or expression of concern of abuse

**Immediate action to be taken:**

- Ensure the safety of the person who is alleged to have been harmed or the person alleged to have caused the harm; if in immediate danger, contact the relevant emergency services e.g. Police, Ambulance.
- Support and reassure the person, recording what is said and/or observed but avoid asking leading questions.
- Log nature of alleged abuse, any information given or witnessed, actions taken, who was present at the time, dates and times of incident(s).
- Secure any evidence.
- Do not question the person alleged to have caused the harm about the incident.
- Listen to the person, ascertain their wishes and explain what will happen next.
- Do not take photographs of any injuries (unless a Policy and Procedure on the taking of photographs is in existence, then this should be followed).
- Report concerns to appropriate Manager **(within 2 hours)** to enable the Manager to assess the risk and safety needs of the adults at risk and assess if the concerns constitute an ‘alert’.
- Ensure all discussions and decisions are recorded.
- Report incident to Police if criminal offence appears to have been committed.

**Within 24 hours (the Manager should):**

- Assess the presenting risk issues and record this risk assessment.
- Discuss with the adult/family at risk a management plan to minimise the risk to the person at risk and others.
- Secure any evidence (records, reports, body maps, clothing, etc.).
- Consider internal disciplinary action if a member of staff is alleged to be involved.
- Consider if a referral to DBS (need to update) is necessary.
- Inform CQC (if in a regulated setting).
- Refer to Adult Services Team or Emergency Duty Service (staff or volunteers must make direct contact with Adult Services/Police/CQC, if Manager is suspected to be implicated).
- Initiate other processes that need to be triggered, e.g. Serious Incident Requiring Investigation.
- Record any actions taken and any reasons for variation on timescales.

**Information to be given at the point of referral by the Manager or ‘Whistleblower’:**

- Details of the adult alleged to have been harmed (name, contact details, DOB, gender, ethnicity and principal language, any disability, any communication issues, next of kin and key others).
- Name and contact details of GP.
- Reasons for the concerns, the context of these and how they came to light.
- An impression of the seriousness of the situation.
- Details of any witnesses.
- Any concerns or doubts about the person’s mental capacity to make a decision about their protection/safety needs.
- Whether the vulnerable person is aware of and has consented to the referral.
- Any expressed wishes of the vulnerable adult.
- Action already taken to protect the adult or others at risk and actions under any other processes, e.g. disciplinary, Serious Incident Processes etc.

**Actions to be discussed/agreed:**

- What interim measures need to be put in place.
- What reports should be sent by the provider.
- Contact with families as agreed with the person at risk or if the adult lacks capacity to make this decision, discuss what would be in their ‘best interests’.
- Contact with funding agencies.
- Contact with regulators.
- What will happen next and timescales.
- The person who will be the named contact for the provider.
- referral to Local Authority Designated Officer (LADO).

**Ongoing action:**

- Ensure ongoing support and risk management to the adult(s) at risk of abuse.
- Contribute to strategy discussions, attend strategy discussions or meetings.
- Participate in single agency or multi-agency investigation.
- Undertake actions as agreed as part of the strategy plan (agreed in strategy discussions or meetings).
- Ensure liaison between Police and Human Resources.
- Liaise with the person at risk and families as required.
- Participate in Case Conferences and Review meetings as required.
- Continue internal management investigation and seek HR advice on implications of employment legislation.
- Ensure referral to the DBS (update) where required.
- Ensure referrals to professional bodies where required.
- Contribute to other enquiries e.g. Serious Incident Requiring Investigations, Serious Case Reviews, Homicide Reviews, etc.
- Ensure staff team receives necessary support and information on a ‘need to know basis’.
APPENDIX 2: Quick Guide for Alerters

Disclosure or expression of concern

**Immediate action to be taken:**

- Ensure the safety of the individual and if in immediate danger, contact the relevant emergency service e.g. police, ambulance, GP.
- Preserve any forensic or other evidence.
- Support and reassure the person, recording what is said or observed, but avoid asking leading questions.
- Log nature of alleged abuse, any information given or witnessed, actions taken, who was present at the time, dates and times of incident(s).
- Report concerns to appropriate supervisor/manager to evaluate seriousness of the situation & whether it falls within the remit of the policy.
- Consider risk issues and record all discussions and decisions.

**Within 24 Hours (record reasons for any variations in timescales):**

- Complete the Safeguarding Alert Form.
- Report incident to police if a criminal offence appears to have been committed clearly stating this is a safeguarding adults referral.
- Inform CQC of incident (Regulation 18)
- Refer to Adult Services (or Out of Hours Team) for investigation clearly stating this is safeguarding adults referral. (Staff to make direct contact with adult services/ police/CQC if manager is implicated).
- Consider internal management/disciplinary action including the need for suspension and/or referral to DBS (update), and/or Professional Registration Body.
- Inform service manager (who will liaise with other departments/organisations as required).

**Information to be given when making a referral:**

- Details of alleged victim (name, contact details, DOB, gender, ethnicity + principal language, any disability, any communication issues).
- Name and contact details of GP.
- Nature of the concerns, reasons and context for these and how they came to light.
- An impression of the seriousness of the situation and any other identified risks.
- Any concerns or doubts about the person’s mental capacity.
- The perspective of the person at risk about the situation and whether the person is aware of and has consented to the referral.
- Action already taken to protect the person & any other referrals or information sharing made.
- Other professionals, carers and any significant family members, neighbours and friends involved.
- Details of the alleged abuser & if they too are a vulnerable adult.

**Ongoing action:**

- Participate in police and/or adult services investigation.
- Attend safeguarding strategy meeting, case conference and review meetings as required.
- Liaise with the Police and Human Resources as required.
- Continue internal management investigation and seek HR advice on implications of employment legislation.
- Ensure staff member(s) implicated in the alleged abuse receives necessary support.
- Inform alerter of action taken following referral.

**USEFUL TELEPHONE NUMBERS:**

**Police**
Email: cru@hampshire.pnn.police.uk
Telephone: 0845 045 45 45

**Care Quality Commission**
Email: enquiries@cqc.org.uk
Telephone: 03000 616161

**DBS Helpline:**
Telephone: 01325 953795
ISA: PO Box 181, Darlington DL1 9FA
APPENDIX 3: Action to be taken when a Clinical incident in the NHS is also a Safeguarding Alert

**Step 1: EVENT**
(Any incident of concern involving people, interventions, equipment, and the environment)

**Step 2: REPORT**
* (This could be an incident form, complaint, verbal report etc.)

**Step 3: REVIEW**
* Is this a SAFEGUARDING CONCERN?
(a vulnerable adult experiencing or at risk of abuse, neglect or exploitation) IF SO

DISCUSS WITH ADULT SERVICES
REFER TO THE POLICE IF A CRIME HAS BEEN ALLEGED

**Step 4:**

- YES
  - Refer to Adult Services. (Re-consider referral to Police if a crime has occurred).
  - And (Consider level and type of investigation(s) required and agree these, response methods and timescales) as part of a strategy discussion with Adult Services
  - Safeguarding process initiated by relevant Adult Social Care Team
  - Assessment/investigation initiated as agreed above
  - Regular communication is maintained

- NO
  - Has a safeguarding concern been identified following further
  - Actions implemented, lessons learnt and shared. Refer to Regulator/ISA if appropriate

Report(s)/response produced and actions identified

Reports should be reviewed within 24 hours in order to progress to Step 4.

Local arrangements for this will involve partnership between health and social care professionals with a lead responsibility for adult safeguarding.

Ref: Adapted from Clinical Governance and Adult Safeguarding. An Integrated Process. DH February 2010
See Section 3D (page 89).
APPENDIX 4: Quick Guide for Investigators

**Alert:** Where the alleged victim is unknown to social services or his/her case is not allocated within a team, the referral will be responded to by the local authority’s first contact assessment team in the first instance. Once initial action has been taken, the referral will be directed to the relevant team for ongoing intervention. Please refer to your agency’s Safeguarding Referral Protocol for more information.

### Within 24 hours of the Safeguarding Referral:

<table>
<thead>
<tr>
<th>Record reasons for any variations in timescales:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Allocate referral to a lead worker who will co-ordinate the case &amp; undertake enquiries and liaise with other agencies.</td>
</tr>
<tr>
<td>• Consider a referral to Police via the Central Referral Unit if a crime is suspected.</td>
</tr>
<tr>
<td>• Identify any immediate action needed to ensure safety &amp; record this assessment.</td>
</tr>
<tr>
<td>• Assess the level of risk &amp; appropriate level of intervention using Intervention Thresholds Framework.</td>
</tr>
<tr>
<td>• Ascertain the need for an advocate, IMCA and/or interpreter.</td>
</tr>
<tr>
<td>• Consider responsibilities if alleged perpetrator is also a vulnerable adult.</td>
</tr>
<tr>
<td>• If a child is at risk, make a referral to Children’s Services.</td>
</tr>
<tr>
<td>• If a serious/high risk situation, undertake strategy discussions with Police, CQC, other agencies and/or teams.</td>
</tr>
<tr>
<td>• If the referral involves a care provider, check most recent inspection report and notify CQC of the referral.</td>
</tr>
<tr>
<td>• Record all relevant information &amp; the risk assessment which is the basis of the decision to share information.</td>
</tr>
<tr>
<td>• Acknowledge the referral in writing.</td>
</tr>
<tr>
<td>• Decide if the concern is valid. If invalid &amp; no further action is needed, record the decision, reasons and complete closure.</td>
</tr>
<tr>
<td>• Allocate a separate worker to the alleged perpetrator, if (s)he also a vulnerable adult, and maintain separate case management.</td>
</tr>
<tr>
<td>• Record the referral on the electronic records system and inform senior managers if indicated by the Intervention Thresholds Framework.</td>
</tr>
</tbody>
</table>

### Within 7 working days of the Safeguarding Referral:

<table>
<thead>
<tr>
<th>Record reasons for any variations in timescales:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Convene a multi-agency strategy meeting to be chaired by a designated manager.</td>
</tr>
<tr>
<td>• Review risk status and any safety issues and consider consent and capacity issues.</td>
</tr>
<tr>
<td>• Consider legal powers potentially available to protect the person at risk.</td>
</tr>
<tr>
<td>• Consider any HR implications and if referrals are required to other agencies e.g. Police, CQC, DBS, HCPC, NMC, GMC.</td>
</tr>
<tr>
<td>• Identify if special measures are needed re interviewing vulnerable witnesses and compete witness profile.</td>
</tr>
<tr>
<td>• Agree an action plan identifying the focus of the investigation, lead roles and timescales.</td>
</tr>
<tr>
<td>• Record on the electronic records system e.g. decisions, actions and timescales agreed. Inform senior manager as appropriate.</td>
</tr>
<tr>
<td>• Ascertain wishes of the person at risk as to outcome they wish to see and whether they wish to attend the Case Conference and what support they will need</td>
</tr>
<tr>
<td>• Liaise with Police: Review the criminal status of findings</td>
</tr>
<tr>
<td>• Carry out agreed investigations or assessments</td>
</tr>
</tbody>
</table>

### Within 21 working days of Safeguarding Strategy Meeting:

<table>
<thead>
<tr>
<th>Record reasons for any variations in timescales:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Convene a Safeguarding Case Conference to be chaired by the designated manager.</td>
</tr>
<tr>
<td>• Review information gathered, risk status and any safety issues.</td>
</tr>
<tr>
<td>• Agree &amp; record a Safeguarding Plan stating who will do what, timescales + monitoring &amp; review arrangements.</td>
</tr>
<tr>
<td>• Record the process and outcomes on the electronic records system.</td>
</tr>
<tr>
<td>• Designated manager to review case prior to closure.</td>
</tr>
<tr>
<td>• Ensure the safeguarding plan is reviewed against delivery within 3 months of the case conference.</td>
</tr>
<tr>
<td>• Undertake monitoring and review and record decisions and outcomes on case record IT system</td>
</tr>
</tbody>
</table>

### USEFUL TELEPHONE NUMBERS:

| **Police** |
| Email: cru@hampshire.pnn.police.uk |
| Telephone: 0845 045 45 45 |

| **Care Quality Commission** |
| Email: enquiries@cqc.org.uk |
| Telephone: 03000 616161 |

| **DBS Helpline:** |
| Telephone: 01325 953795 |
| ISA: PO Box 181, Darlington DL1 9FA |
APPENDIX 5: Investigation processes that can be triggered by a safeguarding adults referral

The following are all issues which could feature in any concern of abuse and the agency/organisation who might have a lead/key role in the investigation.

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Agency/Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal</td>
<td>Police</td>
</tr>
<tr>
<td>Irregular/suspicious activity relating to a bank account</td>
<td>Bank</td>
</tr>
<tr>
<td>Breach of Health and Social Care Act 2008</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Unresolved complaint in a health care setting</td>
<td>Health Service Ombudsman</td>
</tr>
<tr>
<td>Breach of rights of a person detained under the Mental Health Act 1983</td>
<td>Care Quality Commission (Mental Health Act Commissioner)</td>
</tr>
<tr>
<td>Breach of terms of employment</td>
<td>Employer</td>
</tr>
<tr>
<td>Breach of professional code of conduct</td>
<td>Professional Body (Nursing and Midwifery Council/Health and Care Professions Council/Law Society etc.)</td>
</tr>
<tr>
<td>Breach of health and safety legislation</td>
<td>Health and Safety Executive</td>
</tr>
<tr>
<td>Complaint re: failure of service provision</td>
<td>Service provider</td>
</tr>
<tr>
<td>Breach of contract to provide care</td>
<td>Commissioner of service/OFT</td>
</tr>
<tr>
<td>Bogus callers or rogue traders</td>
<td>Trading Standards</td>
</tr>
<tr>
<td>Concerns about persons acting under an appointeeship</td>
<td>Department of Work and Pensions/Adults’ Services</td>
</tr>
<tr>
<td>Ill treatment or neglect of a person lacking capacity</td>
<td>Police</td>
</tr>
<tr>
<td>Anti social behaviour</td>
<td>Local Authority/Police</td>
</tr>
<tr>
<td>Suspicious death</td>
<td>Coroner’s Office/Police</td>
</tr>
<tr>
<td>Concerns about the actions of a deputy or registered attorney</td>
<td>Office of the Public Guardian (OPG)</td>
</tr>
<tr>
<td>Failure to meet standards in NHS hospitals</td>
<td>Care Quality Commission</td>
</tr>
<tr>
<td>Assessment of need for health and social care services</td>
<td>Adult Services/PCT (update)</td>
</tr>
<tr>
<td>Fraud by solicitor appointed as financial deputy</td>
<td>Solicitors' Regulatory Authority/Police</td>
</tr>
<tr>
<td>A person becoming homeless due to experiences of abuse</td>
<td>Housing</td>
</tr>
<tr>
<td>A member of staff having a sexual relationship with a service user with a mental disorder</td>
<td>Police</td>
</tr>
<tr>
<td>Failure by a registered provider to report abuse and allegations of abuse involving people who use the service</td>
<td>CQC</td>
</tr>
</tbody>
</table>

Adapted from ‘Safeguarding Adults’ 2005
# Section 3
## Multi-agency Practice Guidance

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Introduction

This Practice Guidance provides a good practice framework to support the Multi-agency Procedures and is intended to be used as a guide to aid decision making in adult safeguarding cases in Southampton, Hampshire, Isle of Wight and Portsmouth. It does not replace the need for professional decision making informed by professional knowledge, skills and evidence based practice.

This guidance reflects some of the processes involved in making a decision about whether a ‘safeguarding alert’ regarding a person at risk who appears to be at risk of abuse, neglect or exploitation, is progressed through the Adult Safeguarding Procedures.

If a person at risk is experiencing harm which causes “impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development” (Law Commission, Who Decides, 1997), i.e. ‘significant harm’, then they have a right to specialist preventative and protective services.

Definitions used in making threshold decisions are explained, together with factors to be considered in decision making. A person at risk who appears to need Adult Safeguarding Procedures must be assured that their rights will be upheld throughout the procedures.

It is important to remember that not all ‘safeguarding alerts’ meet the definitions:

• the concerns are not in relation to a vulnerable adult

• the concerns are not in relation to abuse by someone else or the concern is not about a person at risk causing harm to others.

So whilst some people/providers may report what they judge to be a safeguarding alert, the person receiving the information within adult services or integrated teams can demonstrate that it does not meet the definition and this should be clearly communicated to the person raising the ‘alert’.

If the criteria for a response under the Safeguarding Procedures has not been met, the person/Team receiving the alert must:

• signpost the person to the most appropriate agency/organisation

• consider whether it is appropriate to offer the person or their carer an assessment or if already known to Adult Services, whether to undertake a review

• inform the ‘alerter’ and the person at risk of the decision made

• obtain consent to share information if other agencies/organisations ‘need to know’, (refer to the principles of the Data Protection Act if there is a need to share without consent)

• record the decision and the outcomes as no further action under Safeguarding Procedures.

Wrongful application of eligibility criteria can confuse the decision as to whether to pass a safeguarding ‘alert’ onto the referral stage for threshold decision making. Even if a person is assessed as being at a ‘low’ or ‘moderate’ risk of losing independence, a concern about the possibility of abuse will move them into a higher band (under current eligibility criteria: “Critical or Substantial risk). Eligibility criteria for adult care services should not be used in making decisions, the essential factor is whether the person meets the criteria of ‘vulnerable adult’ under No Secrets 2000.
Such ‘threshold decisions’ are crucial in ensuring that members of the population who meet the definition of ‘vulnerable adult’, (No Secrets 2000), are able to receive the assistance they need. By definition, these adults are less able to protect themselves or claim their civil or human rights without assistance.

Not everyone who needs support to live their everyday lives is in need of such services, therefore it is important to target resources on those who do. Resources must also be used proportionately, i.e. some people will need the Safeguarding Adults Procedures to be used to fully protect them; in other situations the Safeguarding Adults Procedures can be used to enable a person to self-protect in the present, or future, circumstances.
The criteria used to identify whether an issue should be raised as a safeguarding alert are as follows:

<table>
<thead>
<tr>
<th>Is this person a vulnerable adult?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is abuse/neglect by a third party alleged?</td>
</tr>
<tr>
<td>AND</td>
</tr>
<tr>
<td>Is this person unable to take care of him or herself?</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>Is this person unable to protect him or herself against significant harm or exploitation.</td>
</tr>
</tbody>
</table>

If the answer is YES, then you have a ‘safeguarding alert’

In order to assess whether a referral crosses the threshold for use of the Safeguarding Adults Procedures, the decision needs to be made as to whether ‘significant harm’ is likely to have occurred or not. Types of harm are not always obvious and care should be taken to assess the alert in the context of signs and signals of abuse.

“Harm should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development.” (Source: Who Decides? Lord Chancellor Dept 1997 and Law Commission Review of Adult Social Care Law Consultation 2010.)

Actual, or likelihood of, harm may impact upon the person in one or more areas of their life:

- exercising choice and control
- health and well-being, including mental and emotional as well as physical health and well-being
- personal dignity and respect
- quality of life
- freedom from discrimination
- making a positive contribution
- economic well-being
- freedom from harm, abuse and neglect, taking wider issues of housing and community safety into account.

Significant harm varies between individuals. This requires careful assessment using as much information as is available before a decision is made and includes consideration of the possibility of future significant harm.

The seriousness or extent of the abuse or neglect is often not clear when the alert is made. Some incidents may not have caused immediate significant harm but if they were to recur it is highly likely that there would be significant harm to the vulnerable adult, other adults at risk, or children.

If there are no well managed measures in place to prevent another incident, a situation which has a high likelihood of potential serious significant harm, should cross the threshold for use of safeguarding procedures. Whether abuse is intentional or not is irrelevant, what is important is the harm done and whether the abuse might be repeated.

Safeguarding alerts come from a variety of sources and involve a range of situations. These may include difficulties between individual adults, tensions between an adult and their carer(s), failures in a service to provide care or treatment.
to an acceptable standard, individual cruelty, negligence or neglect. This may be intentional or unintentional and may include deliberate attempts to exploit vulnerable individuals in society. Such variations require a proportionate response.

Safeguarding procedures must be used not only to react to significant harm which has occurred, but to prevent significant harm where there are clear indicators of vulnerability and risk. An alert may initially appear innocuous; however, assumptions should not be made. Careful assessment of past information may indicate that although significant harm has not occurred on this occasion, it is highly likely to in the future, therefore a multi-agency response under Safeguarding Procedures is the best course of action.

The decision should be based on a risk assessment which takes into account the information gathered from the adult (wherever possible) and from partner agencies. The decision should be made by a manager or senior practitioner in the lead agency for safeguarding adults, (Adult Social Care Teams or Integrated Teams) and their decision must be evidenced by the assessment of risk and seriousness shared by the practitioner.

Because of the need for a timely and proportionate response, information gathered to inform the decision cannot be as detailed as that gathered subsequently in a formal safeguarding adults investigation. Formulating good processes for inter-agency discussions will help draw out timely multi-agency information.

It should be noted that the stages of the Adult Safeguarding Procedures can be followed in the way that is most appropriate to the circumstances of the adult, in discussion with the adult and other partner agencies (on a ‘need to know basis’), using other routes and resources following an initial assessment of risk and seriousness.

- Managers/senior practitioners should not feel constrained by the need to follow the process rigidly.
- Managers/senior practitioners will want to consider with partner agencies other routes and resources to ensure proportionate responses.

- If a number of agencies are involved and the matter is complex, then a safeguarding strategy meeting may well be helpful, even if subsequent routes to respond are identified.
- If urgent action is needed to assess and manage risk, then key agencies should liaise via telephone with strategy discussions and action plans recorded and disseminated.
- The process can be stopped at any point, for example, if the person at risk wants no further action taken, the allegation is unsubstantiated, or no significant harm appears to have been caused and the concern can be managed. All decisions should however be recorded.

- All decisions should be recorded and shared with the person at risk (where appropriate) and key partner agencies.

See Appendix 2 – Levels of Seriousness and Intervention

Impact of the alleged abuse on the person

This requires a careful person centred assessment and, if it does not increase the risks to the person at risk, consultation with them and, if appropriate, the people close to them. Impact can vary from serious injury or the possibility of death, to emotional distress which damages the person’s quality of life. Consideration of hindering factors needs to be factored into the assessment of actual or likely impact.

The person at risk preferred course of action needs to be considered in the light of possible impact on other persons at risk, children, the community or others. If the adult has been assessed as not having the capacity to make a particular decision in respect of their safety, protection and support needs, then it has to be decided what course of action is currently in their best interest, and what course of action would be in the public interest. Reference must be made to the Mental Capacity Act and the Code of Practice in respect of Best Interest Decision Making and the role of the Independent Mental Capacity Advocate.
Factors to be considered

- Does the alleged abuse involve actual (or potential) harm or exploitation of a person at risk or children? What impact is the alleged abuse having on the person’s quality of life?
- Is the impact immediately obvious?
- Is there potential that it will emerge at a later date?
- Does the person appear to be having difficulty remembering the cause of the incident or event, but is showing general anxiety or fearfulness?
- Is the person having difficulty articulating their feelings?
- If there is alleged actual or likelihood of abuse, what helps or hinders the person in protecting themselves?
- Is this person reliant on others assistance to meet their basic needs?
- Have they the capacity to assess risk or decide on courses of action to take to protect themselves?
- Are they able to act on the assessed risk or courses of action in the situation they are in?
- Are they under duress? Duress increases vulnerability in all cases, particularly so if those exerting duress are in control of the person’s life (e.g. controlling access to services; delivering care; living at the same address). This dynamic (?) is common in domestic abuse situations
- Does the person have family or friends who will speak up on their behalf? If they are isolated, vulnerability to harm or abuse is increased.

Hindering factors such as those above can also be made worse/exacerbated by other things, for example if the person has experienced previous abuse (domestic/institutional or other) which has diminished their ability to protect themselves, or if the person or the alleged abuser is addicted to substances or gambling.

Poor practice and abuse or neglect

The difference between poor practice and neglect is much contested. If a person is totally dependent on others’ assistance to meet basic needs, continual ‘poor practice’ can lead to serious harm or death.

Useful pointers in deciding if poor practice has occurred which does not require a safeguarding adults response are to ascertain if the concern:

- is a ‘one off’ incident to one individual
- resulted in no harm
- indicated a need for a defined action.

Incidents which indicate that poor practice is affecting more than one adult, that poor practice is recurring and is not a ‘one off’, must result in Safeguarding Adults Procedures being initiated as these incidents can be indicators of more wide spread, ‘institutional’ abuse.

Sometimes a ‘one off’ incident is an indication of a lowering of standards by Health or care providers. Early indications of poor practice must be raised as an ‘alert’, but they can be addressed using other systems, for example:

- quality assurance processes
- care management/care programme approach processes
- complaint investigations
- human resources systems
- Care Quality Commission responses

All of these will ensure that the issue is properly assessed, investigated, recorded, resolved and monitored. Commissioners need to collate records of poor practice concerns and keep the Managers and safeguarding adults leads informed of any escalating concerns about individual agencies.

Examples of the difference between poor practice and neglect can be seen in Appendix 1.
Abuse of one adult in a care setting by another

The significance of the harm caused to the person, rather than the relationship to the person who has abused them, is the most important factor. If both adults are in a health or social care setting, the frequency and risk of harm can be increased and compounded by the emotional distress of living with an abusive person. National enquiries, homicide reviews and Serious Case Reviews show that incidents between people who live in the same care setting can involve manslaughter, rape and sexual assault, grievous bodily harm and common assault, many of which may have been prevented by a careful analysis of more minor incidents.

Multi-agency Safeguarding Procedures will not be needed if it does not appear that any significant harm has occurred, that the incident was an isolated one and that risk assessment and management plans have been amended and monitored to ensure the incident is not repeated. A care management/care co-ordination review of the success of the risk management plan should be undertaken after an appropriate period of time.

Decisions in health settings

“Safeguarding adults is an integral part of patient care. Duties to safeguard patients are required by professional regulators, service regulators and supported in law.”
(Safeguarding Adults; the role of the Health Practitioner, DoH 2011, page 5)

Recent guidance, Safeguarding Adults; the role of the Health Practitioner Department of Health 2011, clearly states that any abuse of people defined as persons at risk in No Secrets 2000 must be raised as a safeguarding adults alert and referred in line with the Multi-agency Safeguarding Procedures.

Multi-agency Safeguarding Procedures will apply where there is concern of abuse, neglect, or exploitation to a patient defined under No Secrets guidance as ‘vulnerable’.

And

Responses to safeguarding adults referrals are co-ordinated by adult services or integrated teams. Multi-agency Safeguarding Procedures set out the roles and responsibilities of staff within the service and within partner agencies.

After an alert is received from a health provider or commissioner the procedures are used as with any other alert, i.e. the risks are assessed and a decision is made by the adult social care team or integrated team as the operational lead on safeguarding adults, and the same criteria of significant harm should be applied.

Timescales for referrals made by a Health commissioner or provider are the same and all actions relating to the safeguarding adults responses and any other investigations - e.g. clinical incidents, complaints, Serious Incidents Requiring Investigation - must be agreed and recorded via a strategy discussion or meetings.

This will ensure that investigations are prioritised and, when appropriate, run in parallel. Good communication protocols between adult social care or integrated teams and clinical governance teams must be used to ensure that different processes are clear and understood, and all assessment and investigative processes inform each other. This integrated approach is supported by the National Patient Safety Agency framework for investigating serious incidents. This framework defines allegations of abuse as serious incidents to be investigated through local safeguarding adults procedures.

Integrating safeguarding adults into clinical governance provides a twofold benefit for both the patient and the service.

For the patient
• Sharing information between agencies, improves the understanding of risk and the patient’s needs, i.e. brings together a jigsaw of small concerns related to the person or service
• improves the quality of the investigation through access to wider multi-disciplinary perspectives and expertise
• other agencies can assist in the patient’s care
• the patient has confidence their concern is managed in an open and transparent way
• ensures the focus is on outcomes for the patient rather than the service
• provides a ‘safety net’ for citizens with greatest need.

For the service and their partners
• Enables the service to collate vital information about their safeguarding adults responsibilities
• identifies and addresses emerging concerns within a service
• provides more robust and transparent investigative process
• manages patient and organisational risk
• avoids duplication – the safeguarding adults investigation also meets investigations required by the service
• improves scrutiny, accountability and assurance for: patients; the service; commissioners: and regulators
• enables learning within and between organisations
• provides opportunity for a multi-agency approach to service improvement

Alerts which fall below the threshold
It is vitally important that the person who made the alert is informed as soon as possible that Safeguarding Adults Procedures are not thought to be appropriate. An alerter who believes that action is being taken may cease to monitor or take protective action in the belief that others are involved. Alerters are also keen to learn whether the alert has been appropriate or not; by providing information and feedback, inappropriate referral patterns can be changed.

If the adult concerned has made an alert or was aware that the alert had been made, they must also be informed that Procedures will not be used.

Any further action or recommendations must be recorded and care taken to ensure that these are carried out. For example, if a provider is asked to change a care or support plan to reduce the risk of a further incident, then this action should be followed up with a an appropriate review.
### APPENDIX 1: Poor Practice

These are just examples and it is important that each case is assessed on its own merits by provider managers/commissioners/practitioners to determine whether the concern is poor practice or abuse which requires a response under safeguarding procedures.

<table>
<thead>
<tr>
<th>Poor practice which requires actions by a provider agencies, e.g. care/nursing homes, hospital wards or domiciliary care agencies, day services, etc.</th>
<th>Possible abuse which requires a response using Safeguarding Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Patient/service user does not receive necessary help to have a drink/meal and no significant harm has occurred to the person or others. If this is an isolated incident and a reasonable explanation is given - e.g. unplanned staffing problem, emergency occurring elsewhere in the home - and the incident is dealt with using internal procedures, this would not be referred under Safeguarding Adults Procedures.</td>
<td>Patient/service user does not receive necessary help to have drink/meal and this is a recurring event, or is happening to more than one vulnerable adult. This constitutes neglectful practice, may be evidence of institutional abuse and would prompt a safeguarding investigation.</td>
</tr>
<tr>
<td><strong>2</strong> Patient/service user does not receive necessary help to get to toilet to maintain continence or have appropriate assistance such as changed incontinence pads. If this happens once and a reasonable explanation is given e.g. unplanned staffing problem, emergency occurring elsewhere in the home and is dealt with in a timely way through internal procedures/processes, this would not be referred under Safeguarding Adults Procedures.</td>
<td>Patient/service user does not receive necessary help to get to the toilet to maintain continence and this is a recurring event, or is happening to more than one vulnerable adult. Neglectful practice, may be evidence of institutional abuse and would prompt a safeguarding investigation.</td>
</tr>
<tr>
<td><strong>3</strong> Patient/service user has not been formally assessed with respect of pressure area management but no discernible harm has arisen. This is an isolated incident; action has been taken to address the pressure area management. This may need to be dealt with under different processes, i.e. disciplinary procedures.</td>
<td>Patient/service user is frail and has been admitted without formal assessment with respect of pressure area management. Care provided with no reference to specialist advice re: diet, care or equipment. Pressure damage occurs. Neglectful practice, breach of regulations and contract, possible institutional abuse. Safeguarding procedures should be instigated.</td>
</tr>
<tr>
<td><strong>4</strong> Patient/service user does not receive medication as prescribed on one occasion, but no harm occurs. GP advised/action taken, internal investigation is undertaken, possible disciplinary action depending on severity of situation.</td>
<td>Patient/service user does not receive medication as a recurring event, or this is happening to more than one vulnerable adult. Neglectful practice, regulatory breach, breach of professional code of conduct if nursing care provided. Dependent on degree of harm, possible criminal offence. Safeguarding procedures should be instigated.</td>
</tr>
<tr>
<td>5</td>
<td>Appropriate moving and handling procedures not followed but patient/service user does not experience harm. Provider acknowledges departure from procedures and inappropriate practice and deals with this appropriately, for example, under disciplinary procedures, staff training provided, to the satisfaction of the service user, care plan is revised.</td>
</tr>
<tr>
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<tr>
<td>6</td>
<td>Patient/service user is spoken to in a rude, insulting, belittling or other inappropriate way by a member of staff. They are not distressed by the incident and this is an isolated occurrence. Provider takes appropriate action, for example, supervision, training, disciplinary, and to the satisfaction of the service user.</td>
</tr>
<tr>
<td>7</td>
<td>Service user does not receive a scheduled domiciliary care visit and no other contact is made to check on their well-being, but no harm occurs. Provider deals with this via appropriate responses for example, commissioners notified, internal investigation, complaints procedures, care management review, to the satisfaction of the service user.</td>
</tr>
<tr>
<td>8</td>
<td>Patient/service user has a fall. The adult is being supported to remain active; a falls assessment has been completed and is reflected in the care plan. A capacity assessment is in place if there is reason to be concerned that the adult does not have capacity to assess the risks to themselves. Appropriate aids and equipment to reduce falls are provided. Appropriate referrals are in place to community health professionals.</td>
</tr>
</tbody>
</table>

*Adapted from Dyfed Powys Policies and Procedures 2007*
APPENDIX 2: Levels of Seriousness and Intervention

Whatever level is chosen, it is a formal process and therefore the rationale for the decision made must be recorded.

The risks should (wherever possible) be explored with the adult and the person-centred risk assessment guidance should be used to assist in exploring the risks and the tool used to record the risks.

The practitioner and manager must review the initial assessment of risk and then use the Levels of Response – Decision Making Tool (below) as a guide to determining proportionate adult safeguarding responses to the risk of abuse, exploitation and neglect to the adult and/or to others in consultation with the person at risk (wherever possible).

Responses to abuse, exploitation and neglect should reflect the wishes and views of the adult alongside the nature and seriousness of the risks to them or others.

Responses must be the least restrictive of the person’s rights and take account of the person’s age, culture, wishes, lifestyle and beliefs. Proportionality also relates to managing concerns in the most effective and efficient way for the adult and for those agencies supporting the adult.
## Level 1 Response – Single Agency/Organisation

<table>
<thead>
<tr>
<th>The Person</th>
<th>Decision Making Criteria</th>
<th>Action/Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognises the risk of abuse and feels able/is supported to take steps to manage the risks for themselves</td>
<td>No-one else affected (children or adults) or other people are affected to a limited extent. The person allegedly causing harm is not a person at risk. No concerns about the person’s capacity to make relevant decisions. No concern that the person is experiencing influence, intimidation or coercion by another. Support networks can be easily identified and engaged. Action can be taken quickly and safely to achieve the outcomes identified by the person. Person has robust strategy in place for themselves which needs no, or only minor, external support. Protective systems are available and engaged. Low level concerns about poor practice or the quality of a care service. The cause for the concern can be quickly and successfully eliminated or reduced using a single agency route. Risk of repeated incidents is low. Low level repeated incidents involving another service user/patient where there is minimal impact on the victim and a safeguarding plan is in place to address concerns regarding the same person alleged to have caused harm.</td>
<td>The person at risk should be empowered to contribute and express their views using appropriate support if necessary Provide access to advocacy. Strategy Discussion(s) will take place with the person and key others to plan a response. Undertake a risk assessment with the person and key others. Determine the outcome of the safeguarding risk assessment - whether the alleged incident/concern took place/was founded. Share with the person and key others. Work with the person and key others and put in place a risk management plan. Assessment/investigation may lead to minor alterations in the way service is provided to a person at risk and/or alterations to the way staff or other resources are deployed in the delivery of support or care. Consider with the person and key others the need to share information on a ‘need to know basis’. The manager/senior practitioner reviews the assessment/investigation and its outcomes, and through a ‘Case Conference discussion’ with the adult and key others ensures that: • the person has been fully involved and a Safeguarding Plan is appropriate and in place the outcome of the investigation is determined i.e. whether the alleged incident/concern took place or was founded • the adults safeguarding process was robust and is appropriately concluded</td>
</tr>
</tbody>
</table>
| Risks can be reduced or managed by another process.  
The adult(s) has the ability to make some relevant decisions.  
**No crime has been committed or could be prevented.** | • there is a decision regarding the final outcome of the assessment/investigation, and any other actions required are fed back to the manager/senior practitioner and will be fed back to the person/others as required and clearly recorded.  
Manager/Senior Practitioner agrees to conclude the adult safeguarding process.  
The rationale for all decisions made must be recorded  
Consider whether a referral to the Fire and Rescue service for a fire safety check should be offered to the individual if their circumstances place them at risk of fire. |
### Level 2 Response – Care Management and Care Programme Approach – continued

<table>
<thead>
<tr>
<th>The Person</th>
<th>Decision Making Criteria</th>
<th>Action/Outcomes</th>
</tr>
</thead>
</table>
| **Recognises the risk of abuse and feels able/is supported to take steps to manage the risks for themselves** | There are concerns that harm may have occurred and there is presenting information of the following:  
- previous history of similar incidents recorded in respect of the vulnerable person at risk of harm  
- previous history of similar incidents recorded in respect of the person alleged to have caused harm  
- a pattern of harm  
- previous history that low level risks have not been effectively managed by the adult or by providers of care and support  
- low impact concerns in the past, but at lengthy and infrequent intervals  
- a likelihood of further low level harm  
- concerns reflect difficulties and tension in the way current support / services are provided to the adult (e.g. some perceived inadequacy in the support / services being provided) | It would be appropriate to ask a service provider to undertake an enquiry into the concern of abuse.  
The person at risk should be empowered to contribute and express their views using appropriate support if necessary.  
Provide access to advocacy.  
There will need to be a **Strategy Discussion** which will need to be recorded.  
Consider whether the needs of the person at risk and/or the person who is alleged to have caused harm should be formally assessed or reviewed.  
Consider that adjustments might need to be made to health and social care services provided to the person at risk and/or to the person who is alleged to have caused harm.  
Ensure that the presenting concerns have been addressed and risk managed.  
The person at risk should be empowered to contribute and express their views using appropriate support if necessary.  
Concerns can be resolved by offering an assessment under the **NHS and Community Care Act 1990**. |
<table>
<thead>
<tr>
<th>Concerns</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>- concerns have been raised about difficulties and tensions within informal support networks e.g. family and friends, which may be perceived as harm but have minimal impact on the adult; on the information available they would not appear to amount to significant harm</td>
<td>- concerns can be resolved via multi-agency risk management meetings under Care Management or the Care Programme Approach.</td>
</tr>
<tr>
<td>- no information to suggest there is any clear intention to harm or exploit the vulnerable adult.</td>
<td>- no crime has been committed or could be prevented.</td>
</tr>
<tr>
<td><strong>No crime has been committed or could be prevented.</strong></td>
<td></td>
</tr>
</tbody>
</table>

The manager/senior practitioner reviews the assessment/investigation and its outcomes, and through a ‘Case Conference discussion’ with the adult and key others ensures that:

- the person has been fully involved and a Safeguarding Plan is appropriate and in place
- the outcome of the investigation is determined i.e. whether the alleged incident/concern took place/was founded
- the adults safeguarding process was robust and is appropriately concluded
- there is a decision regarding the final outcome of the assessment/investigation, and any other actions required are fed back to the manager/senior practitioner and will be fed back to the person/others as required and will be clearly recorded.

The rationale for all decisions made must be recorded

Consider whether a referral to the Fire and Rescue service for a fire safety check should be offered to the individual if their circumstances place them at risk of fire.
## Level 3 Response – Multi-agency Safeguarding Investigation

<table>
<thead>
<tr>
<th>The Person</th>
<th>Decision Making Criteria</th>
<th>Action/Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognises the risk of abuse and feels able/is supported to take steps to manage the risks for themselves</td>
<td>The physical, psychological, financial, sexual or emotional well-being of the person at risk appears to have been adversely affected by the incident. The referral forms part of a pattern of harm either by an individual or service provider. There is information that suggests there is a significant breach of regulations provided by the Health and Social Care Act 2008. There is information that suggests there is a significant Breach of Professional Codes of Conduct. There is an actual or potential risk of significant harm or exploitation to other adults or children. There is information that suggests there is a deliberate intent to exploit or harm a person at risk or children. There is a significant breach in an implied or actual ‘duty of care’ between the person at risk and the person alleged responsible. There is information that suggests there has been a significant breach in contract conditions. <strong>There is information that suggests that a crime has been committed or could be prevented.</strong></td>
<td>There must be discussions with the Police to determine their involvement if there is a suspicion of a crime. A Multi-agency Safeguarding Adults Strategy Meeting must be held. This must be a face-to-face meeting. The person at risk should be empowered to contribute and express their views using appropriate support if necessary. Provide access to advocacy. Ensure that the presenting concerns have been addressed and risk managed. Ensure that there is a clearly recorded action plan and a Safeguarding Plan that has been developed and agreed with the person at risk and key others. A Case Conference will usually take place to: • ensure the investigation has been completed fully and appropriately, and the person has been fully involved • ensure appropriate sanctions against those who have caused the harm • ensure an appropriate Safeguarding Plan has been agreed with the person to prevent or reduce risk of further abuse and agree how this will be monitored and reviewed • determine whether the alleged abuse took place • conclude the adults safeguarding process or agree a review meeting. The rationale for all decisions made must be recorded. Consider whether a referral to the Fire and Rescue service for a fire safety check should be offered to the individual if their circumstances place them at risk of fire.</td>
</tr>
</tbody>
</table>

Provide access to advocacy. Ensure that the presenting concerns have been addressed and risk managed. Ensure that there is a clearly recorded action plan and a Safeguarding Plan that has been developed and agreed with the person at risk and key others. A Case Conference will usually take place to: • ensure the investigation has been completed fully and appropriately, and the person has been fully involved • ensure appropriate sanctions against those who have caused the harm • ensure an appropriate Safeguarding Plan has been agreed with the person to prevent or reduce risk of further abuse and agree how this will be monitored and reviewed • determine whether the alleged abuse took place • conclude the adults safeguarding process or agree a review meeting. The rationale for all decisions made must be recorded. Consider whether a referral to the Fire and Rescue service for a fire safety check should be offered to the individual if their circumstances place them at risk of fire.
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<tr>
<th>Decision Making Criteria</th>
<th>Action/Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognises the risk of abuse and feels able/is supported to take steps to manage the risks for themselves.</td>
<td>Ensure immediate safety of people at risk has been assessed and managed; if the risk is significant, this may need the mobilization of agencies' resources. In such cases, there should be a named senior manager with the responsibility to co-ordinate responses to a major incident. The Director must be informed and Senior Managers must be notified throughout the process. Ensure clarity about information sharing (refer to information sharing guidance). Ensure liaison with all contractors, commissioners, CQC and other agencies that need to know. Provide access to advocacy. Consider strategy to communicate with service users/families.</td>
</tr>
<tr>
<td>Recognises the risk of abuse, but is unwilling to take action to protect themselves.</td>
<td>A strategy meeting must be held and chaired by a Senior Manager. A provider going into administration (NB: this may not always require a large scale investigation response - this will be informed by the initial risk assessment). There is a very serious crime. There are multiple crimes.</td>
</tr>
<tr>
<td>Does not choose to recognise the risk of abuse, with all support given, and refuses all safeguarding interventions.</td>
<td>There are significant indicators of systemic/institutional abuse. There are significant public protection/community safety concerns. There are significant breaches of CQC essential standards of quality and safety. Collective safeguarding alerts (this is where several alerts are received at the same time, or over a period of time, naming individual people being harmed in the care setting).</td>
</tr>
<tr>
<td>There are multiple adults/children adversely affected.</td>
<td>There are significant public protection/community safety concerns. There are significant breaches of CQC essential standards of quality and safety. There are significant indicators of systemic/institutional abuse.</td>
</tr>
<tr>
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</tr>
</tbody>
</table>
Multi-agency Information Sharing Guidance

Key Principles of Information Sharing:

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

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

If there are concerns that a child may be at risk of significant harm; or an adult may be at risk of serious harm, then 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

Ref: Information Sharing: Guidance for Practitioners and Managers HM Government 2008

“Information sharing is the cornerstone of delivering shared understanding of the issues and arriving at shared solutions ... The right information enables partners to carry out evidence-based, targeted community safety interventions and to evaluate their impact. The improved outcome of an intelligence led, problem-solving approach to community safety can only be achieved when partners have access to relevant, robust and up-to-date information from a broad range of sources.”


Information sharing is key to the Government’s goal of delivering better, more efficient public services that are co-ordinated around the needs of the individual. It is essential to enable early intervention and preventative work, for safeguarding and promoting welfare and for wider public protection. Information sharing is a vital element in improving outcomes for all.

This document, must underpin the exchange of information between agencies for the purpose of safeguarding adults in Southampton, Hampshire, Isle of Wight and Portsmouth.

This document does not give agencies an automatic right to receive information or a mandate to provide information, but is instead a process for information sharing in cases in which it is suitable for information to be shared. Sharing information about individuals between public authorities is often essential if adults at risk are to be kept safe or to ensure they receive appropriate services. The sharing of information must only happen when it is legal and necessary to do so and adequate safeguards are in place to protect the security of the information.

To feel confident about making information sharing decisions, it is important that managers and staff:

- understand and apply good practice in sharing information at an early stage as part of preventative or early intervention work
- understand what information is and is not confidential, and the need in some circumstances to make a judgement about whether confidential information can be shared, in the public interest, without consent
Section 3 Multi-agency Practice Guidance

- understand what to do when they have reasonable cause to believe that a child may be suffering, or may be at risk of suffering, significant harm, and are clear of the circumstances when information can be shared where they judge that a child is at risk of significant harm

- understand what to do when they have reasonable cause to believe that an adult may be suffering, or may be at risk of suffering, serious harm

- are clear of the circumstances when information can be shared where they judge that an adult is at risk of serious harm

- are supported by their employer in working through these issues.

The effective and timely sharing of information is essential to deliver high quality services focused on the needs of the individual. Across Southampton, Hampshire, Isle of Wight and Portsmouth (SHIP) we encourage a culture where information is shared with confidence as part of routine service delivery. Sharing information is vital to prevent and detect crime and to ensure that our communities are protected from abuse, neglect or exploitation.

It is accepted from practice, experience and research that the sharing of information between professionals helps to ensure that adults and children in need and at risk receive the care, protection and support they need.

Sharing personal information between partner agencies is vital to the provision of co-ordinated and seamless care for individuals.

Legislation does not prevent the sharing of information between agencies delivering services, although there are important rules and safeguards to be observed.

The 4LSAB Multi-agency Information Sharing Protocol is the overarching agreement which underpins information sharing between agencies and organisations across 4LSAB.

This Protocol is an agreed set of principles about sharing personal or confidential information. It enables each agency or organisation signed up to the protocol to understand the circumstances in which it should share information and what its responsibilities are. The Protocol has been developed in partnership with representatives from the 4LSAB Safeguarding Adults Boards.

Information sharing therefore supports three important aspects of multi-agency safeguarding working:

- **Understanding the problem** – understanding the issues associated with abuse within families and in institutional settings and tackling the issues associated with crime, domestic abuse, anti-social behaviour, hate crime, etc. To understand the problem requires information to be brought together from a range of agencies. This involves exploring patterns relating to the problem, and then deciding on tactical, investigative or strategic responses to support those who are vulnerable to abuse and to manage the most harmful and problematic individuals.

- **Multi-agency in content, multi-agency in outlook** – considering the problem using information from a range of agencies rather than just one agency leads more naturally to a multi-agency response. If the problem is only considered from the view of a single agency, then the natural reaction is often for that agency to be considered as the only one that is in a position to tackle the problem. The inclusion of information from a range of agencies helps them to identify the role that they can play in responding to the problem and delivering a more joined-up approach to addressing it.

- **Supporting partnership working** – if the problem is considered using a range of agency information, then this tends to overcome the reliance on one agency as the single source of information and sole purveyor of a solution to the problem. Relying on just one agency to provide information and respond to the problem with little input from other agencies can undermine the spirit of partnership working. Information sharing helps to foster and improve inter-agency relationships and leads to a more co-ordinated response around the vulnerable adult.
When can information be shared?

It is best practice to obtain consent from the individual at the referral or assessment stage of the adult safeguarding process.

However, obtaining consent is not always possible or consent may be refused. Not obtaining consent, or the refusal to give consent, must not be used as a reason for not sharing information. An individual's personal information can be disclosed without consent if there is an overriding ‘legitimate purpose’ and it is in the ‘public interest’ to disclose.

Staff must always consider the safety and welfare of the person at risk when making decisions on whether to share information about them. For example, where there is concern that an adult may be suffering, or is at risk of suffering, serious harm, the adult’s safety and welfare must be the overriding consideration.

Legitimate purposes include:
- preventing serious harm to an adult (to self or others) - including through prevention, detection and prosecution of a serious crime
- providing urgent medical treatment to an adult
- implementing the Department of Health’s ‘No Secrets’ agenda – which aims to protect persons at risk from abuse.

Public interest includes:
- when there is evidence or reasonable cause to believe that an adult is suffering, or it at risk of suffering, serious harm
- to prevent the adult from harming someone else
- the promotion of the welfare of the adult
- detecting crime
- apprehending offenders
- maintaining public safety
- administration of justice.

The impact of sharing or withholding information

There may be anxieties about the legal or ethical restrictions on sharing information, particularly with other agencies. There should, however, be an awareness of the law and agencies and their staff should comply with their relevant professional codes of conduct, the 4LSAB Multi-agency Procedures and other relevant agency guidance. These rarely provide an absolute barrier to disclosure. A failure to pass on information that might prevent a person at risk from being abused or a more serious tragedy could expose agencies/staff to criticism in the same way as an unjustified disclosure.

Failure to share information may also have a significant impact on the wider community - for example hate crime, honour based violence, domestic abuse - and on the records of personal information relating to the individual, location, circumstances of the alleged offence, previous criminal offences, health record, details of other members of the community, housing records, family relatives and providers of regulated services including statutory agencies.

A decision whether to disclose information may be particularly difficult if a staff member thinks it may damage the trust between themselves and the vulnerable adult. If such concerns arise, advice should be sought from a senior colleague, designated professional, Information Governance/Data Protection Officer, Legal Personnel. If working in the NHS or local authority social services, this also includes the Caldicott Guardian.

The ‘Golden Rules’

It is a requirement of the 4LSAB Safeguarding Adults Information Sharing Protocol that all agencies and staff adhere to the ‘Golden Rules’ for information sharing in all instances of information exchange. These are:
- confirm the identity of the person you are sharing with
- obtain consent to share if safe, appropriate and feasible to do so
• confirm the reason the information is required
• be fully satisfied that it is necessary to share
• check with a manager/specialist or seek legal advice if you are unsure
• don’t share more information than is necessary
• inform the recipient if any of the information is potentially inaccurate or unreliable
• ensure that the information is shared safely and securely
• be clear with the recipient about how the information will be used
• record what information is shared, when, with whom and why; and if you decide not to share, record your reasons.

What are the legal requirements which underpin the ‘Golden Rules’?

The decision whether to disclose information may arise in various contexts. There may be a concern about a person at risk that might be allayed or confirmed if shared with another agency. A staff member may be asked for information in connection with, for example, a crime, an assessment of a vulnerable adult’s needs under S47 of the NHS and Community Care Act 1990 or an assessment under the Mental Health Act 1983. In all cases the main legislation which underpins the sharing of information in relation to persons at risk is:

• Common Law Duty of Confidentiality
• Data Protection Act 1998
• Human Rights Act 1998
• Freedom of Information Act 2000
• Crime and Disorder Act 1998

Each of these pieces of legislation has to be considered separately when deciding whether information can be shared. Other statutory provisions may also be relevant. But in general, the law will not prevent the sharing of information with other agencies / staff members if:

• those likely to be affected consent; or
• the public interest in safeguarding the vulnerable adult’s welfare overrides the need to keep the information confidential; or
• disclosure is required under a court order or other legal obligation.

Confidential information

Confidential information is covered by the Common Law Duty of Confidence. It applies to any information that has been received or accessed in circumstances where it is reasonable to expect that the information will be kept secret or should only be shared with a limited number of specific people.

The key principle to sharing confidential information is that any information confided should not be used for any other purpose or disclosed further, except as originally understood by the confider or with their subsequent permission.

The duty is not absolute and the disclosure of confidential information can be justified if:

• the information is not confidential in nature
• the person to whom the Duty of Confidence is owed has expressly authorised its disclosure
• disclosure is required by a court order
• disclosure is required by legislation or a legal obligation.

There is a serious overriding public interest as the information relates to:

• serious crime
• danger to a person’s life
• danger to other people
• danger to the community
• serious threat to others, including staff
• serious infringement of the law
• risk to the health of the person.
Information sharing when the person at risk has given consent

There are situations where information can be shared legally without obtaining the consent from an individual. An element of information sharing will need to happen as part of a referral and during the strategy discussion/meeting stage, where initial assessments of the risk factors affecting a potentially person at risk are made.

Even if there is no legal requirement to obtain consent before sharing information, it is often good practice to do so. The emphasis throughout this Protocol is on obtaining the informed consent of the adult to share information at the first point of contact.

Informed consent is a freely given, specific and informed indication of a person’s agreement to a course of action, where information is given to that person about the proposed course of action. It may be expressed verbally or in writing, except where an individual cannot write or speak when other forms of communication may be sufficient - see Chapters 3 and 4 of the Mental Capacity Act 2005 Code of Practice [DCA 2007] for guidance.

Staff need to make sure that the person at risk understands what will be recorded, what the information will be used for and with whom it might be shared. If staff do not explain this, they will not be able to give valid informed consent for information sharing to take place.

The following information should be recorded clearly within an organisation’s records when consent to share information has been freely given:

- why the information needs to be shared
- what information the person at risk has consented to be shared
- who the person at risk has consented for the information to be passed to, and any limitations to this
- that this has been explained to the person at risk and they understand the implications of giving consent to share their information
- any comments made by the person at risk in relation to the disclosure

- date consent given
- decisions to refer/not to refer.

Consent should be reviewed through existing working practices, for example, when the vulnerable adult’s personal circumstances change, or an investigation is in progress.

Information given to an individual member of staff, or an organisation’s representative, belongs to the organisation and not that member of staff/representative. Personal information shared with a worker in the course of their employment is:

- confidential to the employing organisation and can be shared within that organisation
- should only be used for the purposes for which it was intended
- can be shared with another organisation either when: permission is given by the person about whom the information is held; or there is an overriding justification, statutory power or duty to share information without the person’s consent.

Information sharing when the person at risk does not have the capacity to consent to information sharing

When someone reaches the age of 18, no one else can take decisions on their behalf. If an adult is not competent to take their own decisions, professionals should share information that is in their ‘best interests’. The capacity to be able to give consent can be assessed by considering:

- has the person got the ability or power to make a particular decision?
- have they got the ability to understand and retain the information relevant to the decision?
- will they be able to understand the reasonably foreseeable consequences of deciding one way or the other?
- will they have the ability to communicate the decision they have come to?

Where an individual is not the legal representative but acts as ‘carer’ to a person not capable of giving consent, it should be considered whether they are acting on the persons behalf and in the persons’ best interests.
As long as the person’s rights are not adversely affected and any action is in the best interests of that person, the most appropriate and safe level of consent must be obtained at the time a decision has to be made.

**Information sharing when the person at risk withholds consent to share information**

Individuals have the right to refuse, or withhold consent, for organisations to share information in relation to suspected abuse. Wherever possible the views and wishes of the person at risk will be respected. However, if it is thought that they are in a situation that will result in their abuse, or if they may be abusing another person, the duty of care overrides the individual’s refusal.

The need to protect the individual or the wider public outweighs their rights to confidentiality. Decisions to share information about the person at risk must be made by the organisation and not a member of staff acting on their own. This, however, should not cause unnecessary delay in the disclosure process.

The worker must explain to the person why the disclosure needs to take place and to whom the information will be passed. This should generally be done, unless it would increase the risks of harm.

The person’s decision to withhold consent to share information must be recorded, along with any further decisions about sharing information.

Decisions to share without consent must make sure that it does not interfere with that person’s human rights. That is to say, that decisions to share information should take account of the principle of proportionality as required under the *Human Rights Act 1998*, and the *European Convention on Human Rights* as well as the *Data Protection Act 1998*, in regard to whether and with whom (i.e. with which agencies) the information will be shared.

**Information sharing with carers, parents, family, partners, etc.**

When the person at risk has the capacity to make the decision, it should be up to them to decide what information is disclosed to their carers/parents/family/partners, and records should reflect this.

When the adult does not have the capacity, consideration should be given to when to share information with carers/parents of the vulnerable adult. In addition, consideration must be given to the relationship between the carers/parents and the alleged abuser.

Clear decisions should be recorded about when and what to share, and who is the most appropriate person to talk to the parent/carer, etc. More generally, an assessment should be made as to whether the sharing of certain information with a particular person or organisation is in the adult’s best interests.

**Information sharing with third parties about the (alleged) person causing harm**

Organisations and workers must ‘honestly and reasonably believe’ that the sharing of information is necessary to protect a person at risk or the wider public and must use the test of ‘pressing social need’. To pass this test the relevant organisation must consider the following issues.

- How strong is the belief in the truth of the particular allegation? The greater the conviction that the allegation is true, the more compelling the need for disclosure.
- What is the interest of the third party in receiving the information? The greater the legitimacy of the interest of the third party in having the information, the more important is the need to disclose.
- What is the degree of risk posed by the individual if disclosure is not made?
- Decisions about who needs to know and what needs to be known should be taken on a case-by-case basis. The consequences of
disclosure should be balanced against the risks to the vulnerable adult. In such cases the issue of proportionality is key.

- This decision will be made at the strategy discussion stage, where it will be determined who within the investigation team will contact and speak to the alleged abuser and how this will be managed.

**Disclosures to other organisations outside of the safeguarding process**

There may be some cases where the risk posed by an individual in the community cannot be managed without the disclosure of some information to a third party outside the organisations immediately involved in the investigation. Such an example would be where an employer, voluntary group organiser or church leader has a position of responsibility/control over the individual, and other persons who may be at serious risk.

Caution should be exercised before making any such disclosure. The following factors should be taken into account.

- Does the individual present a risk of serious harm to the vulnerable adult, or to those for whom the recipient of the information has responsibility? The correct person to receive information will be the person who needs to know in order to minimise or prevent the risks.

- Is there no other practical, less intrusive means of protecting the vulnerable adult, and failure to disclose would put them in danger? Only that information which is necessary to prevent harm should be disclosed, which will rarely be all the information available.

- The disclosure is to the right person and that they understand the confidential and sensitive nature of the information they have received.

- The information will not be disclosed by the recipient third party without the express permission of the original disclosing organisation. Consider consulting the individual about the proposed disclosure; this should be done in all cases, unless to do so would not be safe and appropriate. If it is possible and appropriate to obtain the individual’s consent, then a number of potential objections to the disclosure are overcome.

- Ensure that whoever has been given the information knows what to do with it. Again, where this is a specific person, this may be less problematic but in the case of an employer, for example, advice and support may need to be given.

The risk to the individual should be considered, although it should not outweigh the potential risk to others, were disclosure not to be made. The individual retains his/her rights under the Human Rights Act 1998 and consideration must be given to whether those rights are endangered as a consequence of the disclosure.

**Safeguarding adults meetings and notes**

In order to safeguard a person at risk or other vulnerable people, it may be necessary to share confidential information at safeguarding adults meetings. It is the responsibility of the Chair of that meeting to request any relevant information and to secure the agreement of the relevant parties to sharing this information.

The Chair of the safeguarding meeting will ensure that a confidentiality statement is made at the start of the meeting and all parties understand their responsibilities in respect of confidentiality. Exchange may be verbal or written; however, data protection principles must still apply with attendees only being present where it is appropriate for them to share the information.

Attendees at safeguarding adults meetings will be asked to sign an attendance list which will confirm their individual compliance with the Protocol.

Notes taken at safeguarding meetings will be marked ‘RESTRICTED’. Only those people who have been invited to the meeting will receive copies of the minutes.

Individual requests for access to records will be considered in line with the Data Protection Act and Departmental Policy.
Any requests for access to the notes/minutes of safeguarding adult meetings must be considered on a case by case basis under the *Freedom of Information Act 2000* and/or the *Data Protection Act 1998*, but information will only be disclosed if it is appropriate to do so. For further advice, contact should be made with the Data Protection/Information Governance/Compliance officer or Freedom of Information officer from the relevant organisation, or contact can be made with the Information Commissioner.

If an organisation wishes to disclose confidential information, permission (i.e. consent) must be obtained in writing from the initial owner of the information. If this may not be appropriate, then prior advice should be sought from the Data Protection/Information Governance/Compliance officer or Freedom of Information officer from the relevant organisation, or contact can be made with the Information Commissioner.
Managing Self-Neglect, Mental Capacity and Best Interests

Introduction

Why is self-neglect important in the context of safeguarding of persons at risk?

A failure to engage with people who are not looking after themselves, whether they have mental capacity or not, has serious implications for the health and well-being of the person concerned and for the people engaged in the provision of their care and support. An adult will be considered to be vulnerable under this practice guidance where they are unable or unwilling to provide adequate care for themselves and:

• they are unable to obtain necessary care to meet their needs; and/or
• they are unable to make reasonable or informed decisions because of their state of mental health or because they have a learning disability or an acquired brain injury; and/or
• they are unable to protect themselves adequately against potential exploitation or abuse; and/or
• they have refused essential services without which their health and safety needs cannot be met but do not have the insight to recognise this.

Appendix 1 highlights a number of risk factors and indicators associated with self-neglect. Social care workers must balance lifestyle choices, with the need to protect a person who self-neglects. Allowing a person to self-neglect without intervention or support, could be considered as an omission in care and/or support.

There are clinical, social and ethical decisions to be considered in the management of self-neglect. This guidance has been informed by the research work on self-neglect in older adults undertaken by Mary Rose Day and Patricia Leahy-Warren (2008); the West Sussex County Council Self Neglect Practice Guidance (2010) and the SCIE Report 46(2011). This guidance will be regularly reviewed in line with local and national developments.

The nature of any intervention centres on whether the adult concerned has the mental capacity to make decisions that have legal force. A person may have mental capacity and yet disagree with the views of the local authority or another agency. This right is a right that cannot be taken away from a person who has mental capacity. It does not preclude the local authority or other agency entering into a dialogue with the person in order to explore the area of concern.

It is important that the rights of people to make apparently unwise lifestyle choices and to refuse services are respected. An assessment of the person’s mental capacity to make decisions in this respect must be taken into account with specific consideration of the risks and safety implications of the decisions being made. Rather than a passive approach, staff will be supported to undertake active decision making as whether or not to intervene in cases of self-neglect and it is important that the decision making in this respect is kept under constant review.

It is essential that people working in social care are aware of the rights of individuals in law and of the duties, powers and responsibilities of the local authority as well as those of other agencies. A summary of these is given in Appendix 2.

What is self-neglect?

The term self-neglect is not included in the definition of elder abuse that is in common usage in England.

Self-neglect is “the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the
health and well-being of the self-neglecters and perhaps even to their community." (Gibbons, 2006, page 16)

People working in social care have a vital role in the early recognition and prevention of self-neglect and have a responsibility to recognise and act upon the risk factors associated with self-neglect. Some common risk factors associated with self-neglect, particularly in older people, are shown in Appendix 1. These include age-related changes that result in functional decline, cognitive impairment, frailty or psychiatric illness, which will increase vulnerability to abuse, neglect and self-neglect, as well as increase the potential for developing a number of underlying health conditions.

Guidance – Assessment of Neglect

Working together to effectively assess the needs of people receiving care and support

Where a person at risk (in receipt of services of the local authority or another agency commissioned to provide care) is self-neglecting and/or refusing services and in so doing placing themselves or others at risk of significant harm, a multi-disciplinary approach must be adopted and information shared with the service user about the risk(s) of non-intervention/intervention.

A risk assessment will need to be undertaken which gives consideration to the following aspects of the person’s life:

- observation of home situation
- engagement in activities of daily living
- functional and cognitive abilities of the person
- family and social support networks
- underlying medical conditions
- underlying mental health conditions or substance misuse issues
- environmental factors
- domiciliary care and other services offered/in place
- environmental health monitoring
- neighbourhood visiting by voluntary organisations

- money management and budgeting.

This assessment may identify the need to refer people with self-neglect for a more specialist assessment. Where there is actual self-neglect, or significant risk of it, the practitioner will, in the course of the assessment, need to make and record their judgment about the risks and what an appropriate response to these should be.

Guidance – Intervention and Management

Building a positive relationship with people receiving care and support

The person should, as far as possible, be included and involved in the assessment process and in developing a Safeguarding Plan to reduce or eliminate identified risks. Under normal circumstances, the person should be invited to attend any case conferences.

Where the person continues to refuse all assistance and they have been assessed as having the mental capacity to understand the consequences of such actions, this should be fully recorded. The record should also include a record of the efforts and actions taken by all agencies involved to provide support.

A capacity assessment should be carried out if appropriate, to determine if the person has the capacity to make decisions and time specific decisions.

Where a person is unable to agree to have their needs met because they lack the mental capacity to make this decision, then the ‘best interest’ decision making process should be used. – should there be reference to advocacy?

If the care management process/care programme approach has not been able to mitigate the risk of ‘serious self neglect which could result in significant harm’, the matter should then be referred under the Safeguarding Adults Procedure in order that all subsequent decision making (about what action is or is not taken) occurs within a multi-agency framework.

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

In exceptional circumstances it may be necessary for staff employed by the local social services authority to intervene using S.47 National Assistance Act 1948. This provides for an application to be made to a court of law by the Director of Public Health. If such a course of action is felt to be necessary by staff, following a discussion in professional supervision, legal advice should be sought as soon as practicable.

Mental Capacity Act – Best Interests

What should staff do where someone is believed to be lacking mental capacity to make decisions for him/herself?

Staff should always consider:

- is there a need to formally assess and record that the person who is believed to be lacking mental capacity - to make a specific decision - is in fact mentally incapable of making that decision?
- is it likely that the person may regain mental capacity in the future and therefore should be involved and can make that decision for him/herself in the future?
- the wishes, feelings, values and beliefs of the person who has been assessed as lacking mental capacity
- the views of family members, parents, carers and other people interested in the welfare, if this is practical and appropriate, of the person who has been assessed as lacking mental capacity
- the views of any person who holds an enduring power of attorney (pre-October 2007) or a lasting power of attorney (from October 2007) made by the person now lacking capacity
- the views of any deputy appointed by the Court of Protection to make decisions on the person’s behalf
- whether any decisions that need to be made have in fact already been made based merely on the appearance, age, medical condition or behaviour of the person who has been assessed as lacking mental capacity
- whether people are being motivated by a desire to bring about the death of the person who has been assessed as lacking mental capacity, or are making assumptions about the quality of that person’s life
- any other information that may be relevant.

Further information – available on the internet

Mental Capacity Act 2005

Mental Health Act 1983 (revised 2007)

Office of the Public Guardian (Mental Capacity Act)
http://www.publicguardian.gov.uk/mca/mca.htm

Department of Health (Mental Capacity Act Deprivation of Liberty Safeguards)

SHIP Multi-agency Safeguarding Adults Policy and Procedures

Selected references

APPENDIX 1: Risk factors associated with self-neglect

The characteristics and behaviours commonly used to describe self-neglect, particularly - but not exclusively – in older people are:

- living in very unclean, sometimes verminous, circumstances, such as living with a toilet completely blocked with faeces
- neglecting household maintenance, and therefore creating hazards
- portraying eccentric behaviours or lifestyles, such as obsessive hoarding
- poor diet and nutrition evidenced by, for instance, little or no fresh food in the fridge, or what there is being mouldy
- declining or refusing prescribed medication and/or other community health care support
- refusing to allow access to health and/or social care staff in relation to personal hygiene and care
- refusing to allow access to other organisations with an interest in the property, for example, staff working for utility companies (water, gas, electricity)
- being unwilling to attend external appointments with professional staff, whether social care, health or other organisations (such as housing)
- poor personal hygiene, poor healing/sores, long toe nails, isolation and failure to take medication.

To this list can often be added advancing age, chronic illness, depression, alcohol and substance misuse, personal health care issues such as the presence of mental disorder (including the relapse of major psychiatric features, or a deterioration due to dementia), incontinence (single or double), visual and/or other sensory impairment, mobility difficulties, and/or poor access to specialist community health services such as podiatry services. It is worth noting, however, that poor environmental and personal hygiene may be a result of cognitive impairment, poor eyesight, functional and financial constraints or a matter of personal choice or lifestyle rather than for other reasons.
APPENDIX 2: The Legal Context

There are many legislative responsibilities placed on local authorities and other agencies to intervene in or be involved in some way with the care and welfare of adults who are believed to be vulnerable. Services may need to be provided as a result of neglect, illness, injury or mental disorder. Specific Acts of Parliament include:

National Assistance Act 1948 – including:
Duty to provide residential accommodation to those people aged 18 years or over “who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them”.
Duty to promote the welfare of people with disabilities.
Arrangements whereby an application can be made to a court of law if a person assessed as having capacity is “suffering from grave chronic disease or, being aged, infirm or physically incapacitated, are living in insanitary conditions and are unable to devote to themselves, and are not receiving from other persons, proper care and attention”.

Health Services and Public Health Act 1968 – including:
Duty to make arrangements for promoting the welfare of old people.
Chronically Sick & Disabled Persons Act 1970 – including:
- provision of practical assistance in the home
- assistance in obtaining television, library or similar recreational facilities
- provision of recreational facilities outside the home
- assistance to person in taking advantage of educational facilities
- assistance with travelling to participate in any services provided
- works of adaptation to the home
- facilitating holidays
- provision of meals
- provision of a telephone.

NHS and Community Care Act 1990 – including:
Duty to carry out assessment of individual’s needs for community care services and providing any such services needed.

The Health and Social Care Act 2008 introduced a new single regulatory framework for health and social care. The registered person - usually the owner or manager - has a duty to inform the registration authority within 24 hours of any event that threatens the well-being of any resident (Regulation 18 notification). The registration authority is the Care Quality Commission.

The Mental Health Act 1983 (revised and extended in 2007) provides a comprehensive legislative framework to support the needs of both children and adults. It is based on the presumption that the right of people who have been assessed as having a ‘disorder or disability of mind or brain’ is safeguarded when they are being admitted to or treated within a psychiatric hospital. In addition, as much care and treatment as possible, both in hospital and outside, should be given on an informal basis – where the individual patient is able to exercise their own judgement in the matter (with certain additional safeguards in place for children and young people) - and in the least restrictive conditions possible. The Act also presumes that the main emphasis of care is care within local communities, not within hospital settings. S.135 specifically provides the authority to seek a warrant authorising a police officer to enter premises if it is believed that someone suffering from mental disorder is being ill-treated or neglected or kept otherwise than under proper control anywhere within the jurisdiction of the Court or, being unable to care for himself, is living alone in any such place.

The Mental Capacity Act 2005 became operational during 2007. Underpinning the Act are five statutory principles, the most important of which centre on the presumption of capacity unless proven otherwise, and the requirement to enable mentally capable individuals (aged 16+) to make decisions for themselves, even where
those decisions may be at variance with what other people and organisations feel would be best.

**Mental Capacity Act 2005: Statutory Principles***

*applicable where someone has mental capacity

- Any person, aged 16+, must be assumed to have the capacity to make his/her own decisions unless it is established otherwise
- All practicable steps must first be taken to assist people to make such decisions
- Any person who has capacity has the right to make an unwise decision

The Mental Capacity Act also provides a statutory framework to enable social care (and allied disciplines) to intervene in the lives of a person (aged 16+) where it can be demonstrated that, in relation to a specific decision that needs to be taken, the person lacks mental capacity to make that decision and therefore a decision needs to be made by a third party in the person’s best interests. From April 2009, the Mental Capacity Act 2005 has made it unlawful to deprive of his/her liberty any adult person lacking mental capacity who is living in a care home or staying in a hospital. This can only be lawful if a Deprivation of Liberty Standard Authorisation is in place or a decision has been made to this effect by the Court of Protection.

Statutory agency’s (or agencies’ if plural) practice is also informed by, and needs to refer to, the following relevant legislation:

- Sex Discrimination Act 1975 and subsequent equalities legislation
- Race Relations Acts 1976 and 2000 and subsequent equalities legislation
- Police & Criminal Evidence Act 1984 - Codes of Practice (and subsequent revisions to the Codes)
- Criminal Justice Act 1991 and subsequent criminal justice legislation
- Disability Discrimination Act 1995 and subsequent equalities legislation
APPENDIX 3: Local Safeguarding Adults Policy and Procedures

A significant national development was the joint publication of No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect persons at risk from abuse by the Department of Health and the Home Office in 2000. This 2000 guidance was in 2009 the subject of a comprehensive review, co-ordinated by the Department of Health. The Government published its formal response in 2010 and, amongst other points, it intends to place Safeguarding Adults’ Boards on a statutory footing.

Please refer to the current 4LSAB Multi-agency Safeguarding Adults Policy and Procedures.

The presumption of mental capacity is embedded in care management, self-directed support and risk enablement processes.

Where self neglect and the refusal of assessed services is apparent, there is a requirement on a local authority – effectively with the force of law – to investigate and take action when a person at risk is believed to be suffering abuse. The responsibility is shared with other agencies, with the lead agency identified at the time of the initial investigation.

Common law can be used to intervene, in extremis, in matters of life and death, whilst the police can use powers under the Police and Criminal Evidence Act 1984 to gain entry to domestic premises in such circumstances. It may also be necessary to consider use of S.47 National Assistance Act. However, the local authority legal team should always be consulted if such action is anticipated.
APPENDIX 4: Recording – What should staff be recording, and where?

Staff will be considering the various legislative responsibilities outlined above and also through the use of the 4LSAB Multi-agency Safeguarding Adults Policy and Procedures.

Where assessments of mental capacity relate to day-to-day decisions and caring actions (such as what clothes to wear or what to eat), the Mental Capacity Act Code of Practice advises that no formal capacity assessment procedure or recorded documentation will be needed. The Act provides protection from liability for actions taken, as long as those actions can be understood to have been in a person's best interests. As the seriousness of the decision and/or the action increases, then the need for clear documentation increases.

Some examples of where a formal assessment of capacity would be needed include decision making about:

• where to live, if a significant change is envisaged
• what care services support to receive at home
• whether to report a criminal or abusive act
• where there is a dispute with the person, the family and/or the care team as to the capacity or views of a person
• where the capacity of a person could be open to a legal challenge, such as in relation to a claim for personal injury
• where the person concerned is repeatedly making decisions that place him/herself at risk or could result in preventable suffering or damage
• having serious medical treatment – whilst noting that permission for some serious medical treatments, such as therapeutic sterilisation, can only be granted by the Court of Protection.

These examples are not exhaustive and each situation needs to be judged on its merits, using professional judgment. Clarity is provided in the Mental Capacity Act Code of Practice where it gives guidance, on pages 59 - 60, on where professionals should be formally involved.

In relation to self-neglect, it is clear that the Mental Capacity Act Code of Practice recommends that a professional mental capacity assessment is undertaken. This can then subsequently be used to justify the grounds under which corrective intervening actions are taken to protect the person from further harm. It may also need to be undertaken alongside a risk assessment, using a practice checklist such as the FACE Risk Assessment Tool.

Mental Capacity Act 2005: Statutory Principles*

*applicable where a person lacks mental capacity

• Any actions done or decisions made for a person who lacks capacity must be done in that person's best interests
• Any action that needs to be done or decision that needs to be made must have due regard as to whether it can be effectively achieved in a way that does not restrict the person's rights and freedom of action

Staff should always aim to record any activity where it is clear that there is evidence of nil decision-making capacity on the part of the person seeking assistance, or further assistance, from an organisation.

A specific decision about intervening in the person's best interests may, however, need to be made allied to a formal safeguarding investigation.

Where there is, or is likely to be, a dispute as to how to serve the best interests of the person who is self-neglecting and who lacks mental capacity, there is recourse in law to the Court of Protection. The Court will, however, expect to see evidence of professional decision making and recording having already taken place, and that local mediation arrangements have also been considered.
Framework for addressing safeguarding concerns within NHS Provision

Principles of the Framework

Investigations into safeguarding concerns arising in NHS provision will take place under the auspices of Multi-agency Safeguarding Adult Procedures for which local authorities have the lead co-ordinating responsibility.

The approach outlined in this document reflects No Secrets (DOH 2000) and national guidelines published by the Department of Health in its document called Clinical Governance and Adult Safeguarding - An Integrated Process (February 2010).

Investigations undertaken under this framework will be:

• linked to mainstream Multi-agency Safeguarding Adult Procedures
• transparent with external scrutiny built into the process to promote independence and to avoid self policing
• integrated with the NHS clinical governance framework, e.g. adverse incident reporting, complaints and risk management.

Criteria to determine a NHS led intervention

The following guidance sets out the criteria that will be used to determine when a safeguarding concern occurring in a NHS setting will be investigated by the NHS provider. This needs to be read in conjunction with the 4LSAB Intervention Thresholds Tool.

Decision making criteria:

• a ‘one-off’, isolated incident
• no previous history of similar incidents recorded for the person at risk
• no previous history of similar incidents recorded for the organisation
• no previous history of abuse by the person alleged to be responsible
• not part of a repeating or escalating pattern of abuse
• no clear criminal offence described in the safeguarding alert
• there is not a clear intent to harm or exploit the person at risk
• no indication of ongoing risk to the person at risk or other people
• incident is being managed appropriately by the organisation.

Reporting

NHS adverse incident reporting forms need to be cross referenced with the local Multi-agency Adult Safeguarding Procedure and amended to include the following trigger question:

“Has this incident harmed or placed at risk of harm, a vulnerable adult?”

If yes, does the information presented suggest the need for a safeguarding alert to be raised?

Likely incidents leading to concerns being investigated under Multi-agency Safeguarding Adult Procedures include incidents of significant harm (or risk of significant harm) to persons at risk arising from:

• poor practice
• neglect/acts of omission
• policies or procedures not being followed.

NHS organisations will assess the incident report and if it decided that it falls within the remit of local Multi-agency Safeguarding Adult Procedures, a referral should be made to the relevant local authority area or hospital based social work team.
Level of response:
• the NHS organisation reports incident to the local authority and agrees the level of intervention, an investigation plan and timescales
• the NHS organisation carries out an internal investigation using its usual clinical governance processes
• the NHS organisation reports back the outcome of the investigation to the nominated local authority officer, and a copy of the investigation report together with any action plan will be provided to the local authority
• the NHS organisation will monitor progress against its action plan in liaison with the local authority nominated officer.

Action and outcomes
• The NHS organisation reports incident to the local authority and makes the required notification to regulatory body
• any action taken by the NHS organisation to address presenting concerns are clearly documented and shared with the local authority
• the NHS organisation reports outcomes to the nominated adult social care officer
• the process may result in minor alterations in the way a service is provided to the service user and/or may result in changes to the way staff/other resources are deployed in the delivery of care.
Witness Profile

The purpose of this profile is to provide criminal justice agencies with the right information to support vulnerable witnesses during criminal investigations and/or court proceedings. Please include as much relevant information as possible.

<table>
<thead>
<tr>
<th>General information:</th>
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<tbody>
<tr>
<td>Name:</td>
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<tr>
<td>Preferred form of address:</td>
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<tr>
<td>Pen picture (to include current living circumstances, significant others etc):</td>
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<tr>
<td>Vulnerable because of: (e.g. learning disability, mental health problem etc)</td>
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<tr>
<td>Any particular additional vulnerabilities: (e.g. sexually unaware, poor mobility etc)</td>
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<tr>
<th>Special Requirements:</th>
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<tr>
<td>(e.g. wheelchair access, support worker, assistance with communication, particular aids, screens etc)</td>
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<table>
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<tr>
<th>Medical Needs:</th>
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<tr>
<td>(Medication and side effects, conditions such as epilepsy etc)</td>
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</table>
Appearance and Manner:
(Posture, responsiveness, physical gestures, emotional expression)

Functional Skills:
(Self care, domestic arrangements, travel arrangements, coping strategies – embarrassment, anger, span of concentration)

Comprehension:
(range and ability, time needed to comprehend questions, advice on plain language/preferred terminology)

Expression:
(preferred communication system, aids, language, idiosyncratic expressions etc)

Advice on communication with this person:
(e.g. ways of offering reassurance, confirm importance of answering questions, ask single, focussed questions, re-focussing attention, non-verbal cues from individual)

Signed: .......................................................  Relationship to Witness: ..............................................

Role: ...........................................................  Agency: ................................................................

Date: ........................................................
Purpose of Serious Case Reviews

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

There are three purposes to be fulfilled by an SCR:

• to establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard persons at risk.

• to establish what those lessons are, how they will be acted upon and what is expected to change as a result.

• to improve inter-agency working and better safeguard persons at risk including the review of procedures where they may have failed.

SCRs are not inquiries into how an adult died or suffered injury, or who is culpable.

If there are issues of performance and/or discipline which need to be addressed arising from the review case, then they are to be dealt with within each agency's normal procedures.

The process can be seen in flowchart form at Appendix 1.

**Please see Serious Case Review protocol for the four safeguarding adultsl boards**
APPENDIX 1: Serious Case Review Procedure – Flowchart

Decide whether to use SCR or Serious Case Review in chart

Referral (via referral form)

Safeguarding Lead in Local Authority (registered and forwarded to SCR Panel Chair)

Case considered by SCR Panel

SCR criteria met
- Terms of Reference for SCR drawn up
- Independent Chair identified
- SCR group convened

Serious Case Review
- Internal Management Reviews requested from organisations
- Overview report and Executive Summary produced

Report presented to SCR Panel
- Recommendations and action plan

Full report sent to Director of Adult Services and Chair of Safeguarding Adults Board in responsible local authority for action

Executive Summary and action plan sent to all organisations involved. Local authorities to publish on safeguarding web pages

Action plan monitored by local authority safeguarding lead and reported back to SCR Panel (6 monthly)

SCR Criteria not met
- Feedback to referrer
- Decision re follow up with involved organisations
- Consider alternative investigation such as Serious Incident Requiring Investigation SIRIs (for NHS Services) or Domestic Homicide Review.

Report presented to SCR Panel
- Executive Summary and action plan sent to all organisations involved.

Full report sent to Director of Adult Services and Chair of Safeguarding Adults Board in responsible local authority for action

Action plan monitored by local authority safeguarding lead and reported back to SCR Panel (6 monthly)
APPENDIX 2: Serious Case Review Referral Form

This form should be used to make a referral to the Pan-Hampshire Serious Case Review Panel. Any organisation or professional can make a referral if the details of the case meet the criteria outlined in Section 2 of the Procedure for Undertaking Serious Case Reviews for Adult Safeguarding Cases (March 2011).

The information requested below should be completed and transmitted via a confidential and secure arrangement, to your Local Authority Safeguarding Unit.

The four Local Authority Safeguarding Units can receive confidential information securely through the following arrangements:

- **Hampshire County Council**  safeguarding.account@hants.gscx.gov.uk
- **Southampton City Council**  adult.contact.team@southampton.gscx.gov.uk
- **Portsmouth City Council**  safeguardingadults@portsmouth.gov.uk
- **Isle of Wight Council**  safeguarding.referrals@iow.gov.uk

All requests will be registered and forwarded to the Chair of the Serious Case Review Panel who will convene a meeting to consider the referral.

<table>
<thead>
<tr>
<th>1 Details of person/s injured or harmed</th>
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<tr>
<td><strong>Name</strong></td>
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<td><strong>Date of birth</strong></td>
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<td><strong>Name</strong></td>
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<tr>
<td><strong>Name</strong></td>
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<tr>
<td><strong>Date of birth</strong></td>
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| 2 Date of Incident                     |

| 3 Brief description of incident/occurrence |

| 4 Nature of injuries or harm sustained and to whom |
### Section 3  Multi-agency Practice Guidance

#### 5 Location where incident took place - address, site, room, area.

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#### 6 Name/Address of the Service Provider

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#### 7 Name of Person making the referral (including organisation, address and telephone number/contact details)

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#### 8 Details of why, in your opinion, this referral meets the criteria for an SCR

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</table>

Once this form is complete, please send to your Local Safeguarding Unit (contact details above)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date sent</th>
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<tbody>
<tr>
<td>Signature</td>
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April 2013
Section 3

Key Legislation

This is a summary of relevant legislation, however, legal advice needs to be sought for a more detailed interpretation of the main requirements of each piece of legislation.

In addition, the Social Care Institute for Excellence (SCIE) provides guidance to practitioners in relation to the law as it applies to safeguarding. This is entitled Safeguarding Adults at risk of harm: a legal guide for practitioners and can be found at http://www.scie.org.uk/publications/reports/report50.pdf

The Data Protection Act 1998

Introduction
Since the 1st March 2000, the key legislation governing the obtaining, protection and use of identifiable personal information has been the Data Protection Act 1998 (DPA) and does not apply to information relating to the deceased.

The key difference between the DPA and the previous legislation is that it applies not only to automatically processed personal data, but also to manual personal data.

Principles
The DPA sets out eight principles, which must be complied with when obtaining and using personal data.

Principle 1
Obtain and process personal data fairly and lawfully

Principle 2
Hold data only for the lawful and specified purposes

Principle 3
Personal data shall be adequate, relevant and not excessive in relation to the purposes for which it is processed

Principle 4
Personal data must be accurate and where necessary, kept up to date

Principle 5
Hold data for no longer than necessary

Principle 6
Personal data shall be processed in accordance with the rights of data subjects under the Act

Principle 7
Measures should be taken against unauthorized or unlawful processing of personal data and against accidental loss or destruction or damage to personal data.

Principle 8
Personal data shall not be transferred to a country outside the European Economic Area unless that country ensures an adequate level of protection for the rights of freedoms of data subjects regarding the processing of personal data. The use of personal information by agencies must therefore comply with these principles.

The lawful use of information
When sharing information, compliance with the first DPA principle is crucial to ensuring the sharing of information is carried out lawfully.

To ensure personal information is processed in a lawful manner, one of several specified conditions, which are set out in Schedule 2 of the DPA, must be complied with. These conditions are as follows:

- the individual has given his/her consent to the processing
- the processing is necessary to comply with a legal obligation
- the processing is necessary in order to protect the vital interests of the individual (this is envisaged to be a life and death scenario)
- the processing is necessary in order to pursue the legitimate interest of the organisation or certain third parties (unless prejudicial to the interests of the individual)
• the processing is necessary for the entering into a contract at the request of the individual or performance of a contract to which the individual is a party.

Therefore, as a general rule, if one of the above conditions is satisfied, the processing of information is likely to be lawful. However, if the information to be processed is what is described as “sensitive personal data”, then there are extra conditions that must be satisfied before the processing of information is lawful.

Sensitive personal data is information that relates to:
• the racial or ethnic origin of the individual
• their political opinions
• their religious beliefs of a similar nature (?)
• whether they are a member of a trade union
• their physical or mental health or condition
• their sexual life/preference/orientation
• the commission or alleged commission by them of any offence.

The main conditions are as follows:
• that the individual has given their explicit consent to the processing of the personal information
• that the processing is necessary to perform any legal right or obligations imposed on the organisation in connection with employment
• the processing is necessary to protect the vital interests of the individual or another person, where consent cannot be given by the individual, or the organisation cannot be reasonably expected to obtain consent, or consent is being unreasonably withheld where it is necessary to protect the vital interest of another
• the information contained in the personal information has been made public as a result of steps deliberately taken by the individual
• the processing is necessary in connection with legal proceedings, dealings with legal rights or taking legal advice

• the processing is necessary for the administration of justice or carrying out legal or public functions
• the processing is necessary for medical purposes.

Where information is given to professionals in confidence, then in addition the Common Law Duty of Confidentiality must also be considered.

Individuals’ rights under the Act
The DPA gives seven rights to individuals in respect of their own personal data held by others.
• Right of subject access
• Right to prevent processing likely to cause damage or distress
• Right to prevent processing for the purposes of direct marketing
• Right in relation to automated decision making
• Right to take action for compensation if the individual suffers damage
• Right to make a request to the Commissioner for an assessment to be made as to whether any provisions of the Act have been contravened.

Individuals’ right of access to information
Subject to certain exceptions, any living person who is the subject of information held and processed by an organisation, has a right of access to that information. Where access is refused, the individual may appeal. There are certain statutory exemptions, which may limit access rights. These include, for example, where access to a perpetrator’s details would prejudice the prevention or detection of crime.

The Common Law Duty of Confidentiality
When information is of a confidential character or nature (or given in confidence), it necessarily gains a quality of confidence. This does not mean that the information need be particularly sensitive, but simply that it must not be publicly or generally available. Information is not confidential if it is in the public domain. To decide whether an obligation of confidence exists, the following must be considered:
• whether the information has a necessary quality of confidence

• whether the circumstances of the disclosure have imposed an obligation on the confidant to respect the confidence; this usually means considering whether the information was imparted for a limited purpose.

Most of the information used by the parties to this agreement will be of a confidential nature. Therefore, as a general rule this confidential information should not be disclosed without the consent of the subject. However, the law permits the disclosure of confidential information where there is an overriding public interest or justification for doing so. Examples of this might be child protection or the prevention and detection of crime or public safety.

The Human Rights Act 1998

Article 8 (1) provides that:
Everyone has the right to respect for his private and family life, his home and his correspondence. However, this is a qualified right and Article 8 (2) states that:

“There should be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interest of national security, public safety or the economic wellbeing of the country, for the protection of the rights and freedoms of others.”

Therefore, disclosure of information will need to take Article 8 into consideration. The sharing of information may be necessary, for example, for the protection of health or morals, for the prevention of the rights and freedoms of others, or for the protection of disorder and crime.

Freedom of Information Act 2000

The Freedom of Information Act 2000 grants a right of access to any information held by public authorities, unless there are valid legal reasons why this information should not be disclosed. It is intended to promote a culture of openness and to facilitate a better public understanding of how public authorities carry out their duties, the reasoning behind their decisions, and how public money is spent.

The Freedom of Information Act 2000 does not interfere with the public authority’s obligation to protect personal or confidential data, nor does it inhibit an individual’s right to access their own personal information, as prescribed under the Data Protection Act 1998.

Public authorities have an obligation under the Freedom of Information and Data Protection Acts to consider requests from any person or organisation for access to any information that they hold. This may include safeguarding adult information, including the minutes of meetings and information shared by any other party in connection with safeguarding adult investigations.

Public authorities will not release information if any of the exemptions defined in the Freedom of Information Act 2000 or Data Protection Act 1998 apply. The exemptions include personal information, information supplied in confidence, information for which a claim to legal professional privilege can be maintained, and information where disclosure would prejudice the effective conduct of social work.

There may be circumstances where information relating to safeguarding adult investigations is released, but only where it is appropriate to do so. A situation where information may be released would be where a case has been concluded with no concerns regarding the safety of those involved, and where permission has been received from all relevant parties for the disclosure of the information. However, advice should always be sought from the Legal, Data Protection, Information Governance and Caldicott Guardian as appropriate.

The Crime and Disorder Act 1998

This Act was introduced to provide measures to prevent crime and disorder and anti-social behaviour in the community.

Section 115 of the Act provides that any person can lawfully disclose information where necessary or expedient for the purposes of any provision of the Act, to a chief officer or police, a police authority, a local authority, a probation service or a health authority, even if they do
not otherwise have this power. This power also covers disclosure to people acting on behalf of any of the named bodies. The “purposes” of the Act include a range of measures such as local crime audits, the role of the youth offending team, anti-social behaviour orders, sex offender orders and local child curfew schemes. However, the use of Section 115 must be considered on a case-by-case basis, and must still be compliant with the principles of the DPA.

The Children Act 1989

Section 47 of the Children Act 1989 places a duty on local authorities to make enquiries where they have reasonable cause to suspect that a child in their area may be at risk of suffering significant harm. Section 47 states that unless in all the circumstances it would be unreasonable for them to do so, the following authorities must assist a local authority with these enquiries if requested, in particular by providing relevant information:

- any local authority
- any local education authority
- any housing authority
- any health authority
- any person authorised by the Secretary of State.

A local authority may also request help from those listed above in connection with its functions under Part 3 of the Act. Part 3 of the Act, which comprises of sections 17 - 30, allows for local authorities to provide various types of support for children and families. In particular, section 17 places a general duty on local authorities to provide services for children in need in their area. Section 27 requires that where such an authority could, by taking any specified action, help in the exercise of any of their functions under Part 3 of the Act, other authorities are required to co-operate with a request for help so far as it is compatible with their own statutory duties and does not unduly prejudice the discharge of any of their functions.

The Children Act 2004

Section 10 of the Act places a duty on each children’s services authority to make arrangements to promote co-operation between itself and relevant partner agencies to improve the well-being of children in their area in relation to:

- physical and mental health, and emotional well-being
- protection from harm and neglect
- education, training and recreation
- making a positive contribution to society
- social and economic well-being.

The relevant partners must co-operate with the local authority to make arrangements to improve the well-being of children. The relevant partners are:

- District Councils
- The Police
- The Probation Service
- Youth Offending Teams (YOTs)
- Clinical Commissioning Groups

This statutory guidance for Section 10 of the Act states good information sharing is key to successful collaborative working and arrangements under this section should ensure information is shared for strategic planning purposes and to support effective service delivery. It also states these arrangements should cover issues such as improving the understanding of the legal framework and developing better information sharing practice between and within organisations.

Section 11 of the Act places a duty on key persons and bodies to make arrangements to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children. The key people and bodies are:

- Local Authorities (including District Councils)
- The Police
- The Probation Service
- bodies within the National Health Service (NHS)
• Connexions
• Youth Offending Teams
• Governors/Directors of Prisons and Young Offender Institutions
• Directors of Secure Training Centres
• The British Transport Police.

The Section 11 duty does not give agencies any new functions, nor does it override their existing ones, it simply requires them to:

• carry out their existing functions in a way that takes into account the need to safeguard and promote the welfare of children
• ensure services they contract out to others are provided having regard to this need (to safeguard and promote the welfare of children).

In order to safeguard and promote the welfare of children, arrangements should ensure that:

• all staff in contact with children understand what to do and are aware of the most effective ways of sharing information if they believe a child and family may require targeted or specialist services in order to achieve their optimal outcomes;
• all staff in contact with children understand what to do and when to share information if they believe that a child may be in need, including those children suffering or at risk of significant harm.

**Education Act 2002**

The duty laid out in Section 11 of the Children Act 2004 mirrors the duty imposed by Section 175 of the Education Act 2002 on LEAs and the governing bodies of both maintained schools and further education institutions. This duty is to make arrangements to carry out their functions with a view to safeguarding and promoting the welfare of children and follows the guidance in Safeguarding Children in Education (DfES 2004).


Section 21 of the Act, as amended by Section 38 of the Education and Inspections Act 2006, places a duty on the governing body of a maintained school to promote the well-being of pupils at the school. Well-being in this section is defined with reference to Section 10 of the Children Act 2004 (see paragraph 5.5 above). The Act adds that this duty has to be considered with regard to any relevant Children and Young Person’s Plan.

This duty extends the responsibility of the governing body and maintained schools beyond that of educational achievement and highlights the role of a school in all aspects of the child’s life. Involvement of other services may be required in order to fulfil this duty so there may be an implied power to work collaboratively and share information for this purpose.

**Children (Leaving Care) Act 2000**

The main purpose of the Act is to help young people who have been looked after by a local authority, move from care into living independently in as stable a fashion as possible. To do this it amends the Children Act 1989 (c.41) to place a duty on local authorities to assess and meet need. The responsible local authority is under a duty to assess and meet the care and support needs of eligible and relevant children and young people and to assist former relevant children, in particular in respect of their employment, education and training.

Sharing information with other agencies will enable the local authority to fulfil the statutory duty to provide after care services to young people leaving public care.

**The Care Standards Act 2000**

This Act established the National Care Standards Commission. Part V11 is specifically concerned with the protection of children and persons at risk.

Section 81 of the Act obliges the Secretary of State to keep a list of individuals, who are considered unsuitable to work with persons at risk. Section 82 provides that a person who provides care for persons at risk shall refer a
care worker to the Secretary of State for the following reasons:

- that the provider has dismissed the worker on the grounds of misconduct (whether or not in the course of his employment), which harmed or placed at risk of harm persons at risk

- that the worker has resigned, retired or been made redundant in circumstances such that the provider would have dismissed him, or would have considered dismissing him, on such ground if he had not resigned, retired or been made redundant

- that the provider has, on such grounds, transferred the worker to a position which is not a care position

- that the provider has, on such grounds suspended the worker or provisionally transferred him to a position which is not a care position but has not yet decided whether to dismiss him or to confirm the transfer.

**The Caldicott Principles**

The *Caldicott Principles* laid down by the NHS Executive must also be followed by those employed by any NHS Trust or body(?) The principles are as follows:

**Principle 1 – Justified purpose**

Every proposed use or transfer of patient identifiable information within or from an organisation should be clearly defined and scrutinized, with continuing uses regularly reviewed by an appropriate guardian.

**Principle 2 – Don’t use patient identifiable information unless it is absolutely necessary**

Patient identifiable information items should not be used unless there is no alternative.

**Principle 3 – Use the minimum necessary patient identifiable information**

When use of patient identifiable information is considered to be essential, individual items of information should be justified with the aim of reducing identifiability if possible.

**Principle 4 – Access to patient identifiable information should be on the strict ‘need to know basis’**

Only those individuals who need access to patient identifiable information should have access to it, and they should only have access to the information items that they need to see.

**Principle 5 – Everyone should be aware of their responsibilities**

Action should be taken to ensure that those handling patient identifiable information, both clinical and non-clinical staff, are aware of their responsibilities and obligations to respect patient confidentiality.

**Principle 6 – Understand and comply with the law**

Every use of patient identifiable information must be lawful. Someone in each of these organisations should be responsible for ensuring the organisation complies with relevant legal requirements.

**Immigration and Asylum Act 1999**

Section 20 provides for a range of information sharing for the purposes of the Secretary of State:

- to undertake the administration of immigration controls to detect or prevent
- criminal offences under the *Immigration Act*
- to undertake the provision of support for asylum seekers and their dependents.

**Local Government Act 2000**

Part 1 of the *Local Government Act 2000* gives local authorities powers to take any steps which they consider are likely to promote the well-being of their area or the inhabitants of it.

Section 2 gives local authorities ‘a power to do anything which they consider is likely to achieve any one or more of the following objectives’:

- the promotion or improvement of the economic well-being of their area
Section 3 Multi-agency Practice Guidance

- the promotion or improvement of the social well-being of their area
- the promotion or improvement of the environmental well-being of their area.

Section 2 (5) makes it clear that a local authority may do anything for the benefit of a person or an area outside their authority, if the local authority considers that it is likely to achieve one of the objectives in Section 2(1).

Section 3 is clear that local authorities are unable to do anything (including sharing information) for the purposes of the well-being of people - including children and young people - where they are restricted or prevented from doing so on the face of any relevant legislation, for example, the Human Rights Act, the Data Protection Act or by the Common Law Duty of Confidentiality.

Criminal Justice Act 2003

Section 325 of this Act details the arrangements for assessing risk posed by different offenders.

The “responsible authority” in relation to any area, means the Chief Officer of Police, the local Probation Board and the Minister of the Crown exercising functions in relation to prisons, acting jointly.

The responsible authority must establish arrangements for the purpose of assessing and managing the risks posed in that area by:

a) relevant sexual and violent offenders
b) other persons who, by reason of offences committed by them, are considered by the responsible authority to be persons who may cause serious harm to the public (this includes children). In establishing those arrangements, the responsible authority must act in co-operation with the persons identified below and co-operation may include the exchange of information.

The following agencies have a duty to co-operate with these arrangements:

- every youth offending team established for an area
- the Ministers of the Crown, exercising functions in relation to social security, child support, war pensions, employment and training
- every local education authority
- every local housing authority or social services authority
- every registered social landlord who provides or manages residential accommodation
- every health authority or strategic health authority
- every primary care trust or local health board
- every NHS trust
- every person who is designated by the Secretary of State as a provider of electronic monitoring services.

National Health Service Act 1977

The National Health Service Act 1977 Act provides for a comprehensive health service for England and Wales to improve the physical and mental health of the population and to prevent, diagnose and treat illness.

Section 2 of the Act provides for sharing information with other NHS professionals and practitioners from other agencies carrying out health service functions that would otherwise be carried out by the NHS.

National Health Service Act 2006

Section 82 of the National Health Service Act 2006 places a duty on NHS bodies and local authorities to co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

The Mental Capacity Act 2005

There will be circumstances where an individual adult appears not to be able to make a decision about whether to consent to information being shared with others.
The Mental Capacity Act and the associated code of practice contain guidance about the consideration of a person’s capacity, or lack of capacity, to give consent to sharing information. The starting assumption must be that the person has capacity unless it is established that they do not, and only then after all practical steps to help the person make the relevant decision have been taken but have been unsuccessful. An unwise decision taken by the relevant person does not mean they lack capacity. Where a decision is made on behalf of the person who lacks capacity to share personal information, it must still comply with the requirements of the Data Protection Act and be in their best interests.

Sharing health information can be a contentious area. There is guidance from professional health bodies, which NHS staff refer to, as well as local health trust policies. Local practice agreements need to be in place to ensure consistency across health and social care agencies and it is advisable to find out what these arrangements are when seeking the co-operation of health care staff. In general terms there are two pieces of relevant legislation, outlined briefly below.

Safeguarding Vulnerable Groups 2006

The purpose of the Safeguarding Vulnerable Groups Act 2006 is to restrict contact between children and persons at risk and those who might do them harm.

While the 2006 Act itself is very complex, its key principles are straightforward and they are as follows:

- unsuitable persons should be barred from working with children (or persons at risk);
- employers should have a straightforward means of checking that a person is not barred from working with children (or persons at risk);
- suitability checks should not be one-offs: they should be an element of ongoing assessment of suitability to catch those who commit wrongs following a suitability check.

The Protection of Freedoms Act 2012

The Protection of Freedoms Bill was gained royal assent on 1 May 2012 and includes a reform of the vetting and barring and criminal records regime and a change in the law to allow people who were prosecuted for consensual sex with a person aged 16 or over, at a time when this was illegal, to apply to have their convictions removed from the Police National Computer and other police records if they meet the conditions laid down in the Protection of Freedoms Act 2012.

As a result, if the individual has successfully applied to have them removed, these historical convictions will no longer be released as part of a DBS check.

The Disclosure and Barring Service was introduced in December 2012 and brought together the Independent Safeguarding Authority and the Disclosure and Barring Service and more information can be found at http://www.homeoffice.gov.uk/agencies-public-bodies/dbs/services/
Roles and Responsibilities

Commissioners and Contractors

Commissioners and contractors of services should set out clear expectations of provider agencies and monitor compliance to defined quality standards or benchmarks. NHS commissioners have responsibilities for commissioning high quality health care for all patients in their area. However, they have particular duties for those patients who are less able to protect themselves from harm, neglect or abuse, for example, due to impaired mental capacity.

All commissioners and contractors have a responsibility to:

• ensure that they play an active role in the Adult Safeguarding Boards and liaise with regulatory bodies

• ensure that managers are clear about their leadership role in safeguarding adults and assuring the quality of outcomes for people using services, the supervision and support of staff, and responding to, and investigating, a concern about a person at risk

• ensure that agencies, from whom services are commissioned and contracted with, know about and adhere to relevant CQC registration requirements, guidance and CQC Essential Standards of Quality and Safety

• ensure that all documents such as service specifications, invitations to tender, service contracts and service level agreements adhere to the Multi-agency Safeguarding Adults Policy and Procedures

• commission a workforce with the right skills to understand and implement adult safeguarding principles

• ensure staff have received induction and training appropriate to their levels of responsibility

• ensure that people who commission their own care are given the right information and support to do so from providers who engage with safeguarding adults principles and protocols

• ensure that the commissioning and contracting of services such as brokerage services includes information on safeguarding and dignity

• ensure that services are commissioned in a way that raises service users’ and carers’ expectations in relation to quality of services

• ensure that commissioning staff develop links with front-line staff to review performance of providers in relation to complaints, standards of care and safeguarding

• ensure that contract monitoring has a clear focus on safeguarding and dignity, and that any shortfalls in standards are actively addressed

• ensure that commissioning and contracting regularly audit reports of risk and harm and require providers to address any issues identified

• ensure that reporting across providers is tracked, and under or over reporting patterns are addressed

• ensure that when there is a pattern of concerns, a root cause analysis is carried out and where appropriate, a safeguarding referral is made

• ensure that there is robust, timely action when standards in services place service users at risk.

All staff and volunteers

All staff and volunteers from any service or setting should have in place adult safeguarding policy and procedures. Staff and volunteers from any service or setting who have contact with
persons at risk have a responsibility to be aware of issues of abuse, neglect or exploitation. This includes personal assistants paid for from direct payments or personal budgets.

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

Managers

All Managers in any service or setting should ensure that they:

• make staff aware of their duty to report any allegations or suspicions of abuse to their line manager, or if the line manager is implicated, to another responsible person or to the local authority

• meet their responsibilities under the Health and Social Care Act 2008 and ensure compliance with the CQC Essential Standards of Quality and Safety

• operate safe recruitment practices and routinely take up and check references

• adhere to and operate within their own organisation’s whistleblowing policy in relation to any member of staff who raises concerns

• link safeguarding procedures into internal quality assurance, governance and risk management processes

• have mechanisms in place to ensure that learning from investigations leads to positive change and influences practice.

Managers of ‘regulated activity’ must fulfil their legal obligations under the Safeguarding Vulnerable Groups Act 2006 and the Vetting and Barring Scheme as administered by the Independent Safeguarding Authority (update). Managers have responsibility for making checks on and referring staff and volunteers who have been found to have harmed a person at risk or put a person at risk at risk of significant harm.

Managers in regulated health settings should also report concerns as a Serious Incident Requiring Investigation (SIRI) in line with clinical governance procedures and a decision must be made whether the circumstances meet the criteria for raising a safeguarding alert in line with the Multi-agency Safeguarding Adults Policy and Procedures.

Local authorities

Local authorities with social services responsibilities have the lead co-ordinating role for safeguarding adults at risk of abuse, neglect or exploitation. This includes the co-ordination of the application of this Policy and Procedures; co-ordination of activity between organisations; review of practice; facilitation of joint training; dissemination of information; and monitoring and review of progress within the local authority area.

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

Elected Members (Councillors)

Elected members have the following responsibilities in relation to safeguarding adults:

• they and their fellow councillors understand their responsibilities for safeguarding persons at risk

• the corporate strategy identifies the council’s role in safeguarding persons at risk and what priority this is given

• the council formally considers the annual report of the Safeguarding Adults’ Board, and the issues this identifies for the local council area.

Director of Adult Social Services

The Director of Adult Social Services has specific responsibilities under statutory guidance issued by the Department of Health. Within adult social services, the director has a responsibility to:
• maintain a clear organisational and operational focus on safeguarding adults
• make sure relevant statutory requirements and other national standards are met
• make sure DBS (update) standards are met.
The Director is also responsible for either chairing, or ensuring the effective chairing of, the local Safeguarding Adults Board.

Police
Hampshire Constabulary is determined to achieve equality of outcome for victims of crime. It is recognised that the impact of events which lead to the provision of police services differ according to the needs of the recipient. All police officers and staff in the Constabulary must take into consideration that persons at risk in particular may have difficulty in engaging with the police service due to learning difficulties or other disabilities as well as cultural, language or other communication difficulties.

It is the responsibility of the police to lead investigations where criminal offences are suspected by preserving and gathering evidence at the earliest opportunity. Where necessary the police will interview the alleged victim, the alleged person causing harm, and any witnesses. As the lead investigating agency they will work with the local authority and other partner agencies in line with the Safeguarding Adults Policy and Procedures to ensure that all relevant information is shared and identified risks are acted on with a risk management or Safeguarding Plan being agreed at an early stage.

In cases where criminal proceedings are deemed inappropriate, the police will work with partnership agencies in order to share information and agree courses of action to effectively safeguard adults at risk of harm.

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

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

Managers of health services, their commissioners and regulators will also need assurance that where harm or abuse occurs, responses are in line with local Multi-agency Safeguarding Adults Procedures and national frameworks for Clinical Governance and investigating patient safety incidents. Health services must produce clear guidance to managers and staff that sets out who is responsible for any decision making processes and for initiating action under the above processes and to support clarity about what constitutes a safeguarding adults incident.

Safeguarding in the NHS encompasses:
• a patient centred approach to how services are commissioned and assured
• leading an organisational culture that safeguards patients
• using systems and processes that support safeguarding and connect aligned areas
• developing partnerships with patients, public and multi-agency partners
• using robust assurance to understand and improve safeguarding adults arrangements
• commissioners working with providers, regulators and multi-agency partners to address concerns in services.

NHS managers and boards
Managers and boards have responsibility for implementing six fundamental actions to safeguard adults:
• use the safeguarding principles to shape strategic and operational safeguarding arrangements
• set safeguarding adults within the strategic objectives of the service
• use integrated governance systems and processes to prevent abuse occurring and respond effectively where harm does occur
• work with the local Safeguarding Adults Board, patients and community partners to create safeguards for patients
• provide leadership to safeguard adults
• ensure accountability and use learning within the service and the partnership to bring about improvement.

Health practitioners
Health care staff are often working with patients who, for a range of reasons, may be less able to protect themselves from neglect, harm or abuse. Health care practitioners play a vital role in prevention and reporting, responding and supporting the recovery of adults who may have experienced or are at risk of abuse.

Clinical Commissioning Groups
CCGs are groups of GPs that will, from April 2013, be responsible for designing local health services in England. They will do this by commissioning or buying health and care services including elective hospital care, rehabilitation care, urgent and emergency care, most community health services, mental health and learning disability services

General Practitioners (GPs)
The British Medical Association issued Safeguarding Persons at risk – a Tool Kit for General Practitioners in October 2011, which contains the following guidance for GPs:

“Where doctors or other health professionals suspect that a serious crime may have been, or may be about to be, committed, action should be taken as a matter of urgency. Although health professionals owe a duty of confidentiality to all their patients, this duty is not absolute. Where an adult has the relevant decision making capacity, they retain the freedom to decide how best to manage the risks to which they may be exposed, including whether a referral through multi-agency procedures would help them. Where other individuals may be at risk of harm, however, or where there is concern that a serious crime may be, or may have been, committed a referral must be made through appropriate procedures. In these circumstances health professionals should discuss the matter with the social services adult protection team as a matter of urgency. It may also be necessary directly to contact the police.”

The toolkit also refers to measures GPs should consider in relation to information sharing, reporting wider patient safety concerns and concerns in relation to regulated services and colleagues.

Ambulance Service
There are a number of ways in which staff may receive information or make observations which suggest that a person at risk has been abused or is at risk of harm. Staff will often be the first professionals on the scene and their actions and recording of information may be crucial to subsequent enquiries.

Staff will not investigate suspicions and, if there is someone else present, will avoid letting the person know they are suspicious. If the patient is conveyed to hospital, the staff should inform a senior member of the A&E staff, or nursing staff if conveying to another department, of their concerns about possible abuse. They will complete a patient report form and give a copy to the staff at A&E or other location where clinical responsibility is being handed over. Staff should also follow local procedures for contacting the local authority.

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

PALS staff are in a position to recognise that a concern which is raised with them either by a patient or a carer or friend could indicate that the person is at risk of abuse or neglect. They should raise that concern with their own health trust via senior managers and safeguarding adults leads and raise an alert to the relevant local authority to ensure that appropriate action is taken under the Multi-agency Safeguarding Adults Policy and Procedures.

**Faith communities**

Churches, other places of worship and faith-based organisations provide a wide range of activities for persons at risk and have an important role in safeguarding persons at risk and supporting their families. Religious leaders, staff and volunteers who provide services in places of worship and in faith-based organisations will have various degrees of contact with persons at risk.

Like other organisations that work with persons at risk, churches, other places of worship and faith-based organisations need to have appropriate arrangements in place for safeguarding and promoting the welfare of persons at risk. In particular these should include:

- procedures for staff and others to report concerns that they may have about the abuse, neglect or exploitation of a person at risk
- appropriate codes of practice for staff, particularly those working directly with persons at risk
- safe recruitment procedures, alongside training and supervision of staff (paid or voluntary).

**HealthWatch**

HealthWatch will be a new independent consumer champion and a statutory part of the Care Quality Commission (CQC), to champion services users and carers across health and social care.

**At local level**

- Local HealthWatch organisations will ensure that the views and feedback from patients and carers are an integral part of local commissioning across health and social care.
- Local authorities will be able to commission local HealthWatch or HealthWatch England to provide advocacy and support, helping people access and make choices about services, and supporting individuals who want to make a complaint. In particular, they will support people who lack the means or capacity to make choices; for example, helping them choose which General Practice to register with

- Local HealthWatch will be funded by and accountable to local authorities, and will be involved in local authorities’ new partnership functions. To reinforce local accountability, local authorities will be responsible for ensuring that local HealthWatch are operating effectively, and for putting in place better arrangements if they are not.

- Local HealthWatch will provide a source of intelligence for national HealthWatch and will be able to report concerns about the quality of providers, independently of the local authority.

**At national level**

- HealthWatch England will provide leadership, advice and support to local HealthWatch, and will be able to provide advocacy services on their behalf if the local authority wishes.
- HealthWatch England will provide advice to the Health and Social Care Information Centre on the information which would be of most use to patients to facilitate their choices about their care.
- HealthWatch England will provide advice to the NHS Commissioning Board, Monitor and the Secretary of State.
- Based on information received from local HealthWatch and other sources, HealthWatch England will have powers to propose CQC investigations of poor services.
Monitor

Monitor is the independent regulator of NHS Foundation Trusts. They were established in January 2004 to authorise and regulate NHS foundation trusts. They are independent of central government and directly accountable to Parliament.

The three main strands to their work are:

• determining whether NHS trusts are ready to become NHS foundation trusts
• ensuring that NHS Foundation Trusts comply with the conditions they signed up to – that they are well-led and financially robust
• supporting NHS Foundation Trust development.

Fire & Rescue Service

Fire & Rescue personnel visit people in their homes when carrying out a Home Safety Check. Where personnel have a concern about a person at risk in respect of abuse, neglect or exploitation, they must follow their internal safeguarding procedure.

Staff undertaking Fire Safety (Protection) visits in residential/institutional settings should be trained to recognise a concern and report it through the service procedure.

Where other agencies visit people in their homes, Fire & Rescue advises those employees to look for any indication of fire risk. This may include: burn marks made by carelessly discarded smoking materials; evidence of hoarding, where access may be impeded or could be fuel for a potential fire; and a build-up of grease on cooking equipment (chip pans in particular).

The use of oxygen is also noteworthy, particularly where the user is also a smoker. This situation would trigger an immediate Home Safety Check. Employees from other agencies are not expected to become fire safety experts or to deal with risks they may observe, but they should be aware of the potential risk and make a referral through to their local Fire & Rescue Service so that they can make contact with the occupier to arrange for a Home Safety Check.

Care Quality Commission (CQC)

The CQC regulates and inspects health and social care services including domiciliary services and protects the rights of people detained under the Mental Health Act 1983. They have a role in identifying situations that give rise to concern that a person using a regulated service is or has been at risk of harm, or may receive an allegation or a complaint about a service that could indicate potential risk of harm to an individual or individuals. CQC Safeguarding Protocol describes their role in safeguarding both children and adults. It covers all the relevant health and social care sectors for which CQC has regulatory responsibility. It provides the principles for how CQC will work to help ensure people are protected. It may also provide helpful guidance for stakeholders, providers of services and members of the public on the role of CQC in local safeguarding procedures.

Office of the Public Guardian (OPG)

The Office of the Public Guardian ‘Safeguarding Persons at risk Policy’ states that the organisation will strive to ensure that persons at risk receive their entitlement to safeguards that:

• prevent abuse from occurring and/or continuing, where possible
• identify abuse promptly
• ensure the abuse ceases and the person causing harm is dealt with, wherever possible.

The OPG also undertakes to notify local authorities, the police and other appropriate agencies when an abuse situation is identified.

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

• promoting and raising awareness of legal safeguards and remedies, for example, lasting powers of attorney and the services of the OPG and the Court of Protection
• receiving reports of abuse relating to persons at risk (‘whistleblowing’)
• responding to requests to search the register of deputies and attorneys (provided free of charge to local authorities and registered health bodies)
• investigating reported concerns, on behalf of the Public Guardian, about the actions of a deputy or registered attorney, or someone acting under a single order from the court
• working in partnership with other agencies, including adult social care services and the Police.

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

Local authorities can use the OPG protocol to refer concerns to the OPG relating to anyone who falls within the OPG definition of a vulnerable adult, as given above. The OPG will refer all concerns and allegations relating to people not covered by the OPG Safeguarding Persons at risk Policy to the relevant adult social care service. Where it is considered that a crime has or may have been committed, a report will be made to the police.

Housing organisations

Staff who work in housing organisations are in a position to identify tenants who are vulnerable and are at risk of abuse, neglect and exploitation. The Supporting People (SP) programme has become a major mechanism for the housing and support needs for adults with a wide range of needs. The quality of SP providers’ services is regulated through the Quality Assessment Framework, which includes standards that they must meet with regard to safeguarding adults from abuse. In addition to recognising the risks of abuse of adults to whom they provide accommodation, and in many cases care, staff of housing organisations have an important part to play in establishing Safeguarding Plans.

Crown Prosecution Service (CPS)

The CPS is the principal public prosecuting authority for England and Wales and is headed by the Director of Public Prosecutions. The CPS has produced a policy on prosecuting crimes against older people which is equally applicable to adults at risk, who may also be vulnerable witnesses.

Support is available within the judicial system to support adults at risk to enable them to bring cases to court and to give best evidence. If a person has been the victim of abuse that is also a crime, their support needs can be identified by the police, the CPS and others who have contact with the vulnerable adult. Witness Care Units exist in all judicial areas and are run jointly by the CPS and the police.

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

These include the use of trained intermediaries to help with communication, screens and arrangements for evidence and cross-examination to be given by video link.

Coroners

Coroners are independent judicial officers who are responsible for investigating violent, unnatural deaths or sudden deaths of unknown cause, and deaths in custody, which must be reported to them. The Coroner may have specific questions arising from the death of a vulnerable adult. These are likely to fall within one of the following categories:

• where there is an obvious and serious failing by one or more organisations
• where there are no obvious failings, but the actions taken by organisations require further exploration/explanation
• where a death has occurred and there are concerns for others in the same household or other setting (such as a care home)
• deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions are identified by the Coroner or his or her officers

In the above situations the local Safeguarding Adults Board should give serious consideration to instigating a Serious Case Review.

Probation Service
The Probation Service protects the public by working with offenders to reduce re-offending and harm. It works jointly with other public and voluntary services to identify, assess and manage the risk in the community of offenders who have the potential to do harm. Probation officers use the Offender Assessment System (OASys) to assess risk and identify factors that have contributed to offending. The Probation Service also has a remit to be involved with victims of serious sexual and other violent crimes.

The Probation Service shares information and works in partnership with other agencies including local authorities and health services, and contribute to local MAPPA (in full) to help reduce the re-offending behaviour of sexual and violent offenders in order to protect the public and previous victims from serious harm.

Although the focus of the Probation Service is on those who cause harm, they are also in a position to identify offenders who themselves are at risk from abuse and to take steps to reduce the risk to those offenders in line with the principles of this policy and procedures.

Prison Service
The Prison Service promotes the welfare of all prisoners, particularly persons at risk at risk, and protects them from all kinds of harm and neglect. Prisoners, particularly adults at risk, are provided with a safe and secure environment which protects them from harm and neglect. They receive safe and effective care and support.

Indicators
• The risks to prisoners are recognised and there are guidance and procedures to help reduce and prevent harm or abuse from occurring.
• When abuse is alleged or suspected to have occurred, prompt and appropriate action is taken to protect the prisoner.
• An individual care plan is in place to address a prisoner’s assessed needs.
• Care plans are thorough and reviewed regularly, involving staff from a range of disciplines.
• Up-to-date Government and local guidance about safeguarding adults is accessible and safeguarding procedures are known and used by all staff, including how to make referrals.
• The safeguarding policy and any prison codes of conduct are informed by the underlying five principles of the Mental Capacity Act 2005.
• Where possible, access to advocates and/or appropriate adults is in place to aid prisoners’ capacity to understand and consent.
• The prison has a code of conduct informing staff of their duty to raise legitimate concerns about the conduct of an individual in relation to the treatment and management of prisoners.
• Staff feel confident and safe to raise concerns.
• Staff are aware of their personal and professional responsibility to protect persons at risk and undergo appropriate training.
• Staff are subject to recruitment and vetting procedures which comply with necessary legislation.

Disclosure and Barring Service
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 Disclosure and Barring Service (DBS) and Independent Safeguarding Authority (ISA).
Local Area Teams (LAT)

The LAT is a local extension of the NHS Commissioning Board and will have the following core functions of clinical commissioning group development and assurance, ensuring emergency planning within the NHS to secure both resilience and response and oversight of the whole health system within their area, with a particular focus on quality and safety. The LAT will be responsible for commissioning of highly specialist services in addition to GP and dental services, pharmacy and certain aspects of optical services.
Glossary

This glossary is not an exhaustive list, but reflects some of the key words or terms that could be used in all aspects of adult safeguarding work.

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

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

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

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 a person at risk is or may be a victim of abuse, neglect or exploitation. 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.

Assessment is a process to gather information, assess the health and social care needs of an vulnerable person at risk of abuse, or of an adult who may have caused harm.

CAADA (Co-ordinated Action Against Domestic Abuse) is a national charity supporting a strong multi-agency response to domestic violence. The CAADA DASH (Domestic Abuse, Stalking and Harassment and Honour-based violence) risk identification checklist (RIC) was developed by CAADA and the Association of Chief Police Officers (ACPO).

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 vulnerable adult. Paid workers, including personal assistants, whose job title may be 'carer', are called 'staff' within this document.

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.

Central Referral Unit is where all adult safeguarding referrals to the police are received, risk assessed, graded and allocated for action by the most appropriate police team and/or partner agency.

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

Community Safety Partnerships bring agencies and communities together to tackle crime within their communities. Community Safety Partnerships (CSPs) are made up of representatives from the responsible authorities, these are:

- Police
- Police authorities
- Local authorities
- Fire and Rescue authorities
- Local health boards (LHBs) in Wales
- Primary care trusts (PCTs) in England (update)
- Probation

Community Safety Partnerships were set up as statutory bodies under Sections 5-7 of the Crime and Disorder Act 1998.
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.

CONTEST is the government’s counter-terrorism strategy, whose aim is to:
- respond to the ideological challenge of terrorism and the threat from those who promote it
- prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support
- work with sectors and institutions where there are risks of radicalisation that need to be addressed.

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.

Disclosure and Barring Service
The Disclosure and Barring Service (DBS) was established in 2012 through the Protection of Freedoms Act and merges two former organisations, the Criminal Records Bureau and the Independent Safeguarding Authority. The DBS is designed to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable adults. The DBS search police records and barring lists of prospective employees and issue DBS certificates. They also manage central barred lists of people who are known to have caused harm to vulnerable adults.

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.

Domestic Violence and Abuse is defined as ‘any incident of controlling, coercive or threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality’. Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family; (Home Office 2012).

Domestic Homicide Reviews are commissioned by local Safer Communities Partnerships in response to deaths caused through cases of domestic violence. They are subject to the guidance issued by the Home Office in 2006 under the Domestic Violence Crime and Victims Act 2004. The basis for the domestic homicide review (DHR) process is to ensure agencies are responding appropriately to victims of domestic abuse offering and/or putting in place suitable support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence.

EDO (Emergency Duty Officer) is the social worker on duty in the emergency duty team (EDT).

FACS (Fair Access to Care Services) is a system for deciding how much support people with social care needs can expect, to help them cope and keep them fit and well. It applies to all
the local authorities in England. Its aim is to help social care workers make fair and consistent decisions about the level of support needed, and whether the local council should pay for this.

**HSE (Health and Safety Executive)** is a national independent regulator that aims to reduce work-related death and serious injury across workplaces in the UK.

**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 agreed within a strategy discussion or meeting undertaken by a member of staff of an organisation who has a lead responsibility to investigate the allegations of abuse.

**LGBT (Lesbian, Gay, Bisexual and Transgender)** is an acronym used to refer collectively to lesbian, gay, bisexual and transgender people.

**MAPPA (Multi-agency Public Protection Arrangements)** are statutory arrangements for managing sexual and violent offenders.

**MARAC (Multi-agency Risk Assessment Conference)** is the multi-agency forum of organisations that manage high risk cases of domestic abuse, stalking and 'honour'-based violence.

**Mental Capacity** refers to whether someone has the mental capacity to make a decision or not.

**NHS (National Health Service)** is the publicly funded health care 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.

**Out of Hours or 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.

**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 service created to provide advice and support to NHS patients and their relatives and carers.

**Prevent** is a Government strategy, launched in 2007, which seeks to stop people becoming terrorists or supporting terrorism. It is the preventative strand of the government’s counter-terrorism strategy, CONTEST.

**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.

**Referral** - an alert becomes a referral when it is passed on to a safeguarding adults referral point and accepted as a safeguarding adults referral.

**Safeguarding Adults Process** refers to the decisions and subsequent actions taken on receipt of a referral. This process can include a strategy meeting or discussion, an investigation, a case conference, a care/protection/safety plan and monitoring and review arrangements.

**Safeguarding Adults Work** is used to describe
all work to help adults at risk stay safe from significant harm.

**Safeguarding Assessment** is the process to gather information to assess the health and social care needs of a person at risk experiencing abuse, neglect or exploitation or of an adult who may have caused harm.

**Safer Neighbourhood Teams** are local police working with local people and partner agencies to identify and tackle issues of concern in their area to make neighbourhoods safer.

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

**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.

**SIRI (Serious Incident Requiring Investigation)** is a term used 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.

**Specialist Services** are dedicated teams or services provided for particular service user groups. Examples include Mentally Disordered Offenders Service (MENDOS) and Eating Disorders Services.

**Strategy Discussion** is a multi-agency discussion between relevant organisations, and which include the vulnerable adult, to agree how to proceed with the referral. It can be face-to-face, by telephone or by e-mail.

**Strategy Meeting** is a multi-agency face-to-face meeting, with a chairperson and the relevant individuals involved, including the person 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** or Ill Treatment is an intentional or deliberate omission or failure to carry out an act of care by someone who has care of a person who lacks capacity to care for themselves. *Section 44 of the Mental Capacity Act 2005* makes it a specific criminal offence to wilfully ill-treat or neglect a person who lacks capacity.
Resources and Links

The Human Rights Act 1998
http://www.opsi.gov.uk/ACTS/acts1998/ukpga_19980042_en_1

The European Convention on Human Rights

Data Protection Act 1998
http://www.opsi.gov.uk/acts/acts1998/ukpga_19980029_en_1
ICO guidance for organisations on Data Protection Act and other legislation including good practice notes, codes of practice and technical guidance notes

Crime and Disorder Act 1998
http://www.opsi.gov.uk/acts/acts1998/ukpga_19980037_en_1

Data Protection Act 1998 Legal Guidance, Information Commissioners Office

The Children Act 1989

The Children Act 2004

www.ecm.gov.uk/strategy/guidance

Education Act 2002
http://www.opsi.gov.uk/acts/acts2002/ukpga_20020032_en_1

Education Act 1996
http://www.opsi.gov.uk/acts/acts1996/ukpga_19960056_en_1

Learning and Skills Act 2000
http://www.opsi.gov.uk/acts/acts2000/ukpga_20000021_en_1

Special Educational Needs and Disability Act 2001

Children (Leaving Care) Act 2000
http://www.opsi.gov.uk/Acts/acts2000/ukpga_20000035_en_1

Mental Capacity Act 2005
http://www.opsi.gov.uk/acts/acts2005/ukpga_20050009_en_1

Mental Capacity Act: 2005 Code of Practice (DCA, 2007)
http://www.dca.gov.uk/menincap/legis.htm#codeofpractice

Immigration and Asylum Act 1999

Local Government Act 2000
http://www.opsi.gov.uk/acts/acts2000/ukpga_20000022_en_1

Criminal Justice Act 2003
http://www.opsi.gov.uk/acts/acts2003/ukpga_20030044_en_1

National Health Service Act 1977
http://www.opsi.gov.uk/RevisedStatutes/Acts/ukpga/1977/cukpga_19770049_en_1
National Health Service Act 2006
http://www.dh.gov.uk/en/Publicationsandstatistics/Legislation/Actsandbills/DH_064103

The Adoption and Children Act 2002
http://www.opsi.gov.uk/acts/acts2002/ukpga_20020038_en_1

Further information about adoption and information sharing
http://www.everychildmatters.gov.uk/socialcare/childrenincare/adoption/

Information Sharing and Mental Health Guidance to Support Information Sharing by Mental Health Services

No Secrets 2000

4 LSCB
URL?

Freedom of Information Act 2000

Working Together to Safeguard Children
https://www.education.gov.uk/publications/standard/publicationdetail/page1/DCSF-00305-2010

Care Standards Act 2000
http://www.legislation.gov.uk/ukpga/2000/14/contents

Information Sharing: Guidance for Practitioners and Managers, HM Government 2008
http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/a0072915/information-sharing

Safeguarding Adults: the role of the Health Practitioners, Dept of Health, 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/.../DH_124882

Arrangements to secure children's and adult safeguarding in the future NHS

Other Useful Links

Health and Social Care Act 2012
http://www.legislation.gov.uk/ukpga/2012/7/enacted

Safeguarding Persons at risk Act 2006
http://www.legislation.gov.uk/ukpga/2006/47/contents

Regulated activity (adults), Dept of Health Sept 2012

http://www.charity-commission.gov.uk/our_regulatory_activity/our_approach/safeguarding_strategy.aspx